**VAHPA and members response**

**14 December 2018**

## Background

1. On 6 June 2018, Alfred Health (**AH**) released a Change Impact Statement (**CIS**). That CIS proposed a number of structural and workforce changes to the Radiation Oncology department.

2. The industrial instrument that governs the workplace rights and entitlements of Radiation Therapy Technologists is the *Allied Health Professionals (Victorian Public Health Sector) Single Interest Enterprise Agreement 2016-2020* (**AHP EA 2016**).

3. The changes proposed by Alfred Health are properly described, as *Clause 13 Consultation* of the AHP EA 2016 confirms, as major changes that will have a significant effect on Employees.

4. A key effect of this is that Employees must be given "…a genuine opportunity to influence the decision maker…".

5. On 30 November 2018, AH released the following information to VAHPA and its representatives, on a confidential basis and in accordance with the obligations imposed by the AHP EA 2016:

   (a) Review of The Alfred Radiation Oncology Service, Confidential Report, September 2017 (full report) (**the Review**);

   (b) WAU data for 2015-2016, 2016-2017 and 2017-2018; and

   (c) Booked Weekly Linac Activity AHRO.

6. The following constitutes a response from VAHPA in relation to the proposed change.

## Motivating Factors and Identified Aims

7. The workplace change process was initiated in an attempt to "establish the best organisational plans to respond to external competition and growth at GRO." External competition in this context refers specifically to the 2016 decision of Cabrini Health to end a long-standing period of collaboration with a public provider of radiation oncology in Alfred Health and to embark on a relationship with GenesisCare, a for-profit provider of radiation oncology.

8. There are two other factors cited by Alfred Health in support of progressing a workplace change process. The first is that [redacted] expressed some interest in transitioning out of a managerial role and into a research role and the second is that the Grade 7 RT role has been vacated as a result of a resignation.

9. The CIS has explicit aims: to "Strengthen the leadership at GRO…" (Gippsland Radiation Oncology Service (**GRO**)) and to "support the significant Operations component of management of the service and strengthen professional leadership of the disciplines…".

10. Further, the CIS directs those seeking to understand the logic of the proposed change, in terms of the "Structure of Leadership" and in terms of the twin issues of efficiency and effectiveness, to the recommendations set out in the Review.

**Maintenance of Grade 6 Deputy Radiation Therapist Manager positions**

11. The current proposal has the effect of replacing the two Grade 6 Deputy Radiation Therapist Manager positions with Operations Managers, that is, with generalist managers not required to understand the clinical aspects of radiation oncology,

12. Nothing contained within the Review or otherwise presented to VAHPA in relation to this matter supports the removal of the Grade 6 Radiation Therapists positions. Indeed, there is compelling evidence within:

    (a) the Review;

    (b) contemporary academic thought (see *Dr Rosalie A. Boyce*, an expert on the management and organisation of allied health professions);

    (c) the considered view of the Department of Health and Human Service (**DHHS**) as expressed in numerous position papers and Allied Health workforce planning documents;

    (d) the array of views put by the Radiation Therapists

    that attests to the fact that the Grade 6 positions are an essential and constructive part of the department and are vital to the proper provision of radiation oncology.

13. It is our view, based on a proper reading of the available evidence, that the Grade 6 Radiation Therapy Technologists positions must remain part of the departmental structure and that the Radiation Technologists performing these roles be afforded sufficient opportunity to hone their managerial skills.

**Evidence for maintenance of Grade 6 Deputy Radiation Therapist Manager positions**

14. *First*, the Radiation Therapy workforce, at Alfred Radiation Oncology (**ARO**) and at Gippsland Radiation Oncology Service (**GRO**), stand in opposition to the proposal.

15. The clinical Radiation Therapy cohort, those classified at Grades 1 to 5, most fully appreciate the benefits that flow from having access to vocationally experienced and clinically skilled managers. The view put by this cohort must be taken seriously. The fact the not one member of the clinical Radiation Therapy cohort was consulted during the course of the Review is seriously problematic.

