LEVEL OF DUTIES
WESTERN AUSTRALIAN INDUSTRIAL RELATIONS COMMISSION

CITATION	**:**	2013 WAIRC 00836
CORAM	**:**	PUBLIC SERVICE ARBITRATOR ACTING SENIOR COMMISSIONER P E SCOTT
HEARD	**:**	WEDNESDAY, 7 NOVEMBER 2012, THURSDAY, 8 NOVEMBER 2012, TUESDAY, 27 NOVEMBER 2012, WEDNESDAY, 28 NOVEMBER 2012, THURSDAY, 29 NOVEMBER 2012, MONDAY, 3 DECEMBER 2012, TUESDAY, 4 DECEMBER 2012, THURSDAY, 6 DECEMBER 2012
DELIVERED	**:**	THURSDAY, 3 OCTOBER 2013
FILE NO.	**:**	PSACR 21 OF 2010
BETWEEN	**:**	THE MINISTER FOR HEALTH IN HIS INCORPORATED CAPACITY UNDER S.7 OF THE HOSPITALS AND HEALTH SERVICES ACT 1927 (WA) AS THE HOSPITALS FORMERLY COMPRISED IN THE METROPOLITAN HEALTH SERVICE BOARD Applicant AND THE HEALTH SERVICES UNION OF WESTERN AUSTRALIA (UNION OF WORKERS) Respondent

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CatchWords	**:**	Public Service Arbitrator – Level of classification – Reclassification – Public Hospital Sector – Frontline clerical positions – Waitlist Clerks – Increased work value – Work value test - BiPERS Assessment – 'Conditions under which the work is performed' – Technological change – Increased violence - Information technology and process changes – Four Hour Rule Programme – Broadbanded Classification Structure
Legislation	**:**	*Industrial Relations Act 1979* s 44, s 80E(2)(a) *Hospital Salaried Officers Award*

WA Health – Health Services Union – PACTS – Industrial Agreement 2011

Result	**:**	Application granted in part

Representation:

Applicant	**:**	Mr J Ross
Respondent	**:**	Mr S Millman of counsel

Reasons for Decision

1 This is a matter referred for hearing and determination pursuant to s 44 of the *Industrial Relations Act 1979* (the Act). The parties are in dispute about the level of classification appropriate to 'frontline' clerical positions (FLCPs) including Emergency Department Clerks, Ward Clerks, Clinic Clerks and Admissions Clerks employed in public hospitals in this State.

2 The Health Services Union of Western Australia (Union of Workers) (HSU) seeks that the positions be reclassified on the basis of increased work value. It says that there has been a significant net addition to the work requirements of the positions in respect of the nature of the work, skill and responsibility required, or the conditions under which the work is performed such as to warrant upgrading them to a higher classification. The HSU seeks an order reclassifying the positions from Level G2 to G3.

3 The employer says that the level of work value of the positions is recognised in the current level of classification and that a reclassification of the positions is not appropriate.

4 The current industrial instrument that covers the FLCPs' employment is the *WA Health – Health Services Union – PACTS – Industrial Agreement 2011*.

5 The parties requested that Waitlist Clerks at Sir Charles Gairdner Hospital (SCGH) be dealt with separately and first. This was at least partly due to the basis of their claim being somewhat different to the remainder of the positions under review, in that they rely in part on comparative positions at other hospitals which were classified to Level G3. As I have progressed in consideration of these matters, it has become clear that consideration of one group before the others would require significant repetition of a number of issues and principles. Also, it is said that a number of positions within the main groups of FLCPs also undertake waitlist duties as part of their role, for example, the Booking Clerk, Imaging Services at Royal Perth Hospital (RPH); the Admission Clerk at Osborne Park Hospital (OPH) and the Clinic Clerk at RPH Orthopaedic Clinic. Also, it is important to look at the Waitlist Clerk position in context, not just of other Waitlist Clerk positions, but by reference to other Level G2 positions as they currently stand and as they seek reclassification. Further, some aspects of the claim in the main groups contain a significant element of flow-on from the Waitlist Clerks already at Level G3 and cite those positions as relevant comparison positions. The issue of flow-on is very prominent in this matter. In the circumstances, I concluded that it is more appropriate to deal with all groups at the same time, albeit that each group has some unique features which justifies separate consideration as part of the overall review.

6 I have had the benefit of inspections of indicative FLCPs at King Edward Memorial Hospital (KEMH), Princess Margaret Hospital (PMH), OPH, Fremantle Hospital (FH), SCGH and RPH for the purpose of understanding the context in which these positions perform their duties and to observe the environment and the work.

7 At FH, the work observed was that of the Bed Allocation Clerk in Patient Flow and Ward Clerk in the Intensive Care Unit; at KEMH, Patient Information Management Systems (PIMS) Administration Clerks; at PMH, Ward Clerk in the Orthopaedics Ward; at OPH, Admission Clerk (HIMS); at SCGH, the Waitlist Clerk, Ward Clerk Surgical, Emergency Clerk HIMS and Liaison Officer Emergency Department, and at RPH, Booking Clerk for CT Scans, Ward Clerk – Health Records, Emergency Clerk – Emergency Department, Ward Clerk, Geriatric Department and Outpatient Clinic Clerk – Orthopaedic (Outpatient Clinic, Goderich Street).

8 Following the inspections, copies of manuals, policies and guidelines relating to the various positions were provided at my request.

9 For the HSU, evidence was given by Richard Andrew Barlow, Senior Industrial Organiser with the HSU; Josephine Ellen Ganfield, Waitlist Clerk at SCGH; Margaret Christina Metcalfe, Emergency Department Clerk at SCGH; Margaret Ann Thwaites, Emergency Department Clerk at RPH; Gillian Mary Byrne, Ward Clerk at RPH, currently in Geriatric Medicine; Vicki Lee Chamberlain, Booking Clerk in Nuclear Medicine at RPH; Julie Ann Elshaw, Clinic Clerk in the Orthopaedic Clinic in the Surgical Division of RPH; Vicki Patterson Thompson-Davies, PIMS Officer, Emergency Department Admissions at KEMH; Fiona Mairi Murray, Admissions Clerk at OPH; Kaye Frances Crothers, Ward Clerk, Intensive Care Unit, FH; Lesley Ann Smith, Ward Clerk, Total Care Burns Unit, PMH; Jodee Lyn Dawson, Bed Allocation Clerk, FH; Paola Marie Bannon, Ward Clerk, SCGH and Carole Ann Elizabeth Pritchard, Liaison Officer, Emergency Department, SCGH.

10 The employer called evidence from Dr Robyn Ann Lawrence, Executive Director of SCGH; Lynda Joan Harrison, Nurse Co-Director, SRN 10 of the Surgical Division of SCGH; Mitchell Sydney Jesson who gave evidence about the computer systems and software used in respect of patient administration in the various hospitals; Alan Michael Davies, employed in 2008 by Austral Human Resources to review reclassification requests and who prepared various reports on the review; John Philip Holland, a director of Austral Human Resources and currently an officer of the applicant, involved in the reclassification assessments in these matters.

BACKGROUND

11 In 1995, Waitlist Clerk positions at FH, and subsequently those at RPH, were reclassified to Level G3. From late 2006 to 2009, the HSU and its members lodged numerous group claims with the employer in respect of a significant number of FLCPs classified at Level G2, seeking reclassification to Level G3. The employer instigated a review of the Waitlist Clerk position at SCGH in 2007, engaging SWY Consulting to provide a report. It later reviewed the other FLCPs engaging consultants for the purpose of the review including Dillenger Group Development and Austral Human Resources. Ultimately, the employer's Classification Review Committee rejected the claims on the basis that a significant net addition to work value had not been demonstrated. According to the application filed by the employer for a conference pursuant to s 44 on 20 July 2010, as a consequence of that decision by the CRC, the frontline clerical officers intended to instigate industrial action in support of their reclassification claims. The employer sought the intervention of the Public Service Arbitrator (the Arbitrator). The Arbitrator convened numerous conferences with a view to attempting to resolve the matter by conciliation, however, ultimately the parties agreed that arbitration of the

reclassification claims was the most appropriate course of action. The parties agreed that these are matters, which would normally be the subject of reclassification appeals pursuant to s 80E(2)(a) of the Act and should be dealt with in accordance with the Practice Direction for Reclassification Appeals, with modifications to take account of the significant number of positions concerned and of the desirability of inspections and witness evidence. The process of undertaking the inspections and the hearing was delayed on a number of occasions for various reasons generally associated with the availability of the representatives of the parties. Inspections and the hearing of the matter commenced in November 2012.

12 In addition to the inspections and witness evidence, there were more than 10 volumes of documents submitted. I have found the inspections, witness evidence and the documentation provided by the parties to be of considerable assistance.

13 The evidence demonstrates that the FLCPs generally were last reviewed and reclassified in approximately 1989. Some have been reviewed subsequently.

THE EMPLOYER'S CASE

14 The employer says that the fundamental functions of the positions remain as they were, that technology and processes have changed but not the essence of the skill or responsibility of the positions.

15 The employer relies on evidence of the reviews of the positions undertaken by the consultants. It also refers to the requirements of the positions as they existed prior to the last review, including job descriptions as they existed at that time. It also refers to previous claims for reclassifications of these positions to demonstrate that some of the current claimed changes are not new and were previously used to justify reclassification from Level G1 to Level G2.

16 The employer also says that the indicative duties of these positions fall within the range applicable to Level G2 positions generally.

17 The establishment of the broad-banded structure in 1989 is said to have enabled employees to undertake a broader range of duties and functions within the same level, without it constituting an increase in work value.

18 The Four Hour Rule Programme (FHRP) is said by the employer to be about the organisation of work and reducing repetition and unproductive processes. Of itself, it did not change the level of skills or responsibilities of these positions.

THE HSU'S CASE

19 The HSU says that the evidence demonstrates that the employer's reviews were flawed. It says that the consultants undertook desktop reviews rather than an independent assessment of the positions and the employer ought to have conducted a more thorough and careful review. The HSU says that the consultants confined their examination of the positions under review to merely analysing the Job Description Forms (JDFs) and the skills and responsibilities, and ignored the conditions under which the work is performed. In this context, the HSU says that the employer has erred.

20 Secondly, there has been significant change in duties and responsibilities. The HSU says that the material provided demonstrates that there has been significant change in those measures which constitute the criteria for a work value increase. Issues such as developments in information technology, the FHRP, work volume and the devolution of functions are all significant changes to these positions.

21 Thirdly, the conditions under which the work is performed have changed and the employer's evidence is said to support this, including that Mr Holland and Dr Lawrence acknowledge that there has been significant change including via technology and policy over a significant time period.

22 In summary, the HSU relies on changes in technology, work volume, the training and mentoring of clinical and clerical staff, the diversity of stakeholders with whom they deal, policy changes increasing skill level and responsibility, the performance of higher level functions, increased auditing compliance and the environment in which the work is performed, namely a 'technologically-advanced, patient-focussed, expeditious health system' (t 435) which bears little resemblance to the circumstances under which the work was performed 20 or so years ago.

THE HSU'S EVIDENCE

(a) Specified callings work value review Introductory Paper

23 Richard Andrew Barlow, Senior Industrial Organiser with the HSU, gave evidence of the process undertaken by the HSU in dealing with the claim by the frontline clerks. Mr Barlow has been with the HSU since 1996. He noted that the changes upon which the frontline clerks rely include the FHRP, significant technological change and the nature of the work due to the changing health environment. Mr Barlow also gave evidence of the Specified Callings Work Value Review dealt with in P18 of 2003 and he attached to his witness statement the *Introductory Paper: To accompany Work Value Submissions from the Specified Calling Groups* (the Introductory Paper) of February 2005.

24 Mr Barlow also noted that behind the Introductory Paper there were 20 health professional groups' work value documents which provided specific and detailed evidence regarding changes affecting their particular professional groups. Those included changes to the medical model, changes in registration and education requirements and clinical changes. There was also significant change in work volume.

25 Mr Barlow says that the Introductory Paper was illustrative of the significant changes across the health industry and assists in an understanding of the context of this matter.

(b) Technology

26 Ellen Ganfield, Fiona Murray, Margaret Metcalfe, Margaret Thwaites and others gave evidence of the changes to computer programmes utilised by them including TOPAS, EDIS and others. The requirement to train others in this technology and to assist others in problem solving is also relied upon. Lesley Smith's evidence included the changes applicable to her work due to the use of the Telehealth system, Jodee Dawson regarding CHAnnEL and Vicki Chamberlain regarding nuclear medicine.

27 There was other evidence of the various information technology systems and software utilised within the public health sector for patient records over time including:

- PMAS – Patient Management and Administration System.
- EDIS – Emergency Department Information System, a global system applied throughout the sector. Ms Metcalfe gave evidence of issues of linking patient information from TOPAS to EDIS and the requirement for timely linking of that information (t 132).

- TOPAS – The current system which is in the process of being replaced by webPAS. Clerks use this system to register all presenting patients onto the global computer network which has been in operation since the mid 1990s.
- webPAS is being rolled out through the system, starting at Fremantle and Swan District Hospitals, and was envisaged as being implemented at SCGH within 2013, with people commencing training at the time of hearing. This will supersede a number of other programmes.
- MERITS – a Medical Records Tracking System referred to by Ms Metcalf (t 135) in particular.
- TMS – Theatre Management Schedule used by for Waitlist Clerks at SCGH.

28 Ms Metcalfe also gave useful evidence of the way in which her work used to be undertaken and comparing the old computer system called Cyber (t 137). Ms Metcalfe also gave evidence of linking the Emergency Department's systems with St John Ambulance systems for information relating to patients arriving by ambulance.

29 There was also other reference to earlier computer programmes and systems such as EBS and Crystal.

(c) Increased Work Flow

30 The FHRP was cited by many witnesses as a major factor affecting and reflecting the need for more patients to move more quickly through the system. Evidence of its effect in Bed Allocation, Emergency and on the wards was given.

31 Lesley Smith, Margaret Metcalfe and Margaret Thwaites amongst others, dealt with the increasing work volume. Lesley Smith also noted that the quantity and complexity of patient admissions had increased. A number of witnesses addressed the impact of the significant increase in the volume of patients being dealt with by these positions, as a consequence of the FHRP as well as the necessary efficiencies across the health system which have increased pressure on doctors, nurses and others who are said to ultimately delegate further tasks to the clerical staff.

(d) Mentoring and Training

32 This is said to be of clinical and clerical staff in the performance of clerical functions: see the evidence of Carole Pritchard. Ms Metcalfe gave evidence as to the removal of a position of Training Officer at Level 4, now done by the Emergency Department Clerks on the floor. It usually takes approximately three to four weeks to train an Emergency Department clerk, with ongoing support. Gillian Byrne gave evidence as to the requirement for Ward Clerks to train new members of the team in the complete admission and discharge procedures as well as the various computer systems, including the requirement to provide relief for coverage of other wards and Ms Murray gave evidence regarding her role as a trainer for TOPAS.

(e) The conditions under which the work is performed

(i) Increased violence and problematic behaviour. A number of witnesses gave evidence of patients and visitors attending under the influence of drugs. Some years ago, it was alcohol, heroin and marijuana. More recently, drugs which commonly cause increased aggression and other problematic behaviour include ice and ecstasy. A higher number of patients with mental illness contributed to this environment. FLCPs were still required to deal

with these people to obtain the necessary information, answer queries, admit them to Emergency and the like.

(ii) Increased cultural and language issues due to a greater range and diversity of population.

(iii) Structural issues. The physical location and the changed structures such as Bed Allocation joining Patient Flow Unit at Fremantle Hospital; the Booking Clerk in Nuclear Medicine at RPH being physically isolated from the rest of the work area and having a broad range of functions, and the reception, admission and emergency functions at KEMH, were all cited as examples. Ms Murray gave evidence of the situation at OPH where the Admissions Clerks are said to often be without supervision or clinical help.

(f) Admission and Emergency Clerks gathering more information including:

(i) About patient funding arrangements, such as private health fund details and identifying different types of visa holders, to obtain increased funds for the hospitals. A number of witnesses gave evidence of the Emergency Department Clerks at RPH and SCGH undertaking the work normally performed by Level G4 clerks in registering private patients when the Level G4 clerks are not available after hours (Ms Metcalfe and Ms Byrne).

(ii) Identifying patients with infectious diseases and alerting clinic staff.

(g) Increased exposure due to trauma patients

33 This is said to be the creation of a Trauma Centre, air ambulance arrivals, and other circumstances particularly those confronting Emergency Department Clerks and OPH Admission Clerks.

(h) Increased accuracy and auditing

34 Most witnesses gave evidence of there being increased emphasis on the accuracy of the records they establish and maintain, and of the requirement to audit existing records. An increased level of knowledge of medical terminology, anatomy and diseases, as part of creating and updating the patient records is said to be required.

