SUBMISSION TO
FAIR WORK COMMISSION

Matter No:

AM2016/31

4 YEALY REVIEW OF MODERN AWARDS

NURSES AWARD
(MA000034) AM2014/207

MAY 2017

SUBMISSION IN REPLY

SUBMISSION BY
PRIVATE HOSPITAL INDUSTRY EMPLOYER ASSOCIATIONS

Australian Private Hospitals Association
Australian Private Hospitals Association – South Australia
Australian Private Hospitals Association – Tasmania
Australian Private Hospitals Association – Victoria
Catholic Health Australia
Day Hospitals Australia
Private Hospitals Association of Queensland
Private Hospitals Association of New South Wales
Private Hospitals Association of Western Australia

Contact: **Lucy Fisher – Executive Director**
Private Hospitals Association of Queensland
PO Box 370
Kenmore QLD 4069
Tel: (07) 3279 7600
Email: lucyf@phaq.org

PARTIES TO THIS SUBMISSION

[1] This submission is being lodged on behalf of the Private Hospital Industry Employers' Associations (PHIEA) which includes: Australian Private Hospitals Association (APHA), the Private Hospitals Association of Queensland (PHAQ), APHA – South Australia, APHA – Tasmania; APHA – Victoria, Private Hospitals Association of New South Wales, Private Hospitals Association of Western Australia, Catholic Health Australia and Day Hospitals Australia. These organisations collectively represent approximately 95% of licensed private hospital beds in Australia and in addition, represent approximately 90% of all Free Standing Day Hospitals.

Overview of the Private Hospital Sector

[2] Published data for 2014-15 is the most recent available but in that year, there were 624 private hospitals operating in Australia comprising:

- 282 acute & psychiatric overnight facilities &
- 342 free-standing day hospitals

These facilities had a combined total of 31,774 beds and accounted for 41% of the total separations from all Australian hospitals, providing 4.2 million episodes of admitted patient care and 9.4 million patient days of care in the 2014-15 financial year.

As evidenced by the data source noted below, the private hospitals that the Private Hospital Industry Employer Associations (PHIEA) represent, employed 35,981 FTE nurses in the 2014-15 year. Of these, 30,278 FTE were Registered Nurses and 5,703 Enrolled Nurses.

[3] In preparing a submission relating to the Part Time & Casual Common Issue, PHIEA sought nursing staffing data from a representative sample of acute overnight hospitals which accounted for approximately 42.3% of the industry to determine (1) the percentage of nursing staff employed as either full-time, part-time or casual and (2) the percentage of hours worked by each employee type, which is summarised below:

On average in the 2015 FY;

- 24.9% of nursing employees were full-time and they worked 38.3% of available work hours
- 52.1% were part-time and worked 54.2% of available work hours
- 22.9% were casual and worked 7.4% of available work hours

Hospital staffing data published by the Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS) is expressed in FTEs rather than headcount, but based on the survey profile noted above, PHIEA would conservatively estimate that the 35,981 FTE nursing staff employed in the private hospital sector equates to a headcount in excess of 75,000 nursing personnel.

Data source: AIHW – Australian Hospital Statistics 2014-15 & ABS Private Hospitals 2014-15

BACKGROUND

[4] The Australian Nursing and Midwifery Federation (ANMF) is seeking substantive variations to the Nurses Award in relation to the following matters:

- In Charge Allowance – Registered Nurses
- Leading Hand Allowance – Enrolled Nurses and Nursing Assistants
- Recall to work when on call
- Recall to work when not on call
- Excessive on call
- Free from duty and on call
- Rest breaks between rostered work
- Meal Breaks

[5] In summarising its decision regarding *4 Yearly Review of Modern Awards: Preliminary Jurisdictional Issues* [2015] FWCFB 1788, the Full Bench concluded that:

