Clinical Reconfiguration
Service Plan

Southern Adelaide Local Health Network

March 2017
Version 3.1

<table>
<thead>
<tr>
<th>Date</th>
<th>Version</th>
</tr>
</thead>
<tbody>
<tr>
<td>February 2016</td>
<td>1.0</td>
</tr>
<tr>
<td>March 2016</td>
<td>1.1</td>
</tr>
<tr>
<td>September 2016</td>
<td>2.0</td>
</tr>
<tr>
<td>November 2016</td>
<td>2.1</td>
</tr>
<tr>
<td>January 2017</td>
<td>3.0</td>
</tr>
<tr>
<td>March 2017</td>
<td>3.1</td>
</tr>
</tbody>
</table>
# Contents

1. Executive Summary ............................................................................................................. 3
   - Critical timelines and focus of stage 3 ............................................................................. 3
   - Clinical Reconfiguration ................................................................................................. 4
   - Workforce ......................................................................................................................... 5
2. Introduction .......................................................................................................................... 7
   - Stage 1 .............................................................................................................................. 8
   - Stage 2 .............................................................................................................................. 8
   - Proposed Stage 3 .............................................................................................................. 9
3. Purpose and Strategies ......................................................................................................... 10
4. Capital Works ....................................................................................................................... 13
5. Stages of Clinical Reconfiguration .................................................................................. 14
   - Stage 1 ............................................................................................................................ 14
   - Stage 2 ............................................................................................................................ 15
   - Stage 3 ............................................................................................................................ 15
6. Clinical Reconfiguration in-scope bed configuration ......................................................... 17
7. RGH clinical ward service moves ..................................................................................... 18
8. Clinical Reconfiguration Timeline .................................................................................. 19
9. In-scope areas impacted by SALHN Clinical Reconfiguration and RGH Decommissioning ......................................................................................................................... 20
   - Workforce in-scope services, units and staff ................................................................. 21
   - Human Resource (HR) Principles and Expression of Interest processes ...................... 21
   - Grievance processes ....................................................................................................... 23
1. Executive Summary

On 1 September 2016, Southern Adelaide Local Health Network (SALHN) staff were provided with an update on stage 1 and 2 of clinical reconfiguration. The update was provided via all staff forums across Noarlunga Hospital (NH), the Repatriation General Hospital (RGH) and Flinders Medical Centre (FMC). The forums outlined the proposed SALHN clinical reconfiguration stage 1 and 2 encompassing relocation of overnight in-patient areas, ward mergers and the associated Human Resources (HR) processes. These forums recommenced formal consultation with staff and unions around stage 1 and 2 of clinical reconfiguration, commencing a three week feedback process that completed on 23 September 2016.

Following the three week consultation process, over 85 responses were received from a combination of both SALHN staff and unions. Ongoing meetings were held with staff from in-scope clinical areas providing an opportunity for staff to ask questions and clarify HR processes. Regular consultation has continued with unions throughout this process. A collated themed feedback document was made available to all staff, via the SALHN intranet, in response to the feedback received.

This revised Clinical Reconfiguration Service Plan March 2017, version 3.1 outlines:

- clinical service ward mergers, relocations and proposed timelines for clinical reconfiguration of stages 1, 2 and 3.
- the proposed service moves, for stage 3 clinical reconfiguration and the RGH service moves and decommissioning.
- the HR processes that will support transition of staff as part of clinical reconfiguration and the RGH service moves and decommissioning

Stage 3 planning was included for information purposes in the document released in November 2016, the feedback received has been considered and incorporated into the SALHN Clinical Reconfiguration Service Plan Version 3.1 March 2017 (stage 3) for feedback and consultation. Specifically, the changes from the SALHN Clinical Reconfiguration Service Plan version 2.1, November 2016 to version 3.1, March 2017 include:

- Cardiothoracic surgery relocating from ward 6D FMC (cardiothoracic surgery and medical cardiology) to ward 6B, FMC.
- Stroke/Neurology and Medical Cardiology will be co-located on ward 6D, FMC
  - there will be an additional 4 beds located within ward 6A, FMC, as needed, to support this transition
- Ward 5A Vascular relocating to ward 6C, FMC
- GEM relocation from RGH to ward 5A
- Urology relocation from RGH ward 8 to FMC ward 6G (Renal), creating a combined Renal/Urology ward.

Critical timelines and focus of stage 3

The major focus of stage 3 of the clinical reconfiguration is the creation of a ‘cardiovascular hub’ on the 6th floor of FMC including Ward 6B, Ward 6C and Ward 6D. The ‘cardiovascular hub’ will enable a critical mass
of complimentary clinical skills and supports within a geographical defined area. The creation of a cardiovascular hub will:

- increase cardiac monitoring and telemetry capacity at FMC by 14 beds
- co-locate medical, nursing and allied health teams within areas and ‘hubs’ of clinical specialty.
- provide telemetry and cardiac monitoring capacity to the stroke unit
- support improved patient care and clinical facilities

The ‘cardiovascular hub’ and other changes proposed as part of the clinical reconfiguration will prepare the clinical spaces within SALHN for the inpatient wards and units transitioning from RGH between July and November 2017. It will also strengthen the clinical infrastructure and supports the mechanisms which may be required to assist the Royal Adelaide Hospital (RAH) transition to the new RAH.

Whilst SALHN believes the current investment in alternative models of care (Rehabilitation in the Home, Medical Ambulatory Care Service etc) outlined in this document will continue to reduce requirements for inpatient beds, the focus on stage 3 is the internal reconfiguration of space to improve clinical facilities. The document outlines how this can be done, if needed, in a bed neutral way over the next 3 months as an interim arrangement, until further efficiencies are demonstrated.

