

AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

Workplace Relations Act 1996

Section 503 referral to Full Bench to make a workplace determination

Health Services Union

and

Austin Health and others

(BP2007/4059 and others)

WITNESS STATEMENT OF PETER STEWART BRADFORD

I, **PETER STEWART BRADFORD**, of Royal Melbourne Hospital, Grattan Street, Parkville, in the State of Victoria, Executive Director, say as follows:

- 1 I am the Executive Director, Clinical Governance and Medical Services for Melbourne Health (MH). In this position, I am one of 8 directors reporting directly to the Chief Executive Officer of MH. I have held this position since June 2008.
- 2 Prior to this role, I was the Executive Director of Frankston Acute and Medical Services for the Peninsula Health Service. I held that position for approximately nine years. I have worked in similar executive management positions within the health service industry since 1981.
- 3 I hold Bachelors Degrees in Medicine and Surgery, and a Masters Degree in Public Health. I am a Fellow of the Royal Australasian College of Medical Administrators and a Fellow of the Australian College of Health Service Executives.
- 4 I am authorised to make this statement on behalf of Melbourne Health. I make this statement from my own knowledge except where otherwise indicated. Where I make statements based on information provided by others, I believe such information to be true.

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Melbourne Health

5 MH comprises:

- the Royal Melbourne Hospital (**RMH**) – City Campus;
- the RMH – Royal Park campus;
- North Western Mental Health (**NWMH**);
- North West Dialysis Service (**NWDS**); and
- the Victorian Infectious Diseases Reference Laboratory (**VIDRL**).

MH's services are delivered across the two main sites (City and Royal Park campuses) and thirty-two satellite sites.

6 MH provides comprehensive acute, sub-acute and community-based health care programs to about one-third of metropolitan Melbourne's population. In addition, MH provides general and specialist services to regional and rural Victorians and a number of state-wide services (eg VIDRL). MH is also one of 3 major trauma centres for Victoria. MH is a major quaternary teaching hospital with associations with The University of Melbourne and other major universities.

7 MH has an annual budget of approximately \$700 million and employs around 8000 staff. In the 2007–08 financial year, MH's preliminary accounts indicate that the organisation will break even or make a small loss.

8 The City Campus provides both acute and sub-acute care. Acute psychiatric care is delivered at the City Campus, whilst sub-acute care is delivered at Royal Park.

9 13% of the mental health services delivered by MH are delivered on-campus. The remainder are delivered in community centres or at partner sites (ie Northern Health and Western Health sites).

10 Allied Health (AH) work is performed at each of the major MH sites and all NWMH sites.

Structure of Allied health

11 Allied health refers to a group of professional disciplines as listed below in 12 and 13 and several other disciplines. The role of allied health in health care is to work in a multidisciplinary setting with medical, nursing, and other health care staff members to prevent illness and to diagnose, treat, and rehabilitate inpatients and outpatients. Allied health professionals work

almost exclusively in a multidisciplinary setting in health care organisations but can work independently in some settings.

12 Allied Health at MH is structured into a number of different disciplines. These are:

- Physiotherapy
- Prosthetics
- Occupational therapy
- Music therapy
- Podiatry
- Social work; and
- Radiography.

I do not have direct responsibility for radiography services at MH. These report through Associate Professor Alex Cockram, Acting Executive Director of Royal Melbourne Hospital.

13 Approximately 450 EFT of Allied Health staff are employed by MH. Approximately 277 of these Allied Health staff members work in discipline-based departments and the EFT is broken down as follows:

Discipline	EFT
Music Therapist	0.88
Occupational Therapist (OT)	40.47
Orthotist/Prosthetist	5.45
Physiotherapist (PT)	60.81
Podiatrist	4.74
Radiography/Medical Imaging Technician	70.7
Recreation Therapist	2.73
Social Worker (SW)	32.22
Speech Pathologist	15.48

Other	44.02
TOTAL	277.50

- 14 The remaining EFT are provided within Mental Health services which includes services at Northern Health and Western Health. Allied Health professionals in Mental Health services comprise:

Discipline	EFT
Social work	104.5
Occupational Therapy	67.2

All of these Allied Health professionals work in multi-disciplinary teams rather than in discipline-based departments.

- 15 With the exception of music therapy, each of the Allied Health disciplines operates at both the City and Royal Park campuses. Of the Allied Health disciplines, NWMH has only social work and occupational therapy.
- 16 MH structures a number of multi-disciplinary teams to support Allied Health service delivery. These teams will consist of medical staff, nurses and Allied Health professionals from a variety of disciplines, depending on the needs of the particular program or service. Mental health services are all provided in multi-disciplinary teams.
- 17 Each of the chiefs of the various Allied Health disciplines operates on a cross-campus basis. They report directly to the Allied Health Manager, who in turn reports to me as the Executive Director Clinical Governance and Medical Services.
- 18 Now produced and shown to me and marked "**Exhibit PB-1**" is a chart showing the managerial structure of MH's Allied Health services. This structure was negotiated directly with the HSU and implemented in 2005 through the existing change management processes. Extensive consultation took place with staff. We feel it remains a relevant structure to address staff and organisational needs in a flexible way. This is further discussed in paragraphs 23 and 24 below.