> [60] *The Review is broader in scope than the Transitional Review of modern awards completed in 2013. The Commission is obliged to ensure that modern awards, together with the NES, provide a fair and relevant minimum safety net taking into account, among other things, the need to ensure a 'stable' modern award system (s.134(1)(g)). The need for a 'stable' modern award system suggests that a party seeking to vary a modern award in the context of the Review must advance a merit argument in support of the proposed variation. The extent of such an argument will depend on the circumstances. Some proposed changes may be self evident and can be determined with little formality. However, where a significant change is proposed it must be supported by a submission which addresses the relevant legislative provisions and be accompanied by probative evidence properly directed to demonstrating the facts supporting the proposed variation. In conducting the Review the Commission will also have regard to the historical context applicable to each modern award and will take into account previous decisions relevant to any contested issue. The particular context in which those decisions were made will also need to be considered. Previous Full Bench decisions should generally be followed, in the absence of cogent reasons for not doing so. The Commission will proceed on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time that it was made.*

[6] PHIEA considers that the above summary is highly pertinent when considering the ANMF application to vary the Nurses Award 2010. As we will highlight in this submission, not only have some of these items previously been considered both during the making of the Modern Awards and in the Transitional Review, but also we believe that the minimal evidence provided by the ANMF falls well short of the threshold which should be necessary to support such substantive variations to the minimum safety net provisions of the current Nurses Award.

It is noted that the ANMF has referenced clause numbers from the existing award as amended to 20 December 2016 and not to clause numbers in any exposure draft of the award.

Clause 16.6 In Charge Allowance – Registered Nurses

[7] The ANMF proposes the insertion of the following new clause into the Award:

16.6 In Charge Allowance

(a) A registered nurse who is designated to be in charge of a facility during the day, evening or night shall be paid in addition to his or her appropriate salary, whilst so in charge, the per shift allowance set out as follows:

(i) In charge of facility of less than 100 beds – 2.75% of standard rate
(ii) In charge of facility, 100 beds or more – 4.44% of standard rate
(iii) In charge of a section of a facility – 2.75% of standard rate

(b) This clause shall not apply to registered nurses holding classified positions of a higher grade than registered nurse level 2.

Based on the standard rate the amount of these allowances currently would be $23.47; $37.89 and $23.47.

[8] During the drafting of the Modern Awards, the ANF submitted its *Exemplar Nursing Occupational Award* in October 2008, a document which was reviewed and responded to by employer groups, and as such was an integral component of the AIRC's deliberations when drafting the Nurses Award 2010. This *Exemplar Nursing Occupational Award* contained an In Charge Allowance clause which whilst differently worded, was in essence the same principle.

The PHIEA highlighted at the time, that of the awards covering private hospital nurses, only two State Awards – Nurses (ANF – South Australian Private Sector) Award 2003 and Private Hospital Industry Nurses' (State Award) (NSW) contained in charge allowance provisions of the breadth and scope proposed by the ANF in its *Exemplar Nursing Occupational Award,* with most either having no clauses at all, or in the case of ACT, payable at 2 named facilities only and in Victoria, at 1 named private facility.

[9] During the 2012 Review, the ANF again sought the inclusion of a Nurse in Charge Allowance but the proposal was more limited than the current application to vary as noted overleaf (emphasis added).

16.7 Nurse in charge allowance

A Registered Nurse Level 1 or a Registered Nurse Level 2 directed by the employer to take charge of a health unit, on a Saturday, Sunday, public holiday, or between the hours of 6.00 pm and 8.00 am on any day will:

(a) *If in charge of a worksite of 100 beds or greater, be paid an allowance of $36.00 per shift.*

(b) *If in charge of a worksite of less than 100 beds, be paid an allowance of $21.50 per shift."*

[10] In his decision of 14 November 2012 [2012] FWA 9420 Vice President Watson stated:

[21] The change is sought in order to compensate the senior nurse who may be in charge of a health unit at night or on a weekend or public holiday. The ANF submits that the additional responsibilities taken on in those circumstances are significant and are not taken into account in the minimum award wage for the relevant classifications.