16. It is reasonable for us to conclude that low staff morale (see [redacted] recommendation 30) is in large part a product of a well-founded feeling of disempowerment. This issue would only be exacerbated by the removal of Grade 6 RTs from the structure.

17. It is also important to note that the removal of Grade 6 RTs from the structure will effectively impose a career cap at Grade 5 for RTs employed by Alfred Health. We may reasonably conclude that external candidates with Grade 6 experience will be preferred to internal candidates without Grade 6 experience in circumstances where a Grade 7 RT position was being advertised and filled. This is problematic in many ways but most obviously in that any candidate appointed to a Grade 7 RT position at Alfred will either be an internal applicant with no experience in management or an external application with managerial skills but no knowledge (certainly no recent knowledge) of the department and the complexities of its various systems.

18. Not only is this a problem in terms of staff morale and in terms of succession planning but it is likely to encourage higher rates of staff turnover and the obvious costs implications of that.

19. *Second,* the Review does not make any recommendations that support removing the Grade 6 RTs form the structure.

20. It is worth noting that 4 of the 69 recommendations in the Review deal directly with the Radiation Therapists. Each of these recommendations (10, 39, 40 & 41) in one way or another calls for greater support for the Radiation Therapists.

21. Recommendation 39 calls for a review of the RT governance structure. This structure must provide, "*adequate support provision for junior staff and effective communication channels.*" The review team further note the requirement that all staff be, "a*ppropriately educated, updated and assessed to ensure that they are competent to perform the required duties of an evolving role.*" This speaks directly to the pressing need for clinically skilled and vocationally expert management, that is, for Grade 6 RTs.

22. Even more explicitly, Recommendation 10 identifies how the governance structure can be strengthened: *"with the appointment of a substantive GRO Deputy Chief Radiation Therapist.*" This recommendation is made in the context of ensuring that AH's location of services operates to provide the best care for patients. There is no suggestion AH's RO services will change (in the context of having the two sites). Without the dedicated Grade 6 RT Manager at GRO, the review is clearly indicating that the nourishment and growth of GRO is tied to having clinically experienced leadership.

23. Recommendation 40 goes to the need to ensure that "*adequate and equitable succession management processes are in place within the RT team, as well as opportunities to gain practical and theoretical management skills <u>at all levels</u>.*" Succession planning is important in any particular career path but is particularly so in a health context.

24. The authors of the Review mount a compelling argument in support of the need for thoughtful succession planning. In fact, it is apparent that the lack of appropriate succession planning was a key factor leading to the Review.

25. As you are aware, succession planning requires the identification and development of new leaders who can take on the roles of former leaders when they depart AH. Succession planning seeks to create a pool of competent and capable employees ready to available to take on the senior leadership roles.

26. Removing the Grade 6 RT positions will only exacerbate the already problematic situation around succession planning.

27. The removal of the Grade 6 positions will have a raft of predictable outcomes including:

    (a) there are no opportunities for more junior staff to "provide cover" (using the terminology adopted in the review) for more senior staff during periods of extended leave, removing an effective development tool;

(b) succession planning will fall to the task of the Grade 7 RT Managers, which will be an enormous burden on their workload, and would be greatly assisted by Grade 6 Deputy RT Managers to identify and develop more junior staff;

(c) if staff are encouraged to depart AH in order to gain appropriate Grade 6 RT management experience, AH will lose experienced staff, have a higher turnover rate, suffer reputational damage, and suffer financially through increased recruitment and training.

28. Recommendation 39 is directed at giving *more* opportunities to staff to gain practical and theoretical management skills, not removing those opportunities. It is also directed at giving those opportunities to staff engaged at all levels – clearly there is no implied suggestion by the review team to remove any of the RT levels at all. This would, in the staff and Union's view, have a very damaging impact on AH.