**Clinical Reconfiguration**

Several improvement initiatives implemented in collaboration with clinicians have reduced the requirement for some multi-day beds across SALHN. This has provided the opportunity to reconfigure clinical services across SALHN and has supported the implementation of initial stages of clinical reconfiguration. These initiatives are aimed at streamlining care and reducing the amount of unnecessary time patients stay in hospital.

Clinical reconfiguration is being implemented over three stages and is supported by a significant investment in excess of $200m in new and upgraded infrastructure at FMC, NH and Glenside. There will also be some capital works to support the SALHN clinical reconfiguration that will assist in creating capacity within SALHN for the transfer of services from the RGH. Through the improvements in patient flow, discharge processes and the ‘right sizing’ of wards, more patients will be located with their specialist teams, reducing the amount of time spent by specialist teams locating and caring for patients in other wards. More single rooms are being developed as part of the capital works program with an overall increase of physical beds at FMC.

A significant focus on stage 3 of the clinical reconfiguration is the development of a ‘cardiovascular hub’ on the 6th floor at FMC. Further detail on this is provided under stage 3 Reconfiguration.

The clinical reconfiguration project includes the:

- processes and strategies to enable the RGH service moves and transition of overnight multi-day beds to FMC and NH.
- right sizing of wards to optimise staffing skill mix
• clinical service in-patient overnight bed ward mergers and relocations
• associated HR processes
• internal capital works program within FMC
• planned ward mergers, relocations and timelines associated with clinical reconfiguration
• Consultation on proposed plans for stages 3 clinical reconfiguration and the RGH decommissioning

In line with a commitment made by the Minister for Health, there will be no reduction to hospital beds until improvement in performance and efficiencies can be demonstrated.

To date, improvement initiatives and clinical reconfiguration have successfully:

• supported the trial of a MACS – commenced April 2016.
• reduced the requirement for general medical beds at RGH and NH.
• reduced the requirement for elective short stay surgical beds at FMC
• highlighted under-utilised capacity and opportunities for co-location of clinical areas/services.

Whilst SALHN believes inpatient bed requirements will continue to reduce through investment in alternate models of care (detailed in this document), new capital builds in Ward 4A and 5G, as well as flexible capacity available in ward areas, will enable reconfiguration of stage 3 beds to occur, if needed, in a bed neutral context. The delivery of stage 3 will improve clinical facilities and prepare the site to better support the RAH in their transition to the new RAH and reconfigure services in a way that supports the reallocation of inpatient services from RGH in the future.

Workforce

Nursing, Medical, Allied Health, Patient Support Assistants (PSA) and administrative staff are in scope for the changes across and within RGH, FMC and NH.

The established Transforming Health HR Principles will be applied for SA Public Sector Wages Parity Enterprise Agreement: Salaried 2014 (WPEA: Salaried) staff (ASO, AHP, OPS, PO, TGO, MeS, GFSc) and for Nursing/ Midwifery staff the SA Health – HR Principles – Nursing and Midwifery (February 2017). Some staff will be required to relocate across sites either to NH and/or FMC. This will occur in consideration of organisational needs and professional and personal circumstances.

A formal Expression of Interest (EOI) process has been undertaken for Nursing/ Midwifery staff to ascertain preferences in regard to clinical reconfiguration and the RGH service moves and site decommissioning and to facilitate the future transition of staff. Selection and placement processes are proposed to be confirmed during the first half of 2017 in consideration of this Service Plan. The outcome of the EOI will be communicated to those affected employees at the conclusion of the selection and placement process. Placements will take place following the initial interim ward realignments across FMC and NH and leading up to the decommissioning of RGH subject to further consultation with the Australian Nursing and Midwifery Federation (SA Branch), (ANMF (SA Branch)). However, in the first instance the ward reconfiguration across NH and FMC will be facilitated “as a service” whereby staff within affected wards ward will move in its current state, with the service as an interim arrangement.
An EOI process for in-scope Allied Health employees closed on 8 February 2017. Selection and placement processes will take place over the coming weeks and the outcome will be communicated to in-scope staff in the first half of 2017.

An applicable EOI process for in-scope Administrative employees will continue to be developed in consideration of the in-scope units as outlined in this revised plan and will commence in the coming weeks. Further consultation will take place with the Public Service Association (PSA) in the development of an appropriate EOI for directly affected Administrative Employees – Ward Clerks and information will be provided prior to the commencement of the EOI process.

An EOI process for Hotel Services employees at RGH will be finalised in the coming week and has been subject to consultation with Hotel Services Representative and United Voice. Further information will be provided prior to the commencement of this process. Consultation will continue with UV about applicable processes for Weekly Paid employees as is appropriate.

Consultation will continue with South Australian Salaried Medical Officers Association (SASMOA) and United Voice (UV) in the development of applicable processes and Transition Arrangements as required for Medical Officers.

Ongoing consultation with unions will continue through the SALHN Transforming Health Industrial Liaison Forum and other meetings with representative organisations as appropriate. Staff will continue to be engaged and consulted as part of this process (refer section 8 – Workforce).
2. Introduction

SALHN is constantly evolving to meet the needs of its community. In partnership with clinicians, SALHN has introduced new strategies to improve patient care, minimise delays and reduce inpatient length of stay across the Network.

The recent improvements in patient care have resulted in length of stay improvements for some areas and this has provided the opportunity to reconfigure services across the Network. The length of stay improvements have resulted in:

- one general medical ward at RGH being ‘flexed down’ since December 2015.
- reductions to general medical bed requirements at Noarlunga Hospital.
- Reduced Surgical Short Stay Ward utilisation at Flinders Medical Centre across 15/16 and the unit being completely flexed down since November 16 and now merged and relocated to FMC ward 5D. In the interim the 4GS space will assist the transition of general medical beds from Whittaker (NH).
- Significantly reduced overnight bed occupancy across SALHN.