[22] The Aged Care Employers and other employer representatives submit that this matter was addressed in the award modernisation process, in-charge allowances were sought by the ANF and the Full Bench deliberately refrained from inserting them. They further submit that supervisory functions of the type concerned are already built into the nurse classification definitions. They submit that if additional remuneration is justified it should be based on the precise circumstances in enterprise specific arrangements. As units vary considerably in their size and complexity it is submitted that it is inappropriate to adopt a uniform approach to the allowance in a safety net award.

[23] I do not consider that a case has been established for inserting this allowance. The matter was addressed in the award modernisation process. In my view, in an award such as this with wide-ranging application, there are sound reasons for leaving matters of this nature to the agreement or overaward area where the precise circumstances can be considered and appropriate compensation can be given to the extent that it is agreed to be warranted. I will not make the variation sought.

[11] The 2012 proposal limited the application of the allowance to weekends, public holidays and night shifts on any day and only applied to those who were in charge of a facility.

In contrast, the current proposal from the ANMF is seeking an in charge allowance which would not only apply to any shift on any day of the week but which also contains a very substantial additional application – i.e. it would also apply to those who are in charge of a 'section of a facility'. No definition has been provided by the ANMF as to what a 'section of a facility' might comprise, but potentially it could include any ward or specialty unit of a private hospital, in which case it could be a significant cost impost. In the absence of a definition, it is not possible for PHIEA to attempt to quantify an approximate cost to the private hospital industry.

[12] The evidence provided by the ANMF in support of its in charge allowance application is limited to just 4 witness statements – 2 from nurses at Gympie Private Hospital (Qld) and 2 from Nurses employed at Blue Care Wirunya Centre of Care (Qld).

There are 282 overnight private hospitals and 342 free standing day hospitals collectively operating 31,774 beds and yet the ANMF has only provided witness

statements from 2 employees of one 40 bed regional private hospital in Australia. Self evidently this is manifestly inadequate to support a case for such a significant change to the minimum safety net.

[13] Gympie Private Hospital is operated by Pulse Health Limited and it is relevant to note that the nurses employed by Gympie Private Hospital are covered by the *Pulse Health Limited & QNU Nursing Staff Enterprise Agreement 2014* and therefore comments contained within the 2 staff statements need to be read with that fact in mind and also with the understanding that on average L1 RN rates under this agreement are 28.6% above the award minimum hourly rates and L2 RN rates are on average 44.8% above the minimum hourly rate of the award as shown in the table below.

	Nurses Award 2010 Ordinary Hourly Rate (1/7/2016)	**Gympie Private Hospital EA Rate (1/7/2016)**
Registered Nurse Level 1		
Pay point 1	$22.46	$26.97
Pay point 2	$22.92	$28.35
Pay point 3	$23.48	$29.76
Pay point 4	$24.10	$31.14
Pay point 5	$24.84	$32.52
Pay point 6	$25.56	$33.90
Pay point 7	$26.30	$35.26
Pay point 8 & thereafter	$26.99	$35.61
Registered Nurse Level 2		
Pay point 1	$27.70	$39.61
Pay point 2	$28.14	$40.61
Pay point 3	$28.63	$41.60
Pay point 4 & thereafter	$29.10	$42.60

[14] The ANMF submits that the types of responsibilities assumed by nurses when in charge, as outlined in the witness statements submitted, are not encompassed within the existing classification descriptors for Registered Nurses – Level 1 and Registered Nurses – Level 2 and therefore were not taken into account in rates of pay under the award.

PHIEA would disagree with the ANMF.

Contained within the Registered Nurse Level 1 descriptor is the following statement:

> *"Coordinating services including those of other disciplines or agencies to individual patients or clients within the practice setting*"

The Registered Nurse L2 descriptor states:

> "*..and maybe responsible for planning and coordinating services related to a particular group of clients or patients in the practice setting as delegated by the Clinical Nurse Consultant"*

The modern award does acknowledge that Registered Nurses can become involved in the coordination of other disciplines or agencies at L1, and at L2, the planning and coordination of various services. This was not overlooked when the Modern Award was made and was taken into consideration at the time.