Funding

- 19 Approximately 95% of MH's allied health funding comes from Department of Human Services grants. Small amounts of funding also come from Commonwealth Government grants.
- 20 In addition, we receive some money from payments in respect of patients with private health insurance and from philanthropic donations.

- 21 If MH was required to meet higher Allied Health wages costs, or other cost increases associated with implementing the workplace determination, we would be reliant upon the Department of Human Services to fund this increase in costs. The only other alternative would be if we could create savings within MH's existing structure in order to fill the funding gap. These savings would have to involve redesigning our service delivery program and this might require a re-assessment of the number of Allied Health positions that are required to deliver our services. If it was necessary to reduce service delivery to core services only, then it is also likely that we would not employ as many Allied Health professionals. This would negatively impact on Allied Health professionals since there would not be as many jobs available, but it would also reduce our service delivery capabilities. Non-critical services might experience greater delays and some programmes might have to be cut altogether. These decisions would be taken with a view to patient flow. This rationalisation of the workforce would be our only option if we faced increased wages costs, but did not receive an equivalent increase in external funding.
- 22 The types of non-critical services that might be affected include Allied Health assistants, non-direct patient services such as administration and training, and clinical services which the team or department manager determines to be non-time-critical or non-essential on a case by case basis.
- 23 MH currently has a structure which provides for additional positions that are not mandated by the workplace agreement that currently governs the terms and conditions of employment for Allied Health professionals at MH. The positions of Workforce Development Manager (1.2 EFT), Education Manager (1 EFT) and Service Development Manager (0.6 EFT) are not a requirement under the current award, but these positions have been created as part of a structure that was negotiated between management and staff. These positions are at Chief Grade 3/Grade 4 level. In my view, it represents a progressive structure that delivers good outcomes for staff and patients. The development and education positions described above support staff development and improvements in skill sets and competencies. They coordinate training programs and streamline the delivery of education services at MH. By raising competency levels, the improved delivery of training has a direct beneficial impact on the quality of patient care. The Workforce Development Managers also deputise for the Allied Health managers when they are on leave, and so provide for continuity of management and strategic decision making.
- 24 If MH had to fund new positions or substantially increase existing salaries, this would jeopardise our progressive structures. This would result in a wastage of the significant investments of time and effort that were required to establish the structures in the first place, and would result in a less efficient service delivery system because staff would no longer have the current level of support in developing innovative and improved service models and techniques.

- 25 For instance, if MH had to fund additional chief positions, this would mean that some of the above roles that have been introduced in recent times might have to be abandoned. These additional positions would be jeopardised under any new move to alternative structures as foreshadowed by the Health Services Union (**HSU**). I have outlined above the possible impact of losing these additional positions.

Matters claimed in draft Health Services Union Workplace Determination

- 26 I am aware of the claims made by the HSU in its draft workplace determination (**HSU proposal**). In relation to those claims, I make the following comments.

Chief Structures

- 27 In clause 21.10.7 of the HSU proposal, the HSU are seeking a Chief Structure that would require a Chief of each discipline on every campus, plus an overarching Senior Chief per discipline.
- 28 As shown in the MH organisational chart, Allied Health managers work across the City and Royal Park sites. The Chief for each of the disciplines is a cross-campus role and they report to the Director of Allied Health. We employ one Chief per department and there is no one who is called a Senior Chief. At the mental health sites, a multidisciplinary arrangement applies, with the Allied Health professionals reporting to program managers or team leaders rather than within discipline-specific departments.
- 29 These arrangements are well established and provide clear reporting lines. For example, a social worker who works in the emergency department is professionally and operationally accountable to the Chief of Social Work, although from a practical perspective they would take some day-to-day direction from the leader of the emergency team. However, a social worker in mental health is operationally accountable to the relevant team leader. The mental health social worker is also primarily accountable on a professional level to their multidisciplinary team leader, although the Chief of Social Work might provide some advice or assistance on a more remote basis. The Chief of Social Work's involvement would be more an availability to assist on request rather than day-to-day professional accountability.
- 30 Chiefs currently work approximately half time on each of the two main campuses. Technology is employed to ensure that there is sufficient communication between clinicians and chiefs at the various campuses.
- 31 In my view, whilst it might be appropriate to appoint a separate discipline chief at each site where there was a significant distance between the sites, and if the Chief at one site was unable to provide appropriate professional or operational supervision to Allied Health staff at the other site because of that distance, this is not the case at MH. The Royal Park site is only two kilometres from the Royal Melbourne site. Allied health managers work across both sites and

the Allied Health Director also works at both sites. All managers have mobile phones and are contactable by email. There are offices at both campuses that support the structure.