(i) Patient contact

35 Ms Murray referred to triaging patients, Ms Thompson-Davies and Ms Chamberlain said they were required to monitor patients' conditions and Ms Ganfield says that Waitlist Clerks determine the length of stay where the doctor has not filled this in in the admission form. Some witnesses referred to the need for increased knowledge, not only of medical terminology, but of anatomy and diseases.

THE EMPLOYER'S EVIDENCE

36 From 1997 to 2005, Mr Jesson was a manager, Health Information Management Service at SCGH. Approximately 260 FTE came under his supervision and control, including Clinical Coders, Medical Records Staff, Medical Secretaries, Waitlist Clerks, Emergency Clerks, Freedom of Information, Clerical Relief, Ward Clerks, and Outpatient/Clinic Clerks (exhibit A[5]). He described the use of a medical records tracking system, through an electronic mode instead of filing cards and scanning records. The computerised programme enables the information to be put directly into the system and enables interrogation of data by looking at the screen rather than by pulling out a piece of cardboard. He described it as '[y]ou

put information in, you get information out' (t 301). The employer relies on Mr Jesson's evidence as to the transition from PMAS, the patient administration system, to TOPAS, the current system which is currently in the process of being superseded by webPAS. Mr Jesson says that there are many downstream applications attached to the existing patient administration system, making accurate data entry more important.

37 Mr Jesson also gave evidence that he was the PMAS Replacement Business Manager on the project that customised and implemented TOPAS to public metropolitan hospitals in Western Australia. In this role he led a team of health business experts to confirm that TOPAS could meet the requirements of the hospital.

38 Mr Jesson's current role is as project manager for the implementation of webPAS and webPAS Emergency into the Country Health Service sites in the Great Southern and South West Health Regions and he was responsible for the oversight of a team of health business analysts. He was responsible for running the project schedule including training, configuration, testing, deployment and transition to post 'go-live' support (exhibit A5 [1]).

39 Mr Jesson says that probably the biggest change in the use of technology for FLCPs was going from a manual recording system to PMAS but that was before his time. Then there was the change from PMAS to TOPAS, with the use of a mouse, and some members of staff had not previously utilised computers to a great extent to that point (t 300). He says the basic business process stays the same in performing the job - the biggest change was people getting used to computers rather than the particular system. The step from TOPAS to webPAS will be relatively smaller (t 308).

40 Mr Jesson noted the progress towards the webPAS system to upgrade the Patient Administration System to 'unify the metropolitan and rural health services onto a single system enabling a common identifier to be used state-wide for the first time' (exhibit A [11]). He says that this new system does not require added responsibility or additional tasks and that 'the basic business flows are very similar' to the existing system (exhibit A [12]).

41 Mr Jesson noted that there are many, what he called, 'Down Stream Applications' that feed from the patient administration system, frequently used to replace manual or stand-alone systems, which are increasingly part of the day-to-day activities of many clerical positions. Frontline clerical staff use a range of systems in their daily work and with each new or replacement system, training and assistance in the use of the system may be required and is provided. In his view, '[w]orking with new or replacement computer systems has not … added to the complexity of the role of [sic] the level of responsibility of these positions' (exhibit A [18]).

42 In respect of the question of the application of more rigour in respect of quality assurance, and accuracy, Mr Jesson says that applies to all the staff including 'from cleaning to medicos' (t 309). Mr Jesson noted the importance of accurate data entry regardless of the type of record system.

43 As to the evidence of front line clerical staff auditing their own work, Mr Jesson described that as just checking the quality of their work as opposed to conducting or 'running actual audit programmes', which he said was presenting data and doing work at a different level (t 301). He said that the electronic systems are merely a replacement of a manual function. The information is merely in a different format and instead of having to look at physical manuals or making telephone calls, where assistance is needed, access is via clicking an icon to obtain the information, and help is available. In attempting to find a patient record Mr Jesson says he

would previously have made a phone call and talked to someone at the end of the phone as opposed to finding the information on the electronic record (t 302).

44 Mr Jesson said that in comparing the previous and current systems, there is a balance between some things within the process being easier to undertake and other things more complex.

45 John Holland, a director of Austral Human Resources, and Alan Davies, a consultant with Austral Human Resources, both gave evidence of their roles in the reviews of these positions. Mr Holland also gave evidence of his involvement in the creation, within the public service, of the broadbanded classification structure in the late 1980s and the subsequent modification for the Hospital Salaried Officers classification structure.

46 Mr Holland also gave evidence of the work undertaken to identify indicative duties and responsibilities for Levels G1, G2 and G3, and their equivalents in the public service in the early 1990s. He says that an examination of the claims in this case and the duties as they were performed prior to the last reclassification shows no substantive change, albeit that the way in which the work is performed has been modified, as it has for all clerical positions, by the application of technology and other measures for improved efficiency. The work value may have increased but not significantly.

47 Mr Holland says that all of the FLCPs, including the Waitlist Clerks at SCGH and those Waitlist Clerks at other hospitals which were reclassified to Level G3, are properly within the Level G2 range of duties and responsibilities.

48 Mr Holland says the reviews did not take account of the circumstances under which the work is performed, as it was not clearly identified in the claims.

49 Dr Robyn Lawrence, Executive Director, Sir Charles Gairdner Osborne Park Health Care Group gave evidence of the reforms at SCGH under what she described as 'the former Four Hour Rule Programme' (exhibit A6). Its aim was to have patients dealt with and out of the Emergency Departments within four hours. The FHRP was 'designed to look at the workflow right across the hospital, from a patient presenting to the Emergency Department all the way through, and it was about streamlining work to minimise duplication and complexity so that the patient's flow time was lessened by doing so. That, in itself, should not have resulted in any increase in complexity of the work per se or any increase in work value. It should have lessened it, if anything.' (t 312). She noted that those reforms had resulted in the system-wide redesign of the patient pathway, to remove waste and rework from job roles. She used the word *former* to describe the FHRP because the programme itself has ceased but the outcomes continue without a special name. However, the purpose is still to get patients out of the Emergency Department within four hours which, Dr Lawrence said, improves patient safety and outcomes.

50 Dr Lawrence says there have been no fundamental changes to task allocation of any clinical or non-clinical roles as a result of the FHRP. The volume of patients treated at the hospital had increased, as a result of community demand and not as a result of the FHRP. She was not aware of any increase in the scope or complexity of the tasks allocated to FLCPs. She said that the 'core tasks of clerical and administrative staff have always centred around the accurate entry of patient information into the appropriate IT platform, and these core duties remain unchanged' (exhibit A6[3]).

51 Dr Lawrence described the auditing requirements within the hospital, noting that they did not strictly relate to the FHRP but were required by the Department of Health and by the Auditor-General. She identified that it was part of the standard audit for hospitals to check their

performance against key performance indicators as part of quality management. Generally, though, Dr Lawrence said, there was a requirement for accurate record keeping to ensure the safe management of the patient (t 312).

52 As to the various IT platforms, Dr Lawrence noted that programmes such as TOPAS, MERITS and EDIS have been operating for some time but some of them had reached the end of their useful life, were not able to be upgraded or were being replaced and combined (t 318).

53 In respect of administrative tasks previously fulfilled by nurses now being undertaken by somebody else, Dr Lawrence said that this occurs in a range of situations including that administrative tasks have gone the other way also (t 316).

54 In her role in the North Metropolitan Classification Review Committee, Dr Lawrence said she did not recall that any claims had come before the CRC based on the FHRP and that '[t]he four hour rule did not change work value as a whole and therefore any claim that would have come before us would have been required to put forward some concrete evidence of the change of work value' (t 321).

CONSIDERATION

The Work Value Test

55 In the Statement of Principles arising from the State Wage Case, the Commission has set out the test to be applied for a claimed reclassification based on increased work value as being:

> 7.2 Changes in work value may arise from changes in the nature of the work, skill and responsibility required or the conditions under which work is performed. Changes in work by themselves may not lead to a change in wage rates. The strict test for an alteration in wage rates is that the change in the nature of the work should constitute such a significant net addition to work requirements as to warrant the creation of a new classification or upgrading to a higher classification.
>
> 7.3 In addition to meeting this test a party making a work value application will need to justify any change to wage relativities that might result not only within the relevant internal award classifications structure but also against external classifications to which that structure is related. There must be no likelihood of wage 'leapfrogging' arising out of the changes in relative positions.
>
> 7.4 These are the only circumstances in which rates may be altered on the ground of work value and the altered rates may be applied only to employees whose work has changed in accordance with this provision.
>
> 7.5 In applying the Work Value Change Principle, the Commission will have regard to the need for any alterations to wage relativities between awards to be based on skill, responsibility and the conditions under which work is performed.
>
> 7.6 When new or changed work justifying a higher rate is performed only from time to time by persons covered by a particular classification or where it is performed only by some of the persons covered by the classification, such new or changed work should be compensated by a special allowance which is payable only when the new or changed work is performed by a particular employee and not by increasing the rate for the classification as a whole.
>
> …
>
> 7.10 The expression 'the conditions under which the work is performed' relates to the environment in which the work is done.

> 7.11 The Commission should guard against contrived classifications and over-classification of jobs.

56 This test has not changed for many years. It reflects the work value test which has applied for many years prior to its inclusion in the Statement of Principles arising from the State Wage Case decision (see *Health Services Union of Western Australia (Union of Workers) and Director General of Health* (2008 WAIRC 00253; (2008) 88 WAIG 475, [7] – [15]).

57 Therefore, to satisfy their claim of increased work value, the FLCPs and HSU need to demonstrate that since the positions were last reviewed, in around 1989, the work, skill or responsibility of these positions or the conditions under which the work is performed have changed, and that such change constitutes a significant net addition to work value such as to warrant upgrading to a higher classification. It should be noted, too, that change of itself is not sufficient. It is change which brings a higher level of work, skill or responsibility or changes to the work environment which make it work of a higher level. It is a test to be strictly applied.

58 In *Re Public Hospital Nurses (State) Award* (No 4) (2003) 131 IR 17 (NSW), the New South Wales Industrial Commission made the following comments regarding the work value test.

> [18] These requirements under the work value principle impose a significant burden on an applicant, particularly because of the strict test requiring the applicant to demonstrate a "significant net addition to work requirements so as to warrant the creation of a new classification or upgrading to a higher classification". It might be asked how such a burden exists in a decade or more of rapid and continuing workplace change and the almost universal impact that phenomenon has had on employees. But as the principle makes clear, changes in work by themselves may not justify an increase in wages. Some changes bring about a net *reduction* in work requirements. Others merely reflect the evolving nature of the particular occupation where skills or responsibilities are lost and new ones gained without producing a net addition to work requirements. In many occupations, particularly professional occupations, change, and the requirement to cope with it by coming to terms with new methods and new technology, is an inherent and accepted characteristic of the employment and rarely will this evolutionary process attract extraordinary wage increases under the work value principle. In this respect, we note the observations of Fisher P in *Re Medical Officers – Hospital Specialists (State) Award* (1990) 33 IR 79 at 84 where, after referring to the work value principle, his Honour said:
>
> > One of the problems with the application of the 'strict test' to professional or managerial employment lies in the nature of the change. Change must be accommodated, being an essential part of what professional practice is all about. It does not follow therefore without more, that changes even spectacular changes, necessarily fall within the work value principle.
> >
> > Secondly it is to be understood that new techniques and procedures being with them their own advantages. For every new technological advance there is likely to be somewhere an inferior technology in part or in whole abandoned. Superior technologies give superior results and tend to free practitioners from laborious, uncertain and stressful practice. Changes, subject to habitation, do not necessarily make things more difficult or more demanding. They may, but equally they may remove problems, decrease anxieties and uncertainties and as well be more rewarding and more productive.

59 In *Australian Liquor, Hospitality and Miscellaneous Workers Union re: Child Care Industry (Australian Capital Territory) Award 1998 and Children's Services (Victoria) Award 1998 – re: Wage rates*, the Full Bench of the Australian Industrial Relations Commission (AIRC) said at [190]:

[190] Previous decisions of the Commission suggest that a range of factors may, depending on the circumstances, be relevant to the assessment of whether or not the changes in question constitute the required '*significant net addition to work requirements*'. The following considerations are relevant in this regard:

- Rapidly changing technology, dramatic or unanticipated changes which result in a need for new skills and/or increased responsibility may justify a wage increase on work value grounds. But progressive or evolutionary change is insufficient.
- An increase in the skills, knowledge or other expertise required to adequately undertake the duties concerned demonstrates an increase in work value.
- The mere introduction of a statutory requirement to hold a certificate of competency does not of itself constitute a significant net addition to work requirements. It must be demonstrated that there has been some change in the work itself or in the skills and/or responsibility required. However, where additional training is required to become certified and hence to fulfil a statutory requirement a wage increase may be warranted.
- A requirement to exercise care and caution is, of itself, insufficient to warrant a work value increase. But an increase in the level of responsibility required to be exercised may warrant a wage increase on work value grounds. Such a change may be demonstrated by a requirement to work with less supervision.
- The requirement to exercise a quality control function may constitute a significant net addition to work requirements when associated with increased accountability.
- The fact that the emphasis on some aspects of the work has changed does not in itself constitute a significant net addition to work requirements.
- The introduction of a new training program or the necessity to undertake additional training is illustrative of the increased level of skill required due to the change in the nature of the work. But keeping abreast of changes and developments in any trade or profession is part of the requirements of that trade or profession and generally only some basic changes in the educational requirements can be regarded, of itself, as constituting a change in work value.
- Increased workload generally goes to the issue of manning levels not work value. But, where an increase in workload leads to increased pressure on skills and the speed with which vital decisions must be made then it may be a relevant consideration.

60 In *Australian Municipal, Administrative, Clerical and Services Union v Sydney Water Corporation T/A Sydney Water* [2011] FWA 734, Sams DP noted the definition of 'significant' for the purposes of the work value change measurement. His Honour noted:

[195] It seems to me that the word 'significant' is the key to whether the 'strict test' has been satisfied. The Macquarie Dictionary's definition is 1. Importance: consequence. 2. Expressing a meaning; indicative. 3. Having a special or covert meaning; suggestive.

[196] *Liddy* J in *Mineral Sands (State) Award* at 114, described the word as follows:

> '…Significant' does not necessarily mean 'major', but 'to a meaningful degree, not insignificant, not immaterial, not trivial'. To be significant a factor does not have to be dramatic, sudden or eye-catching. A change, as in this case, may occur subtly, gradually, even covertly but on examination prove to be significant.

[197] *Hungerford* J in *BHP Steel (AIS) Pty Ltd – Hot Strip Mill Restructured Ironworker Award*, noted that changes may be 'cumulatively significant' but individually incremental in nature. I am satisfied that this description is appropriate to describe the many changes in work identified and agreed upon in this case. In addition, I note that Mr Vickers described some of the changes as 'subtle'.

61 These matters are relevant to the consideration of this case along with comments by the Commission in Court Session in such cases as the Clinical Psychologists work value case and the Specified Callings Work Value Case referred to later in these Reasons.

62 In this case, issues of flow-on and leap-frogging need to be considered. The impact of reclassification of a small number of Waitlist Clerk positions at FH and RPH led indirectly to claims in respect of the hundreds of FLCPs throughout the major tertiary hospitals, all relying on a comparison with those Waitlist Clerk positions. I think it is reasonable to assume that there are many more FLCPs in other hospitals and health services awaiting the outcome of these claims to decide whether to go to the starting gate.

63 There are a number of important matters of a general nature which require comment before I deal with the particular case put forward in the whole FLCPs review. The first thing to note is that it is very important that each position be viewed and assessed in context. That context is the whole of the classification structure within, in this case, the Western Australian public hospital sector. It is not the personal qualities and skills or diligence of the occupant, it is the objective requirements of the position, which are the basis of the assessment of the classification.

64 One matter of note is that the witnesses have been performing these jobs for many years. Mr Millman noted that there are four increments within the Level G2 classification, and the top of the level could be achieved within three years of commencement. He said:

> Part of the conundrum, perhaps – I don't know, but part of the basis upon which this application may have been made is the fact that the vast majority of people who are performing these functions have probably achieved three years' worth of service 10 times over. And so they're all stuck at the particular level.
>
> Now, I don't think that there's any power under these instant proceedings to do anything about that, except reclassify them to level 3 (t 436).

65 This proposition misconceives the notion of classifying positions, not people. It is the requirements of the position, not the skills, abilities, experience or competence of the person who fills the position which is relevant. There are four increments in the level, reflecting that the incumbent will be fully competent by the time they reach the top of the level. The evidence is of a person being trained within four weeks and then continuing to develop their competence with support. This does not suggest that the position requires any significant period of training or experience to meet the required level, certainly not many years of training and experience.

66 Further, it is the job the employer requires to be performed, and the way the employer has structured the arrangements under which the work is performed, which are the bases of assessment.