[15] As we have outlined, an in-charge allowance was considered during the development of the modern Nurses Award. It was considered again in 2012 and rejected. PHIEA strongly agrees with the comments made by Vice President Watson in his decision of 14 November 2012 [2012] FWA 9420 when he stated that:

> *[23] I do not consider that a case has been established for inserting this allowance. The matter was addressed in the award modernisation process. In my view, in an award such as this with wide-ranging application, there are sound reasons for leaving matters of this nature to the agreement or over award area where the precise circumstances can be considered and appropriate compensation can be given to the extent that it is agreed to be warranted.*

[16] Despite an in-charge allowance having been considered on two previous occasions, the ANMF is not only making a third attempt for the inclusion of an in charge allowance, but on this occasion, is seeking to significantly expand the scope of the proposed allowance from only being applicable when '*in charge of a facility'* to now also being proposed to apply when a nurse is '*in charge of a section of a facility'*, for which no definition has been provided by the Union, but as previously noted could potentially include a ward or specialty unit within a hospital. In addition, the proposed allowance is not limited to nights, weekends and public holidays but has been extended to apply to <u>any</u> shift.

PHIEA considers that the ANMF has not only failed to advance a merit argument in support of this proposed new allowance but the evidence submitted is totally inadequate to support such a significant proposal.

[17] There are very few private hospital organisations which do not have enterprise agreements in place covering their nursing staff. Therefore, it is open to the ANMF at any time to make a claim for an in charge allowance as part of its enterprise agreement negotiations.

Leading Hand Allowance – Enrolled Nurses and Nursing Assistants

[18] The ANMF is proposing the introduction of a Leading Hand Allowance for Enrolled Nurses and Nursing Assistants performing supervisory functions as noted below:

16.7 Leading Hand Allowance

(a) A leading hand is an enrolled nurse or nursing assistant who is placed in charge of not less than two other employees of the classification of enrolled nurse or nursing assistant

(b) A leading hand will be paid a weekly allowance of the amount specified in the following scale:

Leading hand in charge of	*% of standard rate*
2-5 other employees	*2.67%*
6-10 other employees	*3.81%*
11-15 other employees	*4.81%*
16 or more other employees	*5.88%*

(c) This allowance will be part of salary for all purposes of this award

(d) An employee who works less than 38 hours per week will be entitled to the allowances prescribed by this clause in the same proportion as the average hours worked each week bears to 38 ordinary hours.

[19] In paragraph [30] of its submission of 17 March 2017, the ANMF submits that supervisory responsibilities of ENs and nursing assistants are not currently recognised or compensated for in the Award and are not taken into account in rates of pay under the Award. PHIEA submits that the fact there is no specific leading hand allowance in the Nurses Award 2010 does not mean that it was not considered during the making of the Award.

None of the Awards applicable to private hospital nurses prior to the introduction of the Nurses Award 2010 contained Leading Hand Allowances. Of significance, neither did the ANF's proposed *Exemplar Nursing Occupational Award*. Quite simply, there is no historical precedent in the awards covering private hospital nurses for an allowance of this type to be considered for inclusion as a safety net provision.

[20] As previously noted – in paragraph [60] of the Preliminary Jurisdictional Issues Decision [2015] FWCFB 1788, the Full Bench stated that *"In the absence of cogent reasons for not doing so, the Commission will proceed on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time it was made."*

Enrolled Nurses are required to be registered by the Nursing and Midwifery Board of Australia (NMBA) and as a condition of registration, Enrolled Nurses are expected to be cognisant of and comply with, the NMBA *Standards for Practice: Enrolled Nurses (1 January 2016)* - http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards/enrolled-nurse-standards-for-practice.aspx

Indicator 3.8 within Standard 3 is particularly relevant as it states that an EN:

> *"Provides support and supervision to assistants in nursing (however titled) and to others providing care, such as EN students, to ensure care is provided as outlined within the plan of care and according to institutional policies, protocols and guidelines."*

As noted above, the NMBA *Standards for Practice for Enrolled Nurses* clearly state that support and supervision to assistants in nursing, EN students and others is an inherent part of the EN role.

