

<b>General Immunology</b>	
<ol style="list-style-type: none"><li>1. I am concerned about the loss of scientific expertise and future of the Immunology directorate. The highest level scientist (other than the Scientific Discipline Lead) available is an MeS3. This is a significant reduction to the current scientific capacity of the directorate. Scientists are required if we are to innovate and implement new tests and technologies that will ultimately benefit the community and health system. Furthermore, reducing the scientific capacity puts the continuation of our current high quality safe service at risk. It looks as though we are moving to a very basic service level that will not have the capacity to innovate and add new tests/technologies. Rather than cutting scientific capacity, we should be investing in training to up-skill scientists to clinical scientist who could take on some of the supervisory responsibility currently delegated to supervising pathologists, at a fraction of the cost. It is sad to see a once world-class scientific organisation signal to the workers and the community that they do not value scientists. This does not bode well for the future of pathology and science in South Australia.</li><li>2. SA Pathology no longer values biomedical research. This can be seen by the loss of scientific positions in the new structure. This destruction of research capability is a long term strategy to exit from biomedical research with diminished funding and staffing from SA Pathology to the Centre for Cancer Biology, and disengagement from long-standing collaborative research relationships with Adelaide University. It is very sad to see a once world leading scientific organisation head down this route.</li><li>3. Immunology has always been fiscally conservative and are a very quality focused directorate. At our last directorate meeting it was reported that we were approximately 100K favourable (approximately) last FY. I can't remember when we have ever been unfavourable against budget. I am still not convinced about the severity of cuts that executive say are required. I have heard from senior staff that pathology is less than 1% of the health budged, but our services are used in</li></ol>	

80% of clinical decisions. This seems like good value to me. If this is true, cuts will make little difference to the overall health budget, but will place patients at risk as the quality of our service will be diminished.

4. Immunology has not had the same investment in automated technology as other areas, yet we are being made to have approximately the same % of cuts as Automated, who has a very long history of investment in automated technology.
5. I can see the benefit of consolidating ADL services to a single site. This makes sense, however this should have been at nRAH. The health department should have consolidated pathology at the nRAH. To think that the state has payed so much for a hospital that can-not accommodate all of the current pathology services is very disappointing. This was a disastrous decision for the state, and for pathology.
6. I am heartened that the staff are still managing to produce quality results, however the moral and stress levels are at an all-time low.
7. There is no co-ordinated whole of organisation plans for reducing costs (other than by making staff redundant). Every staff member in the organisation would know how to save the organisation money by reducing waste and improving processes, but Executive have not been pro-active in establishing a lean, co-operative culture that leverages off the ideas from workers to improve efficiency. I was speaking to a cleaner the other day who said they know how to save 10s of thousands of dollars per year on waste disposal. There is no reward for innovation to save costs, and people fear that they will lose their jobs if they do. Executive are leading from the 5<sup>th</sup> floor of their isolated building and are not spending enough time or resources engaging with the workers on the floor. New technology and software are no magic bullets. There is no magic bullet. Efficient organisations take years to develop through culture change and slow systematic continual improvement. This slow process of improving organisational culture to value efficiency can be rapidly destroyed by ineffective management. We used to have organisational that prided itself in a high quality culture, which was highlighted in our old tag line "Quality Pathology Supporting Training and Medical

Research". Executive management seem intent on pushing staff to the brink of failure by engaging in once in a generation organisational change at the same time (EPLIS, nRAH, retraction of CCB/Adelaide Uni Research away from SA Pathology and EIP1.1). Staff (and management enacting executive decisions) are being overwhelmed. The Executive are responsible for the current culture which is dominated by fear, dismay and distrust which has led to a lot of anger and infighting within and between directorates as internal power struggles ensue.

8. What is the strategic direction of the organisation? This has not been clear for some time. Austerity and budget prudence is not a strategy, but is something that is a discipline that should always be applied. If the right incentives are in place to allow for cost saving measures, this should occur as a matter of course. A part of the problem is the perverse incentives (disincentives) to save money. Why would you make a process more efficient when it means that somebody will lose their job? Why would you transfer an assay to put on an automated analyser when the area that worked up the assay doesn't get the revenue once the test is transferred?

9. Workers do not trust executive management. This will need to be addressed if management expects continued excellence from their workers. Happy workers are productive workers and the converse is true. There is a perception that this current round of cuts is just the beginning and future cuts will continue year on year.

10. Efficiencies of support services enable the lab to undertake their functions. Efficiency improvement projects should look at all processes that affect laboratory operations which are the areas that add value. Why aren't we looking at improving the efficiency of the shared services that laboratory staff have to engage with (eg procurement, HR, ICTS, SLS, etc etc) that are enablers of the laboratory operations.

<p><b>Immunology</b> <b>Feedback to report:</b></p> <p>This is a piecemeal cost cutting at the value add end of operations. If efficiency improvements are genuine redesign would look at all costs to production to ensure that we are not cutting too hard in the value add areas (laboratory workers). Management that are genuinely concerned about the welfare of their staff that are the most important assets of our organisation would surely look at all possible ways to save money, via process improvement, and show genuine results, BEFORE cutting staff.</p> <p>In the interests of transparency, can staff please have a break down of SA Pathology executive pay, so that we can understand the amounts of executive pay to the cost of Pathology.</p> <ol style="list-style-type: none"><li>1. Pathology Director</li><li>2. Deputy Pathology Director</li><li>3. Chief Scientist</li><li>4. Marketing Director</li><li>5. Director Automated Laboratories</li><li>6. Director ICTS</li><li>7. Finance Director</li><li>8. HR Director</li></ol> <p>What is the percentage of executive budget (including executive support functions) against all costs to production?</p> <p>The assess the value of the what EY and Beas-ton have provided the state to develop such a piecemeal strategy for improving operational efficiency, can we please understand what these private organisations have been paid to generate these reports? Would these costs have been better placed into management and staff training?</p>	
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ICTS process in pathology (and whole of health) are entirely inefficient. Improvements in efficiency of ICTS would lead to a tremendous improvement in productivity of the laboratory environment. Unfortunately the track record of ICTS in pathology and health is poor to say the least. ICTS is not included in this efficiency improvement exercise.

The assumptions that the laboratory at the new RAH and that EPLIS will improve laboratory efficiency are poorly defined, and heroic given the number of staff that are assigned to be cut. SA Pathology (and health) have shown very poor track record of successfully implementing labour and saving automated equipment (see ADVIA Centaur and Siemens track, and the increase of staff required to run those systems? And electronic management software (see EPAS). What modelling has been under-taken to estimate the labour saving from the nRAH and EPLIS systems.

There are many many problems with the new EPLIS and track systems.

Why are SA Pathology relying so heavily on technology and new equipment productively, (which will not work)? The transformation to a “lean” organisational is not dependant on technological “enablers”, but rather investment in staff culture and training to get all staff to be thinking about waste reduction/process improvement at all times! Thinking that poorly designed processes, a bloated and unaccountable culture, utilising the latest equipment/software will bring about efficiency improvements is highly improbable.

Some examples of how these new systems will lead to more work are as follows:

1. The new LIS and the automated track at the new RAH are not compatible for handling samples aliquots. An aliquot from the primary sample is given a unique suffix by the track. However, the LIS cannot handle the suffix. The aliquot sample will be sent to the ADL for testing. Upon receipt, lab staff at the ADL will then need to relabel the sample within the lab to enable entry into the LIS. This is extra, non value adding, error prone labour that will be required for the ADL staff. I thought all these processes were meant to eliminate work around, but in reality we are creating more work around with this new system. Not very lean.
2. The nRAH has only 4 courier spots allocated. Couriers trying to deliver samples to the

nRAH will be ramping, or driving around waiting for another courier to leave. Once a courier finds a park, they then need to walk 200m to the nearest elevator, wait for the lift, catch a lift up two levels, walk another 50m to get to the specimen reception. A lot of waste in transport here. Not a very "lean" process.