67 Within the public sector, positions are established and their classification determined by reference to objective factors. It is to be assumed that the classification as established by the employer is correct, and it is for the person who challenges the correctness of that classification to prove otherwise. This may be done in one of two ways. The first and most common is to demonstrate that since the position was last classified, it has been the subject of changes which constitute a significant addition to work value. This is done by reference to the nature of the work, the skills and responsibilities of the position or the circumstances under which it is performed. This is the basis of the great bulk of the claim in this case.

68 The second way is to demonstrate that the position is wrongly classified by reference to like positions. The Waitlist Clerks at SCGH rely in part on this ground, in particular by reference to other Waitlist Clerk positions within the public health sector.

69 However, the position must ultimately fit within the overall classification structure, by reference to the levels of other positions.

70 There are some overarching issues which can be dealt with. I intend to deal initially with the background to group reclassifications in the public health sector which set the scene.

Specified Callings Work Value Review – Introductory Paper

71 The HSU has relied, to some extent, on the review of specified callings, or allied health professionals, in the public health sector as setting the scene for these claims. However, I think it is important to go back a step further and look at the Clinical Psychologists work value case.

Clinical Psychologists Case and Work Value

72 The Commission in Court Session dealt with a claim by the Hospital Salaried Officers Association of Western Australia, now the HSU, regarding the classification structure as it applied to clinical psychologists, on the basis of a claim of increased work value ((2003) 83 WAIG 23; 2002 WAIRC 07218). This case was the precursor to the specified callings review, it being the first of the callings to be reviewed. In the clinical psychologists' case the Commission set out some useful guidance regarding work value claims. They said:

> 144. From time to time, the Commission has noted that particular matters can or cannot be considered as part of a Work Value assessment. Those changes which are evolutionary and apply to the workforce generally, such as changes from the manual to automated or computerised systems are not indicative of an increase in work value (*The Australian Liquor, Hospitality and Miscellaneous Workers Union, Miscellaneous Workers Division, Western Australian Branch v The Honourable Minister for Education* CR 49 of 1997 (79 WAIG 648)). 'Mere changes in volume of work or mere changes in technology will not always be sufficient to warrant a new rate of pay … it is a plain fact of life that technology changes and employees must expect to adapt to meet those changes as and when necessary'. (*Hamersley Iron Pty Limited v The Construction, Mining, Energy, Timberyards, Sawmills and Woodworkers Union of Australia – Western Australian Branch and Others* (1994) 74 WAIG 926).
>
> 145. As to the degree of change required for there to be an increase in work value, it matters not whether changes have been evolutionary or revolutionary. Evolutionary change can be just as substantial and significant as revolutionary change. (*Hospital Salaried Officers Association of Western Australia (Union of Workers) v Royal Perth Hospital and Others* (1987) 76 WAIG 554 at 557). Incremental or cumulative change, when taken as a whole, may constitute such a level of change that developments have exceeded those which would reasonably be expected.

…

148. Importantly the Work Value Changes Principle stipulates that the time from which work value changes in an award should be measured is the date of operation of the second structural efficiency adjustment allowable under the September 1989 State Wage Decision (1989) 69 WAIG 2917. Under that State Wage Decision the structural efficiency principle enabled parties to undertake a 'fundamental review of the award with a view to implementing measures to improve efficiency of industry and to provide employees with access to more varied, fulfilling and better paid positions' (op. cit. at 2917). The wage system comprehends classifications based on skill acquisition and training within the framework of a career structure.

149. With the second structural efficiency increase to this Award, in October 1989, (69 WAIG 3290) the classification structure was changed. The classifications were broad banded to create the structure as it applies today. Subsequently, the HSOA obtained industrial and award coverage of clinical psychologists in the public health sector, the vast majority of whom had previously been covered by the Public Service Award 1992 (No. PSAA 4 of 1989). The new amalgamated clinical psychologists group then had access to classification criteria progression, which enabled movement from level 6 through to level 7 and level 8 upon satisfying the appropriate professional progress criteria.

150. The questions to be determined are:

    1. What changes have occurred in the requirements of clinical psychologists in the public health sector since the structural efficiency adjustment?

    2. Do the changes apply across the sector?

    3. Do those changes constitute a net addition to the work value?

…

155. It is true that not all of these developments apply equally to each area of work, or at each level. For example, level 6 Registrars are required to spend an additional year in supervised training on account of the increased demands, complexity and body of knowledge, but would not be involved in specialisation. The more senior levels have increased supervision responsibilities. However, there is sufficient change across the board, and in the various sectors, such as in regional services, in youth services, in gerontology, surgical areas, and all others, to enable a conclusion that there is a high level of change across all of the public health sector clinical psychologist positions before the Commission. It is a matter of how those changes ought be reflected at the various levels.

156. As to the claim that changes to the work environment of community-based work rather than the previous hospital based focus, and the use of multi-disciplinary teams, these are common across the mental health sector. The clinical psychologist operating within that system is no different from the mental health nurse, occupational therapist, psychiatrist, or medical practitioner in that respect. The clinical psychologist may head the multi-disciplinary team, but so might other professionals. That does not mean that there is no increase in work value. We conclude that the change to the community based approach has lead to increased efficiency and cost effectiveness of treatment, by the significant reduction of in-patient bed days and by the use of the multi-disciplinary approach. Other professions may contribute to this and any such contribution would need to be weighed with any other changes to the professions should they make a similar claim.

73 These findings are of significance in what followed in the review of the classification of health professionals, or specified callings ((2006) 86 WAIG 279; 2006 WAIRC 03473). As part of that claim, an Introductory Paper dealing with the changes said to have occurred across the

whole of the public health sector as they affected health professionals, was submitted to the Commission.

74 The Introductory Paper, at section 2. Changes in Scope, notes that there were a number of common areas of change across all specified callings which had been grouped as service delivery, demographic or structural changes. In respect of service delivery changes, these were identified as including:

- The impact of a greater number of diseases making treatment more complex and increasing the number of patients with co morbidities.
- Pressure from shorter length of hospital stay for many conditions creating increased liaison between health professionals and community based health care including general practitioners and other external organisations.
- Patient treatment being initiated in acute stage of recovery in ICU and in emergency departments requiring increased skills for management of the complex and diverse caseloads.

(Introductory Paper, page 4)

75 The Introductory Paper also notes that:

> Less time in hospital does not mean that services are reduced. Instead health professionals must provide the same services in very different conditions, either during a greatly reduced hospital admission or in at-home and community services.
>
> To meet this change in the nature of their work, health professionals constantly increase skills and responsibilities to ensure that the appropriate level of care is provided. Health professionals have built up a comprehensive knowledge that incorporates both the overarching DOH changes and the regional health service internal directorates. Outside the tertiary hospitals, the evolution of population health units from the previous community centres is an example of DOH and regional change that has created change:
>
> - In the community based multidisciplinary teams that the health professionals work in.
> - To a focus on priority groups such as very young children.
> - In skills required in the health professional positions.

(Introductory Paper page 6)

76 Emphasis on an intersectoral approach to care planning was said to have increased the complexity of work, increased liaisons and increased knowledge of external bodies.

77 There is also reference to programme development and involvement in planning committees, requiring higher levels of skill and responsibility, including increased professional autonomy.

78 Under 2.1.1 Alternative Models of Care, it is said that alternative models of care have been developed in the last 15 years due to the changed health care environment which has resulted in:

> a recognised shift from medically directed care to more collaborative interdisciplinary care, where the team members are the case managers for the patients. Case management is a system for delivering care that coordinates interdisciplinary care services, plans care, identifies expected outcomes, and helps facilitate the patient and family toward those outcomes. This new model of care is dependent on early assessment of the patient by the relevant members of the team and means changes in the nature of work and in skills and responsibilities for health professionals.

(Introductory Paper page 7)

79 The Introductory Paper goes on to refer to the greater autonomy of members of the treatment and intervention teams and the change in the arrangement from the medically headed system to different models including the team based approach.

80 At page 8 of the Introductory Paper, there is a list of issues which set out how health professionals work in alternative models of health service delivery including early intervention; linkages between hospital and community services; shorter average stays in hospital; diverting patient admissions at the Emergency Department to such services as social work, physiotherapy and occupational therapy of elderly people and referral for in-home services; collaboration and liaison between health service providers to support integrated care; home based care such as Homelink which was introduced in late 1990s; palliative care at home, and self-management of chronic diseases requiring the health professionals to educate and support the patients in this model of care.

81 The Introductory Paper also deals with changes in technology and gives examples of increased knowledge, for example, of surgical procedures by health professionals and its impact on early discharge of patients. Change in diagnostic technology requires an increase in skills to undertake procedures. The development of new drugs increasing longevity and life expectancy requires increased knowledge for certain of the specific callings. Medical imaging technology and teleradiology replaced the need to physically transport films to radiologists, and increased the required level of the medical imaging technologist's skills.

82 The use of Telemedicine requires the health professionals to develop new skills for education, clinical and management use as well as adapting their service provision to ensure best use of technology.

83 Changes in information technology were said to have expanded the scope of practice and greatly increased the competencies required by health professionals. Internet access is said to have increased community access to health information creating new levels of awareness and sophistication in patients in relation to the management of their health, and this information may not be reliable. Health professionals are said to have a new role in interpreting web-based information for clients (Introductory Paper page 14).

84 There are also references in the Introductory Paper to changes such as through Evidence Based Practice, demographic and population changes, health and morbidity trends and many other changes relating to models of care.

85 In terms of structural change, there is reference to the clustering of metropolitan health boards and the development of the Western Australian Country Health Service. These are said to have a major impact on health services and health practitioners. The focus, from the late 1990's, on bed management, waiting lists and discharge programmes affected the way patients were managed, requiring increased skills and devolution of coordination and direction of health professionals (pages 23, 24).

86 Issues of clinical governance and devolution of responsibility including registration requirements, professional standards, fitness to practise issues and accountability are all matters which have increased the responsibilities of health professionals. Professional education has significantly increased for many of the individual health professions and examples were given of higher standards of academic requirements for particular programmes. The Introductory Paper deals with increased levels of responsibility for health professionals

and changes in the nature of work arising from clinical governance requirements, legislation, financial management and human resources management.

Conclusions Regarding the Introductory Paper

87 It is fair to say that the Introductory Paper is merely that, an introduction. The substance of the particular work value claims of the health professionals is contained within 23 volumes, one for each of the health professions covered by the HSU. Some of those are very detailed in the descriptions of the requirements of the positions, for example, that relating to the profession of occupational therapy is some 300 pages and that for dietitians is 160. Others are significantly shorter such as that relating to audiology which is 29 pages.

88 Each of the volumes addresses the requirements of the particular profession by reference to:

- Definition and scope of practice of the profession;
- Changes in the scope of practice, training, qualifications, standards and registration of the professions;
- Areas of specialisation; and
- Impact and effectiveness in respect of the changes.

89 In this context, the Introductory Paper is to be seen just as an introduction. The 'meat' is in the individual professional submissions.

90 Most significantly, where the Introductory Paper refers to changes in for example, service delivery, it is not that change of itself which is significant, but the effect it has on the work, skills and responsibilities of the position and the conditions under which the work is performed.

91 One of the most significant aspects in terms of providing any degree of comparison between frontline clerks and health professionals is set out at '3.1.4 Changes in the conditions under which the work is carried out' at page 36 of the Introductory Paper. Those changes, as far as health professionals were concerned, dealt with changes in traditional managerial and professional health cultures, risk management and accountability. The circumstances of multidisciplinary teams and rural and remote organisational changes were some of those changed conditions under which the work is performed.

92 The HSU relies upon the Introductory Paper as being illustrative of changes across the public health sector. Some of those changes may also be applicable to FLCPs, however, their effect has been quite different. Having examined both the Introductory Paper and the multiplicity of specific health profession claims, I am unable to find that there is a significant degree of commonality between the effect of those changes on specified callings and the FLCPs. By this I mean that the changes affecting the FLCPs may include shorter stays in hospital which may affect, for example, the work volume of ward clerks, and increased presentations of patients in Emergency Departments requiring speedier attention to comply with the FHRP. The impact for clerical staff is on workload and work pressure whereas its impact on the professions also required increased skill and responsibility.

93 The issues affecting FLCPs, generally speaking, perhaps with the exception of Clinic Clerks, relate to hospital-based services. The health professionals were required to take on added responsibility for the patient and in a context going beyond the hospital setting. The health professionals also relied on significant professional qualifications and practice issues.

94 Not only did the work context change from only being hospital based and medically led to community based and in a team arrangement, but it required increased professional skill, education and accountability. The FLCPs have undergone change but its magnitude, scope or effect are different. Whether the change to FLCPs is of a significant net addition to work value requires assessment of the work of FLCPs. I find that reference to the Introductory Paper does little to assist in identifying the effect of the changes on the work of FLCPs.

Broadbanding and the Public Health Sector

95 The current classification of these positions as Level G2 within the Hospital Salaried Officer classification structure needs to be seen in the context of the review and rationalisation of classifications and career structures within a number of awards including the *Hospital Salaried Officers Award* No 39 of 1968 (the Award) which took place in 1989 as part of the implementation of the Structural Efficiency Principle. Following lengthy negotiations, the parties to the Award, having observed the creation and implementation of the public service broadbanded structure and its implications, agreed on a range of measures for the Award. At the hearing before Fielding C on the 10 October 1989 ((1989) 69 WAIG 3290), the parties submitted a Memorandum of Agreement (the Memorandum) which said amongst other things that:

> The union and the employers agree to amend the above awards to include career structures and multiskilled classifications.

96 Under Clause 2 – OBJECTIVES, it noted that one of those objectives was to '[p]rovide better and more fulfilling jobs with varied skills within a band enabling more mobility within that band and between bands (Vertical and Horizontal Mobility).

97 Appendix 2 – BROADBANDING PROPOSAL FOR HOSPITAL SALARIED OFFICERS, under the heading DEVELOPMENT OF PROPOSAL, noted that in 1987 the Office of Industrial Relations conducted a feasibility study into the relevance of broadbanding, as it had been applied in the public service, for hospital salaried officers. It said:

> Cognisant of the organisational and occupational group problems which resulted from the introduction of broadbanding in the public service, the Office of Industrial Relations developed a slightly different model for the hospital industry. This new model was designed to retain existing hierarchical and reporting structures wherever possible, whilst at the same time providing increased flexibility in the utilisation of human resources.

98 The Memorandum went on to note the advantages of the proposed model of broadbanding, including the rationalisation of 142 classifications and 398 salary points into 11 classifications and 43 salary points, resulting in appointments and salary administration being simplified. There were also advantages of reducing minor promotions, particularly in clerical grades, because of the extension of the existing limited salary table range to a greater range. There was flexibility to transfer staff within their level because they were no longer appointed to a specific post and there would be the capacity for 'staff rotation through a variety of work areas, thereby enhancing succession planning and multi-skilling'. The expansion of salary ranges was to provide more logically incremental patterns and career structures.

99 The new Level G1 was to be a combination of the former classifications A1.L1-L3, A3, A1.L4, B1.1 and B6.

100 Level G2 in the new broadbanded structure was a promotional grouping combining the old A1.L5, A4.1-3, B1.2 and 3, A2.1, B2.1.

101 Level G3 was a new promotional grouping of A4.4, 5 and 6, A2.2 and 3, B2.2 and 3.

102 When dealing with the issue of broadbanding in respect of the public service, Fielding C said:

> In the case of the broadbanded classifications, it must be understood and accepted that bands are broad and within each band the range of duties will be wider than under the former scheme of multiple classifications and hence not any change in duties justifies reclassification from one band to another.
>
> …
>
> The object of dealing with reclassification applications in the Commission is so that they will be resolved in accordance with its wage and salary fixing principles. There has undoubtedly been an increase over time in the level of classification for many in the Service; a 'reclassification creep', with the only apparent justification being the effluxion of time or a newly acquired grandiose title ((1988) 68 WAIG 2008-9).

103 These comments, firstly as to the broadening of the range of duties within each new level, and the need to ensure that change of itself, particularly by the broadening of the scope of duties which fit within the particular levels, will not lead to 'reclassification creep', are as pertinent to hospital salaried officers as they were to public service officers.

104 Therefore, in considering these claims, two particular principles need to be borne in mind: firstly, broadbanding means where a job previously had a limited range of duties, it could now take on a broad range of duties at the same level. This means that an increase in the range of duties of the same level does not necessarily increase the work value of the position. This is what is meant by multiskilling. Secondly, it is necessary to examine the skills and responsibilities of a position to ascertain if there has been change, and if so, what is the level of change and does it constitute a significant net addition to work value?

Historical Level of FLCP Duties

105 The positions the subject of this application are Level G2 positions. The respondent has included within its documents at Volume 1, Tab 5 a bundle of job description forms or duty statements for FLCPs dating back, in some cases, to the 1980s. There are also job descriptions contained in Reclassification Requests in the Employers' Volumes 2A and 2B. These job descriptions are very helpful in ascertaining the requirements of the FLCPs at the time from which change is said to have occurred and to enable comparison with the positions as they are at the time of this assessment.