The clinical reconfiguration is occurring in several stages across RGH, FMC and NH, supported by a capital works program. The clinical reconfigurations, including capital works, is to be completed to support the preparation for the transfer of services from the RGH in 2017. The SALHN clinical reconfiguration is creating a number of efficiencies and quality improvements which will:

- improve patient care, outcomes and support improved patient flow and discharge processes.
- right size wards to optimise skill mix and availability of senior staff.
- enable more patients to be located with their specialist team reducing unproductive time spent locating and caring for patients in other wards.
- provide more single rooms for improved patient care and more purpose built areas to support specialty areas.
- include capital works to maximise available inpatient spaces.
- prepare SALHN for the transfer of services from RGH to FMC and NH.

Clinical reconfiguration stages 1, 2 across RGH, FMC and NH and the proposed stage 3 service changes

SALHN acknowledges that whilst these are indicative timelines, consultation continues with staff and Unions regarding demonstration of efficiencies, as per the commitment by the Minister for Health that there will be no reductions to hospital beds until improvements in performance and efficiencies can be demonstrated.
### Stage 1

#### In-scope Bed configuration

<table>
<thead>
<tr>
<th>Stage</th>
<th>Pre configuration</th>
<th>Post Configuration</th>
<th>Comment</th>
<th>Proposed timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>RGH 2/6</td>
<td>RGH 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1B</td>
<td>FMC 4GS</td>
<td>FMC 5D</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1B</td>
<td>FMC 5D</td>
<td>FMC 5A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1B</td>
<td>FMC 5A</td>
<td>FMC 5A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C</td>
<td>FMC 4A</td>
<td>FMC 4GS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C</td>
<td>NH Whittaker</td>
<td>NH Whittaker</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C</td>
<td>FMC 6A</td>
<td>FMC 6A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1D</td>
<td>FMC 6B</td>
<td>FMC 6B</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 1.0 Clinical Reconfiguration stage 1 ward relocation and mergers

### Stage 2

#### In-scope Bed configuration

<table>
<thead>
<tr>
<th>Stage</th>
<th>Pre configuration</th>
<th>Post Configuration</th>
<th>Comment</th>
<th>Proposed timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A</td>
<td>FMC 5A</td>
<td>FMC 5A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2A</td>
<td>FMC 5C</td>
<td>FMC 5C</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2B</td>
<td>FMC 6C</td>
<td>FMC 6C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 2.0 Clinical Reconfiguration stage 2 ward relocation and mergers
Proposed Stage 3 (for consultation March 2017)

<table>
<thead>
<tr>
<th>In-scope Bed configuration</th>
<th>Comment</th>
<th>Proposed timeline</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage</strong></td>
<td><strong>Ward</strong></td>
<td><strong>Beds</strong></td>
</tr>
<tr>
<td>3A</td>
<td>FMC 6B</td>
<td>12</td>
</tr>
<tr>
<td>3B(A)</td>
<td>FMC 6D</td>
<td>14</td>
</tr>
<tr>
<td>3B(B)</td>
<td>FMC 6C</td>
<td>20</td>
</tr>
<tr>
<td>3C</td>
<td>FMC 5A</td>
<td>18</td>
</tr>
<tr>
<td>3D</td>
<td>FMC 4D</td>
<td>28</td>
</tr>
<tr>
<td>3E</td>
<td>Ward 6G</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 3.0 Clinical Reconfiguration stage 3 ward relocation and bed reductions

**Consultation RGH Service Moves for Geriatric Evaluation Management (GEM) services**

During March 2017 consultation will occur in relation to the proposed three GEM/Sub-acute wards following the RGH decommissioning across FMC and NH.

- FMC
  - one 24 bed GEM ward (5A)
- NH (this proposal is still subject to final decision/approval)
  - one 24 bed GEM / Sub-acute ward (Whittaker)
  - one 16 bed GEM - Behaviours of Concern ward (Myles)
3. **Purpose and Strategies**

The purpose of the SALHN clinical reconfiguration service plan is to provide an overview of the strategies and service moves across RGH, FMC and NH. It also outlines the process for the different stages of clinical reconfiguration, the associated HR processes, capital works plans and proposed timelines.

SALHN is committed to evolving and developing new and more efficient and patient-centred ways of providing care to manage growing demand. Clinicians have been engaged in developing strategies which have reduced the time patients wait for treatment or subacute services. This has resulted in reduced multi-day bed requirements and opportunities to reconfigure clinical services and spaces.

These strategies include (but are not limited to):

**Long stay patient strategy**

Improving internal processes for accessing tests, procedures or aged care assessments, and facilitating timely discharge has reduced length of stay for many patients who historically have had a length of stay greater than 14 days. Many of these patients no longer require acute medical care and are waiting for subacute services or alternate placement accommodation. In November 2015, there were more than 100 patients at FMC with a length of stay greater than 14 days. This has reduced by approximately 30 percent.

**Timely Aged Care Assessment Team (ACAT) assessments**

In 2014/15 the average waiting time for ACAT assessment was over 8 days at FMC, 8 days at RGH and 5.5 days at Noarlunga. Additional ACAT assessors have been recruited and changes have been made to the management of ACAT assessment appointments. Length of stay for patients awaiting assessment to return home or to residential facilities has reduced significantly with the vast majority of assessments now completed within two working days, with an average waiting time of 1.5 days (excluding weekends and public holidays). There is a reduction of up to six days wait for some patients, resulting in reduced multi-day bed requirements.

**Medical Ambulatory Care Service (MACS)**

MACS is a trial specialist led ambulatory model of care located at the GP Plus Super Clinic Noarlunga. It aims to:

- Provide rapid access to specialist medical ambulatory care services for patients.
- Substitute hospital admissions through more timely access to specialist care and follow up in the community.
- Substitute Emergency Department presentations for care that is better provided in an ambulatory setting.
- Support patients to remain at home while still receiving specialist care in an ambulatory setting.
- Enable early hospital discharge of medical inpatients providing rapid access to follow up appointments.
This model supports a more consumer focused model of care and aims to substitute appropriate inpatient work to outpatient and community management.