The laboratory will still be expected to interact with inefficient "shared services" such as ORACLE?Bassware, CHRI21, SLS.

Pathologists are a cost to overall laboratory production. It is illogical and disingenuous to exclude Pathologists from reform. One medico is worth at least 4 scientists on a dollar for dollar basis. If the organisation is genuine in cutting costs, it would include HIGH COST pathologists of which there are far too many. Executive and SA Health are scared of the medical union and will not touch Pathologists, and will rather cut heavily the "hands on" laboratory technical and scientific staff.

Pathologist employed as a laboratory staff member had their contract renewed during the "re-configuration" process. Although this position was a purely laboratory position, this saving was not counted as a saving for the laboratory. This decision to let the pathologist go turned out to be a very poor decision as it seem that pathologist are excluded from laboratory operating costs. We may as well have kept the pathologist as the savings were not assigned to the laboratory, the loss of their expertise has been felt acutely.

In the interest of understanding how medical staff costs impact on overall budget, can we please have a breakdown of the following:

1. Number of medical staff paid for by SA Pathology
2. The annual cost of these wages and what these costs are as percentage of all lcosts

Anatomical Pathology and Genetics and Molecular Pathology do not have the same percentage of cuts as other departments.

You have massive staff trust deficit. What is being done to change the culture of the

<p>organisation that has led to the reason for change? What is the strategic plan for the future? How are you going to improve accountability and expected attitudes, norms of appropriate behaviour to execute the massive changes required to be more efficient organisations?</p> <p>How are you going to manage the breakdown in trust that staff members that survive the cull will surely have. What are the drivers to encourage staff to work efficiently, reducing waste, when they believe that another round of job cuts will be around the corner?</p> <p>Quality and safety will be compromised as staff are concerned about the jobs and will be less likely to report incidents/customer complaints/hazards that have an impact on staff/patient safety.</p> <p>Technology and software do not make productive companies in and of themselves. Organisational culture is the most important driuver for executing the organisational strategy....which is? Austerity is not a strategy, it is a discipline.</p> <p>EPLIS – accelerated roll out to December 2017, to cut staff earlier (supposedly). Increasing the stress on staff to undertake business as usual AND to build/test EPLIS to then be made redundant.</p> <p>HR Rules are nonsense. Trained experienced staff can go for their classification (not below, or above). This makes a mockery of the universal principles of “best person for the role”. It also is hugely wasteful of training already undertaken by the incumbents in a role.</p>	
<p><b>General</b></p>	
<p>1. In the field of pathology, laboratory experience and knowledge is very important. This experience and knowledge can take years to obtain. Some temporary employees have been in these roles for a long period of time (ongoing extended contracts), and have gained specialised skills and knowledge to perform, interpret and report patient results. It is unfair and unacceptable to disregard the work that they have provided to the department. Temporary employees should have the same rights to apply for a position in their department first to maintain the high level of experience and skills to</p>	

ensure that patient results are accurate and efficient.

2. Employees should have the right to apply for positions at all levels and classifications. For example; a MeS-2 scientist should be able to apply for a MeS-1 position in the new structure. There would be fewer MeS-2 position in the new structure and more MeS-1 or TGO-2 positions. These positions should be made available for someone who is a MeS-2 as they would have the experience and knowledge in that department and will be able to perform assays, report patient results and maintain optimal lab standards (ISO, NATA accreditation).
3. The job matching process should be applied to existing employees within the department. This should include current temporary and on-going contract positions. A department should be able to fulfil its positions with experienced and knowledgeable employees first because patient care should always be put ahead of cost cutting. When you take away trained and experienced staff who understand the lab work that they perform, understand how to operate and troubleshoot equipment problems and understand the importance of the results they provide for patients, there will be a dramatic decline in lab production and performance and SA Pathology's reputation will be in risk.
4. Currently, the moral of the staff at SA Pathology is very low. The uncertainty of our future is worrying and unfair for current employees who are worried about the future and whether they will have a job.
5. Currently, SA Pathology is quite short staffed across every department. The work load is continuously high and staff seem to over work themselves to get the jobs done. This pattern of work creates stress and health problems for staff and most of the time results in sick or stress leave. It is important to remember that the wellbeing of the SA Pathology employees are important also.
6. The HR principles are not suitable for the area of pathology, in particular laboratory work. Scientist/Technical staff have experience and qualifications that are taken into account during an interview process. Their experience should be considered for all levels of laboratory work. If they can fulfil the job specification requirements, they should be able to apply. The HR principle that an MeS-1 can only apply for a MeS-1 position is unreasonable, they should be able to apply for higher (MeS-2) or lower (TGO) positions to job match and fill the departments positions in the new structure

<p>first.</p> <p>7. Finally, a reminder that after all the cost cutting and down regulating has been done. It is so important to ensure that a patient's well-being is upheld. SA Pathology's reputation for providing a quality service for the public and being involved in training and development is critical to uphold. Incorrect restructuring and redeployment of staff will jeopardise this and put patient care as well as staff health at risk. Regarding the experience of current staff the new structure (both permanent and temporary) is so important to maintain the high quality of lab work and performance. To hire inexperienced people will require time for training and will mean that work out put will be reduced.</p> <p>8.</p>	
<p><b>EPLIS / Millennium</b></p>	
<p>The experience with those working on the project and staff using the system at the Women's and Children's Hospital is that more staff will be needed once Millennium has been rolled out to all sites. This opinion comes from the people actually using the system. The notion that Millennium will need fewer staff is fantasy and wishful thinking and not based on any hard evidence. Millennium is a good system that has a much higher degree of complexity than the Ultra system it replaces. It was designed to be a total solution to handle the complex tasks of Pathology. It was not designed to replace staff. The Pathology Director telling us we will need less staff because of Millennium <u>has never used it.</u></p> <p><b>Take home message: Experienced staff using the new EPLIS system tell us they need more staff because of the new system.</b></p> <p><b>nRAH</b></p> <p>A brand new laboratory in a brand new hospital is not the time or the place to be guessing about staffing numbers. We should be very clear that there is no other laboratory exactly like the new laboratory. It is apparent from the proposed cuts published in the latest proposal that the intention of SA Pathology is to staff this modern, highly technical, laboratory with the least qualified staff possible. It defies all logic and demonstrates that money is the motivation behind these decisions. I have spent time in the new laboratory and the volume and</p>	

complexity of the new systems is staggering. We have millions and millions of dollars worth of highly technical pathology testing analysers and equipment. The amount of maintenance alone will keep a small army of Technician's and Scientist's busy on each shift.

**Take home message: Understaffing Australia's newest most Hi-Tech hospital pathology laboratory using the lowest numbers and lowest skill levels possible is not efficiency. It is idiocy.**

**Efficiency!!**

Decimating the numbers of pathology staff that perform lifesaving testing in no way shape or form could be considered "efficiency". If SA Health goes ahead with the ill-considered cull of staff from SA Pathology, they will need to consider increasing staff in hospital autopsy rooms. It is a fact that Pathology Tests are used to make life and death decisions. SA Pathology has already spent too much time in the news under the headline of "PATHOLOGY BLUNDER" and "MORE PATHOLOGY MISTAKES". With understaffed and under skilled laboratories it is only a matter of when and not if mistakes will be made.

**Take home message: Pathology Laboratories are only as good as their staff. Are South Australians prepared to accept the risk of their results being wrong so SA Health can save a few dollars?**

**New Hospital and Emergency Department Upgrades**

The announcement of hospital upgrades and in some cases doubling the size of Emergency Departments at multiple hospitals will see a corresponding increase in Pathology tests being ordered. The Emergency Department is a prolific user of Pathology Services and Doctors rely heavily on Pathology Results to decide on the most appropriate treatment for their patients. It is also known that Pathology Test requests have been growing at between 5% and 8% a year. This is well understood to be in line with our aging population.