106 The first such document in Volume 1 tab 5 is for a Medical Records Clerk in the Emergency Centre of RPH. It had a classification of A1.L5, equivalent to a Level G2 position. The way in which the document has been photocopied has resulted in the last digit of the date being absent, however, what is clear is that it applied in the 1980s. The duties set out for that position were as follows:

1. Participates in a rotating roster (24hr. shifts)
2. Provision of a reception and enquiry service for patients attending the Emergency Centre covering all areas, reception counter, treatment, assessment and resuscitation areas. Completes emergency attendance documentation for patients requesting to see a doctor. Also for patients admitted by ambulance or private car. Identifies patient in Hospital Patient Master Index and arranges update if necessary. Responsible for the initiation of new file, no hard copy, or flagged records. Arranges registration of new files, new information, or changes to current information. Responsible for calling all medical records.

3. Completes admission documentation, including financial classification forms, for patients admitted through the Emergency Department, clinics and doctors private rooms. Arranges bed location via Bed Allocation Centre. Provides a country list for The Friends/Social Work Dept.

4. Maintains attendance/admission register. Answers telephone enquiries from both medical staff, and patients. Responsible for patient identification labels, on all patients attending Emergency Centre, Recording of Emergency Centre statistics. Maintains the files held in Emergency Centre, including the filing of all loose reports, loose filing, and latest documentation written by medical staff. Returns Medical Record to filing room after completion.

5. Attends to duties of 'Liaison Clerk' which include distribution of documentation to relevant areas. The making of outpatient appointments, booking ultrasounds, holter monitors etc., or any investigations that are required. Ensuring adequate stationery is provided for all areas of the Emergency Department, including the re-ordering, each week.

6. Responsible for press calls concerning patients being treated in the Emergency Department. Provides daily admitting rosters for the Emergency Department. Redirects all phone calls which are received through the Liaison's Access phone. Responsible for the taking down of laboratory results, for Emergency Centre patients, and relaying them to the appropriate doctor.

7. Responsible for booking in and paying out of patient's cash and valuables, after normal working hours, public holidays and weekends. This includes deceased property. Provides relief for booked admission clerk during lunch breaks, annual leave, provides a 24 hour service for all the above duties.

107 The next duty statement is for a Clinic Clerk position, number 781, at RPH. This position was classified at Level A1 under the pre-broadbanding system and it bears a stamp indicating that it was registered on 21 May 1990. Its duties were as follows:

Maintain Out-patient appointment books and arrange appointments for new and review patients referred both from within and outside the Hospital.

Arrange bookings for various medical tests and procedures as required by the Doctors and pass on any instructions that may be required for those tests and to direct patients to various Departments.

The collation of patients loose reports within the medical record in a pre-determined order on the day of attendance for readiness at the Clinic.

Intercept all telephone calls, evaluate and initiate any action required.

Responsible for the collection and disposal of all medical records, x-rays and dictation to appropriate departments within the Hospital.

Liaise with Doctors, Nursing Staff and other Departmental staff regarding the day to day running of the Clinic.

Copy, collate and distribute daily clinic lists.

Initiate action on all incoming mail.

Statistical analysis of outpatients daily attendances.

Forward written and verbal information to Documentation Centre for all new hospital cases and change or update of patient information.

Train and orientate new staff.

The organisation of transport for inpatients and outpatients using orderlies, St John Ambulance and other voluntary transports, liaising with the Social Worker.

Ordering and maintaining stationery supplies for the Clinic.

Completion of such other clerical tasks as may be allocated.

I note that this position, at level A1, may have been an equivalent to either Level G1 or Level G2 under the current classification structure.

108 The next is for a Ward Clerk at RPH, position number 1876, and was classified at A1.5, equivalent to Level G2. This was registered on 9 March 1989. The duties for this position were:

1. Filing of all medical results and reports relating to inpatient stay.

   Collation of patient records in a pre-determined order on discharge and arrange completion of Morbidity Coding, Interim Discharge Letter and Summary.

   Checking of ward census and liaison with Bed Allocation Centre re: notification of discharges, transfers and condition changes.

   Requesting of x-rays and returning them to the X-ray Department after discharge.

   Completing patient admission and classification forms for patients unable to elect at admission point.

2. Advise shift co-ordinator and medical staff regarding patients admission.

   Prepare all necessary ward forms associated with admission and enter on bed list.

   Intercept all telephone calls, screen intelligently, and direct visitors to appropriate patients' rooms.

   Arrange inpatient, outpatient and general appointments and transport.

   Record telephoned laboratory results and notify medical staff.

   Advise relatives of discharge (when required).

   Advise shift co-ordinator of theatre lists and pre-meds for following day.

   Liaise with social worker.

3. Ordering stationery.

   Distribute mail and telephone messages to patients and staff.

   Writing up Nurses Roster.

   Keeping pre-admission notes made up and ready for admission.

   Responsible for the completion of acute care forms and return to Patients Fees Department.

109 The next position is a Ward Clerk at SCGH, registered in November 1988, classified as A1.L4. However, according to the notations, I conclude that its reclassification to A1.L5 (Level G2) was approved by the Classification Review Committee in 1990. Its duties in 1988 were:

1. Liaise with Medical, Nursing, Allied Health and Hotel Services staff regarding the day to day organisation of the ward.
2. Quality Control – Ensure set standard is maintained for the ward area.
3. Notification to ward staff of an admission.
4. Receive all phone calls and screen intelligently.

5. Admit patients and liaise with patients and relatives.
6. Arrange transport for patients movements.
7. Arrange outpatient appointments.
8. Record medical test results that come through by telephone.
9. Arrange appointments for patients tests, etc.
10. Keep patient bed board up to date.
11. Take messages from Medical, Nursing, Allied health and Hotel Services staff to relay to telephone caller.
12. Arrange notes and x-rays for various meetings that are conducted on the ward area. Send notes to appropriate areas for outpatient clinics.
13. Distribute mail to patients, Medical and Nursing staff.
14. Relay telephone message to patients, Medical, Nursing, Allied Health and Hotel Services staff at Ward Clerks discretion.
15. Documentation of admission papers as necessary.
16. Follow-up incomplete admission papers as necessary.
17. Update the ward census of all patient admissions, transfers, discharges and deaths. Notify Bed Allocation of the above.
18. Notify Bed Allocation of the bed state.
19. Notify nursing staff of possible infectious patients requiring isolation.
20. Ensure medical records and x-rays are available on admission of patient.
21. Liaise with patients or relatives regarding bed availability.
22. Take pre-med time orders from theatre and notify nursing staff immediately.
23. Orientate new nursing and medical staff to clerical/ward requirements.
24. Train relief clerks to cover ward area for sick and annual leave.
25. Notify nursing staff if aware of patient in medical difficulties.
26. Request supply items and stock ward with stationery.
27. Photocopy as necessary.
28. Keep ward stocked with sufficient amount of starter packs.
29. Complete minor work requests and forward to Engineering.
30. Arrange connection, maintain record and organise disconnection of private telephones.

MEDICAL RECORDS

31. Maintenance of patients medical records on ward area e.g. all filing checking of labels, general tidying up etc.
32. Obtaining and monitoring movements of the patients medical record and x-ray from admission to completion of inpatient summary.
33. Maintain a daily outstanding summary list. Totals to be submitted on a weekly basis.
34. Ensure medical staff complete summaries and coding.

110 The next is for a Ward Clerk position at Armadale Kelmscott Memorial Hospital which is not one of the hospitals under the current claim.

111 The following job description is for a Ward Clerk at PMH. This was classified at Level G1 in March 1991. The duties of this position were:

1. Co-ordinates (without direct supervision) the daily administrative requirements of the ward.

   Liaises with Medical, Nursing, Allied Health and other Hospital and Support Services Staff, patients and visitors to ensure effective functioning of the ward.

2. Arranges patient admissions, transfers and discharges.

3. Maintains ward bed availability information and advises Bed Allocation Centre of patient movements.

   Liaises with shift co-ordinator and advises relevant medical staff of patient admission details.

4. Arranges all appointment schedules for all inpatients and outpatients, internally and externally.

5. Records, collates and directs the distribution of diagnostic investigation results (pathology, radiology etc) and other patient data for Medical, Nursing Staff and patient's Medical Records.

6. Advises medical and nursing staff of ward procedures and co-ordinates same (eg: Lady Lawley Cottage discharge).

7. Maintains patient's medical records from admission to discharge, being responsible for accuracy of order and tidiness. Requests and returns patient related documentation and x-rays.

8. Assesses needs and arranges patient requirements with regard to transport, Interpreter Services, P.A.T.S.

9. Trains new/relief Ward Clerks.

10. Maintains filing systems. Policy Manuals and all stationery requirements for the ward.

11. Monitors and screens all telephone calls, mail and visitors to the ward and initiates appropriate action.

12. Types cases summaries and correspondence from tapes/long hand as required.

13. Other duties related to this position approved by the Head of Department.

112 There is a further job description form for PMH part-time Ward Clerk at Level G2. This one is effective from September 1991. The duties are identical to the one above, classified at Level G1, indicating the reclassification of the Ward Clerk position at that time.

113 The next is a job description form for a Ward Clerk, item No. BL125 at Bentley classified at A1-L3 in 1989 equivalent to the current Level G1. There is a Reclassification Request form for that position. That claim relied on a number of duties said to have been taken over from nursing staff. The introduction of computers and non-nursing duties had changed the structure of the ward clerk position. It is not my intention to recite each claim but I note that many of the items referred to in this Reclassification Request form have a great similarity with those currently before the Commission including the interception and screening of telephone calls from family members of patients which was previously a nursing duty; arranging appointments for tests; ensuring the accuracy of patient records; dealing with people from diverse cultures; identifying patients with infectious diseases. The summary is of particular note. It says:

In summing up I would say that the most significant change in the ward clerk duties is that she/he has become a member of the medical/nursing team, rather than just a clerical worker. This new role requires much greater responsibility in decision making and oral and written communication skills and having the ability to have input in decisions with regard to the improvement efficiencies in coping with an ever increasing need with a reduced budget.

114 The comparison positions relied upon in that case were Ward Clerks, Level G2, at Armadale Kelmscott Hospital and at PMH. According to the correspondence contained on the file, as of 15 August 1989, this position was reclassified to A1.L4 which was also in the Level G1 classification.

115 The next document is a duty statement, as at January 1990, for a Bed Allocation/Main Reception Clerk at PMH and was classified at A1.L5, equivalent to Level G2. The duties for that position are as follows:

1. Bed Allocation Duties

    1.1 Allocate beds for all admissions arising from booked admissions, Emergency Department, Outpatient clinics, liaising with nursing/clerical staff.

    1.2 Receive and input all information regarding Transfers between wards, Separations, Leave and Specialty Transfer. Advise nursing/clerical staff of all patient movement.

    1.3 Update patients' condition, medical insurance details and all other relevant details in respect of patients' admissions.

    1.4 Operate the computerised Patient Care System in functions available to this department.

    1.5 Responsible for checking and distribution of Booked Admission List, Patient Master Index and producing other computer reports for departmental and ward use.

    1.6 Maintenance and updating of computerised Patient Master Index function, including amendments to personal details, address changes, insertion of medical particulars and cross-referencing.

    1.7 Maintenance of Bed Board and responsibility for maintenance of back-up system by manual means.

    1.8 Telephone enquiries from parents of patients regarding availability of beds for booked admissions.

2. Main Reception Duties

    2.1 Reception, registration, admission and discharge of patients from the Emergency Department, Primary Care Clinic and Admission Bureau.

    2.2 Input new registrations and update existing data on the computerised Patient Care System.

    2.3 Generate computerised patient attendance documents and identification labels from printers.

    2.4 Prepare new records for patients and process existing records as necessary.

    2.5 Prepare downtime registration documentation.

2.6 Deal with personal and telephone enquiries relating to whereabouts and condition of patients.

2.7 Maintain report and label printers.

2.8 Relieve in the Emergency Department and Primary Care Clinic as required.

3. Other Duties

3.1 Perform other duties relating to this post as required.

116 The next is a job description, as at 28 September 1989, for a Clerk PMI (Patient Master Index)/ATS, in the Admission and Discharge Services of SCGH, position number 508/034 classified A1-L4, which is the equivalent of the current Level G1, had the following duties:

1. A.T.S.

- To find and allocate beds for elective and emergency admissions.
- To maintain the accuracy of the bed control board.
- To record the presence and movement of patients.
- To update and record patient bookings.
- To input all information supplied to the waiting and booking lists.
- To ensure the production, collation and distribution of computer reports as directed.
- Telephone enquiries and liaising with medical staff and patients on admissions and cancellations.

2. P.M.I.

To maintain the accuracy of the Patient Master Index by:

- registering new patients
- updating index records with new information

To perform Master Index search when requested via computer and microfiche.

To receive requests for medical records and handle as appropriate.

To maintain organ donor registers.

3. GENERAL

To assist in maintaining the accuracy of computer records.

To maintain daily work controls.

To handle enquiries as appropriate.

To assist with operation of facsimile machine and log, then notify departments.

To assist in on-the-job training of new recruits.

The prime function of this position was:

1. Responsible for the maintenance and update of computerised Patient Master Index system including allocation of unit medical record number and amendments to patient personal details.

2. Responsible for the maintenance and update of the Patient Care System including allocation of beds and recording of patient bed movements.

117 A position of Assistant (Bed Control) at SCGH, in December 1981, was classified by the CRC at A1-5, equivalent to Level G2, and had the following duties:

1. To deputise for the Bed Control Officer as required.
2. To be aware of all procedures and processes within the Centre.
3. To handle all telephone requests for admissions i.e. less than 48 hours and arrange the allocation of beds with the Bed Control Officer.
4. To ensure that all documents are sent out to elective patients at the appropriate time.
5. To ensure that all inpatient bed request forms are complete before being sent to PMS/ATS.
6. To liaise with patients regarding:
    (a) Details on admission advice form;
    (b) Arranging admission if there is no time to arrange this by mail;
    (c) Cancellation or postponement of admission.
7. To liaise with secretarial staff in consultant's private rooms as required.

118 Other duty statements from the late 1980s and early 1990s contained in the Reclassification Requests cover the Clinic Clerks, Radiology at RPH in 1992, Level 1, Clinic Clerks Medical Records, RPH in 1990; Clerks, Emergency Centre, RPH, in late 1980s and others.

Indicative Duties for Levels 2 and 3

119 I also note Mr Holland's evidence about the identification of the duties carried out by Level G2 positions which included the former A1.L5 and the former A2.L1 prior to broadbanding. As Mr Holland says, the A1.L5 level reflected the low end of the HSU level G2 classification, and A2.L1 reflected the high end of the classification. Those indicative duties for A1.L5 included:-

Arranging patient admissions, transfers and discharges.

Completing emergency attendance documentation.

Obtaining, maintaining and monitoring all medical records.

Determining patient's financial classification through interview.

Arranging beds via the Bed Allocation Centre.

Recording statistics.

Making outpatient appointments, including those for various medical tests and procedures, images and other investigations.

Recording medical test results.

Arranging transport for patients.

Liaising with medical, nursing and allied health staff.

Ensuring the maintenance of quality standards for the work area.

Screening patients for identification of infectious diseases e.g. MRSA, Hepatitis B.

Notifying nursing staff of possible infectious patients requiring isolation.

Orientating new nursing and medical staff to clerical requirements.

Training and orientating new and relief staff.

Notifying nursing staff of patients in medical difficulties.

Completing minor works requests.

Arranging the completion of summaries and coding.

(exhibit A8)

120 The duties at A2.L1 are not described in Mr Holland's statement, however they also form part of the Level G2 classification.

121 Mr Holland also says that during 1999 and 2000, SCGH carried out a comprehensive analysis of duties and associated skills and other attributes for Medical Records Clerks at Levels G1 and G2. He says that this process involved extensive consultation with position holders, supervisors and the HSU. As a result, in October 2000, SCGH published a detailed document titled 'Competency Assessment Package – Progression of Medical Records Clerks to HSOA Level 1/2'. Mr Holland says that the job descriptions and documents referred to enabled the development of a list of common duties which characterised Level G2 and Level G3 respectively. He says:

> The duties for Level 2 cover areas such as scheduling, records, collating and related duties, administrative support and related duties, liaising, and finance and maintenance. The duties for Level 3 cover areas of coordination, liaising, supervision and mentoring, finance, maintenance, research/projects, and policies, procedures and quality assurance.

(exhibit 4 *Waitlist Clerks)[13] Witness Statement of John Holland (Appendix D to the applicant's outline of submissions and statement regarding Wait List Clerks L2 Inpatient Booking Service – Patient Flow Unit, Sir Charles Gairdner Hospital).