**Standardisation of care for planned surgical activity**

The clinical reconfiguration has identified opportunities to increase the number of patients that can be admitted on the day of surgery and/or managed as same day or 23 hour surgery. The provision of clinically appropriate same day or 23 hour surgery is reducing the demand on multi-day beds.

**Same Day and Extended Day Surgery**

Processes have been established to support compliance with the SA Health Same Day and Extended Day Surgery Policy Directives

**Enhancing patient care and collocation of services**

The co-location of clinical services through the ‘right sizing’ of wards to optimise skill mix and specialist expertise will improve patient flow, enabling more patients to be located and cared for within their home units. Please see clinical reconfiguration 3 for examples including the development of a ‘cardiovascular hub’

**MCAG Rehabilitation Service project recommendations**

The Rehabilitation Service project aims to improve access to rehabilitation services across the State through standardised models of care and rehabilitation pathways. For SALHN, this will support timely access for stroke and orthopaedic hip fracture patients from acute in-patient beds to rehabilitation. The recommendations include the:

- expansion of ambulatory (Rehabilitation in the Home and Day Rehabilitation) services
- dedicated tele-rehabilitation equipment and staff to ensure these services are embedded in business as usual activities
- state-wide pathways for rehabilitation including fractured hips, stroke, amputee, reconditioning, brain injury and spinal cord injuries

Patients will be directed to the most appropriate setting which could be at home (home rehabilitation), via tele-rehabilitation, in hospital outpatients areas (Day Rehabilitation) or an inpatient bed.

**SALHN Older Persons Service (previously known as the Frailty Pathway)**

A Model of Care for older people *who are frail or at risk of becoming frail*, is being developed that will:

- Prevent avoidable emergency department (ED) presentations and hospitalisation;
- Provide alternatives to hospitalisation and maximise care provided in the community; and
- Minimise the risk for older people who require hospitalisation.
A dedicated team to support the management of older people presenting to the Emergency Department is being established. Services provided in the community are being enhanced (e.g. Rehabilitation in the Home and Hospital @Home) and will include access to geriatricians for older people who are discharged back to their usual place of residence (including Residential Aged Care Facilities). This strategy is expected to provide substitution inpatient beds by supporting reduced hospitalisation requirements and length of stay.

**Hip and Knee Arthroplasty**

A multidisciplinary pathway for patients undergoing elective hip and knee arthroplasty has been developed and implemented to support patient discharge home or to rehabilitation in less than 3 days. Knee replacement has averaged an 80% discharge on or by day 3 since January 16. Hip replacements have averaged 68% discharge on or by day 3 since January 16. This has resulted in reduced multi-day bed requirements.

**Care Awaiting Placement Service (CAPS)**

SALHN is progressing a further 10 CAPS beds in the community for patients awaiting residential aged care placement. This is a direct (and more appropriate) substitution of multi-day beds.

**Enhancing Patient Journey Projects**

The development, piloting and implementation of consistent processes for managing the patient journey across the care continuum to enhance quality care and reduce extended length of stay.
4. Capital Works

A capital works program has commenced and will support SALHN’s clinical reconfiguration to provide additional in-patient and clinical procedural capacity at FMC. The capital works is being undertaken in a staged approach with the FMC internal ward building having commenced. There will be no impact upon patient care or clinical services during the capital works period.

FMC ward 4A is undergoing capital works to create an additional eight medical beds. The eight bed configuration will encompass one four bed bay and four single rooms to support specific patient needs and to support flow out of the Emergency Department for patients requiring single room accommodation for clinical needs. The capital works for ward 4A has commenced and will complete in March 17. This will result in an increase in bed capacity of ward 4A from 16 beds to 24 beds.

A dedicated SALHN day procedure area will be custom built to accommodate services which have historically been provided in inpatient beds, such as infusions and procedures. The dedicated space will include a combination of chairs and/or a procedural room. This will accommodate the relocation of the services from the Haematology/Oncology Day Unit on Ward 5G (and other appropriate day procedures) to an area accompanying the level 2 medical outpatient clinics. These capital works are due to commence shortly and is expected to be completed in June 17.

The vacated space on Ward 5G will undergo refurbishment to increase the physical bed space of ward 5G (Haematology/Oncology ward) from 16 beds to 24 beds. The increase in bed capacity will include the configuration of four single rooms and one four bed bay. The refurbishment for the 5G space is due to commence shortly and complete in June 17.

Minor capital works will be completed prior to October 17 to Noarlunga Hospital facilities to support the transition of specialist aged care services to Noarlunga Hospital in October 17.

Overall, the capital works associated with the clinical reconfiguration will provide:

- additional physical 16 bed capacity at FMC.
- additional single room capacity at FMC (8)
- a SALHN day procedure unit that will support timely access to dedicated space for delivery of day procedures and substitution of some work that has historically been provided in multi-day beds.
- additional monitoring capacity for cardiac and stroke patients including increased telemetry capacity (14 beds).
- improvements to Whittaker and Myles wards, Noarlunga Hospital in order to prepare the wards for specialty GEM and subacute restorative care.