**Take home message: Decreasing the numbers of Pathology Scientists and Technicians while demand for Pathology Services is increasing simply does not add up.**

<p><b>Confidence in SA Pathology Results if the cuts go ahead</b>  <b>Speaking personally:</b>          I regularly need Pathology Testing. I have always requested that my GP use SA Pathology for my testing and I have always had full confidence in the results.          If the proposed cuts proceed, at the levels that are being proposed, I don't believe I would have the confidence to have my testing performed at SA Pathology in the future. This makes me really sad. Cutting the numbers proposed and lowering average skill level across the whole organisation will take its toll on quality I believe. Mistakes will inevitably happen.</p> <p><b>Take home message: If a staff member will not have their test done at SA Pathology, would you??</b></p>	
<p><b>Lyell McEwin Hospital</b></p> <p>9. With EPLIS and the NRAH, what do you have as a plan if they do not perform to the levels that are required to support these jobs cuts?</p> <p>10. Also, if experienced staff are taken from their roster, and then it is realised the numbers were too low, then that experience is lost as they cannot reapply for 3 years. There is a risk of losing years of skills and experience prematurely when we do not know how the systems will work at our site.</p> <p>11. MeS-2 staff have taken the biggest cut at the LMH, we work in a multi-tasked environment in a major Adelaide hospital and their experience is very much required. Has this massive loss of knowledge been considered? And how will this be overcome? With staffing levels being so low how will training be supported? How can you ensure a safe working environment for staff and patients given these losses, especially that of experienced scientists?</p> <p>12. Training and multitasking are mentioned, are the MS-2 staff that are not required for the new structure expected to teach those moving into their positions their</p>	

“redundant” role?

13. How can patient safety be ENSURED when we are struggling now? We already have the new analysers, and the LMH is not currently considered for EPAS?
14. We are working almost to an UNSAFE level for STAFF AND PATIENTS at the moment, regardless of what is coming with the new IT. IF the IT performs as it is expected to, we would be able to cope with the workloads, NOT then further lose staff? Regardless of whether patients are affected or not initially by the cuts, if staff numbers are reduced and workloads are high, it is inevitable that sick leave and stress leave will increase; we can already see that beginning. This will then indirectly impact patient care.
15. One enabler in this restructure is analyser technology. The LMH had analysers selected for us and an install date had been negotiated. During the implementation phase, before the LMH install, concerns were raised by some laboratory SA Pathology staff that the analysers we were to receive would not be for our purpose, this was realised to be true, and 1 year later our new larger throughput analysers were installed. Only once installed did we realise, due to maintenance amongst other things, that we were still not able to provide the hospital with the service required of us, and 2 weeks post install our old e411 was recommissioned to assist. This shows that even with careful planning and consideration, until things are implemented fully, you cannot tell how they will work in the laboratory in real life. Also it shows, laboratory staff knows their workplace and their jobs, and their opinion should be considered. How can you ensure this will not happen with EPLIS?
16. The remaining area supervisor MeS-2's assist the managers with various duties, including QC review, training, QAP, internal comparisons, stock control, amongst various other things. It is hard enough, and takes careful time management, to do this in the current structure, and often things need to be left to ensure patient samples can be processed. LMH managers, would not be able to complete all these duties without help from MeS-2 staff. Do these duties disappear? How are they going to complete them after the decrease in staff is implemented? Will this impact out NATA

<p>accreditations?</p> <p>17. Are we basing these numbers on a “perfect model” where everything works perfectly?</p> <p>18. If so, do you think this is dangerous, as we all know the laboratory faces many challenges daily? Would this be an impact to patient care?</p> <p>19. There are no TGO 0s in the new structure only TGO 1s. Was this intentional or are the TGO 0s in with the TGO 1 numbers.?</p>	
<p><b>Transfusion – Women’s and Children’s</b></p>	
<p>Concerns for the new org chart are as follows:</p> <p>No MeS2s other than a supervisor. This supervisor position is in the current structure, however no job was ever advertised for it. The current incumbent was put in to the position during a time of when we lost our MeS3/4 manager when he took a package 2 years ago.</p> <p>Incorrect information on current structure - it says for WCH automated lab ( which we fall in to now) has pre-testing staff from 0700-2300. We only have them 0800-1800.</p> <p>Proposing changes before EPLIS is even rolled out statewide. We have gone live with EPLIS. It is not a user friendly system and actually has increased the amount of steps we need to do in order to complete our work.</p> <p>Not enough people to cover a 24/7 roster - would be a high amount of "undesirable" shifts for everyone.</p> <p>Proposed structure has downgraded current MeS positions to TGO1's. TGO1's are not to work unsupervised in transfusion. There are not enough MeSs to supervise them 24/7. No effort has been made to see the high level of tests that we perform that can't be done by junior staff and places patients at risk.</p> <p>No allowance for career progression</p>	

<p>Multiskilling areas that should remain separate due to degree of difficulty</p> <p>What was the IMVS has a history of employing degree educated staff on base grade technical positions - therefore exploiting people that need to get a job to just get their foot in the door. The culture at WCH was always employ on the basis of your education.</p> <p>Doesn't appear to be much of a scope for part-time staff. I am working extra hours as it is to help out with filling our roster - can't see where they can cut from!! Twice in the past fortnight, we have been contacted after hours by the Statewide On Call Transfusion Scientist asking for our expert advice on patient situations.</p> <p>The first was to ask what "special blood" needed to be sent to retrieve a mum and baby.</p> <p>The second was to ask us to crossmatch blood for a complex baby at Lyell McEwin Hospital as the multi-skilled staff there were not confident to do so themselves.</p> <p>We have also been asked to supply FMC with 3 units of reconstituted blood for an exchange transfusion.</p> <p>The above highlights the need to retain specialist staff within the Transfusion Lab at the WCH - and also suggests multi-skilling doesn't work too well at other sites.</p>	
<p>Feedback and concerns on WCH current and proposed Organisations Chart for Automated Laboratories - WCH "core Plus".</p> <p>Page 25 Figure 3- The Current Organisational Chart is incorrect for WCH. The chart does not show 1.7FTE TGO3.</p> <p>Originally these positions were TGO-2 and we gained personal reclassification but they are</p>	

not even listed at the original TGO2 level as the Org Chart only shows 1 TGO-2 and there is currently one TGO2 within Automated. There may be other positions missing but these are the two we know about given they are our positions. The good thing is they are present on the proposed Core Laboratories Organisational Chart on page 26 Figure 4. But is concerning they are made to look like new positions.

The major concerns:

1. Insufficient staffing numbers to facilitate a 24/7 roster. Especially regarding workload, sick leave cover, Annual leave etc.
2. The document states that the “WCH Core Plus” will perform all routine and Urgent hospital samples for Haematology, Chemistry, Haemostasis and Transfusion. The WCH Core lab already now only test Hospital patient based samples and we already have EPLIS and our workload is ridiculous. There are no further technology “enablers” to implement here at the WCH Core Lab/ Transfusion to purportedly create “efficiencies” that allow for reductions in numbers unless Hospital patient work is sent off sit.
3. The introduction of EPAS (the only technology enabler left) will only serve to alleviate pre testing workload not Lab services. Therefore the proposed Staffing levels are inadequate now let alone reducing staffing numbers further.
4. There is Insufficient positions higher than TGO-1 irrespective of this supposed new supervisory model where by each section has a Scientific lead and an area supervisor. It has always been the case in the last 30years of my pathology experience that a minimum of mes1/TGO2 was required to work alone (unsupervised) or as “shift supervisor” in a Transfusion Medicine environment when the supervisor (mon-Fri 9-5) was not physically present. This has also been the position of IMVS and now SA Pathology and one has to assume it is still the case as they state patient

safety is paramount?

5. The level of responsibility and accountability cannot be “remotely” carried out when it is the person on the ground whom has to make urgent judgement and experience based decisions.

The so called full integration of Transfusion services into a “Core Lab Plus” model does not negate this responsibility and in the new proposed structure they have only allowed for 1MES1 and 1.7TGO3 that is 2.7FTE. How can a senior person be rostered on every out of hours shift with only 2.7 EFT?