Classification Tool

122 Mr Holland also referred to a tool prepared as part of a review of FLCPs called the 'Classification Tool' which set out the background to the development of the classification tool and the historical relationships between various levels. This document also notes the list of common duties for positions as Level G2 having been developed, including Appendix 1 Level 2 HSU List of Common Duties and Appendix 2 Characteristics of Level 3. (See Employer's Volume 1, Tab 3). (I note for completeness that these two appendices have some other appendix numbers on them and I surmise that that is because they have been used as appendices, within different numbers, for other purposes. For the purposes of this case they are Appendix 1 and 2.) The Level 2 duties are listed below. The duties marked with an asterisk are said to align with 'lower PSA Level 1 duties', which equals HSU Level 1, contained in the Public Service Classification Benchmark Manual.

Scheduling, records, collating and related duties

- Co-ordinates all clinical appointments via TOPAS for all clinics.
- Collates medical records including all reports and documentation for patient appointments.
- Processes arrivals and discharges for patients attending clinics.
- Maintains a suitable medical record tracking system in keeping with policies and guidelines.
- Maintains patient filing.
- Receives and processes all incoming mail. *
- Maintains patient medical records being responsible for accuracy of order and tidiness as necessary.

- Arranges bookings for Diagnostic procedures.
- Monitors and screens all telephone calls, mail and visitors to the ward and initiates appropriate action. *
- Liaises with patients, verbally and/or by correspondence, regarding waiting list inquiries/admission arrangements/hospital requirements.
- Collects documents and despatches medical records * to and from the Health Record Management Service and Outpatients Clinics.
- Performs data entry as required * on departmental systems including PSOLIS.
- Arranges outpatients clinics and subsequent liaison with patients on computerised patient information system TOPAS.
- Prepares and maintains medical records ensuring all relevant results and reports are available and appropriate filed, together with other paper work relating to the outpatient attendance.
- Arranges diagnostic tests and procedures, providing instructions and directions to patients. Ensures relevant x-rays are available for outpatient clinics.
- Organises patient transport and orderly services as required.
- Allocates beds for emergency admissions and elective admissions.
- Records new patients attending the Hospital and issue new medical records for those patients.
- Records patient admissions, discharges and movements on the Patient Administration System.
- Amends/updates patient identification details * on the Central Patient Index.
- Provides patient labels for wards and various departments.
- Receives patients to the ward, allocates bed and ensures patient data is complete and correct.
- Coordinates procedures and processes for the Section.
- Organises pre admission and pre anaesthetic and advises patients accordingly.
- Ensures medical and other records are filed, retrieved and prepared for patient attendances.
- Organises the culling archiving and destruction of medical records.
- Utilises computer systems to identify patients, processing of patient examinations, register and update patient information, and to identify and rectify data discrepancies.
- Collates monthly workload statistics.
- Maintains Coordinates complaints database and assists with producing complaint reports.
- Maintains Coordinates patient feedback and compliments databases.
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- Maintains Coordinates patient feedback and compliments databases.

- Schedules patient appointments in consultation with Clinicians and provides assistance about waiting lists and bookings procedures, and alerts clinicians to discrepancies.
- Schedules efficient theatre lists in consultation with clinician

Admin support and related duties

- Carries out full range of administrative duties, including reception *, word processing *, data entry *, mail collection and delivery *, and maintenance of filing systems * including archiving.
- Assists with the operation of various meetings, * teleconferences and videoconferences, including arranging catering, booking of rooms and equipment and providing technical support.
- Coordinates monthly staff meetings * including development of agenda and taking of minutes.
- Screens telephone calls and initiate appropriate action. *
- Orders relevant medical records.
- Undertakes the handling of the mail distribution and telephone calls as required. *
- Maintains office records and filing system. *
- Maintains office stationery stock levels.
- Provides comprehensive administration and clerical systems support (including data processing *).
- Undertakes receptionist duties and operates switchboard * and is responsible for triaging calls to staff.
- Acts as a confidential medical receptionist.
- Handles all enquiries inter-hospital and public, via phone and in person and directs queries to appropriate personnel. *
- Manages appointment diary, Provides reception service, Coordinates client service, Maintains Head of Department's diary. *
- Maintains staff training programme, Maintains department statistics.
- Maintains intradepartmental files. *
- Performs confidential administrative and secretarial support.
- Prepares manuals and documents such as agendas, minutes, report production, overhead and presentations.
- Maintains register for incoming and outgoing mail. *
- Provides data entry * and variations to administration roster for Rostar/HCN. Performs data entry for Compu store for archiving of records.
- Provides clerical services for outpatient's clinics including reception duties, telephone interception and liaison duties. *
- Provides a reception service * to the virtual ward and clinic area.
- Receives visitors (patients, staff or members of the public) and phone calls and responds, informs or directs appropriate. *
- Researches and reports on matters under consideration as directed.

Liaising

- Liaises with staff to distribute and respond to all confidential and general correspondence, memorandums and reports.
- Liaises with patient service agencies, e.g. Transport, Interpreter, to ensure appropriate services for patient.
- Provides information regarding procedures and protocols to patients.
- Screens medical record enquiries and process general requests for information from doctors, specialists' rooms, DCD and Centrelink.
- Liaises with medical staff to obtain tests results prior to scheduling patients.
- Liaises with patients, consultants, registrars, medical imaging technologists, nurses, residents, booked admission and other hospital staff, departments and clinics, as well as external clinics.
- Liaises with clinical and infrastructure support staff to ensure optimum service is provided at all times.
- Liaises with senior officials in the public and private sectors and with Senior Management.
- Liaises with complainants by phone and in person, and makes appointments for complainants.

Finance and Maintenance

- Raises purchase orders, receives goods and services, and prepares invoices for payment.
- Follows up account and payment enquiries. *
- Processes vehicle log books and fuel receipts, including monthly FBT reporting.
- Arranges staff travel and accommodation bookings. *
- Responsible for receiving accounts payable * including cost centre coding.
- Provides facilities support for visiting health practitioners and specialists. Maintains security of all monies held patient private property and PATS and performs reconciliations.
- Responsible for balancing and receipting of all monies received. *
- Prepares banking. Provides month end figures for management report. Prepares private medical officers accounts for payment and batches all creditors' accounts in a timely manner.
- Maintains petty cash advance and balance at end of each month.
- Responsible for coding and batching of invoices with Purchase Orders.
- Accounts receivable processing including generation of debtor invoices. *
- Worker's compensation, Ineligible outpatients, Tenants' electricity/water consumption, Customs, Reconciliation of Petty Cash, Flexi purchase statements, EFTPOS, meal ticket receipts, Pay phone receipts, PathWest statements, Australia Post and Telstra statements.
- Calculation and processing of staff air conditioning subsidies. Journal entries and record keeping for patients' morbidity aids, patients' valuables and maintenance of monetary forms register.

- Maintains the office supplies system.
- Arranges maintenance of equipment and buildings and prepares the maintenance requisitions.
- Arranges servicing, cleaning and maintenance of service vehicles.

123 Appendix 2 – Characteristics of Level 3 provides:

Reporting lines:

The Level 3 clerical positions which were examined typically report to a Level 4 Coordinator or similar position. Administration Assistant positions often report to a Manager.

Duties which characterise Level 3:

Coordination and related duties

- Analyses/manipulates/interrogates computer systems to identify and rectify data discrepancies.
- Coordinates and administers health statistical collection for the Health Service including interrogating and analysing data for reports and presentation.

Liaising, internally and externally

- Deals with enquiries from lawyers, the family court, police, DCD and external agencies related to access to personal information and health service documents.
- Deals with contentious and sensitive external enquiries.

Supervision and mentoring

- Supervises and coordinates the activities of Departmental secretarial and clerical staff including implementation of new systems, procedures and work methods, determine priorities and work allocation within the Department.
- Undertakes recruitment and selection, and implements and maintains performance management for staff under supervision.
- Organises relief staff and rosters for positions under supervision.

Finance and Maintenance

- Assists in monitoring and maintaining the budget and finances for the unit, and assists in the preparation of the annual budget.

Research/Projects

- Carries out investigation and research related to special projects, and prepares reports.

Policies/Procedures/QA

- Develops and maintains administrative and clerical policies and procedures.
- Implements and monitors continuous quality improvement programs and completes project work.
- Reviews and initiates changes to policy and/or procedure manuals.

Selection Criteria:

- Supervisor skills and knowledge of contemporary human resource management principles including Employment Equity.

- Demonstrated experience in the supervision of staff, including allocating and prioritising work effectively.
- Ability to provide leadership within a multi-disciplinary team framework.
- Well developed written and presentation skills for the preparation of correspondence, minutes, reports and presentations.
- High level of organisational, problem solving and analytical skills.
- Proven ability to exercise discretion and initiate, including in issues of a highly sensitive and confidential nature.
- Ability to analyse and evaluate problems, develop solutions and make decisions.
- Experience in interrogating computer applications and systems.
- Advanced IT skills.
- Understanding of accounting procedures.
- Demonstrated competence in book-keeping and financial reporting procedures.
- Extensive administrative and clerical experience.
- Significant experience providing secretarial and/or administrative support to senior level officers.
- Knowledge of recruitment and rostering processes.
- Knowledge of OS&H principles, including maintaining a Duty of Care.
- Knowledge and understanding of Quality Improvement principles and their practical application.

124 I have quite deliberately set out in detail the contents of historical duty statements and the indicative duties for the various levels rather than merely making reference to them in the hope that the individuals concerned will take the opportunity to read them and see for themselves the work set out for FLCPs over this period.

Performing Duties at a higher or lower level

125 Each position is made up of a bundle of duties and responsibilities, some of which fall squarely within the level allocated to the position. They should be the vast bulk of duties and responsibilities and they are the basis for determining the level of the position. However, some duties and responsibilities may, for the sake of convenience or for historical reasons, be at a higher or lower level than the bulk of duties and responsibilities upon which the position's classification is set. The fact that a position contains some higher level duties and responsibilities does not justify the position being at a higher level. The position may lose those duties and responsibilities without the position being reclassified downwards if the bulk of the remaining duties and responsibilities are appropriate to the position's classification level. Likewise, a position may lose some lower level duties and responsibilities without affecting the level of classification of that position.

126 This re-arrangement of duties and responsibilities is pertinent to these claims. A number of examples of duties and responsibilities which were previously allocated to higher level positions have been taken on by the FLCPs. Examples include the ED Clerks obtaining financial and insurance fund information from patients after hours and encouraging privately insured patients to claim on their health fund, a duty undertaken by a higher level position during ordinary business hours. However, this duty of itself requires no higher level of skill or

responsibility to be exercised by the FLCPs than they exercise in obtaining other information from patients presenting to ED. It is also a duty which was performed by the Medical Records Clerk in the Emergency Centre of RPH in the 1980s and the Bed Allocation/Main Reception Clerk at PMH in January 1990. They may not have taken the next step, beyond obtaining the information, of encouraging the use of the private health fund but that is a matter of providing an explanation to the patient. It fits within the context of their other work at Level G2. When that work is performed by the higher level position, it is only a small part of the job where the other duties and responsibilities are generally at a higher level.

127 The same can be said of the FLCPs taking over telephone call answering from nurses – this is not a new or higher level duty and as noted earlier, formed part of the claim for a reclassification for the Ward Clerk at Bentley, which appears to have been reclassified in 1989. The Ward Clerk, RPH and SCGH performed this duty in 1988 and 1989. However, one would not expect that a Level G2 position would be conveying sensitive or detailed information of a clinical nature to a family member. Likewise, the evidence of some FLCPs being required to make telephone calls to arrange replacements for leave is not a higher level duty merely because it might otherwise be undertaken by a supervisor.

128 Therefore, firstly, these are not actually new duties. Secondly, the mere fact that new duties, formerly undertaken by a higher level position, have been taken on by the FLCPs does not necessarily, and in this case does not actually, mean that the duty or responsibility is of a higher level justifying a claim of increased work value. I conclude that the evidence of duties and responsibilities taken on from higher level positions does not, in this case, demonstrate higher work value.

129 As to the broadening of the scope of duties as envisaged in broadbanding, in PSA 36-42 of 2007, it was claimed that an increased number of tasks being performed within a shorter rotation period required greater flexibility and a broader knowledge of functions. In that case, I said that:

> It is important to note that particular skills and responsibilities are assessed as being at particular levels. A combination of two such skills or responsibilities at that same level still constitutes the same level of work value. A combination of five of them still constitutes the same level. The question is whether the work itself is significantly more complex and requires greater *levels* of skill and responsibility, justifying a higher level of classification (emphasis added).

130 As to the background to the classification structure and indicative duties for Levels 1, 2 and 3 in the HSU structure, Mr Holland's evidence was largely unchallenged. Having examined the duty statements and JDFs provided to me, I accept that Appendix 1 and Appendix 2 are indicative Level G2 and G3 duties and responsibilities respectively, and that this evidence is an appropriate basis upon which to examine these claims.

131 I have considered not only the old and existing JDFs and position descriptions in what might be called a desktop review. I have also looked at what the employees have written in the Reclassification Request Forms and the Position Evaluation Questionnaires, what they have said in their witness statements and in their viva voce evidence, and I have seen them at their work places where they have described and demonstrated the work they perform. That demonstrates and I find that the duties and responsibilities of positions of Admissions Clerk, Emergency Department Clerk, Clinic Clerk, Ward Clerk, Bed Allocation Clerk, PMI/ATS Clerk, Bed Control Clerk and Bookings and Waitlisting at around the time of the broadbanding were not discernibly different to the duties and responsibilities of the Level G2 FLCPs the

subject of this matter. In fact, it is arguable that there may have been some aspect of classification creep.

132 For example, the Clinic Clerk, RPH, duty statement for May 1990 aligns well with the current requirements of the job as described by Ms Elshaw in her evidence (see Employer's Volume 2A, Tab 6, Duty Statement for Clinic Clerk, Item No 781). Even though the wording for the old and the proposed Statement of Duties is not the same, the effect is not significantly different.

133 A number of Booking Clerk, Radiology, Level G2 positions in the MRI Unit, RPH as at 31 July 1992, had duties of a similar nature to those included as part of the claim for all Booking clerks in the Division of Imaging Services at RPH (see Employer's Volume 2A, Tab 2). For example, the 1992 job required 'Prepares and forwards instructions and preparation for M.R.I./C.T. examinations' and 'Completes M.R.I./C.T. pre-examination documentation'. These duties are merely differently described in the Reclassification Request Form, for example, 'liaise with ward staff to determine if specific tasks need to be followed ie what preparation, contrast, medication is required? Is Cannulating required?' It seems that the requirements remain much as they were.

134 The Booking Clerk needs a general but basic understanding of what is to happen in the process the patient is to go through, not in terms of the clinical aspects but of the practical requirements. A basic knowledge of anatomy was a desirable criteria in 1989. However, as Ms Chamberlain says in her evidence, she is dealing with the clerical functions, and the Nuclear Medicine Administrative Procedures Manual (Frontline Clerks Policies and Procedures Volume 2, Tab 17) 'fairly well details every action clerical – clerically you have to take on the system, does it not? Yes?' (t 187).

135 Due to restrictions of staff positions and of the physical layout of the Department, Ms Chamberlain keeps an eye on patients and deals with them, not clinically, but in the same way as the Ward Clerk at SCGH in 1988, where the duties included '[n]otify nursing staff if aware of patient in medical difficulty'.

136 The JDF for the Clerk Radiology Level 1 at Diagnostic Radiology at RPH (position number P0559416) effective from 1 April 1992 also has some aspects which tend to indicate that the position continues to carry out the same level of duties albeit that the Booking Clerk is Level G2. For example, in 1992 the duties included:

> 2. Answers requests for x-rays and reports by phone and FAX. Carries out search for all requested packets and reports notifying requestee of results. Reads reports as required.
>
> 3. Responsible for scrutinising all x-ray requests to ensure relevant details are provided. Follow-up as necessary to ensure completeness.
>
> 4. Determines from clinical diagnosis which x-ray requests are urgent and refers these to Casualty for X-ray.
>
> …
>
> 7. Organises and arranges appointments for patients referred for special prepared examinations.
>
> 8. Prepares patient preparation instructions and notifications and distributes to wards or patients.
>
> (Employer's Volume 2A, Tab 2, Position No. P0559131 – P0559416)

137 Again, basic anatomy knowledge was a desirable criteria.

138 As to the issue of problem solving, I note that in the Position Evaluation Questionnaire attached to the Reclassification Request Form for Booking Clerk, the Imaging Services Division at RPH, it is said that if there is no appointment slot available for a particular patient who needs to be dealt with urgently, the Booking Clerk discusses the matter with the Radiologist, to resolve the issue. (Employer's Volume 2A, Tab 2, Position Evaluation Questionnaire, p4.) This is an appropriate level of problem solving for a Level G2 position - to seek assistance from a more senior person if they are unable to resolve it themselves.