- 32 To have a Chief of each discipline at both our major sites would not improve the quality of service delivery and would impose additional costs which the health service would be unable to meet. It is also unnecessary when the existing Chiefs are already available to deal with any matters that arise.
- 33 The employment and allocation of Chiefs to a site should be a decision made by having regard to the particular circumstances of the service and the site. Relevant factors would include the number of staff, the level of service demand, the ease of communication between sites and the relative seniority of other staff within the discipline. The health service needs to have the flexibility to appoint Chiefs on a needs basis rather than in accordance with strict rules.
- 34 For MH, employing a chief of each discipline at every site would take money away from education, from developing the workforce and, most importantly, from having sufficient clinicians on the ground performing core services.

Allied Health staff profile

- 35 Clause 18 and Schedule 2 of the HSU proposal are seeking a staffing profile at the Grade 1-3 levels of an equal 1/3 ratio per grade.
- 36 Currently, MH has what we would describe as a pyramid structure that represents how Allied Health professionals are engaged at various grades. We also have Allied Health Assistants (**AHAs**) who support the work of the specific disciplines. These AHAs are available to perform some of the more routine aspects of Allied Health treatment, to leave the Allied Health professional free for more complex diagnostic work. AHAs might have a Certificate 3 from TAFE or they might have trained on the job. They will always be closely supervised by the allied health professional.
- 37 The way the pyramid structure works is that, for example, in the physiotherapy department at both the City and Royal Park Campuses, the bulk of the Allied Health professionals are in the Grade 1 and 2 classifications. This is because of patient requirements. We need a greater proportion of staff performing straightforward clinical duties, as opposed to teaching, administration or senior clinical positions. There would simply not be enough people to actually perform the day-to-day work if we did not have this number of Grade 1 and 2s. If we had to employ an equal number of Grade 3s then the department would be too top-heavy and there would be insufficient workload to sustain those Grade 3 positions.
- 38 MH is of the view that our current structure is balanced and effective, and is the structure most adapted to meeting our service requirements.

- 39 The HSU's proposed changes would significantly alter our Allied Health structure, imposing additional costs which we cannot afford without providing corresponding benefits to patients or service delivery outcomes. The additional costs would come from either reclassifying existing junior employees to higher grades, or from having to increase the overall level of EFT to provide equal numbers at the higher grades.
- 40 In all disciplines at MH, the greater part of the workforce is required to be at the lower levels in order to be able to effectively clinically service patients and their health needs. It makes very little sense to have equal numbers of staff at each of the grades. This would reduce the number of staff dedicated to clinical work and would also not provide an appropriate career structure for more advanced Allied Health professionals. Having too many chiefs without enough people performing clinical work will not deliver best quality patient care, and there is no point having a Chief when there are not sufficient staff below them requiring full-time supervision and administration. MH needs to have the flexibility to be able to take a commonsense approach to determining when it is appropriate to have a chief supervising Allied Health professionals in a particular discipline, without detracting from the clear need for professional leadership and management within our organisation.

Automatic progression

- 41 Many of the amended definitions in the classification structure in Schedule 1 of the HSU proposal do not include the requirement that a person be appointed to a particular grade.
- 42 Allied Health professionals should not move up to a higher grade without being appointed to that grade, either in a substantive or acting capacity. It does not make sense to get rid of the requirement for there to be a plausible business case justifying progression. Progression should occur when there is a need for an Allied Health professional at the higher grade and when management determines that an employee at a lower grade is appropriately qualified and experienced to advance to the next grade. There is no point having people automatically progress to the higher grade if they are not capable of fulfilling the duties of the higher grade, or if there is insufficient workload to sustain the higher position.
- 43 The HSU's proposal would undermine MH's structured recruitment process, and take away our ability to manage our workforce in accordance with service needs.
- 44 In addition, it would mean that MH would be disinclined to give people opportunities to increase their skills by performing higher duties for short periods of time. MH would run the risk that these staff members would make a claim for regrading to a higher grade on the basis of actually performing the duties even after they had returned to their previous substantive role, rather than being appointed to that grade. A disinclination to give people these new opportunities and experiences would be detrimental to their development. It would also make it harder for MH to internally fill temporary vacancies caused by short-term absences.