Basic Maths tells you that you have 16 shifts ever week that are out of hours (7ND, 7 Evening and 2Morning on Weekends) even with 2.7 and if you did all your shifts out of hours ie permanent ND or E you can only cover 13 or 14 of these shifts each week and cover for sick leave or Annual leave is non-existent. Even if they state that Transfusion section supervisor participates fully on the roster (which they currently do not) that is only 3.7 for all out of hours shifts and if the scientific lead is absent (which is greater 50% (currently 90% of the time due to meetings etc) TGO-1s during 9-5 with little to no Transfusion experience will be effectively only receiving supervision by form of remote input.

Transfusion requirements and decisions are often required to be immediate. Therefore there is an inherent level of accountability and responsibility in the dispatching of blood and blood products without your working being checked at any level before this occurs. The issuing of Blood and Blood products is not unlike a Pharmacist for which you must have a degree and min levels of experience. If for the last 30years Patient safety has required at least an Mes1 or TGO2 why now can it appear a TGO-1 can perform this level of accountability or responsibility because they certainly have not provided for enough senior positions on out of hour shifts. This is of grave concern for Patient safety.

Also another inaccuracy is on page 24 table 3 it states that Pre testing currently occurs from

<p>7-23hrs 7 days a week this is not the case here at the WCH. We have Pretesting from 8am until 6pm Mon-Fri and 8am to 1pm sat and Sun. All other hours has been done by Lab staff.</p>	
<p><b>Women's and Children's - GENERAL</b></p>	
<ol style="list-style-type: none"> <li>1. Considering the majority of MeS2 positions are substantive MeS1, who have peer-reviewed to MeS2 based on their actual responsibilities, which have been agreed to by SA Path executive, how can they say that the positions are now TGO-1 level? <i>(What has changed in these roles?)</i></li> <li>2. What impact will this have on turn-around time?</li> <li>3. This was organised with the assumption that our new computing system would improve efficiency. It has been installed here at the WCH, and it is more work than the old system. After 2 months, we are using it to the best of its ability, at it is a cumbersome millstone of a program. Efficiencies will not be gained here. We may see some improvement when EPAS begins to talk to it, but that is some time away.</li> </ol>	
<ol style="list-style-type: none"> <li>4. My major concern is : our substantive positions are recognised as TGO2/MeS1, difference being diploma vs degree. Since the inception of the Core laboratory it has been clearly recognised by the WCH and the Medical Laboratory Science industry standard, amongst other scientific associations, that the multidiscipline job roles expected to be performed in a multidiscipline 24/7 tertiary hospital pathology laboratory are best served by the TGO2/MeS1 qualifications. Having a degree entitles progression to MeS2 as part of the EB agreement for those scientists meeting the necessary requirements set by SA Pathology.</li> <li>5. How can the proposed configuration see fit to declassify positions to classifications for</li> </ol>	

<p>which there are no recognised university courses ?</p> <p>6. How can Sa Pathology continue to promote excellence, staff development, recognise achievement and endorse progression, yet completely dismantle in the proposed configuration at WCH ?</p> <p>7. How can all this happen with no change to job role ? and if there is to be significant job role change, have staff numbers required to enable current expected service outputs been considered?</p> <p>8. Can the proposed configuration really deliver a safe pathology service ?</p> <p>9. Is Sa Pathology anticipating employing degree qualified scientists at a lesser classification as there are no recognised university courses for the technical stream?</p>	
<p><b>Women’s and Children’s - LABORATORY SERVICES – WCH CORE LABORATORY</b></p>	
<p>We are a primary hospital for obstetric, neonatal and paediatric services, including paediatric oncology for SA and NT. Our laboratory services the specialised needs of the WCH, much the same as the regional laboratories service their hospitals. Perhaps WCH Automated laboratory could be placed “out of scope” for the time being, like the regional laboratories.</p> <p>With a level of automation which has not changed for about 10 years, nor will change anytime in the future, there is little justification in cutting scientific staff. The enablers cited for change, namely the Millennium LIS / EPAS interaction, will help the sample entry section to become more efficient, but not the actual workstations, which remain organisationally unchanged. Why then, are the scientific staff (who work at these stations) being cut by 80%? The proposed model, of having lower-skilled staff process the work which is then overseen</p>	

remotely from another laboratory, ignores the reality of the labour-intensive nature of working with small samples, such as that from premature neonates and small infants, and the higher percentage of samples which require more complicated laboratory analysis than equivalent adult tests.

Since there will be a new Women's and Babies' Hospital built within the next few years, would it not be better to wait until this happens, and restructure the laboratories at the same time as the new hospitals, as there will be a physical requirement to downsize (ie – since the hospitals are adjoining, there will not need to be a separate laboratory). The WCH Automated laboratory could then be downsized to service the smaller Children's Hospital which will remain on-site or move to the old RAH site, as the case may be. A reduction of staff would thus justifiably occur through the amalgamation of hospital services. This strategy would also not downgrade the current service to the Paediatric Haematology and Oncology clinic, which uniquely services both SA and NT, while resulting in only 3 staff more than in the proposed structure - minor when compared to the 198 proposed to be cut overall.

In response to the proposed structure for WCH. Note that quarantining of job positions would result in only 2 medical scientists, of 12, retaining their jobs, so an almost complete turnover of staff will occur.

This laboratory also is the primary laboratory servicing the only paediatric haematology and oncology unit for SA and NT (based at the WCH), and as such is the first stage in diagnosing serious conditions such as leukaemia in children. Two scientists will not be able to service paediatric leukaemia services for 2 states.

**Industrial Perspective**

In the proposed workforce configuration, the Automated Laboratory lab services at WCH will be reduced from 14.3 FTE to 10 FTE scientific staff, excluding the MeS4 and MeS3 positions. The proposed configuration aims at degrading 7 of the 10.8 FTE MeS1/MeS2 positions to TGO-1 laboratory technician positions, whilst making 1.8 FTE MeS1/MeS2, 1.0 FTE MeS1 and 1.5 FTE TGO-2 positions redundant (Ref. Current organisational vs proposed

organisational chart).

It is very important to note that the current 10.8 MeS2 classified staff have progressed from their substantive MeS1 positions by meeting stringent criteria, set by SA Pathology. The opportunity for progression is constantly promoted by SA Pathology and is part of the Hospital Scientist Award.

The current multi-skilled scientific staff configuration at the WCH was created in 1995 with the inception of the Core Laboratory. The hospital recognised the need for an efficient and progressive multidiscipline front line Core Laboratory model, capable of delivering high quality, safe and fast 24/7 pathology services to the neonates, children and pregnant women of South Australia, second to none in the nation.

The current staff configuration was selected with an appreciation of staff education, knowledge, aptitude and ability, required to fulfil multidisciplinary job demands in this specific population. Staff are required to confidently and effectively work within multiple disciplines with minimal or no supervision across a 24/7 roster, providing valid results in a timely manner. In addition to this, they support hospital staff by providing accurate information and advice when required.

In section 2.5 of the consultation paper one of the highlighted benefits of the proposed changes is to achieve:

3. A multi-skilled workforce led by specialist scientist/managers to allow greater flexibility to respond to clinical and service needs; and opportunities to explore areas of special interest and career progression.

The WCH Core Laboratory achieved this 'benefit' some 20 years ago, having optimised a multi-skilled work force who have progressed under experienced, skilled and competent leadership. To replace 10.8 substantive MeS1 positions with 7 TGO-1 technicians whilst expecting the same service level is contradictory and impracticable.

Furthermore, to try and reinvent the wheel by replacing 65% of the current MeS1/MeS2 workforce with TGO-1 classifications (of which the minimal qualification required is a certificate from TAFE) and effectively perform the same job is very unrealistic and has the potential to cause significant pressure, stress and burnout of employees who do not possess the necessary experience to manage this.

Table 1 displays TGO-1 vs MeS1 job roles with the differences highlighted in yellow. It is obvious the two job roles are essentially the same.