29. The review report also more generally does not support the removal of the Grade 6 Deputy RT Managers. In this regard, we note the following:

(a) Recommendation 4: continuing to develop and promote areas [redacted] *including: Stereotactic, Prostate Brachytherapy, CNS and surface imaging verification.*" [redacted] AH provides, unlike some of its competitors, very particularized care. The ARO is a specialized unit that undertakes the most complex treatment in the state. It is necessary, in order to exploit these opportunities, for AH to have high level clinical support, with its full suite of staff. Irrespective of the workload/activity figures (which do not reflect the complexity of the services provided), senior RT leadership is required to develop these opportunities with respect to, but not limited to, staff planning and training – duties that must be performed by a clinically trained RT.

(b) Forming the above recommendation, the review report makes findings which are generally supportive of having experienced senior leaders, with a clinical background. Such as:

(i) On page 3 of the Executive Summary: the future of radiation oncology being an increase in treatment accuracy, which results in increased complexity in planning, and the need for more complex imaging.

(ii) On page 3 of the Executive Summary: the move to no longer requiring RO's to be present at all simulations puts a greater pressure on RT's and consequently, RT management.

(iii) On page 6-7 of the Executive Summary: the service is "well short of governance and leadership best practice". It seems at odds with that statement to remove positions which are leadership positions.

(c) Recommendation 24: "*formally review the AHRO governance structure to establish an appropriate, inclusive and comprehensive committee and decision-making structure and processes and reflect the two campuses, single service nature of AHRO*." The proposed structure refers to having a single Grade 7 RT Manager at each site, with no leadership support. It seems more likely that that leadership structure will continue to embed the silo nature of the two sites that the review report admonishes.

30. *Third*, the removal is inconsistent with the work being performed by Victorian Department of Human Services and Raven Consulting Group in developing the *Allied Health Careers Pathway Blueprint*[1]. As you are aware, that work is being performed to arrest the "high early career attrition from the allied health professions", with "lack of career pathways and poor progression" being identified as the primary causes.

31. The work being performed has identified already that employers need to work with employees to develop a career pathway. It has been recognised that larger employers, such as AH, have opportunities that smaller counterparts lack, that is, greater capacity for diverse working roles. The Raven Consulting Group have recognised that more diverse working roles can lead to career pathways not available at other sites, making places such as AH more attractive to better candidates. Like the succession planning issues identified above, this means there is a better "pipeline" of potential leaders at AH. The fact of having two sites is also a driver for attracting candidates who want the opportunity for diverse work.

32. *Fourth*, the multimillion dollar *Allied Health Workforce Enhancement Plan*, does not support it. The AHWEP, developed between VAHPA and Kathleen Philip, Victorian Chief Allied Health Advisor during negotiations for the current Allied Health enterprise agreement, clearly supports clear career pathways for allied health professionals.

33. Part of the AHWEP is the Allied Health Leadership Education Program, which aims to facilitate a shift from operational to strategic management. It is noted that there is a need to build leadership capacity within allied health, to mirror the work done in medicine and nursing, and that there is an underrepresentation of allied health workers at executive levels of management.

34. The removal of Grade 6 Deputy RT Managers would be significantly detrimental in this regard. The AHLEP identifies that developing leadership improves engagement levels, increasing retention, improves organisational performance and improves quality of care, efficiency and patient safety outcomes. It is simply illogical that AH would not strive for these outcomes by maintaining a career pathway for RT's that includes Grade 6 positions.

35. *Fifth*, the enterprise agreement is drafted in such a way that a Grade 7 RT Manager must be supported by a Grade 6 Deputy RT Manager. The two roles are integrated to achieve a comprehensive and appropriate management, which ensures "the efficient and effective development and delivery of a high-quality radiation therapy service." This is not work that can be performed by anyone. It is work that must be performed by clinically trained and appropriately skilled workforce.