Back-filling

- 45 Clause 49 of the HSU proposal seeks 100% backfill for all annual leave absences of 5 days or more.
- 46 MH currently does back fill positions in many of its large disciplines. We do not necessarily back fill ADO's or sick leave, and we only back fill about 50% of annual leave and long service leave absences, although this might vary across disciplines and sections. Where we do provide back-fill, we would generally only do so for absences greater than 1 week.
- 47 It is difficult to back fill individual positions for short amounts of time due to work force availability issues, patterns of work, and models of care that do not necessarily facilitate AH professionals stepping into short term roles. For example, if a prosthetist who specialises in facial prostheses is on leave for a week and we have no other facial specialist, it would be inefficient and produce a worse outcome for the patient for this person's work to be performed by another prosthetist. Similarly, a social worker may have built up strong therapeutic relationships over a period of time and this cannot be replaced by a short-term stand-in. In these circumstances, the non-critical work done by those professionals would be performed by the regular employee after their period of leave. If one of these individuals was away for a longer period, however, we would train someone to take their place.
- 48 Where positions are not back filled during leave, other allied health professionals take up the clinical load of those persons missing. Cases are triaged on the basis of their criticality, with acute services given priority. At certain times of the year, back-fill is not necessary because service demands are reduced. For example, over the Christmas period there is little elective surgery which means that we can close beds and reduce patient numbers. There is a corresponding decrease in demand for Allied Health services over this period and we in fact encourage Allied Health staff to take leave at this time. Given the reduced service demands, it would not make sense to back-fill these absences.
- 49 For these reasons, it is not necessary for the delivery of a quality service to have a compulsory requirement to provide the level of backfill sought by the HSU. We backfill to the extent required to maintain continuity and quality of care, however the health service should have the flexibility to manage its backfill requirements based on service demands as they might vary from time to time.
- 50 Further, the cost implications of 100% back fill are prohibitive. For example, in physiotherapy we currently back-fill 50% of extended absences which equates to an additional 2 EFT physiotherapists. If we were required to provide 100% back-fill in accordance with the HSU's claim, we would have to hire a further 2 full-time physiotherapists at an annual cost of approximately \$150,000 to MH.

Fixed term employees

- 51 Clause 15 of the HSU proposal would restrict MH's ability to engage employees on a fixed-term or temporary basis.
- 52 MH currently employs fixed term employees in situations where ongoing employees are taking long term leave or where short term funding sources become available. Some graduate health professionals are also on fixed term contracts.
- 53 Using fixed term contracts as permitted by the current EBA gives MH the flexibility to staff limited-term projects and longer-term temporary vacancies in accordance with fluctuating service needs. These projects and vacancies may be for more than 12 months, and without the ability to offer fixed-term employment we would struggle to fill these positions. This would mean that limited-term projects might not be able to go ahead, since we would not be financially capable of providing employment to the employee at the end of the project. It would also mean that some temporary vacancies might not be filled and other staff would have to pick up the workload of these absent employees.

Organisational change

- 54 Clause 8 of the HSU proposal seeks to impose a prescriptive and detailed change/consultation process that would have to be followed in relation to any change proposed by MH that would be likely to have a significant impact on any employee.
- 55 MH currently has an organisational change agreement with the HSU. This covers redeployment, redundancy and decision making structures for managing organisational change. These include monthly organisational change meetings, which are attended by a representative from the HSU. Our current workplace change process works well to ensure adequate consultation on the matters which are of most significance to, and have the greatest impact on, employees.
- 56 Currently, organisational change that affects Allied Health professionals would come to the MH organisational change committee once every 3 to 4 months. It is managed appropriately through engagement in these processes.
- 57 However, the organisational change structure proposed by the HSU means that we would be obliged to commence the consultation processes even if we were only considering implementing change. Also we would have to undertake the process even if the proposed changes were only going to affect a small number of employees. Both of these requirements are overly onerous, and would not be an efficient use of time and resources in a health service that is already overstretched in terms of allocation of funds and resources.

- 58 Change impact statements are already used in order to be able to gauge the effect of change on staff, and this enables us to manage change appropriately. The HSU's proposal would require an organisation the size of MH to employ more Human Resources staff to manage the consultation and change processes, and this would divert funds away from clinical work. This is not the best use of MH's limited funding. We should not be put in a position where we have to reduce clinical services in favour of administration positions.
- 59 In any health service, and particularly one the size of MH, decisions are made constantly that will have an impact on some employees. Some of these decisions need to be made and implemented immediately and some only affect a small number of staff. It would not be an efficient use of resources to undertake the level of consultation and discussion required by the HSU in relation to these sorts of decisions. We already have appropriate processes in place to assess the impact of major changes and to consult in relation to these. MH needs to have the discretion to determine when consultation is required, rather than being constrained by a formula.