**Table 1**

Comparing proposed TGO-1 with the proposed MeS1 job role:

	TGO-1	MeS1
Primary Objectives	# Requirement to exercise <b>knowledge</b> of the theory of the discipline  # Perform duties which	# Undertake, facilitate, and apply scientific and technical <b>knowledge and expertise</b> to perform range of routine

	<p>require <b>expertise</b>, experience and technical skills to apply standardised practices and procedures in the conduct of a range of technical activities</p> <p><b>? – Do these duties include analysis and reporting of results as per MeS1</b></p> <p># Participate in technical project work which requires applied knowledge and skill</p>	<p>diagnostic techniques, including participation in problem definition, planning, execution, analysis and reporting in conjunction with key result areas of responsibility</p> <p># with supervision, contribute to the development, selection and adoption of new techniques and methods.</p>		
<p>Challenges associated with Role</p>	<p># Understanding variations between test requirements</p> <p># Maintain an accurate, complex integrated workflow</p> <p># Provide high quality and accurate results within a timeframe determined through established KPIs (as per service provision)</p>	<p># Understanding variations between test requirements</p> <p># Maintain an accurate, complex integrated workflow</p> <p># Provide a test result within an acceptable turnaround time.</p>		

<p>Service Provision</p>	<p># Receive specimens into the laboratory (LIS) and perform identity checks in accordance with established laboratory protocols</p> <p># <u>Assist</u> with diagnostic tests as directed and in accordance with established lab methods.</p> <p># Provide high quality and accurate results within a timeframe determined through established KPIs</p> <p><b>? – How can one provide high quality and accurate results, yet the role states that the holder of this position can only <u>assist</u> with diagnostic testing.? This is nonsensical as one needs to perform tests to provide results, consistent with MeS1 role.</b></p> <p># Validate and report results to section supervisor</p> <p># Ensure high standard of</p>	<p># Receive specimens into the laboratory (LIS) and perform identity checks in accordance with established laboratory protocols.</p> <p># Perform diagnostic tests as directed and in accordance with established laboratory methods</p> <p># Provide high quality and accurate results within a timeframe determined through established KPIs</p>		
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	<p>analytical performance is achieved and maintained</p> <p><b>?- Consistent with MeS1 role of testing and maintaining laboratory equipment in accordance with established maintenance protocols and promptly advise supervisors in the event of malfunction.</b></p> <p><b>This role goes hand in hand with ensuring high standard of analytical performance is achieved and maintained.</b></p> <p># Provide a general reception service by handling customer enquiries effectively and efficiently and by providing accurate and relevant information.</p> <p><b>?- Do the enquiries include test results and interpretation, considering this role is to perform tests and validate and report</b></p>	<p># Review results for analytical validity and where appropriate provide interpretation within the context of a diagnostic report</p> <p># Test and maintain laboratory equipment in accordance with established maintenance protocols and promptly advise supervisors in the event of malfunction</p>		
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	<p><b>results to the section supervisor.</b></p> <p><b>Who are the clients a TGO-1 can and can't liaise with?</b></p> <p><b>What happens after hours?</b></p> <p># Safeguard the confidentiality of laboratory results</p> <p># Under supervision contribute to the research and development activities of the department by assisting with the development, validation and introduction of new tests</p> <p># Assist with storage of reagents, specimens, equipment and the safe transport and disposal of specimens. Bring to the attention of their supervisors shortage of materials required to maintain services.</p> <p># Housekeeping duties</p>	<p># Liaise with departmental/unit medical scientists and medical staff as appropriate regarding diagnostic interpretive or scientific /technical problems</p> <p># Liaise with clients in relation to specimen and test related enquiries, provision of test results and interpretation following appropriate review of test results</p>		
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	<p># Maintain records of results and sample storage</p> <p># Assist as required in training of new staff in established methods</p> <p># Receive and prepare specimens for analysis and carry out diagnostic tests according to standard procedures, in the diagnostic laboratories as required.</p> <p><b>?- Prioritising work is inherent to this role</b></p>	<p># Safeguard the confidentiality of laboratory results</p> <p># Assist with work required to implement new methods and procedures, including evaluation and interpretation of new reagents, test procedures and equipment</p> <p># Assist with storage of reagents, specimens, equipment and the safe transport and disposal of specimens. Bring to the attention of their supervisors shortage of materials required to</p>		
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		<p>maintain services</p> <p># Housekeeping duties</p> <p># Maintain records of results and sample storage.</p> <p># Prioritise work in accordance to clinical urgency and process accordingly</p> <p># Assist with equipment setup through participation in user acceptance testing within the framework of established change management governance protocols.</p> <p># Participate in computing requirements of the laboratory including the</p>		
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		<p>LIS, user acceptance testing and various equipment set up and operation</p> <p># Exercise professional judgement within prescribed areas</p>		
Quality Management	<p>Active participation in the application of Quality Management principles in accordance with appropriate regulatory framework. This includes:</p> <p># Procedural audits and reviews as directed</p> <p># Implementation of new methods and procedures</p> <p># Ensuring acknowledgement of relevant procedural updates</p> <p># Ensuring appropriate and</p>	<p>Active participation in the application of Quality Management principles in accordance with appropriate regulatory framework. This includes:</p> <p># Procedural audits and reviews as directed</p> <p># Implementation of new methods and procedures</p> <p># Ensuring acknowledgement of relevant procedural updates</p>		

	<p>immediate reporting of incidents, errors and complaints.</p> <p># Understanding, maintaining and applying the principles of internal quality control and external quality assurance programs and solve problems that may arise</p>	<p># Ensuring appropriate and immediate reporting of incidents, errors and complaints</p> <p># Understanding, maintaining and applying the principles of internal quality control and external quality assurance programs and solve problems that may arise.</p> <p>#Participate in risk management and continuous quality improvement activities as part of day to day work practices.</p>	
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NB. Differences in job roles between TGO-1 vs MeS1 are highlighted in yellow.

- As identified above, it is apparent that the role differences are not significant. (Reference: HR Principles Transforming Health, Sept 2016 stating < 20 % role

change does not constitute a different position).

- In my professional opinion and as outlined, the expectation of the TGO-1 position requires the same output, knowledge and experience as the MeS1 position, therefore the de-classification of this position is unjustified.
- However, to ensure an unbiased approach, I invite independent reviewers by the professional associations AIMS, AACB, and the RCPA to provide their opinion as to whether the TGO-1 vs MeS1 job roles actually can be considered different positions.
- I also invite their comment as to what the minimal classification and qualification required is to best fit the role that we are currently deliberating upon.

### **Operational Perspective**

The proposal to reduce lab service staff from 14.3 to 10 FTE will not allow for a sustainable 24/7 roster and the laboratory *without question*, will not be able to deliver current service expectations to the hospital.

In effect, the new TGO-1 staff will be replacing highly skilled, competent and qualified scientists who have been job matched by SA Pathology to deliver a safe and quality pathology service.

They will be replaced by TAFE certified staff, who do not have the relevant preparation, experience or skill set for this role, *however*, are expected to deliver the same service level regarding timeframes, quality and support.

This expectation is not only impossible from an operational perspective, it is also a threat to the confidence and mental health of both the MeS1 staffs' roles in question, as well as the

TGO-1 staff expected to seamlessly step into their shoes.

Should the proposed staff configuration be implemented, I question:

- How 70% of the Lab services new workforce at the TGO-1 qualification and classification will allow for safe and efficient continuity of service?
- How a 24/7 roster will function when 70% of the workforce are newly selected individuals that will require 24/7 supervision and extensive training.

### **Conclusion**

- SA Health should hold grave concerns at the dismantling of an established, progressive, fit for purpose and nationally renowned laboratory established by the WCH which has demonstrated 20 years of service excellence across the board.
- This proposal also devalues the Medical Laboratory Science industry in assuming a TAFE Laboratory Technician certificate is adequate to perform the role of a Medical Laboratory Scientist.
- This proposal further attacks the Hospital Scientist Award by quite evidently penalising the entitlement of scientific peer progression.