139 I find that the FLCPs in these circumstances are performing the clerical, that is recording and information, functions according to standard procedures and directions. Those procedures are set out in physical and electronic manuals, guidelines and policies (See two volumes of documents provided at my request). One of the features of this case is that all of the witnesses have done their jobs for many years, so they have an excellent understanding of the procedures and guidelines. In those circumstances, they do not need to frequently refer to the manuals as I suspect they have encountered almost every possible issue over their many years' of experience.

140 Not only are the functions largely unchanged, but the level of duties and responsibilities required have not increased.

141 Taking into account the duties and responsibilities of the FLCPs as they were in 1989 and the early 1990s, by reference to the duty statements of the time, to the current job descriptions, the indicative duties for Levels G1, 2 and 3, the purpose and object of broadbanding and, most particularly, the inspections and the witness evidence, I find that, save for the application of technology and increased workflow and efficiency, the FLCPs perform work of roughly the same nature and level of responsibility as they did at the time of broadbanding. They may, as was intended with broadbanding, perform a broader range of duties at the same level.

142 This is particularly so for Emergency Department Clerks, Admission Clerks and Ward Clerks. The position of Bed Allocation and Waitlist Clerks are not dissimilar in levels of skill and responsibility.

143 However, I find that the evidence demonstrates that there have been changes in the way the work is performed. Those changes include greater use of information technology and increased work flow. It is also said that there is increased complexity.

Technology

144 The use of information technology has long been accepted as part of the development in the method of clerical and administration staff performing their function. I referred to earlier decisions that changes from manual to automated or computerised systems are not indicative of increased work value.

145 Also in 1993, Public Service Arbitrator Negus in PSA 130 of 1993 noted that:

> The introduction of the Materials Management System (hereinafter called M.M.S.) has caused a remarkable improvement in the productivity of the requisition, storage and supply section located at Armadale Kelmscott Hospital. The same could no doubt be said of every other location at which the computerised system had been introduced. Management is now able to have access regularly and frequently to statistical summaries which were formerly beyond the capacity of clerks to produce, using manual record systems.

> The officers who learn to use the new information technology systems obviously acquire a raft of new skills and abilities associated with those systems. It does not follow logically that the work value of the prime function has automatically increased. The farmer in 1935 who learnt to drive a tractor so as to plough three times the area than that which could be covered each day by his team of horses was at the end of the day performing the same function i.e. tilling the soil.

146 In 2004, in PSA 6 to 14 of 2004 regarding Information Technology Support Officers seeking reclassification from Level 4 to Level 5, I noted that:

> In this case, it is clear and incontrovertible that there has been a significant change over the years in the whole area of information technology including since broadbanding occurred. The degree of change in the work, skill and responsibilities of these positions to encompass two levels of reclassification would need to be substantial indeed. Having considered the evidence before me, I am of the view that these positions have increased in work value over time, however, that increase in work value is met by the Level 4 reclassification. Much of the change in the area of information technology can be said to apply to the whole workforce which utilises information technology in the process of performing other work. It is not merely limited to those who specialise in providing support in the implementation of those systems and keeping them operating. Albeit that there are particular aspects of information technology which might affect these sorts of positions more than others, nonetheless changes in technology, changes in developments in programmes from one to another, can probably be compared with the sorts of changes that might have occurred to the job of an administrative person where once that person used a typewriter or a comptometer to now utilising the computer system to do that same work.

147 In June 2006, the decision in PSA 1 of 2006 where the applicant in that matter was seeking reclassification of the TOPAS Trainer HSU Level 4 to HSU Level 5, noted:

> In respect of the issue of an increased number of packages required to be trained in, the realities of the computer-age work environment mean that that of itself is nothing new. If it were that the typist of 30 years ago, who has become the operator of various computer packages today, could claim to have significantly enhanced her or his work value according to the number of packages learned and operated over the years, an unrealistic situation would arise across the workforce. Those sorts of changes in technology are quite normal in today's workforce.

148 As to the issue of changes to and increases in the number of computer packages, in PSA 36-42 of 2007, it was said that:

> [t]hese positions require the application of a range of different packages and familiarity with particular processes within their workplace. This of itself is no different from the clerical work environment generally. The pen was replaced by the typewriter which has been replaced by a variety of different computer packages and clerical offices throughout Perth both in the public and private sectors now require entry level positions to operate and manipulate information and to enter data in a variety of different packages that years ago would never have been contemplated. That of itself does not satisfy the test of increased work value (see also PSA 8 of 1999).

149 For the FLCPs, there has been change in the way they perform their work by the application of technology by various computer programmes to enable greater efficiency and productivity. There has also been the replacement of old technology, such as record cards, the pen, electric typewriters, gestetners and microfiche. However, that is no different to any other clerical position throughout the modern world, where computers with expanded applications have gradually increased the scope of work which may be performed on those computers. Ms Metcalfe's evidence of the method of making labels and about the current computer system which enables tracking of records, data entry and the production of files and labels for patients, was most illustrative of that change, as was Mr Jesson's comparison of manual completion of records as compared with computerised records.

150 There has been a change in the skill requirements but those skill requirements overall are not necessarily of a higher level.

151 Many of the witnesses relied upon an increased number of computer programmes and software for the purpose of demonstrating increased knowledge. In fact, it would seem that the current introduction of webPAS may replace a number of computer programmes. The mere number of computer applications is not indicative of any increased level of skill. Rather, it may be a broadening of skill at the same level. This was envisaged in the broadbanding of the classification structure by reference to multiskilling and the removal of the requirement for promotion beyond the limited tasks that were originally allocated to a position and the transferability of skills from one area to another. (See also *Hamersley Iron Pty Limited v The CMETSWU*, Supra.)

152 Therefore, I conclude that both the application of computer technology to the performance of work and the changes in the computer programmes have not led to a significant increase in work value. They simply allow more of the same level of work, more efficiently.

153 I am unable to conclude, on the basis of the evidence that there has been an increased skill level or complexity in the work due to the use of technology.

154 I note the evidence of witnesses who deal with technology such as that used in Telehealth, CHAnnEL and nuclear medicine. It is clear that while there is computer and audiovisual equipment involved, the responsibility of these positions is to deal with the aspects relating to the clerical functions. In that respect, their duties, skills and responsibilities are at Level G2.

Work Volume or Workload

155 The reclassification appeal process is not to be treated as a moving feast. By that I mean that when an employee makes a request of the employer for a reclassification, or when the employer instigates a review, the time for consideration of the level of the duties, skills and responsibilities and the conditions under which the work is performed is the time when a sufficiently detailed request for review has been submitted, not the time of the hearing of the appeal by the Arbitrator. Where, subsequent to the Request for Reclassification or the employer's review, the employee submits further information or the employer gathers further information, that time is also relevant. However, changes which have occurred in the job between the instigation of the review, whether instigated by the employee or by the employer, and the Arbitrator deciding the matter, are not to be taken into account. That is because the reclassification appeal is against the employer's decision. The Practice Direction has as one of its objectives, to clarify that it is not a matter of the parties providing additional information to support their case during the appeal process, which information has not already been considered by the other party. This is to prevent the appeal process simply becoming an ambush of the other party, but also to ensure that there is a particular point in time at which the requirements of the position are to be considered.

156 Therefore, in this case, the appropriate time for consideration of these jobs is the time when the employer considered the requests for reclassification or undertook its review. This means that the FHRP, which was instigated in 2009 is not, strictly speaking, within this appeal process. However, in the circumstances of this case, I have considered the FHRP on the basis that any reclassifications resulting from that particular change ought to apply, not from the date of the original Reclassification Requests but from the date when the FHRP was implemented.

157 There is no doubt or dispute that the number of patients attending public hospitals has increased significantly causing delays in patients being attended to and able to leave. FHRP

was 'a programme of clinical service redesign (CSR) that focused on improving the quality of patient care and patient flow' (Four Hour Rule Programme – Progress and Issues Review – Professor Bryant Stokes AM, December 2011 page 1). The growth in demand in emergency, elective and outpatient services across major hospitals was one of the major factors in the creation of the FHRP which commenced in April 2009 (see Figure 1, page 2). In Professor Stokes' report, he notes the pressures on senior nurses to 'push and pull patients along the care continuum' (page 4), and that '[t]here is a substantial flow-on to the support staff related to administrative, cleaning and transport processes along a truncated length of stay.' He also says:

> The implementation of the FHRP has seen the advent of a range of short stay type units in EDs. These include Short Stay Units, Emergency Medical Wards, Observation Wards, Clinical Decision Units, etc. Although inpatient admission rates have not increased, the creation of such wards has driven up the overall admission rate technically, and thus the burden of work across all staffing groups. This has caused increased pressure on support services to process the admission and discharge transactions (page 4).

158 In respect of administrative staff, Professor Stokes notes 'particularly ward, ED and coding clerks, … have an enormous workload with more units of work per unit time occurring and with apparent duplication of forms for admission and discharge' (page 5). Those matters were identified as matters to be addressed in the future as part of this review.

159 A number of the HSU witnesses gave evidence regarding the FHRP and its impact upon their work. Some of these aspects are also dealt with in other parts of these Reasons. Ms Pritchard, a Liaison Officer in the Emergency Department of SCGH, gave evidence that the FHRP had created greater work volume. Prior to the FHRP, nurses were taking calls. As part of the review and re-organisation, it was decided that taking calls interfered with nurses undertaking other work to meet the four hour deadline. The Liaison Officers now deal with phone calls from relatives, some of whom may be dissatisfied with the hospital system, and they required a lot more skill in understanding and empathy (t 389). She said that there is a time management skill in dealing with the pressure of work. Ms Pritchard described the requirement to deal with patients' relatives who want to speak to a doctor and that rather than automatically putting calls through to a doctor, the Liaison Officer needs to screen the calls and find out exactly what the caller is seeking to direct them to the right person.

160 Ms Pritchard also gave evidence that due to the FHRP, pressures now exist in the Emergency Department requiring a higher level of accuracy and a self-directed work arrangement (t 403). There has also been a requirement to collect data for management, prepare that in an Excel spreadsheet and deal with discrepancies, for example if a clinician has not entered the diagnosis in the data.

161 Ms Metcalfe said that one of the biggest changes in her role arises from the FHRP because in order for it to work a significant amount of work has to be done under pressure (t 133).

162 Ms Thwaites noted that the requirement to deal with the increased volume of work had been exacerbated by the introduction of the FHRP and also there was now a requirement for more detailed and accurate data which is monitored by the Health Department (t 159).

163 Ms Chamberlain gave evidence of the impact of the Four Hour Rule on imaging. She noted that 'the people in ED are under pressure to either admit patients or make sure that they are fit to be discharged, so they rely heavily on the Imaging Department to either confirm a diagnosis or confirm that the patient is, in fact, fit to go home. So we are doing a lot more emergency scans.' (t 181). Ms Chamberlain also noted the increased workload and responsibilities of the

Nuclear Medicine Booking Clerk arising from the increase of workload of the clinicians, technology and nursing staff within the department (t 182).

164 Ms Thompson-Davies gave evidence of the requirements to accurately record data in the various software packages in the Emergency Department and the requirement to work 'much quicker', and 'to have a lot of knowledge about what is going on'... to move the patients quickly (t 200).

165 Ms Crothers gave evidence of the requirements for accurate filing and recording in the MERIT System which had increased due to the FHRP (t 241), in getting patients in and out quickly, requiring her to get the notes together and out as quickly as possible, to contact family members and let them know the patient has been transferred out of Intensive Care to the ward. She noted that Intensive Care has a lot of direct admissions and this affects her work in creating records.

166 Ms Smith gave evidence that, because of the requirement to utilise any spare beds, different types of patients are received in the Burns Ward other than just those with burns conditions. This added complexity to her work.

167 Ms Dawson gave evidence that the FHRP had the impact of requiring them to approve people a lot quicker on CHAnnEL (t 258), to meet certain key performance indicators to place patients within a certain period of time, and that the bed managers are audited against the key performance indicators.

168 Ms Dawson also gave evidence that as a result of the FHRP, new roles were developed, such as the Emergency Department Navigators whose role, I understand, is a clinical one, to move patients out of Emergency as quickly as a bed can be provided for them. Ms Dawson's role is to liaise with the Emergency Department Navigators regarding patient movements (t 258).

169 Ms Bannon gave evidence of what she says is the additional responsibility for Ward Clerks to ensure that patients are transferred to the Discharge Lounge as quickly as possible, to free up the bed in the ward.

170 On 4 December 2012, during the course of the hearing, I raised with the parties whether the evidence and submissions in respect of the FHRP in particular related to that aspect of the work value test dealing with 'the conditions under which the work is performed', as in the environment, and whether the FHRP, not of itself but because of the conditions to which it responded, creates greater pressure on employees undertaking their work; that issues such as antisocial and aggressive behaviour of patients and their visitors has an impact on the work environment also and possibly requires enhanced communication skills which might mean enhanced work value. The HSU noted that this was the point they were seeking to make, not that work volume or technological change in themselves had changed the work value, but for the conditions under which the work was performed constitutes a significant net addition to work value.

171 In these circumstances, I note firstly that it is difficult to separate these components, that they are heavily interelated. However, I intend to deal with the issue of work volume or workload by reference to two considerations: firstly, whether the FHRP, or the conditions which led to its implementation, has led to an increase in work value by reference to the increase in workload itself and then, secondly, by reference to the issue of the work environment.

172 In respect of the first aspect, the issue of work flow, this is a largely a matter of workload. It is well established that increased workload of itself does not constitute an increase in work value (see PSA 8 of 1999 and others).

173 The increased workload brought about by higher patient numbers requires increased efficiency and this has been dealt with by restructuring work flows, and in some cases, duties. It requires working more effectively by removing duplication and repetition, to free up staff time and resources. The work of the FLCPs has been reorganised in such cases. However, it seems that the bulk of changes in skill and responsibility have fallen to the nurses in particular, and this has resulted in the creation of new positions to "push and pull" patients through the system.

174 Managers have worked with their clerical staff to find ways to combine the paperwork or recording processes to reduce duplication, complexity and to increase flexibility to cope with increased workload. Ms Pritchard described how the Liaison Officers, with their manager, initiated a new document which brought together all of the pieces of paper which were normally referred to the Liaison Officers. This resulted in greater efficiency. Ms Thwaites noted that the FHRP had had an impact not only on the medical and clinical staff but also on the ancillary staff, and in the case of clerks, they had to develop different strategies to deal with the limited time factor, gathering of information and changing reporting methods (t 153). She described the system of bed allocation clerks, bed managers and patient flow coordinators being implemented as a consequence of the FHRP (t 154).

175 There is no evidence that the increased work load or volume has generally increased the level of skill required for time management beyond those applicable to Level G2. However, I will deal separately later with the situation regarding Liaison Officers at SCGH.

176 Therefore, I conclude that the increased workload, work flow and the FHRP have not generally resulted in a significant net addition to work value. They have resulted in increased efficiency and productivity, not new higher level skills, complexity or responsibilities, which are work value matters. Those issues of increased efficiency and productivity may well be the basis for separate consideration at another time.

177 I will deal separately with the impact of the FHRP on the question of the work environment as part of consideration of the conditions under which the work is performed,

Mentoring and Training

178 I have set out earlier, in general terms, the work which the witnesses say supports this ground. I note that the Clinic Clerk position at RPH, classified Level A.1 in May 1990 contained the duty of '[t]rain and orientate new staff'. The Ward Clerk position at RPH in March 1989, Level A1.5 was required to '[t]rain relief clerks to cover ward areas for sick and annual leave'. The Ward Clerk at PMH, Level G1 in March 1991 'advise(s) medical and nursing staff of ward procedures and co-ordinated same' and 'trains new/relief Ward Clerks'. The Clerk (PMI) at SCGH, A1-4, in 1989, assisted in on-the-job training of new recruits.

179 According to Mr Holland's evidence, the former A1.5 duties included 'training and orientating new and relief staff', that is, it was a Level G2 duty.

180 There is nothing unique or of a higher skill or responsibility level in employees, at every level, training and orientating new staff members, be that at their own level or higher, as to the requirements of their own positions. Once a person has become familiar with the requirements of their own job, it is not difficult to show a suitably qualified person how that job is done. Further, when a person is familiar with a particular computer package, it requires no higher

level of skill to help someone who is having difficulty. If they are unable to resolve the problem, there are specialist IT staff to assist. There is no real difference between the ordinary training and orientation of a new person of the same level or the orientation of, for example, a nurse, in the clerical aspects of the use of a particular computer programme. These situations apply to FLCPs whether training new or relief FLCP holders or clinical staff about computer records access. This does not constitute a real change, nor is it beyond the requirements of Level G2.

181 There is no evidence of what is said to constitute the mentoring which the FLCPs are said to undertake. Mentoring is more than training a person in the skills which the trainer holds.