Qualified rate

- 60 The HSU's proposal in clause 21.1.3 (to appoint all Allied Health professionals to a minimum of Grade 1, Year 4 level) would render the Year 1 to Year 3 classifications for Grade 1 redundant. All entry level professionals have a Bachelor's degree so the HSU's proposal would mean that everyone would commence at Grade 1 Year 4.
- 61 Commencing at this higher increment means that Allied Health professionals will have to stay longer at that level, thereby reducing their abilities for professional advancement and appropriate financial recognition of improvements in skills during their first few years. A Bachelor's degree does not equate to 3 years professional experience, so we could not advance these people to Grade 2 after one year because they would simply not be capable of performing the duties and skills required of a Grade 2.
- 62 Being required to pay all new graduates at a Grade 1 Year 4 level would significantly increase costs without providing any improvement to the delivery of Allied Health services or any improvement in the skill level of junior staff.

Independent work

- 63 Clause 21.10.3 of the HSU proposal would require a minimum Grade 2 classification for any employee who is working independently or is the only person employed in their discipline.
- 64 It is difficult to see how an Allied Health professional could be classed as working independently. Even if an Allied Health professional conducts home visits, they would not be acting "independently". There is always a support structure in place to provide supervision and assistance to junior staff. This support structure is also available where an Allied Health

professional is the only Allied Health staff member on a ward at a particular time, so they could not be considered to be working independently either.

- 65 For example, we have only one social worker covering the emergency department at any one time, and because radiography is a 24-hour seven-days a week service, there may be radiographers who are working by themselves outside of peak hours. These people are still not really working independently, because there is always a chain of accountability and support in place. There would be senior clinicians available to assist, even if this was by phone.

Community health services

- 66 Clause 21.10.5 of the HSU Proposal provides for a minimum Grade 2 classification for Allied Health staff working in community health and psychiatric services.
- 67 MH only has a small number of health professionals in community health roles that are not already at Grade 2 Year 1. The only exceptions might be people coming in for training at entry level roles. There would be at most perhaps two in each of our Allied Health disciplines. If we were not able to rotate Grade 1s through these community health roles then they would miss out on a valuable training experience. It would mean that the Grade 2s who were in these roles did not have prior experience and this might negatively impact the standard of care. Where Grade 1s are employed in community health roles on a training basis, they would always be provided with appropriate supervision and support.

Minimum of clinical grade fours

- 68 The HSU proposal at clause 21.11 would require MH to employ a Grade 4 senior clinician on each site and in each section of every Allied Health department.
- 69 MH currently only employs two clinical Grade 4s, one each in the physiotherapy and speech pathology departments. I note that the selection criteria for appointment to Grade 4 are quite rigorous. Applicants must have 10 years of experience in the discipline and must be working towards a higher level degree.
- 70 Given the national shortage of some disciplines of Allied Health professional, I do not think that there would be sufficient numbers of clinical Grade 4s at the requisite level of quality available in the workforce for appointment to the number of clinical Grade 4 roles proposed by the HSU. It would be inappropriate and ultimately detrimental to the standard of care if we were forced to appoint people to this level even if they did not meet the current rigorous requirements in terms of qualifications and experience. They would not be able to perform the job as well as should be expected of that grade, since they would lack the relevant skills and experience. People should be graded according to their own competencies, and not pushed to levels they are not ready for simply because MH is required to meet certain union-imposed criteria. We need to be able to

provide high quality service delivery, as well as appropriate career structures in which employees do not progress before they are ready.

Clinical educators

- 71 Under clause 21.13 of the HSU proposal, we would have to employ a dedicated Grade 4 clinical educator in every department with 25 or more employees.
- 72 MH already employs 1 EFT for an Educators position and 0.6 EFT for a Service Development position (a total of 1.6 EFT). MH also employs two clinical grade 4 positions in Physiotherapy and Speech Pathology who support education of more junior staff. We therefore support the concept of having clinical educators in the larger departments, however the requirement to have Grade 4 clinical educators for all areas with 25 EFT would be too costly in our view. The HSU's proposal would require MH to have a Grade 4 clinical educator in each of the physiotherapy, occupational therapy, social work and speech pathology departments. We do not receive funding for this number of positions, and staff training requirements do not justify that level of clinical educators. We already cater adequately for staff training needs within the existing classification structures. Each Grade is expected to contribute to the training and supervision of the grade below, and senior clinicians take on a teaching load. MH is a teaching hospital and all grades are expected to provide clinical teaching /support to students and junior staff. The current EFT for the education specific positions was developed in consultation with staff, and provides a good balance between education that is provided by dedicated educator positions, and training that is provided in a clinical setting within the general classification structure.