The TAFE certificate for laboratory technician is not designed to prepare staff to undertake the job roles as stated in table1. Undoubtedly, Medical Laboratory Science graduates will be employed to perform the TGO-1 role. This must raise the question of ethics and whether it's consistent with the Australian ethos.

<p>It is most disturbing to note that the proposed benefit stated in the consultation paper is in transparent conflict with the proposed working configuration at WCH.</p>	
<p><b>Women’s and Children’s - Stat/core, 24/7 laboratory</b></p>	
<p>We who work in the stat/core, 24/7 laboratory at the WCH are concerned with the proposed cuts to the scientist numbers in our team – to the dumbing down of our service to the hospital. We know that unskilled workers cant provide the same service without mistakes that we provide – no matter how many layers of supervision are in place. Below is a statement which we have put together. We are multi-skilled scientists – many of us are arguably the most multi-skilled in the organisation – and yet we are the ones being targeted.</p> <p>How can they legally reclassify us or the work we are doing to the level of unskilled workers?</p> <p>I would like to ask/have clarified</p> <ul style="list-style-type: none"> <li>● By what process these declassifications are to occur?</li> <li>● In light of roster requirements, how will the job roles change to provide a 24 hr pathology service to the WCH?</li> <li>● How will these new declassified (non scientific) positions be staffed? Will we, the current substantives, have an opportunity to apply for these declassified positions?</li> <li>● The certificate and diploma for the technical stream was done away with some time ago in recognition of the need for qualified Medical Scientists in the laboratories. What will be the minimum qualifications of a TGO as they will be replacing substantive qualified staff in TGO2/MES1 positions? (many who have progressed to a MeS2 level)</li> <li>● The consultation paper states in section 2.5</li> </ul> <p>Benefits of the proposed change:</p> <ol style="list-style-type: none"> <li>1. A multi-skilled workforce led by specialist scientists/managers to allow greater flexibility to respond to clinical and service needs; and opportunities to explore areas</li> </ol>	

<p>of special interest and career progression.</p> <p>The current Core Lab configuration at the WCH was modelled on industry standards to deliver a safe a consistently high standard pathology service to the Women’s and Children’s Hospital Pathology service is provided 24/7 where staff are required to work independently over a number of disciplines as per job role description.</p> <p>Staff are well trained and have been multi-skilled since the inception of the Core Lab at WCH providing an efficient and flexible response to clinical and service needs consistent with section 2.5 of proposed operational configuration and its benefits.</p> <p>Very important to note, staff were initially employed at the TGO2/MeS2 level through the encouragement and recognition by SA Pathology and by meeting the necessary requirements, consistent with section 2.5 of the consultation paper. Also important to note that the opportunity to progress to the MeS2 classification is integral to the medical science award and progression have been sanctioned by SA Pathology.</p> <p>Staff have performed and aligned themselves to organisational goals, both current and proposed, yet the proposed configuration which clearly aims at declassifying positions is a blatant contradiction of this consultation paper with respect to the WCH core Laboratory.</p> <p>How can this be, let alone allowed? Legal? We would like the opinion of an industrial lawyer on this plan to declassify our positions.</p> <p>There is no question that staff current job roles are best served by TGO2/MeS1 classifications and can be easily benchmarked against like pathology services nationally and internationally.</p> <p>This proposal is not consistent with the proposed configuration for the WCH Core lab.</p>	
<p><b>Queen Elizabeth Hospital &amp; GENERAL</b></p>	
<p>3. Considering Blood Transfusion, a large contingent of TQEH was left off the SA</p>	

Pathology proposed (&current) document - will a timely new document be issued?

4. Will Job and Person Specifications (JPS) be drawn up for each position. I note how can the 20% variation in criteria for a position to be an ongoing on be justified. We would expect there to be JPS ahead of the allocating of people to positions.
5. The QEH Core laboratory will also be combining with Blood Transfusion. Core staff learning transfusion on top of the their Biochemistry and Haematology disciplines and Blood Transfusion staff learning to do Biochemistry. Would this constitute a greater than 20% variation in everyone's roles? Who adjudicates on the 20% variation? Is it person with laboratory experience? Or is everything up to the lab manager? How do you keep this equitable?
6. Who makes the decisions on awarding the positions. How do you stop personal bias. Every manager at every site will already have people in mind? What does merit mean? We would expect there would be three objective people from other (off site laboratories) to reduce this bias and make the process more equitable. For example some staff have had it indicated to them indirectly that some one else is the most likely candidate when that person has experience in only one discipline and the role is as supervisor of two disciplines. Surely this would be more than a 20% variation from current role.
7. In the organisation chart for the QEH Core lab will the supervisory staff be multi or single disciplined? This is not specified in the chart. Also will those positions be for rostering 24/7 otherwise how will the roster work to cover 24/7 and leave arrangements for greatly reduced remaining staff?
8. All other Core Lab sites have an MeS1 what is the reason for TQEH not having any?
9. On Member has been acting in the role of Temporary OPS4 at TQEH for five years.

There is no role for an OPS4 in the new structure. The person's substantive is OPS3 can she apply for the OPS 3 Position at TQEH? At other Core Labs?

10. I the PSA going to recommend industrial actions. What action would the PSA suggest that staff concerned can take?
11. The current explanation of the quarantining of positions (classification and potentially by site) is too open ended and not transparent. Again can manipulated to give preferences to favoured staff members. The 'case by case' explanation not transparent and open. We NEED to know the rules of the process. Not that is all at management's whim. Which seems to be what they are proposing at present.
12. How will the \$250M upgrade for TQEH impact services at TQEH and the laboratory will this impact the positions at TQEH?
13. The WCH pretesting area has 1 X OPS 3 and 5 OPS2 with the TGO's and ASO going. This would indicate new positions. Will these positions be open to TQEH staff or will something go on in the backgrounds. Staff at TQEH will be watching this closely.
14. Further there are proposed at Modbury Hospital (we were told at the recent road show TQEH Core lab is modelled on Modbury and Noarlunga Hospitals. Modbury is allocated 1 X OPS 3 for 4 X OPS 2 and TQEH 1 X OPS 3 for 8 X OPS 2 - why are the ratios so different?
15. urther neither Noarlunga Modbury had Anatomical Pathology but TQEH DOES? Does that mean TQEH is different to the Hospitals it is being compared to?
16. What happens to permanent staff who take contract positions temporarily in other roles, will they need to apply for their positions? Can they loose their substantive position?

<p>4. Since quarantine will be by classification and then by role. The Automated core laboratory staff (Medical scientist and technical officer) roles are not as generic role as AS02 but are we quarantined across the discipline rather than site. i.e. can staff apply for Automated core laboratory position at all site TQEH, RAH, LMH, FMC etc</p> <p>5. Will Job and Person Specifications (JPS) be drawn up for each position. I note how can the 20% variation in criteria for a position to be an ongoing on be justified. We would expect there to be JPS ahead of the allocating of people to positions.</p> <p>6. In the proposed organisation chart for the TQEH Core lab will section supervisors (Haem/chem) MES X 2 and TGO3 x 1 will be working multi or single disciplined?</p> <p>Will one Mes-2/TG03 be allocated for each discipline (haem only/chem only) or be working for both discipline haem and chem .This is not specified in the chart.</p> <p>7. In the proposed TQEH core lab for Section supervisors will the ME2 x2 and TGO 3 X1 be for rostering 24/7 otherwise how will the roster work to cover 24/7 and leave arrangements for greatly reduced remaining staff?</p> <p>But if the section supervisors are to be rostered 24/7 shift work, will there be time for them to perform administrative task. I.e. training scientific and technical staff, QC's calibration management, Writing monthly Qc's report, performing ,monitoring and reviewing internal and external Qc's, preparing for ISO/NATA audit, attendance at professional user groups and meeting, analyser maintenance and troubleshooting,</p>	
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performing staff performance review, stock consumable ordering etc.