<table>
<thead>
<tr>
<th>Description</th>
<th>Update on Progress</th>
<th>Estimated Completion Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC Ward 4A</td>
<td>Additional 8 beds (including 4 additional single rooms)</td>
<td>March 2017</td>
</tr>
<tr>
<td>Ward 6B - Cardiac Ward</td>
<td>cardiac protection and additional cardiac monitoring (approx 8 weeks work)</td>
<td>May/June 2017</td>
</tr>
<tr>
<td>FMC Medical Day Unit 25</td>
<td>New day procedure unit</td>
<td>June 2017</td>
</tr>
<tr>
<td>Ward 5G</td>
<td>Additional 8 beds (including 4 additional single rooms)</td>
<td>June 2017</td>
</tr>
<tr>
<td>NHS Myles Ward</td>
<td>Minor capital works to support GEM- behaviour of concern focus</td>
<td>Prior to sept 17</td>
</tr>
<tr>
<td>NHS Whittaker ward</td>
<td>Minor capital works to support GEM focus</td>
<td>Prior to sept 17</td>
</tr>
</tbody>
</table>
5. **Stages of Clinical Reconfiguration**

The commitment made by the Minister for Health that there will be no reduction to hospital beds until improvement in performance and efficiencies can be demonstrated will be upheld. Some of the improvement and efficiency initiatives which have and will enable SALHN to successfully reconfigure clinical services are outlined below.

**Stage 1**

**RGH Wards 2 and 6 (Stage 1A) (complete pending HR processes)**

At the RGH, bed reductions have been demonstrated within general medicine with the sustained ‘flexing down’ of Ward 2 since December 2015. This has resulted in the merger of the medical wards 2 and 6. In consultation with staff and unions, HR processes will soon be finalised to formalise staff preferences and placement for ward and unit areas.

**FMC Surgical (Stage 1B) (complete pending HR processes)**

- **4GS Surgical Short Stay ward, Ward 5A and Ward 5D**
  
  FMC 4GS Elective Surgical Short Stay (ESS) ward is an 18 bed, six day ward. Efficiencies have been demonstrated within the elective short stay ward (4GS) with sustained flexing down of the unit. 4GS has not been utilised since November 2016 with staff of 4GS and 5D co-located.

**FMC and NH Medical (Stage 1C) (transition plan in process – interim step toward 4GS)**

- **Whittaker Ward (NH)**, The General Medical beds currently open at Whittaker Ward, NH will transition to Ward 4GS, FMC with a maximum capacity of 18 beds. This exceeds the current occupancy of Whittaker Ward. The commencement date of transition will be Wednesday, 19 April 2017, with full interim transition completed by Tuesday, 2 May 2017.

The Service Plan (Stage 1) proposed that the transition of Whittaker would take place ‘as a service’. During December 2016, SALHN undertook an Expression of Interest (EOI) process to facilitate staff relocation. To facilitate the transition of services to FMC current Whittaker nursing employees would relocate to FMC as an interim arrangement until nursing EOI placement processes have been completed.

As part of the interim arrangements, should affected staff, due to extenuating circumstances, be unable to transition to FMC, discussions will be facilitated with the affected employee and the Director of Nursing, Noarlunga Hospital and/or Nursing Manager. Personal and professional circumstances will be considered as much as reasonably possible and on a case by case basis.
Noarlunga Hospital (NH) Community Emergency Department (ED)

NH Community Emergency Department (ED) will continue to provide 24-hour emergency care to the local community, including paediatric emergency care. Implementation of the South Australian Ambulance Service (SAAS) and SA Health triage guidelines has been implemented for FMC and NH EDs.

FMC Medical and Geriatric Evaluation Management Service (Stages- 1D)
- Ward 6B (Acute Care of the Elderly-ACE)

Stage 1D reflects flexible capacity for 6B. Please see stage 3A for detailed plans. Current average occupancy for ward 6B is approximately 12 beds.

Stage 2

Stage 2 reconfiguration reflects flexible capacity within SALHN.
- Ward 5A (Vascular – stage 2A)
- Ward 5C (Orthopaedics and Plastics – stage 2B)
- Ward 6C (Stroke, Neurology and general medicine - stage 2C)

SALHN will continue to flex capacity up and down pending demand, activity and acuity and will be managed in the first instance as usual business. As length of stay improvements are demonstrated, multiday beds will be flexed down and as a reduction in bed capacity is achieved, formal closure of these beds will occur noting local consultation continues with the in-scope clinical areas, staff and unions in the formalisation of the bed closures.

Stage 3

- Whilst stage 3 planning was included in the previous Clinical Reconfiguration Service Plan November 2016, version 2.1 for information purposes, feedback received during early consultation periods has been considered and is incorporated into stage 3 Clinical Reconfiguration Service Plan March 2017, version 3.1. Specifically the changes from Clinical Reconfiguration Service Plan version 2.1 to version 3.1 include:

  - Stage 3A proposes the reduction of 10 beds within the ACE Ward FMC. Ultimately, patients with complex behaviours of concern are proposed to be located within a 16 bed, dedicated unit at NH. In the interim, co-location of behaviour of concern patients will occur predominantly within additional beds in WD4A, in a bed neutral context if needed.
• Ward 6B (ACE) has a maximum capacity of 16 beds and is currently occupied to approximately 12 beds. Ward 6B is proposed to be the cardio-thoracic surgical ward; forming a key component of a ‘cardio-vascular hub’ proposed for the 6th floor.

• Significant work over 2-3 months is proposed to ‘cardio-protect’ the wiring and provide telemetry and cardiac monitoring capacity to the unit. Once complete this will increase the cardiac monitoring capacity at FMC by 14 beds.

• In order to facilitate the works, it is proposed the existing ACE patients within the unit are relocated predominantly to the new beds being commissioned in 4A (8 new beds. Flexible capacity is available to support this transition.

• It is proposed the transition of ACE patients from 6B to 4A and 6A will occur in early April, enabling the capital works and monitoring completion in ward 6B by early June 2017.

• Stage 3B (A) proposed change of cardiothoracic surgery relocating from ward 6D FMC (cardiothoracic surgery and medical cardiology) to ward 6B, FMC in June 2017.
  o The relocation of cardiothoracic beds (with no proposed reduction of beds) will provide a dedicated cardiothoracic surgical ward on 6B. Monitors and associated equipment will be equipped on the ward, increasing the overall monitoring capacity at FMC by 14.