[21] Team based care has been an integral part of the nursing model in private hospitals for several decades but the precise role and responsibilities of ENs and nursing assistants varies significantly depending on the healthcare setting within which they practice.

Similar to the in-charge allowance, PHIEA is of the view that any discussion regarding a Leading Hand Allowance should be confined to enterprise agreement negotiations.

[22] PHIEA submits that the ANMF has failed to provide a merit based argument or any probative evidence in support of such a significant new allowance, which would apply as a safety net provision across the whole of the health industry where nurses are employed. Accordingly, PHIEA considers the application should be rejected.

Telephone & Other Remote Call

[23] The ANMF is proposing to vary existing clauses 28.5 and 28.6 to specify that the provisions would be extended to apply to situations where nurses are recalled to perform work remotely, for example via telephone as per below (ANMF proposed amendments highlighted in red):

28.5 Recall to work when on call

(a) An employee who is required to be on call and who is recalled to work, will be paid for a minimum of three hours work at the appropriate overtime rate. To avoid doubt, this includes any occasion where the work can be managed without the employee having to return to the workplace, such as by telephone.

28.6 Recall to work when not on call

(a) An employee who is not required to be on call and who is recalled to work after leaving the employer's premises will be paid for a minimum of three hours work at the appropriate overtime rate. To avoid doubt, this includes any occasion where the work can be managed without the employee having to return to the workplace, such as by telephone.

[24] In the private hospital industry, if a nurse is recalled to work, it generally means that the person needs to physically return to the hospital. In some other sectors of the health industry in which nurses' work – such as aged care – there may well be circumstances where staff are specifically rostered to provide remote telephone advice but this is very different to triggering a 'recall to work overtime' scenario as proposed by the ANMF.

[25] There are of course occasions where a nurse may be contacted at home to address a query which may have arisen since the person concluded their shift. For example, a piece of equipment may be missing from its usual location but its absence has not been recorded, so a call may be made to see if the nurse was aware of where it might be.

Something in a patient's chart may not be particularly legible, so a call is made to clarify the previous nurse's entry. Under the ANMF proposal, calls such as this could well trigger a minimum 3 hour overtime provision.

[26] The Nurses Award satisfied the modern awards objective at the time it was made and PHIEA does not consider the ANMF has provided a sufficient merit based argument in support of its application to vary the existing provisions to include telephone calls. The evidence provided is limited and suggestive of some work load management issues, rather than any underlying deficiency in the award safety net provisions.

PHIEA does not support the ANMF proposal to amend the Recall to Work provisions and considers that this should be a matter for discussion during enterprise agreement negotiations.

Excessive On Call

[27] The ANMF is proposing to expand the existing on call provisions to introduce a new clause 16.4 (c) which would provide for the accrual of additional annual leave on a sliding scale of one additional day of annual leave for each 10 occasions of being placed on call to a maximum of 5 days in any one year as per the clause below.

> 16.4 (c) Employees shall accrue up to an additional 5 days of annual leave if they are placed on call for 50 or more times in any one year, according to the following:
>
> Placed on call for 10 or more times in any one year – 1 day additional annual leave
> Placed on call for 20 or more times in any one year – 2 days additional annual leave
> Placed on call for 30 or more times in any one year – 3 days additional annual leave
> Placed on call for 40 or more times in any one year – 4 days additional annual leave
> Placed on call for 50 or more times in any one year – 5 days additional annual leave

[28] None of the Awards applicable to private hospital nurses prior to the introduction of the Nurses Award 2010 contained provision for the accrual of additional annual leave based on the number of times a nurse was placed on call, nor did the ANF's proposed *Exemplar Nursing Occupational Award*. Like many of the claims in the current ANMF application, there is no historical precedent in the awards covering private hospital nurses, for an allowance of this type to be considered for inclusion as a safety net provision.