Professional registration costs

- 73 MH should not be required to cover the professional registration costs of Allied Health staff, as is being claimed in clause 25.5 of the HSU proposal. It is the professional responsibility of the individual to ensure they hold the prerequisite credentials for their position. In addition, the portability of registration means that the registration is owned by the individual and not by the health service. MH might end up paying for a registration that is only used to the benefit of MH for one month out of twelve, for example in the case of a staff member who left shortly after renewal of registration or in the case of part-time staff.
- 74 This could also set a precedent whereby we would be subject to claims to pay the registration costs of doctors and nurses as well. This would result in a huge increase in costs for the health service and we have no way of meeting such an increase without cutting services.

Minimum engagement

- 75 Under clause 27.1.4 of the HSU proposal, MH would be bound to pay a minimum of 4 hours' pay for each period of engagement, regardless of how many hours the Allied Health professional in question actually worked.

- 76 Requiring staff who work at the weekend to be engaged for a minimum of four hours on each occasion removes flexibility in rostering and the ability of Allied Health managers to staff their services according to levels of demand. For example, a radiographer can be called in for periods of less than four hour on a regular basis. For instance, CT scans only take half an hour to adequately perform. It is financially unsustainable for MH to be required to pay a minimum of four hours, when the task that needs to be performed takes less than an hour. The HSU's proposal would result in a large wasted wages outlay. This might detract from the level or quality of services we are able to offer in other areas or at other times because we would have to divert funds away from clinical services in order to pay for hours that were not actually worked.

Meal breaks

- 77 Under clause 28.3 of the HSU proposal, MH would be required to pay an allowance to staff who missed 3 or more meal breaks in a fortnight.
- 78 In my view, it would be an unusual occurrence that Allied Health professionals are "unable" to take their meal breaks. MH expects Allied Health professionals to manage their own appointments and load in an autonomous and responsible fashion. It should not be necessary to be missing meal breaks if days are well planned. The HSU's proposal might in fact encourage people to be less time-efficient, because there would be a financial reward in missing meal breaks. This would not be to the benefit of staff well-being or the quality of service provided to patients.

Supplementary rosters

- 79 The HSU proposal in clause 30.1, which requires each health service to maintain a supplementary roster of people willing to work extra hours, would not suit MH's service or staffing needs.
- 80 MH already has rosters for people who are on-call. It would be rare for people to be looking to pick up extra shifts outside of the on-call roster, although this does occasionally happen in radiography and medical records. Our current roster system provides adequate cover and gives us the flexibility to be able to fill vacant shifts depending on the needs of the service rather than on the basis of who the supplementary roster says should be called in next. The vacant position will not always be the same level of position, or have the same associated duties. If the HSU's proposal were implemented, we might be put in a position of having to call an allied health professional whose skill mix was inappropriate for the work that actually needed to be carried out.

Overtime for part-time employees

- 81 Paying overtime rates for part-time employees working outside their ordinary hours of engagement (as claimed in clause 31.3.5 of the HSU proposal) would create a significant financial burden for the health service. It would also reduce equity between employees, and leave open the possibility of employees contriving situations of working outside regular hours in order to achieve maximum financial benefit. For instance, an employee could contract to reduce their hours to part-time hours and then apply to pick up extra work at a higher rate. MH cannot afford to staff its Allied Health services on this basis. It is also better from the point of view of consistency and continuity of services to encourage full-time work where possible, or at least regular rostered part-timers.

Time off in lieu

- 82 Under clause 31.4 of the HSU proposal, the union wants employees to be able to choose to take time off in lieu of being paid overtime.
- 83 MH does not currently operate a time off in lieu scheme, mainly because it is extremely difficult to manage the time that is owed. It requires additional resources to be spent on administration and record-keeping.
- 84 It is also difficult to manage the process of authorising overtime. It is not always clear who has required an employee to work the overtime, and there would need to be tight controls and rigorous oversight of the amount of overtime that is taken by employees. Not only can the health service not afford to be paying large amounts of overtime, but it is also detrimental to the well-being of staff to consistently be working over their rostered hours. Sometimes it is unavoidable but we should not create extra incentives for people to be inefficient during their rostered working hours.

Childcare for short-notice shifts

- 85 Clause 31.7 of the HSU proposal makes a claim for childcare expenses to be reimbursed to an employee who is called in to work on less than 24 hours notice.
- 86 MH is usually able to find volunteers to work shifts at short notice, and would rarely have to require an employee to come in on less than 24 hours notice. In these circumstances, the obligation to pay childcare would not very often arise at MH.
- 87 We are supportive of employees with children and provide flexible working practices. In the unlikely event that we did ask an employee to work on short notice, we would give consideration to any claim for childcare expenses but we should not be locked into an inflexible requirement. This should be a discretionary-based decision which takes into account the needs of the employee, patients and the health service.