Conditions under which the work is Performed

182 The 'conditions under which work is performed' relates to the environment in which the work is done.

183 The original Reclassification Requests, made in 2006 and 2007, did not rely on the FHRP, as it had not been introduced then. Nor did they rely on changes to the conditions under which the work was performed, or at least they did not do so explicitly. They relied on claims of increased skills and responsibility and structural changes including taking on duties from other positions.

184 Those requests made in 2009 (and some earlier) refer to the changed work environment, with claims of increased complexity and work volume. (Employers Volume 2A, Tabs 5 – 10, Attachment A, re Clinic Clerks, and 2B, Tab 13 ED Clerks (2009) Tab 15, Ward Clerks (2007), Tab 17, various positions PMH.) However, they are described under the heading dealing with changes to responsibilities.

185 I note that the BiPERS assessment tool including the Position Evaluation Questionnaire and the Reclassification Request form do not provide for specific reliance on changes to the conditions under which the work is performed.

186 The BiPERS system is used within the public sector as a tool in the classification process. Part of that system involves the employee who seeks a reclassification completing a Position Evaluation Questionnaire. This deals with the minimum requirements of the position by reference to specified factors: education level, experience, scope of activities, interpersonal skills, kinds of problems, instructions received, influence on results, personnel supervised/controlled, size of organisation unit, and subordination level. There is no particular factor for identifying the circumstances under which the work is performed.

187 The employer's own Reclassification Request Form, which is also completed by the employee has a number of questions for the employee to answer. These deal with the prime functions of the position; changes to that prime function; changes in the work performed; the skills and abilities required to undertake the duties, and changes in responsibilities. There are other questions about any duties or responsibilities which may have been removed from the position, the reporting relationships, and the identification of comparative positions. Again, there is no question which addresses changes to the conditions under which the work is performed.

188 During his evidence, Mr Holland conceded that the issue of the conditions under which the work is performed was not specifically included as part of the assessment reports of these positions (t 369). It is clear that a thorough assessment ought to have also expressly considered the final part of the Work Value test. I suggest, too, that the assessment tool requires some adjustment where the work value of the position is to be assesed.

189 There are no cases to which the parties have referred me, nor I am aware of, any authorities, which give any guidance as to how this aspect of the Work Value test is to be applied. In days gone by, employees may have been granted 'disability' allowances to compensate them for particular conditions in which they had to work.

190 In this case, the employees are said to work under particular circumstances, which are said to have changed, and the changes are said to constitute part of the significant net addition to work value. The changes to the work environment are said to include the workload and work flow pressures brought on by increased hospital attendances, resulting in the FHRP; increased violence and aggression from patients and visitors requiring 'increased qualitative contacts with patients, family and carers' and more sophisticated communication and negotiating skills; increased cultural and language diversity also requiring better communication skills; increased exposure to trauma patients. It is clear that in considering how these aspects relate to the circumstances in which the work is performed, that there is a cross-over with claimed higher level skills, responsibility and complexity.

191 Work Flow/Workload and the FHRP

In respect of increased work flow and workload, and the pressure and complexity arising from this I find without reservation, that this constitutes change to the work environment in that it is busier and there is increased pressure to meet deadlines. However, systems and procedures are in place to ensure that work is handled in a planned and reasonably well controlled way, to cope with the pressures which the environment brings.

I have also noted earlier, that where this case makes reference to the work environment relied upon by the health professionals, that the effects on each group are different and not generally comparable.

Further, FLCPs are not alone. The same work environment of work flow, work load, pressure and complexity also applies to nurses, medical practitioners, allied health professionals, patient care assistants and others working in public hospitals. The evidence suggests that it is the creation of new nursing led positions and new ward arrangements which have borne the brunt of this change. In any event, it is part of the normal working conditions in busy public hospitals. If this aspect of this claim were accepted as being an appropriate consideration as part of a work value review, the flow-on potential would be enormous, well beyond FLCPs.

I am not satisfied that this circumstances as it applies to the bulk of FLCPs constitutes a significant net addition to work requirements such as, either alone or together with other factors, to represent an increase in work value. Even if that were the case, the flow on potential is significant and militates against the granting of such a claim.

192 Increased violence due to drug abuse and societal changes

The HSU says there is an increased level of violence and aggression within many of the patients and their friends and relatives with whom they have to deal. In PSA 53 of 1997, Senior Commissioner Fielding said:

> I even accept that regrettably persons in the community tend to be more aggressive than was once the case and take out the ill feelings towards Government on those who have the misfortune to serve on the counters. However, overall I am far from convinced that there has been any change in the fundamental function of these positions. The occupants are still dealing with customers either by telephone or at the counter or by a combination of both on the basis of predetermined and standard data. This is typically the role of a Level 1 position.

193 I also note my own reasons for decision in Sean Thoms and Others in PSA 4 to 21 of 2010 that:

> There is in reality increased aggression and violence in the way some people present in hospitals, but that has been the case for some years and there has not been any demonstration since the positions were last reviewed this has actually resulted in a significant net addition to the work value of the positions. The positions still exercise the same level of skill and responsibility that they have done for some time and they do so now in a broader context, including the implementation of the Non-smoking Policy.

194 There are a number of aspects of the Admission Clerks, OPH, position which appear to be somewhat different from those applying in the major hospitals, particularly those where there is an Emergency Department. I acknowledge the evidence of Ms Murray as to the circumstances faced by the Admissions Clerk there when members of the public attend expecting to be able to see a doctor as they might in a hospital where there is an Emergency Department. This requires the Admissions Clerk to redirect the person or, in particular circumstances to call the Clinical Nurse Manager to attend. Some of the circumstances described by Ms Murray in which she has been faced with demanding and sometimes emotional situations must be quite confronting, particularly if there is no immediate assistance from the Clinical Nurse Manager who may be at another part of the hospital. It seems to me that this is an issue of a structural nature which requires addressing by the hospital to ensure that those Admission Clerks are not placed in circumstances of unreasonable demands. Otherwise, I am not satisfied that this position is of a higher level than other admissions, emergency or other FLCPs.

195 I also acknowledge the circumstances described by Ms Metcalfe where Emergency Department Clerks are faced with families in distress and she has also described the other circumstances of violent and mentally ill patients attending. She says that some new Emergency Department Clerks are unable to cope with these circumstances and that ED Clerks need to have a lot of fortitude to undertake their work. I accept that this is so. However, it does not necessarily constitute a significant net addition to work value.

196 Having noted the above comments, I do not intend to, in any way, diminish the significance to those FLCP employees of the stress and difficulty in dealing with those situations. In particular, I note the evidence of the Emergency Department Clerks and the Admission Clerks. However, they are not required to deal with them alone. Where necessary, there is a team able to respond to situations of danger and aggression.

197 It is also a situation facing all staff who have direct contact with the public whether they are in public hospitals or other government agencies, albeit that I recognise the concentration of those circumstances in Emergency Departments at particular times. It is not, of itself, a matter of increased work value for this group of positions. Also I am not satisfied that it requires them to exercise significantly higher communications or negotiation skills than were exercised previously in dealing with a variety of people in a variety of conditions and circumstances although it may be more frequent. I think there is a tendency to reflect on the work circumstances of the past and fail to recognise the difficulties which faced those dealing with the public. In the past, there were not the organised response teams available to deal with extreme situations.

198 Increased cultural and language issues

Throughout the history of this State, there have been waves of migrants from different parts of the world. Over the years, FLCPs have been faced with changing and growing diversity of cultural groups. This requires patience and maturity in communication. They are now

performing the same work, utilising the same level of communication skills, but in dealing with a broader range of people. This is nothing new to these positions. It was part of the successful claim for reclassification for the Ward Clerk at Bentley Hospital in 1992.

199 Structural issues

Some of the evidence was of FLCPs working in isolation of other members of staff and without direct supervision or support. Some of the circumstances included relocation and reorganisation of departments such as amalgamation and splits.

200 In 1992, Public Service Arbitrator Negus dealt with the issue of re-arrangement of work within an organisation in PSA 200 and 204 of 1992, in relation to clerical functions at Edith Cowan University and noted:

> The work value assessment comes from an overview -: the same group of people are doing the same overall function that they previously did. It is organised in a different way, the same tasks being performed in a new sequence. None of the tasks has been transformed into a higher level duty. There is no increase in work value. A new recruit at the base level would need to be trained in several of the tasks before becoming as useful to the team as his more experienced co-workers. Perhaps that is why there are 9 incremental steps in the Level 1 broad band?
>
> The principle of logic remains intact – if the whole work of the section is broken into variously shaped or redesigned parts – no matter how many times one performs the experiment, the sum of the parts can never exceed the original whole.

201 With respect, I endorse those comments as they relate to the work and organisation arrangements for FLCPs.

202 Firstly, I note that some FLCPs work in busy departments and wards, surrounded by others. Some of those co-workers are of the same calling, for example Emergency Department Clerks at RPH and Waitlist clerks. Some of the co-workers are other callings such as nurses, allied health professionals, medical practitioners, etc, for example, Ward Clerks, Waitlist Clerks, Bed Allocation Clerks. Some have no co-workers in the immediate location eg Booking Clerk in Nuclear Medicine at RPH. Some FLCPs have supervisors close by, others do not.

203 Where that change has expanded duties and responsibilities, the evidence is that the changed duties are not of a higher level. I refer back to the situation which broadbanding provided for a broader range of duties, all within the same level.

204 There is no evidence that the re-arrangement of departments or work of itself brings increased work value. It is simply change, and reorganisation of work will continue to occur as efforts are made to sustain the work of the organisation.

Other Issues

205 Gathering More Information.

Firstly, I acknowledge that as time has passed, Admissions and ED Clerks in particular have been required to gather more information from patients. However, this is simply more of the same type of work, rather than increased complexity. The officers know what information they are required to obtain, they interview the patient and, if necessary as in the past, deal with the answers sometimes by seeking clarification or speaking with relatives, where available.

'Determining patient's financial classification through interview' and 'completes admission documentation, including financial classification forms' was a duty of the A1.L5 position in

the pre-broadbanded structure (see duties of Medical Records Clerk in the Emergency Centre at RPH, in the late 1980s).

Identifying patients with infectious diseases and notifying clinical staff was a duty of the Ward Clerk at SCGH in 1988, at the former A1.L5 classification.

206 Increased exposure to trauma patients.

It is said that this is due to patients arriving via air ambulance and other circumstances where, in particular, ED Clerks encounter severely injured patients.

The evidence does not actually identify any changed circumstances which may mean that FLCP staff are dealing with patients whose conditions are more traumatic or distressing than those patients who have attended in the past.

The circumstances Ms Murray faces at OPH appear to be similar, however, in those circumstances, clinical staff are not always immediately to hand. However, I have dealt with that circumstance earlier.

In all of the circumstances, I am not able to reach a conclusion that FLCP staff generally do face increased trauma compared with 25 years ago.

207 Accuracy and auditing.

The evidence demonstrates, and I accept, that over time, there has been an increased focus on the accuracy of the patients' records, both in their creation and updating, and by way of checking records already in the system. Also, the developments in the electronic systems means that records can be reviewed and reports created with greater ease.

I accept, too, that, as Ms Metcalfe says, the apparent scrutiny of their work adds to the pressure the FLCPs officers feel.

Part of the auditing requirements referred to by Ms Ganfield include a change from telephoning patients to confirm their details and whether or not they had yet had their surgery, then updating the patient's records and the waitlist. This process is now undertaken by a form letter being sent to the patient.

As Mr Jesson says, the quality assurance focus applies across the staff, and no more or less on the FLCPs. Accuracy in the patients' records is and always has been important.

Many of the aspects of the work referred to by the witnesses as auditing are simply checking the accuracy of their own work or the work of others, correcting obvious errors and filling in incomplete information by reference to manuals and guidelines.

Quality assurance systems are common within organisations and this has been a development since at least the 1990s. They ensure safe treatment of patients and are a useful tool in assessing efficiency. They provide means for analysis of processes to find better and more efficient ways of arranging work.

As noted in *ALHMWU re: Child Care Industry (ACT) Award* (supra), the requirement to exercise care or the exercise of a quality control function is not sufficient. There needs to be an increased level of responsibility, which is not evident in this case.

I conclude that, of themselves, the requirements to perform work accurately, to run computer programmes designed to audit processes and accuracy and to create automatic reports of the level required of the FLCPs, is not a higher level skill or responsibility. Accuracy and efficiency in the performance of work is an inherent requirement of any job. There is no

increased work value arising from it. There may be other positions, whose role is the analysis of the audit reports, which have higher level functions, but that is not the level of responsibility or skill required of the FLCPs. Further, there does not appear to be any added responsibility or accountability rising from the FLCPs' involvement in quality control work.

208 Increased knowledge of medical terminology, anatomy and diseases.

These positions require a familiarity with medical terminology. The evidence was that with developments in the medical field comes the requirement for FLCPs to have greater knowledge of medical terminology. However, there is little evidence to demonstrate the nature and effect of such changes. I am unable to conclude that this constitutes a higher level skill. The requirement is still to be able to accurately record information. Certainly the correct spelling of terms such as diseases and treatments is essential. However, the extent of actual knowledge and understanding of meaning is limited. Where Waitlist, Booking and Admissions positions are required to deal with terminology, which affects what they do beyond the recording stage, they have access to manuals and procedures, as well as in the case of Waitlist Clerks, access to two senior officers including a Coordinator Inpatient Booking Services and the Waitlist Nurse Manager. Others such as the Booking Clerk in Nuclear Medicine at RPH have access to clinicians with whom they liaise on a regular basis to clarify information, booking arrangements and coordination issues.

209 There has been no real explanation as to any requirement on FLCPs to have a more detailed knowledge of anatomy than has applied for many years. A basic knowledge has always been a desirable selection criteria. These are not clinical positions. The requirements of the positions are for recording and updating information. They may need to know what to do in making bookings for such things as tests, and may need to provide patients with information about the pre-test routines to be followed. However, that information is available to the Clerk, and they convey it.

210 Given the lack of evidence to support a claim that this requirement has changed to become something other than more of the same level of skill being required, I am unable to find that this constitutes a significant net addition to work requirements.

211 Patient Contact

The HSU made clear in its submissions that the FLCPs in the circumstances described in [36] of triaging and monitoring patients, are not undertaking any clinical function, and they do not rely on such claims. I trust that this also applies to Ms Elshaw's evidence that a few weeks prior to her evidence, one of the clinicians had to cancel one of his clinics due to an emergency. As a consequence Ms Elshaw had to go through the files of the patients whose appointments were affected. Her evidence suggests that she was the one to decide which of those patients needed to see another doctor, and which could be re-scheduled for another later time and if so, how long they would need to wait. She said she needed an understanding of medical terminology associated with that specialty to enable her to make those decisions (t 190-1).

212 I have examined the procedures manual for Outpatient Clinics, which suggests that the level of urgency attached to patients' appointments is already contained in the patients' records. Those procedures indicate that the CPAN nurse determines whether referrals are flagged 'urgent or ASAP'. There are procedures for dealing with patients who request that their appointments be brought forward, including checking with the doctor first. There is also a procedure for handling unexpected patients, who are referred to the Nurse in Charge or the doctor for assessment. It also notes that any difficulties are to be referred to the Nurse in Charge.

213 If the circumstances are as Ms Elshaw described, then there is the appearance of the performance of a clinical function. If however, there are either guidelines in place, or clear priorities within the patients' notes, or there is more senior or clinical oversight, then the duty is not of a higher level. If those things are not present, then I strongly suggest that hospital management needs to examine the situation and rectify the deficiency.

WAITLIST CLERKS – SCGH

214 In March 2007, SWY Consulting undertook a review of the classification of the Central Admission Services Waitlist Officer position at RPH and recommended that it be classified HSU Level G3. This conclusion appears to have been based primarily on the classification of Waitlist Clerks HSU Level G3 at FH and accordingly the RPH Waitlist Clerk positions were reclassified to Level G3.

215 The Waitlist Clerks at SCGH seek reclassification of their positions from Level G2 to Level G3, based largely on the reclassification of Waitlist Clerks at FH and RPH. It is also noted that there are Waitlist Clerks at Swan Districts Hospital, Rockingham Hospital, KEMH, PMH and Armadale Hospital. The positions were reclassified from Level G1 to Level G2 in 1988.

216 The original Reclassification Request Form also listed the changes in level of responsibility as being the basis of the claimed increase in work value rather than any change in function.

217 It is said that the changes in the work include:

> Substantial knowledge and adherence to current:
>
> - Standard procedures (North Metro Health Services Guidelines);
> - State and SCG Hospital Waitlist Policy (Health Department Guidelines); and
> - Management strategies of electronic data system entry (TOPAS, Word, Excel, -MERITS and IBS online).
> - Increased responsibility in liaison with the Coordinator Pre-admission Bookings regarding appointment rescheduling and cancellations;
> - Continuous updating of the electronic appointment schedule details on the waitlist booking (TOPAS) and manual internal office data entry;
> - Prompt communication to patients, advising of changes to admission arrangements (cancellations and rescheduling).