If the review is being conducted "*on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time that it was made",* PHIEA submits that the ANMF has failed to provide sufficient evidence to warrant the consideration of a change to the safety net of this magnitude. The ANMF has only provided 5 witness statements in support of its entire suite of proposals, all of which are from Queensland and which relate to just 2 employer organisations, hardly sufficient evidence to demonstrate any underlying deficiency in the existing safety net provisions.

PHIEA is aware that some private hospital enterprise agreements contain provision for additional annual leave based on either (a) the number of times placed on call or (b) the number of times actually called in. The issue of additional annual leave linked to the number of times placed on call or called back to work, is a matter for discussion during enterprise agreement negotiations where any site specific matters may be duly considered and a clause developed which is appropriate for that particular enterprise and its employees.

Free from Duty and On Call

[29] The ANMF is proposing to amend existing clause 21.4 to introduce a new requirement that would not allow an employee to be placed on the on-call roster on their day off, as per the proposed clause below (ANMF proposed amendment highlighted in red):

> *21.4 Each employee must be free from duty for not less than two full days in each week or four full days in each fortnight or eight full days in each 28 day cycle. Where practicable, such days off must be consecutive. For the purposes of this sub-clause, duty includes time an employee is on call.*

There is no historical precedent in the awards covering private hospitals for the inclusion of such a clause as part of the minimum safety net.

[30] Private Hospitals provide care for their patients 24/7 and must have the ability to call employees back to work if unexpected absences occur within the rostered team or if patient demand should increase unexpectedly.

Nurses and midwives can only be placed on the on-call roster when they are not rostered to work – i.e. on their days off. To remove days off from this equation, which historically have always been included, would be to introduce rostering restrictions that may not meet the needs of the patients or the business.

[31] As noted for some of the other claims, the witness evidence provided by the ANMF is very limited and certainly insufficient to support the ANMF's statement at paragraph [70] of its submission of 17 March 2017 that "*nurses are effectively performing either work duties or on call most of the time.*"

[32] PHIEA maintains that the ANMF has not provided sufficient evidence to justify consideration of a change to the safety net of this magnitude and therefore the proposal should be rejected. If the Union has identified workload management concerns at particular work sites, then it is a matter which more appropriately should be raised either through a disputes procedure or during enterprise agreement negotiations.

Rest Breaks Between Rostered Work

[33] The ANMF is not only proposing to increase the rest break between periods of work from eight (8) hours to ten (10) hours, but also to introduce an overtime penalty as per its proposed clause 23.3 below. (ANMF proposed amendments highlighted in red).

23 Rest breaks between rostered work

23.1 An employee will be allowed a rest break of ten hours between the completion of one ordinary work period or shift and the commencement of another ordinary work period or shift

23.2 By mutual agreement between employer and employee, the ten hour rest break may be reduced to eight hours

23.3 If, on the instruction of the employer, an employee resumes or continues to work without having had 10 consecutive hours off duty, or 8 hours as agreed, they will be paid at the rate of double time until released from duty for such period.

[34] In its *Exemplar Nursing Occupational Award*, submitted during the making of the Nurses Award 2010, the ANF proposed that employees should be allowed a break of 10 hours between the termination of one shift and the commencement of another. The ANF also proposed that the 10 hour break could be reduced to 8 hours by agreement between the employer and the employee.

Evidence provided at the time, identified that of the awards applicable to private hospital nurses, the majority provided for an 8 hour break. This majority provision of an 8 hour rest break between periods of ordinary work was then reflected in the Nurses Award 2010.

[35] PHIEA submits that the minimum duration of a rest break between periods of rostered ordinary work was considered during the making of the Nurses Award 2010 and the current clause reflects the majority provision of the previous industrial instruments.

Only one witness statement makes reference to the break between rostered periods of ordinary work, therefore we consider that the ANMF has failed to provide comprehensive evidence of a systemic and widespread deficiency with the current 8 hour minimum break between rostered periods of ordinary work. Accordingly, PHIEA does not consider that any change to the current safety net provision is necessary.