• Stage 3B (B) proposed change of location for Stroke/Neurology. Feedback has been received regarding the suitability of 6B for Stroke/Neurology patients. As a result it is proposed that Stroke/Neurology and Medical Cardiology Units be co-located on ward 6D in June 2017. With the care of some acute stroke patients currently occurring in the Coronary Care Unit, the models of care and staff skill sets are seen to be complimentary within the units.
  o Approximately 16 acute stroke beds are proposed to relocate to ward 6D and restorative stroke/neuro beds (flexible but estimated at 4) is proposed for ward 6A, if needed.
  o This will enable telemetry and cardiac monitoring support for stroke/neurology patients.

• Stage 3C proposed relocation of Ward 5A Vascular to Ward 6C, FMC in June 2017.
  o The relocation of Vascular beds to the 5th floor provides a unique opportunity to co-locate specialist & complementary units together creating a Cardiac, Stroke/Neurology and Vascular hub on the 6th floor
  o Ward 5A has existing physical infrastructure to support a gym/rehabilitation spaces. Following feedback from staff this is appears the preferred option for a future GEM/Rehabilitation zone.

• Stage 3D, no change

• Stage 3E proposed change of location for the Urology relocation from RGH Ward 8 to FMC ward 6G (Renal) is the preferred ward enabling a renal/urology hub.

Additional bed capacity for the division of medicine will be available in ward 5G (8 additional beds being built/commissioned) to create the capacity within 6G for renal patients, as needed.
### 6. Clinical Reconfiguration in-scope bed configuration

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Division</th>
<th>Stage</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
<th>Bed Change</th>
<th>Future Beds</th>
<th>Flex Capacity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>RGH</td>
<td>Medicine</td>
<td>1A</td>
<td>Ward 2</td>
<td>General Medicine</td>
<td>18</td>
<td>-18</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>RGH</td>
<td>Medicine</td>
<td>6</td>
<td>Ward 6</td>
<td>General Medicine</td>
<td>24</td>
<td>0</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Surgery</td>
<td>4GS</td>
<td>Ward 4GS</td>
<td>Surgical Short Stay</td>
<td>18</td>
<td>-18</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Surgery</td>
<td>5A</td>
<td>Ward 5A</td>
<td>Vascular</td>
<td>22</td>
<td>0</td>
<td>26</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NH</td>
<td>Medicine</td>
<td>1C</td>
<td>Ward 4GS</td>
<td>General Medicine</td>
<td>28</td>
<td>-28</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>1D</td>
<td>Ward 6A</td>
<td>Respiratory + Derm Infectious Diseases</td>
<td>24</td>
<td>+16</td>
<td>TBD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>1D</td>
<td>Ward 6B</td>
<td>Acute Care Elderly-ACE</td>
<td>16</td>
<td>-6</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Stage 1**: +10 beds

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Division</th>
<th>Stage</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
<th>Bed Change</th>
<th>Future Beds</th>
<th>Flex Capacity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC</td>
<td>Surgery</td>
<td>2A</td>
<td>Ward 5A</td>
<td>Vascular</td>
<td>26</td>
<td>-8</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Surgery</td>
<td>2B</td>
<td>Ward 5C</td>
<td>Orthopaedics + Plastics</td>
<td>28</td>
<td>-8</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>2C</td>
<td>Ward 6C</td>
<td>Stroke + Neurology + Medicine</td>
<td>26</td>
<td>-6</td>
<td>20</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Stage 2**: +22 beds

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Division</th>
<th>Stage</th>
<th>Ward</th>
<th>Specialty</th>
<th>Beds</th>
<th>Bed Change</th>
<th>Future Beds</th>
<th>Flex Capacity</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3A</td>
<td>Ward 6B</td>
<td>ACE</td>
<td>10</td>
<td>-10</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3AB</td>
<td>Ward 4A</td>
<td>General Medicine</td>
<td>16</td>
<td>0</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3BA</td>
<td>Ward 6B</td>
<td>Cardiac Thoracic Surgery</td>
<td>14</td>
<td>0</td>
<td>14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3BB</td>
<td>Ward 6D</td>
<td>Stroke + Neurology</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3C</td>
<td>Ward 5A</td>
<td>Vascular</td>
<td>18</td>
<td>0</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3D</td>
<td>Ward 4D</td>
<td>General Medicine</td>
<td>28</td>
<td>-4</td>
<td>24</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3E</td>
<td>Ward 6G</td>
<td>Renal + Medicine</td>
<td>26</td>
<td>-10</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FMC</td>
<td>Medicine</td>
<td>3F</td>
<td>Ward 5G</td>
<td>Haem/Oncology</td>
<td>16</td>
<td>0</td>
<td>16</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Total Stage 3**: +22 beds

**Total**: +64 beds

- **Stage 1**: +10 beds
- **Stage 2**: +22 beds
- **Stage 3**: +22 beds

**Total**: +64 beds
7. RGH clinical ward service moves (planning only – indicative timeline maybe adjusted subject to nRAH ramp down)