Additional annual leave

- 88 Clause 38.8 of the HSU proposal would, if implemented, force MH to grant an extra week of annual leave to any employee who worked one or more weekends.
- 89 Working one weekend in a year should not entitle a person to an additional week's leave. There are fundamental issues of equity between employees here. For example, in a small department Allied Health staff might be rostered on for 10 weekends per year whereas in big departments there would be sufficient staff for everyone to only work one weekend. If these two groups both received the same amount of additional annual leave it would be unfair to the group who are working significantly more weekends.

Study and professional development leave

- 90 The HSU proposals in clauses 44 and 46 would substantially increase the level of study and professional development leave entitlements of MH Allied Health staff.
- 91 In 2007/08, 2,601 hours of study leave were taken by MH Allied Health staff. MH professionals currently receive three professional development days and two study leave days each year. It is used by a high number of allied health professionals and people are generally keen to make use of it. MH considers this level of study and professional development leave to be adequate to meet our employees' learning and development needs. There is no need for an extension of paid study leave as requested by the HSU. There would also be increased costs from the HSU's study leave proposal which we cannot meet within our current budget.

Transport allowance

- 92 Clause 52 of the HSU proposal provides for an increase in the travelling allowance for Allied Health staff.
- 93 Pool cars are available for allied health professionals who require them. In particular, occupational therapists have access to a designated fleet of vehicles. Cab charges are also available, and employees are encouraged to use public transport where appropriate. The travel allowance and provision of vehicles as requested by the HSU is unnecessary. Our current arrangements are more than adequate to cater for the transport needs of staff.

Workplace bullying policy

- 94 I refer to clause 54 of the HSU proposal, in relation to the prevention and management of workplace bullying.
- 95 MH already has a workplace bullying policy in place which we consider to be adequate to meet any issues as they arise. Imposing an inflexible system-wide policy does not enable managers to deal with specific issues as they arise, and it may result in issues escalating that could otherwise have been dealt with informally and without involvement of senior levels of managers.

Patient loads and “throughput targets” – Response to Michelle O’Rourke

- 96 I have been provided with a copy of the witness statement of Michelle O’Rourke of Southern Health, submitted on behalf of the HSU. In relation to paragraphs 18-20 of that statement, I make the following comments.
- 97 At MH we regularly adjust staffing levels in accordance with operational needs. Allied Health, as with other services within our hospitals, experience up and down variations in workload. Department Chiefs and team leaders need to have the capacity to manage these fluctuations on a needs basis rather than in accordance with a pre-determined formula that does not take into account the particular demands of the service.
- 98 If beds are restructured to a different purpose, this does not necessarily increase the overall level of service demand. Rather, it changes the nature of the services that are required. EFT that has been freed up in one area can be redistributed to another discipline or section if necessary. Again, this is something that would be determined with regards to the specific circumstances. For example, when we changed the classification of various rehabilitation beds, we reduced throughput in another area to compensate.
- 99 The pressure to discharge patients is not only experienced by Allied Health professionals. It is a system-wide pressure and is something that all professional employees are expected to manage to a reasonable level. One of the key reasons for employing Allied Health professionals is to assist in preparing patients for discharge, and therefore the fact that there might be a pressure to effect these discharges is not something that is beyond the expected parameters of an Allied Health position. Discharge planning is, and has been for many years, a routine, ordinary process for the entire clinical team in all inpatient units and forms part of the “usual care” provided by a treating team (including Allied Health staff).
- 100 In relation to Attachment 1 to Ms O’Rourke’s statement, I make the following comments. Guidelines such as these are developed by multidisciplinary professional groups setting out their ideal guidelines for the provision of their services. Actually meeting these guidelines would consume more resources than we have available.
- 101 These guidelines are important but are not necessarily supported by evidence establishing that they are absolute requirements; rather, they are guidelines determined unilaterally by a particular industry group. Guidelines from service providers in relation to the resources with which they would like to operate are factors which we would take into account in developing MH-specific service delivery models, but we cannot be bound by this type of generic guideline.
- 102 Allied Health, as with many professions within the health system, is constantly evolving and there are new innovations and ideas about how services should be delivered. These changes are picked up by MH in both our day-to-day planning and our year-to-year strategic decision

making. These are things that need to be considered at the Health Service and service management level.

- 103 Requests from Allied Health regarding the manner in which services are to be provided should be negotiated at the level of the individual hospital or health service. There are many different factors to be taken into account (such as numbers of staff, types of services, complexity of cases etc) which need to be assessed on a case-by-case basis rather than imposing a rigid umbrella arrangement across the whole of the health system.