36. In summary, the workplace change proposal stands in manifest defiance of the thoughts and views of the expert review team. There is overwhelming evidence in support of a structure that maintains the Grade 6 Deputy RT Management positions.

**No introduction of Operations and Deputy Operations Manager positions**

37. The proposed change introduces two positions, Operations Manager and Deputy Operations Manager. Neither position is required to have any clinical qualifications.

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[1] http://www.ravencg.com.au/images/documents/C5062-AHCPP-Blueprint-OrgSummary-(PUBLIC).pdf

38. The two positions should not be introduced to the structure at AH, for the following reasons.

39. *First*, it is unnecessary when there are competent and capable allied health professionals with capacity to do that work, or to develop their skills to do that work. For instance, the current Grade 6 Deputy RT Managers could perform those roles, or develop any skills required.

40. This is supported by the review report which makes a variety of recommendations to improve governance, which are touted to be performed by the Operations positions, but which are necessarily required to be performed by clinicians.

41. For instance, Recommendation 14 suggests implementing strategies "*to ensure all staff are confident using new technology…*" This will be made impossible if such a task was directed to a non-clinically trained person. For example if ARO were to transition to an electronic record keeping system, which is inevitable, to do so effectively would require a clinically trained person to develop and implement the system. This would certainly be required to ensure all staff are confident in using any new technology, as the recommendation suggests.

42. There are many examples of service delivery improvements being delivered by Grade 6 Deputy RT Managers which could not have had the same outcome if implemented by a generalist manager. Those include electronic portal imaging (which attracted international conferences), safety systems that improve patient safety and record and verify system (first implemented by AH, and now used across the world).

43. Further, the review team was critical of a position which did not have a clinical background [redacted]. The reviewers clearly saw that role has holding AH back from reaching its potential. It could be possible for that history to repeat with the introduction of operations roles.

44. *Second*, the proposed positions descriptions for the Operations roles appear to be accountable for senior RT positions, including Grade 7 RT Managers. It is unacceptable for a non-clinically trained person to manage a senior leader such as an RT Manager. It has the effect of diminishing the seniority of the RT Manager role and has the potential to undermine the authority of that role. This is especially so if the recruits for the Operations roles are very junior (as seems to be the case when reviewing the position description and the associated enterprise agreement).

45. As you are aware, clause 88 of the enterprise agreement requires AH to ensure that all employees receive "supervision by a qualified and clinically appropriate health professional." While we understand that AH has updated the Grade 7 position descriptions, following correspondence from Maurice Blackburn on 24 October 2018, the amendments do not satisfy the requirements of the enterprise agreement. In particular the October 2018 position descriptions:

    (a) state the position is "accountable to" the Deputy Operations Manager and is within the "Operations" division (page 1);

    (b) state that "professional oversight will be through the Director of Allied Health." (page 6); and

    (c) state that "clinical oversight will be through the Deputy Head of Unit at relevant site".

46. This has the potential to produce absurd results. The Director of Allied Health is not referred to in the proposed structure contained in the CIS. None of those amendments directly address the requirement of supervision by a qualified and clinically appropriate health professional, as required by the enterprise agreement.

47. *Third*, for the reasons outlined in paragraphs 10-18, above, the operations manager roles should not be introduced, especially not so as an *apparent* replacement of the two Grade 6 Deputy RT's.

**Conclusion**

48. There is an abundance of evidence contained herein which does not support the proposed changes to the RT workforce. The review team was considering whether the impact of the introduction of the Cabrini service would have a significant impact on ARO, which, if it happened, may have led to a need for an altered workforce. However, the Booked Weekly Linac Activity AHRO (which does not take into account the differing levels of complexity of services provided), appears not to support a conclusion that Cabrini would have a significant impact. It is fair to say there has been some impact, but not significant. Now is not the time to diminish clinical leadership at AHRO. It is, as the report identifies, the time to utilise the existing skills and experience to exploit growth opportunities.