<table>
<thead>
<tr>
<th>From Hospital</th>
<th>Ward</th>
<th>Current beds</th>
<th>To Hospital</th>
<th>Ward</th>
<th>Current Beds</th>
<th>Bed change</th>
<th>Future Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RGH</td>
<td>Ward 8</td>
<td>24</td>
<td>FMC</td>
<td>Ward 5A/5C</td>
<td>18/20</td>
<td>+8</td>
<td>26/28</td>
</tr>
<tr>
<td>NH</td>
<td>Myles</td>
<td>7</td>
<td>NH</td>
<td>Collins</td>
<td>0</td>
<td>+8</td>
<td>8</td>
</tr>
<tr>
<td>RGH</td>
<td>HDU</td>
<td>4</td>
<td>FMC</td>
<td>ICCU</td>
<td>28</td>
<td>0</td>
<td>28</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>From Hospital</th>
<th>Ward</th>
<th>Current beds</th>
<th>To Hospital</th>
<th>Ward</th>
<th>Current Beds</th>
<th>Bed change</th>
<th>Future Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>RGH</td>
<td>Ward 6</td>
<td>64</td>
<td>FMC</td>
<td>Ward 5A</td>
<td>0</td>
<td>+24</td>
<td>24</td>
</tr>
<tr>
<td>RGH</td>
<td>Ward 1</td>
<td>30</td>
<td>NH</td>
<td>Whittaker</td>
<td>0</td>
<td>+24</td>
<td>24</td>
</tr>
<tr>
<td>RGH</td>
<td>Ward 5</td>
<td>30</td>
<td>NH</td>
<td>Myles</td>
<td>0</td>
<td>+16</td>
<td>16</td>
</tr>
<tr>
<td>RGH</td>
<td>Ward 18</td>
<td>55</td>
<td>FMC</td>
<td>New Build</td>
<td>0</td>
<td>+30</td>
<td>30</td>
</tr>
<tr>
<td>RGH</td>
<td>Daw House</td>
<td>15</td>
<td>FMC</td>
<td>New Build</td>
<td>0</td>
<td>+15</td>
<td>15</td>
</tr>
<tr>
<td>RGH</td>
<td>Rehab A,B,V</td>
<td>55</td>
<td>FMC</td>
<td>New Build</td>
<td>0</td>
<td>+55</td>
<td>55</td>
</tr>
<tr>
<td>RGH</td>
<td>Ward 17</td>
<td>24</td>
<td>Glenside</td>
<td>New Build</td>
<td>0</td>
<td>+24</td>
<td>24</td>
</tr>
</tbody>
</table>

1. Numbers reflect funded public activity only

RGH Decommissioning Total: -11
8. Clinical Reconfiguration Timeline

Proposed Clinical Reconfiguration Timeline

Please note - timing subject to consultation and demonstration of efficiencies.

[Diagram showing the timeline of clinical reconfiguration phases with specific timelines and actions.]
### 9. In-scope areas impacted by SALHN Clinical Reconfiguration and RGH Decommissioning

<table>
<thead>
<tr>
<th>Stage</th>
<th>Mental Health</th>
<th>Medicine Cardiac &amp; Critical Care</th>
<th>Surgery &amp; Perioperative Medicine</th>
<th>Rehabilitation, Palliative and Aged Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>RGH Ward 2/6</strong>&lt;br&gt; General Medicine&lt;br&gt; FMC 6B&lt;br&gt; Acute Care Elderly (ACE)&lt;br&gt; <strong>NH Whittaker</strong>&lt;br&gt; General Medicine&lt;br&gt; FMC 4A&lt;br&gt; General Medicine&lt;br&gt; FMC 6A&lt;br&gt; Respiratory/ Dermatology / Infectious Diseases</td>
<td>FMC 4GS&lt;br&gt; Surgical Short Stay&lt;br&gt; FMC 5D&lt;br&gt; Surgical Short Stay (Emergency)&lt;br&gt; FMC 5A&lt;br&gt; Vascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>RGH Ward 2/6</strong>&lt;br&gt; General Medicine&lt;br&gt; FMC 6B&lt;br&gt; Acute Care Elderly (ACE)&lt;br&gt; <strong>FMC 6D</strong>&lt;br&gt; Cardithoracic Surgery/ Medical Cardiology&lt;br&gt; FMC 6C&lt;br&gt; Neurology / Stroke</td>
<td>FMC 5A&lt;br&gt; Vascular&lt;br&gt; FMC 5C&lt;br&gt; Orthopaedics / Plastics</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>FMC 6B&lt;br&gt; Acute Care Elderly (ACE)&lt;br&gt; <strong>FMC 6D</strong>&lt;br&gt; Cardithoracic Surgery/ Medical Cardiology&lt;br&gt; FMC 6C&lt;br&gt; Neurology / Stroke</td>
<td>FMC 5A&lt;br&gt; Vascular&lt;br&gt; FMC 6C&lt;br&gt; Vascular/ Tracheostomy&lt;br&gt; <strong>RGH Ward 8</strong>&lt;br&gt; Orthopaedics/ Urology/ Gen Surgery</td>
<td>FMC 5A&lt;br&gt; GEM</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>FMC 6B</strong>&lt;br&gt; Div. of Medicine/ Cardithoracic Surgery&lt;br&gt; <strong>FMC 6D</strong>&lt;br&gt; Medical Cardiology/ Stroke Neurology&lt;br&gt; FMC 4D&lt;br&gt; General Medicine&lt;br&gt; <strong>FMC 6G</strong>&lt;br&gt; Renal/ Urology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>RGH Ward 6</strong>&lt;br&gt; General Medicine/ GEM&lt;br&gt; <strong>RGH Ward 3</strong>&lt;br&gt; HDU&lt;br&gt; FMC ICCU</td>
<td><strong>RGH Ward 8</strong>&lt;br&gt; Orthopaedics/ Gen Surgery&lt;br&gt; <strong>NH Myles</strong>&lt;br&gt; Gen Surgery/ Private&lt;br&gt; FMC 5C&lt;br&gt; Orthopaedics/ Plastics</td>
<td><strong>RGH Ward 1</strong>&lt;br&gt; GEM&lt;br&gt; <strong>RGH Ward 5</strong>&lt;br&gt; GEM - (Behaviours of Concern)&lt;br&gt; <strong>RGH</strong>&lt;br&gt; Daw House&lt;br&gt; <strong>RGH</strong>&lt;br&gt; Rehab A,B &amp; V</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>RGH Ward 17</strong>&lt;br&gt; <strong>RGH Ward 18</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 4.0 Workforce in-scope services and staff

*Identifies wards/units and services proposed to transition ‘as a service’. Note, Whittaker relates to Stage 1, 16 beds.