[36] There is no historical precedent relating to the ANMF proposal to introduce an overtime penalty in circumstances where an employee has not had the minimum break period between ordinary rostered shifts. Penalties are of course applicable if employees do not have the minimum rest period after overtime.

In the absence of any robust evidence highlighting a significant deficiency with the existing provision, the ANMF proposal should be rejected. It is of course always open to the ANMF to pursue its claim as part of enterprise agreement negotiations.

Meal Breaks

[37] The ANMF has proposed an amendment to the existing meal break clause as indicated below:

27.1 Meal Breaks

(a) An employee who works in excess of five hours will be entitled to an unpaid meal break of not less than 30 minutes and not more than 60 minutes. Such meal breaks will be taken between the fourth and the sixth hour after beginning work, unless otherwise agreed by the majority of employees affected. Provided that, by agreement of individual employees, employees who work shifts of six hours or less may forfeit the meal break.

(b) Where an employee is required to ~~remain available or~~ be on duty during a meal break, the employee will be paid overtime for all time worked until the meal break is taken

(c) Where an employee is required by the employer to remain available during a meal break, but is free from duty, the employee will be paid at ordinary rates for a 30 minute meal break. If the employee is recalled to perform duty during this period the employee will be paid overtime for all time worked until the balance of the meal break is taken.

[38] As noted by the ANMF in paragraph 99 of its submission of 17 March 2017, during the 2012 Awards Review, a similar claim to prescribe when meal breaks should be taken, was rejected by Vice President Watson on the grounds that the proposed variation would inhibit flexibility. In his decision of 14 November 2012 [2012] FWA 9420 he stated:

> *In my view the employers have correctly acknowledged the obligations under the Award. Any practice whereby an employee is not provided with a meal break must result in overtime payments being made until the scheduled meal break is given. A small amount of give and take based on operational requirements is understandable, but a failure to provide a break, or overtime payments until the end of a shift would not be consistent with the intent of the clause. Nevertheless, I do not consider that a case has been made out for regulating the time for the meal break in the way proposed by the ANF. Such an approach would inhibit the existing flexibility which is no doubt necessary in many operations covered by this Award. The clarifications of obligation in this decision and the availability of the disputes procedure should assist in the event of further difficulties with regard to meal breaks."*

[39] Several predecessor awards specified when the meal break was to be taken which quite commonly was between the fourth and sixth hour after commencing work, however as PHIEA noted in its submissions to the 2012 review, shift lengths and start and finish times have changed considerably since these former awards were originally drafted. Shift changes have arisen in part to accommodate wherever possible the increasing number of nursing personnel who wish to have hours of work which suit their personal and/or family circumstances and partly to align with the varying staffing requirements of the hospital at different times of the day. For example, in the private hospital sector it is common for staff to have staggered start and finish times such that some nurses working a day time 8 hour shift may not commence until 10.00 am and work until 6.00 pm rather than the more traditional shift time of 7.00 am – 3.00 pm.

[40] Whilst PHIEA does not object to there being some indicative time frame as to when a meal break should be taken, we do not support the wording proposed by the ANMF as it is too prescriptive and in our opinion does not take into consideration 8 hour shifts where the 4th and 6th hour may not straddle a logical meal time.

For nurses working 7.00 am – 3.00 pm a specified break between the 4th & 6th hour would straddle the 11.00 am – 1.00 pm lunch period which is entirely reasonable, however for nurses working a 10.00 am to 6.00 pm shift, specifying that a meal break must be taken between the 4th and 6th hour would mean that the earliest time these nurses would have a meal break would be 2.00 p.m. and it may not be until 4.00 pm which some staff may well consider is too late in the day for their 30 minute 'lunch' break.

Part time staff comprise a significant percentage of the nursing workforce, many of whom only wish to work a maximum 6 hour shift to fit in with their family commitments. These staff often request the ability to forego their 30 minute meal break and leave work at the completion of the 6th hour rather than have an unpaid meal break during the shift and remain at work for 6.5 hours.