DATED: 9 September 2008

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PETER STEWART BRADFORD

AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

Workplace Relations Act 1996

Section 503 referral to Full Bench to make a workplace determination

Health Services Union

and

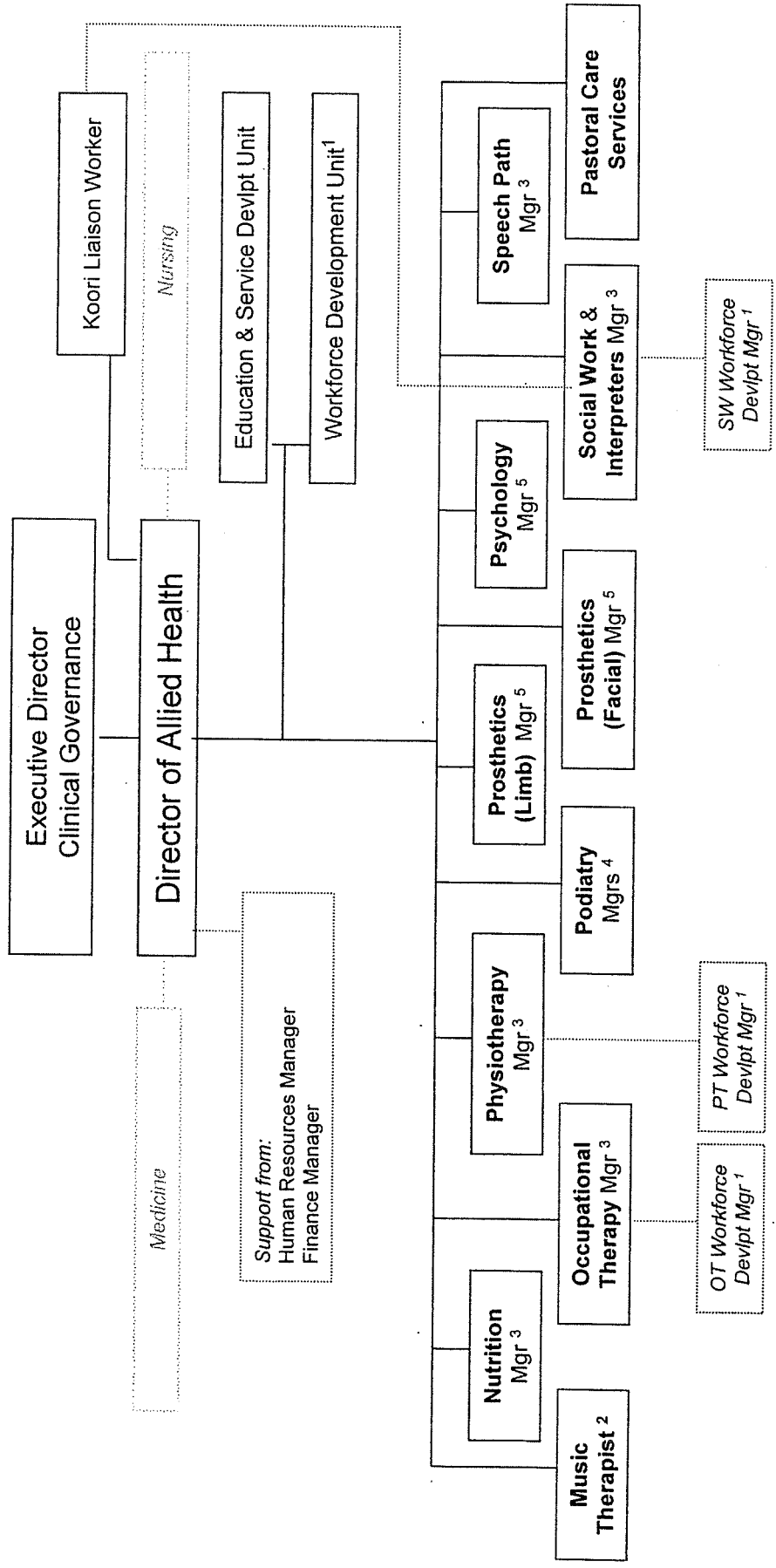
Austin Health and others

(BP2007/4059 and others)

EXHIBIT PB-1

This is the Exhibit referred to in the witness statement of Peter Bradford dated 9 September 2008 and marked **PB-1**.

Allied Health Managerial Structure: 2008



1. Workforce Development Unit consists of OT & PT WDMgr (0.5) & SW WDMgr (0.2) – cross-AH role
 2. Music Therapist = 0.6 clinician
 3. Discipline Managers @ 1.0 EFT, responsible for both CC & RP staff, and have MH Divisional Exec roles
 4. Sr Clinician Podiatrists at CC & RP with site-mgt responsibilities
 5. Clinician / Managers of smaller disciplines
- Nb This diagram represents management structures, in alphabetical order, not order of magnitude of budget / EFT