8. All other Core Lab sites have an MeS1 what is the reason for TQEH not having any
9. In the proposed chart noticed only TQEH Scientific leader Mes3 has a combine role of both Haem/chem. Does this mean the MeS-3 will be expected to have experiences and skills in both areas? Currently Mes-3 only skills in single section. Does this position in the proposed structure necessitate a new J&P since the change is more than 20%. Also will it then mean the position will be opened for other quarantine candidate to apply.
10. How will the \$250M upgrade for TQEH impact services at TQEH and the laboratory. Since the service will remain the same, will this still impact the reduction of staff at TQEH?
11. 13) Further neither Noarlunga and Modbury had Anatomical Pathology but TQEH DOES? Does that mean TQEH is different to the Hospitals it is being compared to?
12. Staff numbers will be too low. Many issues to be considered:
  - a. Additional duties to run the laboratory to high standard and accreditation
  - b. Qc's management

<ul style="list-style-type: none"> <li>c. Maintenance of analysers</li> <li>d. NAT/ISO</li> <li>e. Preventative, daily, weekly, monthly maintenance</li> <li>f. Pipette calibration</li> <li>g. Sick leave, annual leave, long service leave</li> <li>h. Training education student placements for work experience from high school students for 1-2 weeks and University placement for 3 months or more.</li> </ul> <p>13. Core lab is 24/7 roster, if not managed with consideration of staff numbers and rostering it can cause issue with fatigue and stress which can compound over time and cause illness and sick leave. Staff health and wellbeing needs to be in considered.</p> <p>14. Lab set up different to Frome rd. No Speci track, no automatic lid removal or splits plus manually lid replacement and storage, this all take time.</p>	
<p><b>Automated Chemistry - General</b></p>	
<p>I highlight some of the figures that have now been replaced in the new "SA Pathology</p>	

Proposed Operational Configuration and Workforce Model for Consultation 31 May 2017". There are 21 levels across 5 classifications affected but 3 of these levels account for greater than 59% of the cuts. That is 14% of the workforce receives 59% of the cuts. This is the level two classifications that indicate you are trained and competent and no longer a base grade beginner under training. These are the staff that are the most actively engaged in the core functions of Pathology actually doing the work of testing.

	Current	Proposed	Decrease	Increase	Variance
ASO1	6.7	0	-6.7	0	-6.7
ASO2	65.5	30.9	-35.1	0.5	-34.6
ASO3	8.5	5	-4.5	1	-3.5
ASO4	3	2	-1	0	-1
ASO5	4	4.9	0	0.9	0.9
Totals	87.7	42.8	-47.3	2.4	-44.9
OPS1	16.9	5.3	-11.7	0.1	-11.6
OPS2	62.06	83.8	0	21.74	21.74
OPS3	9.9	11	0	1.1	1.1
OPS4	1	0	-1	0	-1
OPS5	1	1	0	0	0
Totals	90.86	101.1	-12.7	22.94	10.24
MES1	88.3	67.7	-22	1.4	-20.6
MES2	144.63	102.3	-43.83	1.5	-42.33
MES3	67.76	57.5	-10.26	0	-10.26
MES4	28.8	22.8	-7	1	-6
MES5	12	11	-1	0	-1
MES6	6.5	2.3	-4.2	0	-4.2
Totals	347.99	263.6	-88.29	3.9	-84.39
TGO0	32	9.9	-23.25	1.15	-22.1
TGO1	151.08	154.85	-13.93	17.7	3.77

TGO2	104.8	65.6	-40	0.8	-39.2
TGO3	48.1	32.9	-15.2	0	-15.2
TGO4	2.8	1	-1.8	0	-1.8
Totals	338.78	264.25	-94.18	19.65	-74.53

It is clear from the numbers (from page 46 – 5.12 of the proposed changes) that they plan to increase the OPS classifications to enable the use of this cheaper labour in the laboratory. This level is unskilled and with no formal qualification in laboratory work. This is a disaster waiting to happen.

For clarity I have highlighted the three groups most affected by the cuts proposed. It is not meant to diminish the losses to the other groups but to highlight the disparity.

ASO2	65.5	30.9	-35.1	0.5	-34.6
TGO2	104.8	65.6	-40	0.8	-39.2
MES2	144.63	102.3	-43.83	1.5	-42.33

The numbers that have been proposed for my laboratory, the Automated Chemistry laboratory of the new Royal Adelaide Hospital, means that without any doubt staff will be placed under huge increases in their workload with very few staff left to cope. Stress will increase under ridiculous workloads and inevitably mistakes will be made leading to yet another SA Pathology news headline. Let us all hope it is not a mistake that costs somebody their life.

This is an unprecedented erosion of our working conditions. Ever decreasing staff levels doing and ever increasing amount of work!

The figures generated by SA Pathology depend on increases in efficiency and the benefits from systems not even in place yet!!

**GENERAL**

*Q5. Do you have any feedback relating to the Automated Laboratory/Core Laboratory operational configuration or workforce model?*

Yes. Section 4.2.4: Transfusion at Noarlunga not mentioned. Section 5.1.1.1: To maintain the

24/7 service required by the associated hospitals, Core Labs eg Noarlunga require a defined number of staff to maintain the number of shifts. To ensure that these staff are working at full capacity, GP work for the surrounding catchment area should be performed at those Core labs, not just Hospital (Urgent & Routine) work.

With regard to the Automated lab at Frome Rd/ and at nRAH: Automated Testing lab at Frome Rd is already mostly automated, the lab at nRAH is also a track system. It is proposed that the 2 labs will be run concurrently from September 17 until at least January 2018. Each lab will require a full complement of staff for this time- because even though the analysis is performed on Automatic Analysers, the tasks of maintenance, calibration, loading & unloading of specimens, reagents, calibrators & QCs etc requires human input. The track systems may each be running at less than capacity (number of patient episodes), but the required human support of the equipment is not reduced, even if the numbers of tests performed is reduced. Staff will need to be familiar with 2 IT systems, as EPLIS will be used at nRAH but ULTRA will still be in use at Frome Rd. This is likely to result in increased TAT. The number of Senior/experienced staff required to Validate results and QC & deal with customer issues will not be reduced, particularly as it is likely that there may be a shift in Reference Ranges for the new equipment and requestors will not be familiar with new reporting. "Quality" tasks required for maintaining accreditation will also not decrease with the move to the nRAH, these tasks require the input of senior & experienced staff. A focus of the Operational Configuration and Workforce Model is a reduction in duplication, however the inefficient process of double and triple entry of QC results onto different systems has not been addressed.

The split of staff numbers between Chemistry & Haematology at nRAH appears to be inequitable, as Chemistry requires more human intervention than Haematology.

Reduced staff numbers appear to be reliant on "Multi-skilling". Currently there are only 2 staff at Frome Road who are fully "Multi-skilled" - one of these is a TGO 0 staff member and there is no place for him in the proposed model. "Multi-skilling" is a time intensive learning process and this learning will take place in a new environment which will also require learning. The

"Multi-skilling" will need to occur while staff are also performing at full capacity on new equipment- it appears that the proposed timeline of achieving Multi-skilling by February 2019 may be optimistic.

*6. Do you have any feedback relating to the Chemical Pathology operational configuration or workforce model?*

Yes. Figure 6: Currently 4xTGO2 staff with over 100 years of experience between them perform much of the routine work performed in the Chemical Pathology Department. One of these staff members is one of the few experienced people in Australia in the maintenance and use of the Quadropole LCMS used for analysis of Vitamin D, epi- Vitamin D & Urinary Cortisol- these tests make up a large proportion of the work of the department. Maintenance & trouble shooting of the ICP mass spectrometer (for Trace elements & heavy metals) is done by another TGO2: these 2 roles are covered by one MeS1- this coverage is not sustainable (for sick leave & annual leave of the MeS1). Toxicology testing for Drug Screens & sample preparation for confirmations, plus toxicology on-call is done by the other 2 TGO2- this workload is also a large proportion of the department. The proposed Org Chart for Chemical Pathology does not include TGO2 positions for any of these extremely valuable and experienced staff.