**RGH Ward 2 and Ward 6 have been merged since December 2015 - quarantined processes apply for these staff for the ward 2/6 merge.

Ward 6G Renal and Ward 6D Cardithoracic Surgery/ Medical Cardiology are proposed to transition ‘as a service’ as part of Stage 3 of Clinical Reconfiguration for more detail refer Stage 3. Where required appropriate processes will be undertaken to facilitate the longer term placement of affected staff.
Workforce in-scope services, units and staff

Staff in the Divisions, Wards/Units provided in Table 4.0 are in-scope as part of the Clinical Reconfiguration and RGH decommissioning process.

As indicated in the Executive Summary the relocation of wards across NH and FMC will initially, as an interim arrangement, be undertaken ‘as a service’. The interim arrangements will apply until an assessment of the responses to the Nursing EOI is completed with the outcome being communicated to in scope staff about longer term placements in the coming months.

Human Resource (HR) Principles and Expression of Interest processes

The SA Health HR Principles Nursing/Midwifery (February 2017) and the SA Public Sector Wages Parity: Salaried 2014 (WPEA: Salaried) – ASO, OPS, AHP, TGO, PO, MeS GFSc HR Principles will be applied to facilitate the transition of staff as part of this change process.

Consultation will take place with the SA Salaried Medical Officers Association (SASMOA) and United Voice (UV) about applicable arrangements for the relevant occupational groups.

For weekly paid employees the SA Public Sector Wages Parity Enterprise Agreement : Weekly Paid 2015 (WPEA: Weekly Paid) and the Guideline of the Commissioner for Public Sector Employment (CPSE): Changes to Workforce Composition and Managing Excess Weekly Paid Employees-Redeployment, Retraining and Redundancy will apply.

Nursing/ Midwifery

An EOI process was undertaken for in-scope Nursing/ Midwifery employees. Selection and placement processes will be completed in the coming months subject to further consultation with the ANMF. Placement will be undertaken following the initial ward alignment across FMC and NH and the lead up to RGH decommissioning.

Should any ward moves occur prior to finalisation of EOI processes, it is proposed they be treated as an interim ‘as a service’ interim arrangement with finalisation of EOI processes determining longer term placement of staff. Staff preferences will be considered as much as reasonably possible.

Allied Health employees

An EOI process for in-scope Allied Health employees closed on 8 February 2017. Selection and placement processes will take place over the coming weeks and the outcome communicated to in scope staff by the first half of 2017.

In scope Allied Health Professionals include:

Ongoing (permanent) Allied Health employees - OPS1, OPS2, AHP2 and AHP3 allocated permanently to:

- Whittaker Ward-Noarlunga Hospital
- Ward 2-Repatriation General Hospital
• Ward 6-Repatriation General Hospital
• GEM 1-Repatriation General Hospital
• GEM 5-Repatriation General Hospital

In-scope employees were requested to provide their preferences for placement within General Medicine at FMC or Geriatric Evaluation and Management (GEM) Services.

AHP 1 and peer reviewed AHP 2 employees were not eligible for this EOI. AHP1 positions across SALHN are rotational positions across units and services. Peer reviewed AHP2 positions are proposed to rotate across SALHN services.

The transition of Allied Health staff will take place in accordance with the Transforming Health HR Principles SA Public Sector Wages Parity Enterprise Agreement: Salaried 2014 (WPEA:Salaried). Quarantined process may take place as appropriate and where applicable; and, subject to consultation with interested parties.

**Administrative – Ward Clerk employees**

An applicable EOI process for in-scope administrative employees will continue to be developed in consideration of the in-scope units as outlined in this revised plan and will commence in the coming weeks.

In-scope ward based administrative staff – Ward Clerks/ Administrative Assistants across SALHN will be invited to express their interest for positions in wards/units.

In-scope administrative staff will be invited at to identify their preferred location and specialty area. All in-scope staff within the identified Divisions, wards and units may submit an EOI at the appropriate time and be considered for placement in accordance with the SALHN Clinical Reconfiguration Service Plan. Placement may be staged in accordance with the timelines provided.

Where staff are allocated directly to a service that is proposed to transition ‘as a service’ (as provided at Section 2.1.) staff will transition with that service.

Further information will be provided prior to the commencement of this process and consultation will continue with the PSA in the finalisation an EOI for directly affected Administrative Employees – Ward Clerks.

**Patient Services Assistants (PSA) staff**

Subject to further consultation and where possible, staff at RGH will be reallocated to other areas within SALHN. Staff at NH may be reallocated to other areas within NH or FMC.

An EOI for RGH Hotel Services staff will be undertaken over the coming weeks and has been subject to consultation with Hotel Service Representatives and United Voice. Further information will be provided prior to the commencement of this process. Further transition process for affected Weekly Paid employees across SALHN will be established in consultation with staff and United Voice as is required.
The provisions of the WPEA: Weekly Paid and the Guideline of the CPSE: Changes to Workforce Composition and Managing Excess Weekly Paid Employees - Redeployment, Retraining and Redundancy will be applied to facilitate the transition of Weekly Paid employees.

**Salaried Medical Officers**

There will be further consultation with SASMOA and affected medical officers about the proposal and the impact on medical officers. Consultation will take place to establish appropriate transition arrangements in consideration of the impact of the clinical reconfiguration and RGH service moves and decommissioning process.

**EOI Timeline and Stages**

Placement within respective Divisions, services and wards/ units will be in accordance with the proposed timelines as identified earlier in this document.

Notice periods and transfer will occur in accordance with the applicable HR Principles and underpinning industrial instruments.

**Grievance processes**

Grievances arising from a decision as part of EOI processes will be managed in accordance with the Grievance process provided in the respective HR Principles and as provided by the respective industrial instruments and legislation.