[41] The prescribing of a timeframe for when meal breaks should be taken has also been raised in the Health Professionals & Support Services Award, with a proposed clause submitted by the HSU. PHIEA considers that the HSU's clause is preferable as, whilst it indicates that the meal break should be taken between the 4th and 6th hour it retains some necessary flexibility, by the inclusion of the words "*where reasonably practicable.*"

The HSU clause reads:

Unpaid meal breaks

(a) An employee who works in excess of five hours will be entitled to an unpaid meal break of between 30 minutes and 60 minutes. The meal break will, wherever reasonably practicable, be taken between the fourth and sixth hours of commencing work.

(b) The time of taking the meal break may be varied by agreement between the employer and employee.

(c) An employee who works not more than six hours may elect to forgo the meal break, with the consent of the employer.

PHIEA would support the inclusion of the proposed HSU clause noted above, in both the Health Professionals and Support Services Award and the Nurses Award and considers that this would be a reasonable compromise for a revised safety net provision.

Any further amendments regarding meal break provisions to those noted above, should occur at the enterprise level as part of agreement negotiations.

[42] PHIEA considers that VP Watson's statement noted in paragraph [38] of this submission clarifies the employer's obligation to provide a meal break or make overtime payments until the scheduled meal break is taken and accordingly we do not consider that the amendments proposed by the ANMF in 27.1 (b) and (c) and noted on page 13 of this submission, are necessary.

SUMMARY

[43] The ANMF has proposed a number of significant variations to the Nurses Award 2010, some of which have been considered previously, both during the making of the modern award and in the 2012 review; others are completely new and without historical precedent in the previous awards covering nurses and some are significant expansions to existing provisions, for which minimal evidence has been submitted.

Noting that the *'Commission will proceed on the basis that prima facie the modern award being reviewed achieved the modern awards objective at the time it was made",* PHIEA considers that in each of its claims, the ANMF has failed to provide sufficient evidence that the proposed variation is **necessary** to achieve the modern awards objective.

[44] According to published data from the Nursing and Midwifery Board of Australia in December 2016, there are approximately 370,000 practising enrolled nurses, registered nurses and registered midwives in Australia. The Nurses Award covers employers in the health industry and their employees in the classifications listed in Schedule A of the Award. The exclusion to coverage are nurses employed in primary or secondary schools.

Therefore, it would be reasonable to estimate that a very significant percentage of these 370,000 practising nurses would be covered by the Nurses Award, and yet in support of its claim for some very substantive amendments to the safety net provisions, the ANMF has only provided a total of 5 employee witness statements from staff employed by just 1 private hospital organisation and 1 aged care organisation, both from the same state (Queensland).

[45] By any objective metric, this paucity of evidence cannot be considered to be reflective of the industry as a whole, such that in order to satisfy the modern award objectives, it is necessary to amend the safety net provisions as proposed.

[46] The health industry is highly complex and nursing personnel are employed in a myriad of enterprises of differing size, complexity and scope of nursing services provided, such that any consideration of in charge or leading hand allowances should only be addressed at the enterprise level. If there is agreement between the parties that some additional payment may be warranted, an appropriate level of remuneration may then be negotiated which would take into account the precise role and responsibilities of the position, in that particular healthcare setting.

[47] Similarly, PHIEA considers that the ANMF proposals relating to recall, excessive on call, free from duty and on call, and rest breaks between rostered work are all matters for enterprise bargaining, particularly in those situations where a workload management issue may have been identified.

[48] If the ANMF proposals were to be added to the Nurses Award 2010 it would increase costs for employers and raise the bar for the BOOT. Enterprise Agreements are highly prevalent in the private hospital industry with very few organisations not having an agreement in place covering their nursing staff. Any increase to the safety net provisions would potentially have a negative impact on collective bargaining within the private hospital industry.

PHIEA considers that the ANMF proposed amendments are not necessary to meet the modern awards objective and are all matters which the ANMF is at liberty to raise during enterprise agreement negotiations.

In closing PHIEA does not support any of the variations proposed by the ANMF

[END OF SUBMISSION]