218 In respect of booked admissions, it is said that the requirement is:

> To liaise with multi-disciplinary staff including the ward and theatre staff, G Block Admissions and Bed Manager regarding acute admissions, cancellations and rescheduling.
>
> - Efficient organisation of inter-hospital/agency transfers including liaison with other hospitals/agency staff; and
> - Maintenance of number of elective admissions using internal office processes and TOPAS data entry.

219 There are also said to be quality performance activities including efficient and accurate data entry, dispatching referral and cancellation letters to patients; other advice to patients;

organisation and management of forward scheduling admission processes, and maintenance of other daily tasks.

220 The level of change in skill and responsibility is said to relate to medical terminology; patient diagnosis coding; legal responsibilities; accurate documentation; standard procedures and policies; accurate and clear communication with patient; well developed negotiation and problem solving skills; the ability to organise and prioritise workloads and meet timelines, and the ability to communicate accurately and clearly with medical personnel.

221 I have had the benefit of attending the work place and observing the Waitlist Clerks in their work as well as viewing the processes involved in that work. Ms Ganfield gave evidence of having been a Waitlist Clerk since approximately 2001. Ms Ganfield also refers to having a bed board to allocate patients and update daily. The Waitlist Clerks also now book onto the Theatre Management System as well as booking waitlist patients into other hospitals such as Osborne Park and Swan Districts.

222 It is said that the Waitlist Clerks are now required to have a greater knowledge of medical and surgical procedures as patients can be booked into five different wards. It is also said that there is an increased requirement for communication skills due to the need to liaise with consultants and anaesthetists with regard to their preferences and procedures.

223 The requirement to perform audits, collate results and advise management of those results as part of quality assurance processes is also said to be an increased responsibility.

224 All of the Waitlist Clerks have to be flexible and become familiar with specialties other than their own particular allocation. The waitlist procedures for each specialty are the same, however, things such as terminology and personnel, in particular the clinicians, differ.

225 Ms Ganfield clarified the work undertaken in audits. She said that a few years ago, when the Waitlist Clerks initially sought reclassification, they were undertaking audits a couple of times a year. During less busy periods they would be asked by the manager to ring every patient to confirm that they have the correct details and whether or not they had had their procedures, to ensure that the waitlist was up to date. Now, this is done by letter. All of the records are then checked to ensure they are correct. The computer records are then annotated to record changes and status of patients.

226 As to the issue of legal requirements referred to in the Request for Reclassification, Ms Ganfield says that most likely relates to privacy requirements regarding patient information.

227 Ms Ganfield gave evidence of the process involved in waitlisting a patient for surgery. The Waitlist Clerk receives a Request for Admission/Waitlist Inclusion form (the Form) from the medical practitioner which the practitioner is required to have completed. It is not uncommon for essential information to be incomplete. Ms Ganfield noted that some doctors do not tend to fill in that section of the Form indicating the expected length of the patient's stay in hospital. In her witness statement, Ms Ganfield says that Waitlist Clerks 'now determine from the procedure they are having that the patient is suitable for one night stay ward, a two night ward, a day ward or multi day ward, as these wards are managed by the amount of patients per day they can take' (Witness statement of Josephine Ellen Ganfield [22]).

228 Lynda Joan Harrison, Nurse Co-director, SRN10, of the Surgical Division at SCGH gave evidence of her role providing leadership and management of the medical, nursing and clerical staff. The Waitlist Nurse Manager, SRN3, and the Coordinator Inpatient Booking Services,

Level G5, to whom the Waitlist Clerks report, report directly to her. She described the responsibilities of the Coordinator as including 'coordinating and supervising the activities of the Waitlist Clerks, evaluating work practices, maintaining, monitoring and auditing the operational functionality of key systems supporting the Elective Waitlist, coordinating the effective management of patients on waiting lists, complying with technical bulletins and operational circulars, and implementing scheduled reporting and analysis' (Witness statement of Linda Joan Harrison [3]).

229 Ms Harrison says that the registrars, consultants and other medical practitioners are responsible for the completion of the Forms, which the Waitlist Clerks work from in the waitlisting process. These set out the nature of the operation, the location of the operation and the anticipated length of stay. She described the responsibility of the Waitlist Clerks as being 'to ensure these are accurately logged' [6]. Decisions regarding the admitting team and doctor to be assigned to a patient, the hospital at which the patient will undergo the surgery, the clinical urgency and the anticipated length of stay are made by medical staff, not by clerical staff. In the case of category 1 patients, whose surgery is urgent, if the surgeon has not completed all aspects of the Form, the Waitlist Clerk phones the surgeon to try to get the Form completed so that the surgery is not delayed by the return of the Form. According to proper procedure the Waitlist Clerk ought to send the Form back to have the surgeon complete it, however, both Ms Ganfield and Ms Harrison confirm that this would probably take another week to get back to the Waitlist Clerk and the person may have missed their surgery. So the Waitlist Clerks refer to the various categories of surgery in the manual appropriate to the particular specialty to ascertain the particular anticipated length of stay, or contact the doctor for advice.

230 Depending upon what information the doctor has not completed in the Form, the Waitlist Clerk may contact the doctor seeking further information or if they have indicative information within their manuals they may refer to that information.

231 Ms Harrison says the Waitlist Clerks require an understanding of terminology but not of medical and surgical procedures and associated instrumentation requirements or of diseases or anatomy - they are clinical matters.

232 Ms Harrison is supportive of the Waitlist Clerks being on the same level of classification as Waitlist Clerks in other hospitals.

233 Mr Holland gave evidence that the Waitlist Clerk positions were reclassified in 1989, however, they were also reviewed in 1998 and 1999 but insufficient change was found to warrant a further reclassification. The positions were found to be at the low end of the Level G2 range. He examined the proposed job description prepared for the Waitlist Clerk position should it be reclassified to Level G3 and found that the role and function was very consistent with that which applied in 1989. Comparisons were made with the allocation of duties and roles as they were in 1989. Mr Holland also referred to the documents contained within section 3 of the employer's folder of documents. Mr Holland says '[t]he tables will show there's a high correlation between the proposed duties and the claimed changes to the role of the position and to duties that occurred in a variety of positions at the low end which transferred across at the low end of the G2 scale back around about 1989' (t 83). He says this means that the duties have been around for a long time. Some degree of change would be expected for the positions to then better fit within Level 2 of the broadbanded classification structure. He also says that there has been subsequent development as anticipated, but, ultimately, the alignment of the duties is with the Public Service Level 1, at the lower end of that level, which actually equates to HSU Level G1.

234 Mr Davies concluded that there had not been such a significant increase in work value to satisfy the requirements of the Work Value Principle sufficient to warrant the reclassification of the position to Level G3.

235 He found:

> The duties proposed in the review position are consistent with the duties undertaken by the comparative positions in the other teaching hospitals classified at Level 3. However a work value assessment of the comparative positions does not clearly demonstrate that they are of the equivalent work value to other positions classified at Level 3 across the Health Industry. The duties and responsibilities are more closely aligned to common Level 2 functions.
>
> (Statement of Alan Davies [5])

236 Mr Davies noted the particular arguments in favour of the higher level of classification, including that the Waitlist Clerks were now required to ensure all category 1 patients have dates for their surgery included on the spreadsheet and the complexity of patients' details. The clerks now send letters to patients and are required to enter patient's details on the template letter. They are also required to contact the patient to determine their preference of hospital as the theatre lists for SCGH and OPH are included on the same sheet. He also took account of the auditing requirements on consent forms and that there is a higher number of patients waiting for elective surgery than the waitlists at Fremantle or RPH, which requires the clerks to have very effective organisational and management skills.

237 The assessment of Waitlist Clerks was put on hold when what Mr Davies described as a flood of HSU applications across the board in respect of the FLCPs.

238 Mr Davies acknowledged that the positions consist of a combination of duties normally attributed to a Level G1, Level G2 or Level G3 but said that the majority of the duties fitted within Level G2 and this was the basis of the recommendation that the positions remain at Level G2. He said that within government employment, no matter what the role is, the person sometimes performs duties ranging from Level 1 to Level 10.

CONSIDERATION REGARDING WAITLIST CLERKS

239 The primary function of this position is to coordinate the patient waitlist in liaison with clinicians from the relevant medical specialties. The Waitlist Clerks' work is to maintain the additions and deletions and urgency codes on waitlists and booked pre-admission clinic appointments. As part of this role, there is a requirement to liaise with patients and clinicians which has been a very longstanding duty for a Level G2.

240 They are supervised by the Coordinator Inpatient Bookings Clerk Level G5 and a Nurse Manager SRN3. Each Waitlist Clerk works on particular surgical specialties and becomes familiar with the medical personnel and terminology. They also relieve each other, so gain a familiarity with more than their own medical specialty.

241 I have observed the workplace and the performance of this work, have heard the witness evidence and examined the SCGH Standard Operating Procedures for Waitlist Clerks and the Department of Health Waitlist Policy. I note that there are Standard Operating Procedures which set out in 18 pages the processes to be undertaken in making inpatient bookings on the waitlist, file the waitlist booking forms, undertake the daily write up of the bed allocation board, undertake daily and weekly reports on the various types of admissions and surgery, the processes for cancellations and deferrals, and the processes for OPH – Orthopaedics bookings, SCGH - cardiology bookings and SCGH urology. The Elective Surgery Access policy details

the processes for managing the waitlist for elective surgery. This includes an identification of the categories of surgery, as to whether they are urgent, semi-urgent or non-urgent. The Elective Surgery Access policy also sets out the recommended prioritisation of various surgical procedures, for example, whether they are priority one (within 30 days), priority two (within 90 days) or priority three (within 365 days). There are sample letters to patients and other sample documents for use by staff.

242 The booking process starts with the Form, which the medical practitioner is required to complete, requesting a patient be placed on the waitlist. The Waitlist Clerk receives the Form, checks that it is complete, and if not returns it to the doctor for completion. The Waitlist Clerks are aware of the need for expeditious work, particularly for urgent cases, and, instead of returning incomplete forms to the doctors in such cases, might telephone or otherwise contact the doctor for direction in completing those incomplete sections of the forms. Alternatively, they can refer to the lists available to them which set out the standard information such as the indicative length of stay for the particular type of surgery.

243 Although it is said that the Waitlist Clerks 'determine' the length of hospital stay for the patient where the doctor has not completed that section of the Form, this is not so. There are standards already determined. The Waitlist Clerk refers to a manual which provides that information according to the nature of the surgery. In fact, the scope for the exercise of any discretion by the Waitlist Clerks is quite limited. They do not perform any work which might be classified as clinical. Their role and function is clerical.

244 Many of the issues claimed by Waitlist Clerks as reflecting a significant increase in work value are the same as those claimed by other FLCPs. The work of Waitlist Clerks has a lot in common with Booking Clerks and Bed Allocation Clerks. By this I mean that there is a requirement to receive, check and record information, and make verbal and written contacts to achieve that purpose. The process includes allocating each patient into a vacant slot for surgery, and rearranging those placements according to changed circumstances. The placements are to be according to the prioritisations set out in the Form and the documentation available to Clerks, in particular the Elective Surgery Access Policy, and as noted above there is a guide to the length of stay for each type of surgery.

245 To perform this role, there is a need to be familiar with terminology, process, locations, resources and medical personnel. All of this is done under supervision and assistance of a higher level clerical coordinator and senior nurse, with the capacity to refer to and liaise with the medical specialists.

246 Having observed the workplace and the performance of the work, having heard the evidence and examined the documents, I am unable to discern that the work value of this position is at a higher level than the remainder of the FLCPs generally, including those positions which have similar functions such as Bed Allocation Clerks and Booking Clerks. I note that those positions are not the same but the same types of processes are involved even if the technology is slightly different for each. Like Ward Clerks, who are allocated to particular wards and become familiar with the particular requirements of their ward, the Waitlist Clerks become familiar with particular allocations for surgery. However, like Ward Clerks who have to relieve Ward Clerks in other wards, Waitlist Clerks also relieve Waitlist Clerks from other specialties. It is, however, work of the same nature and level of skill.

247 Whilst on a cursory examination, the Waitlist Clerks' work may appear to be more complex than for some other jobs, when broken down into its elements, those elements are at the same level as those for other Level G2 positions. The combination of the elements and the

circumstances under which they are performed does not, in this case, make the job more complex. The manuals, procedures and training, together with the familiarity which comes with regular performance of this work means that this is not beyond the scope of work which would be expected of a Level G2 position. In those circumstances, I find that, notwithstanding that some other Waitlist Clerk positions have been classified at Level G3, from the evidence before me the position of Waitlist Clerks at SCGH is not generally higher than Level G2.

248 I have also taken into account the evidence of Fiona Murray as to what she says is the increased complexity in the waitlisting process she is involved with, due to surgicentre and ambulatory initiatives resulting in increased responsibility including the need for inter-hospital liaison for waitlist bookings. The difference which might be said to have occurred is that over time, where once each hospital was quite separate with separate processes and procedures, and had its computer programmes, there is now a greater interlinking of hospitals and transferring of patients between them. For example OPH and SCGH have a greater interconnection. All of the hospitals are now moving towards the same information technology programmes and those programmes have been integrated across the sector. Whilst this might add a level of complexity, it is not so great as to significantly increase the work value of these positions.

LIAISON OFFICERS – EMERGENCY DEPARTMENT, SCGH

249 Having considered all of the other FLCPs and comparing them with the position of the Liaison Officer in the Emergency Department at SCGH, I note that on a strict assessment of the duties and responsibilities, this position performs many of the same type of functions, utilising the same skills and abilities as, for example, the Emergency Department Clerks and the Ward Clerks. There is one difference which struck me as quite significant when I undertook the inspections. This position has a higher level of complexity than those other positions because of the multiplicity of functions being performed and the reports, files, and other documentation all being dealt with at the same time by this position as it acts as a coordinating role for the patient records and information within a busy Emergency Department. This is the only context within which I observed this significantly higher level of complexity and pressure. The liaison duties require this position to be at the hub of the Emergency Department, in ensuring that patients flow efficiently from the Emergency Department. The requirement for organisational and time management skills and to be able to work effectively both unsupervised and as part of a team is, in my observation, at a higher level in this position than in the remainder of the FLCPs.

250 The Liaison Officer performs duties and has responsibilities which are very similar to those of a Ward Clerk however, the working environment requires them to be exercised at a higher level. Their communication, negotiation, organisational and time management skills need to be of a higher level, particularly after hours. The range of internal and external communications is broad and more complex than applies to other Level G2 positions, and is more aligned with Level G3 skills and responsibilities. The same level of complexity is not evident in the other FLCPs. I make this point quite strongly that this is the only position which I would contemplate being at a higher level than the remaining FLCPs.

251 As with the other positions, it is not simply an examination of the list of duties or of the essential and desirable criteria for appointment, which is important. It is an observation of the work being undertaken in the work environment. Accordingly, because of that higher level of skill and because of the circumstances under which the work is performed, I would grant a reclassification to Level G3 for the Liaison Clerk in the Emergency Department at SCGH.

252 There may be flow-on implications to this conclusion, however, I note that there are a very limited number of tertiary hospitals with Emergency Departments of the same size and complexity as SCGH. Mr Radici's original report and his Addendum report noted that the Liaison Officer position at SCGH is not the same as the same titled positions at RPH and FH, and, as he recommended Level G3 for the SCGH Liaison Officer, there should be no flow-on to those other positions (see Employer's Volume 3, Tab 11).

253 In those circumstances, I would anticipate that if there is any potential flow-on at all, it would be very limited indeed.

CONCLUSION

254 The FLCPs are essential to the smooth and efficient operation of our public hospitals and the records they establish and maintain, and the bookings and scheduling they undertake, are essential to the speedy and safe treatment of patients within the health system. The nature of the work and responsibilities have not changed to any significant degree since they were last reviewed. However, the way they perform those functions, including the skills utilised, the organisation of the work, the means they utilise and the work environment have all changed, for some positions more than others. There is a commonality of some duties across various groups.

255 Technology, particularly in the form of utilisation and continuous development of computerised record keeping has also changed both the way the work is performed and the particular skills required. Some packages and systems have replaced others to enable more to be done, more efficiently. This has required training. However, the level of skill required is not significantly higher than it was in the management of that information via the previous manual means. The other significant change, in some areas more than others, is the work environment. However, generally, that change has not added significantly to the work value of these positions except in respect of the Liaison Officer at SCGH.

256 Overall, the work of the FLCPs is appropriately classified at Level G2. A reasonably well trained and competent person will perform the work with only limited and indirect supervision.

257 These positions do not perform the duties nor do they require the levels of skills and responsibility appropriate to Level G3. The only exception to these conclusions is the Liaison Officer in the Emergency Department at SCGH, and this is due largely to the complexity of the working environment.

258 An order will issue reclassifying the Liaison Officer position at SCGH, otherwise the matter will be dismissed.