*10. Do you have any feedback relating to the Microbiology & Infectious Diseases operational configuration or workforce model?*

Yes. This department has already undertaken consolidation and staff rationalisation. The proposed Org chart appears to be very lean and may not be sustainable to cover leave requirements.

*11. Do you have any feedback or suggestions about implementation planning?*

The timelines for implementation of this plan are dependent on the successful

implementation of a number of new enablers, for which the performance is not known and which may not provide the workload savings expected. To set firm numbers of job losses when there are unknowns of this magnitude appears to be premature.

*13. Please provide any additional feedback or questions you may have on the consultation paper*

1. The paper describes the implementation of "One" SA Pathology within CALHN. I believe that "One" SA Pathology could be better achieved by the set up of a separate "Service" LHN, provided the Salary Sacrifice arrangements can be maintained.

2. Section 3.2.1 'Sharing of Skills' states: "Integration of this workforce model with the ability to provide high quality research, teaching..." but staffing levels in the model are designed to cover operational pathology needs only, with no additional staffing available to undertake extra non-operational workload.

The process of developing a new Operational Model has been driven largely by the requirement to become more cost effective and so is driven by the need to save money. In this case, why has there been a decision by Finance to not invoice non-MBS testing performed for interstate patients and referrals from Private Pathology Providers since last October? I understand that this decision has resulted in ~\$3 million of uncollected revenue for SA Pathology.

**PROPOSED ADMINISTRATION JOB CUTS**

**We are not on the organisational charts that was tabled at the latest presentation.**

Apparently we are on another chart – 4.3 Support Processes.

When this org chart will become available?

I do not think that NOT providing the whole picture is good for anyone and is only causing more stress.

*(Job cuts are proposed but there is no organisational structure.)*When *(will)* this org chart will become available. 4.3 Support Processes is part of the admin restructure.

### 4.3 Support Processes

Current administrative activities are manual and labour intensive and require efficiency improvement

The end goal for this project is to define and improve internal administrative processes and controls to reduce labour intensive support processes and excess expenditure, by:

- Evaluating current job plans and determining if accountability for budgetary requirements can be included
- Improved compliance with internal processes and controls through regular monitoring
  - Providing further education of financial management processes
  - Defining level of service and appropriate workforce change
- Reduction in the level of administrative interaction required when using external parties such as PCSM, ICT and HR functions.
  - Establishing and communicating procurement proposal format

#### Modbury- GENERAL

2. Is SA Pathology proposing to open up an EOI for remaining positions Statewide or

<p>will it be managed through LHN regions?</p> <ol style="list-style-type: none"> <li>3. What is the contingency plan if the enablers are not able to be rolled out?</li> <li>4. Why is NHS staffing proposal more than Modbry when Modbry has 8x more onsite work than NHS. What is the rationale for staffing proposal in the smaller hospitals?</li> <li>5. Are current positions that haven't been filled being held?</li> </ol>	
<p><b>Lyell McEwin Hospital</b></p> <p>How can patient (and staff) safety be ENSURED when we are STRUGGLING now? We already have the new analysers, and the LMH currently has no schedule for EPAS? We find it hard to believe that EPLIS will be the enabler it is expected to be, and deliver the job cuts (SAFELY) that are planned. We are working almost to an UNSAFE level for STAFF AND PATIENTS at the moment, regardless of what is coming with the new IT. If the IT performs as it is expected to, we would be able to cope with the workloads, NOT then further lose staff? Regardless of whether or not it is believed patients will be affected INITIALLY by the cuts, if staff numbers are reduced and workloads are high, it is inevitable that sick leave and stress leave will increase; we can already see that beginning. This will then indirectly impact patient care. Pushing staff to breaking point is enough to impact patient care in itself.</p> <p>One enabler in this restructure is analyser technology. During the implementation phase at the LMH, just before the install, concerns were raised by some SA Pathology laboratory staff that the analysers we were to receive would not be fit for our requirements, this was realised to be true, and 1 year later our new larger throughput analysers were installed. Only once installed did we realise, due to maintenance amongst other things, that we were still not able to provide the hospital with the service required of us, and 2 weeks post install our old e411 was recommissioned to assist.</p> <p>This shows that even with careful planning and consideration, until things are implemented fully, you cannot tell how they will work in the laboratory in real life. Also it shows, laboratory staff KNOW THEIR WORKPLACE AND THEIR JOBS, and their opinion SHOULD BE considered. This applies to our upcoming EPLIS implementation and staff reductions. Staff on the floor should be consulted with fully to ensure patient and staff safety is not at risk.</p>	

MeS-2 staff have taken the biggest cut at the LMH, we work in a multi-skilled environment in a major Adelaide hospital and their experience is very much required. Has this massive loss of knowledge been considered? How will this be overcome? Has the 24/7 day model which includes a busy transfusion lab really been considered? With staffing levels being so low how will training and competency be supported? How can you ensure a safe working environment for staff and patients given these losses, especially that of experienced scientists?

Results sometimes require interpretation by the supervising scientists and not everything fits into a perfect mould. These MeS-2 positions are very much required for their knowledge and competence in making those interpretive decisions on the floor daily. Having the levels of these scientists that we do now allows a good spread of experience and supervision over many shifts in many areas of the multi-skilled environment.

Some manuals currently even state to refer to supervisor in particular situations for them to interpret accordingly, so SA Pathology in the past has valued the knowledge and opinion of these experienced positions. Why has this changed?

The remaining area supervisor MeS-2's assist the managers with various duties, including QC review, training, QAP, internal comparisons, stock control, amongst various other things. It is hard enough, and takes careful time management, to do this in the current structure, and often things need to be left to ensure patient samples can be processed. LMH managers would not be able to complete all these duties without help from MeS-2 staff. Do these duties disappear? How are they going to complete them after the decrease in staff is implemented? Will this impact our NATA accreditations, both from a supervision and compliance point of view? Will the current MeS-2s and MeS-3s even have enough time to ensure these supporting tasks can be performed to ensure we are NATA compliant. Is this risk justified? The MeS-2s will have to be full time performing samples in the lab, and working on the rotation, to support the roster. When will these extra duties get completed? Also, when the restructure occurs, training and multi-skilling are mentioned – are the MeS-2 staff that are not required for the new structure expected to teach those left how to perform the duties required to their “redundant” role? Especially when their jobs are busy enough just trying to support the lab day to day.

If experienced staff are taken from the roster, and then it is realised afterwards that the numbers were too low, then that experience is lost as they can not reapply for 3 years. There

is a risk of losing years of skills and experience prematurely when we do not know how the systems will work at our site. With EPLIS and the NRAH, what do you have as a plan if they do not perform to the levels that are required to support these job cuts?

Are we basing these numbers on a “perfect model” where everything is working perfectly, and all on the roster are in attendance, and able to focus their attention just on routine work 100% of the day? Where EPAS, EPLIS and the new analysers work in perfect harmony, perfectly, all the time? Current numbers supplied for the LMH seem to support this fear. If this is based on the “perfect” situation do you think this is dangerous, as we all know the laboratory faces many challenges daily? Wouldn't this be an impact to patient care? We need to staff almost for our “worst” day, not beginning with barely having enough people to put together a 24/7 multi-disciplinary roster to begin with.

How does

11. sick leave
12. annual leave
13. special leave
14. analyser downtime due to maintenance including routine and breakdown
15. network outages, both routine and breakdown
16. problem samples
17. phone calls
18. various troubleshooting
19. training of new staff
20. training staff on new equipment or systems
21. staff attending meetings/conferences
22. assisting with coroner chain of custody events etc

come into this? These situations take staff off the floor, or limit the use of our enablers, and each of these (could/would) occur in, I would expect, all departments. We need the flexibility in the system to help cover these events. This is not even including the routine, daily, weekly,

monthly tasks required to support and ensure the labs run smoothly.	
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