Introduction

Everyone has the right to safe and timely medical care. The healthcare system is under constant strain and there is serious concern about the sustainability of medical staffing levels in Australian hospitals. South Australia is no different, the public hospital system is buckling under a shortage of doctors, nurses and trained staff. Ambulance ramping, long wait times, delayed elective surgeries, and staff burnout dominate the news cycle.

Now is the time to act. As a smaller jurisdiction with enviable lifestyle advantages, South Australia has a unique opportunity to become the national leader in the medical workforce planning.

Healthcare has changed significantly over the last two decades and, as a result, the demand for services is growing faster than both the population and the economy [1]. Increasing demand is, in part, driven by an ageing population and the associated increasing rates of co-morbidities. The supply of medical staff is simply not keeping up [2]. This is partly attributed to changes in the demographics of the medical workforce and growing demands for greater work-life balance and partly to the lack of serious and holistic medical workforce planning for more than a decade [1] [3] [4]. Significant attention has rightly been given to General Practitioners and primary health workers, but it is vital that Governments also invest in hospital sector staffing. There is an immediate need for systematic and data-driven medical workforce planning.

The need for medical workforce planning in our public hospitals has been clearly established by both the State and Federal Governments. In 2021 the Australian Government released their 'National Medical Workforce Strategy 2021 – 2031' and in 2022 SA Health released the 'Workforce Strategic Directions 2022' report [1, 5]. Both documents clearly identify the need to conduct extensive workforce planning but, as of December 2024, there is no evidence any workforce planning has been conducted for doctors in the South Australian public hospital system in more than a decade.

South Australian nurses have rightly won nurse-to-patient ratios. This report demonstrates that after a decade of neglect similar attention needs to be directed towards establishing minimum staffing standards for doctors.

Inadequate workforce planning manifests as staff shortages and puts pressure on the public health system and has serious and lasting consequences for patients, workers, and productivity.

As this report details, a lack of planning contributes to burnout and stress for doctors working in hospitals, exacerbating issues with attraction and retention. In extreme cases it leads to trained staff exiting the public health system. In fact, in March 2024 the SA Government conducted their 'People Matter' staff wellbeing survey in which almost 4 in 10 surveyed Doctors indicated they did not see themselves staying in the public hospital system over the next three years.

Workforce planning is also necessary to ensure staff have adequate time for both service delivery and – vitally - trainee supervision. A failure to do so is detrimental as it sees the long-term sustainability of the sector sacrificed for the provision of immediate care. Every Australian Doctor – including GPs – is trained in our hospitals. Without adequate Senior Doctors the training chain collapses. Understaffing leads to long wait times, an overreliance on locum doctors, and delayed procedures for patients which – in turn – increases the burden of disease and leads to budget blowouts and reduced productivity.

Following a decade of neglect, it is evident that there is sincere political will to respond to the growing crisis in South Australia's health sector. Since taking office, the South Australian Labor Government has acknowledged the failures of the past and are focused on capacity building – committing an additional $7.1 billion in health funding, including $742.3 million (over five years) to help ensure the system is "*appropriately and permanently resourced to meet higher levels of demand moving forward*" [6]. Likewise, the Federal Labor Government have announced a suite of initiatives intended to directly and indirectly relieve pressure on the hospital system including $56.3 million to towards increasing aged and palliative care demands, new Medicare Mental Health Centres, and increasing the number of bulk billed GP visits.

The public health system is a complex organism, and no single policy lever will solve the problem. But given South Australian hospitals are struggling to staff existing facilities, medical workforce planning is more necessary than ever to ensure positive patient outcomes, worker safety, and sustainable growth of this industry. Without adequate planning, mismatches between the workforce (including graduates) and demand are not just likely, they are certain.

What is Workforce Planning?

The question at the centre of medical workforce planning is deceptively simple: how many doctors and medical staff, and with what capabilities, do we need to provide safe, timely and effective care for patients? It is an evidence-based discipline that is – at its core – about planning for, and managing, the most important organisational resource: its people. It requires *"the repeated, systematic and cyclical identification, analysis and planning of organisational needs in terms of people"* [7].

Workforce planning requires two separate but interrelated tasks. The first, **operational workforce planning** covers a well-defined period, usually 12 months, aligned with the organisation's planning cycle. The second, **strategic workforce planning** is concerned with organisational strategy and covers a longer period of time, often 3 to 5 years [8].[1] In both cases workforce planning requires consideration of supply and demand issues as well as strategic alignment with – in this case – government and health objectives.

It is central to the efficient and productive functioning of an organisation and, when enacted correctly, guides workforce training and development. Vitally, it is a *continuous and ongoing* process reliant on an accurate understanding of current and future workforce needs, that makes explicit the workforce requirements of an organisation [8, p. 7]. It requires the generation of organisational intelligence to inform current and future staffing needs in order to develop a clear understanding of internal and external factors. Where suitable it should include workforce and labour market analysis including supply, demand, skills mix, trainee development, leave entitlements, workforce demographics and succession planning, operational changes, and technological innovations to anticipate and plan for future demand.

Medical workforce planning requires close cooperation between governments, professions, and the higher education and training sectors to ensure the future workforce demands can be met [9].

In essence, the aim is to ensure employers are cognisant of, and resilient to, structural and cultural changes across their workforce. In this way it is distinct from a workforce strategy, like the National Medical Workforce Strategy 2021-2031, which sets a direction and argues for the importance of workforce planning but is not itself workforce planning [1].

WHY IS WORKFORCE PLANNING IMPORTANT?

At its core workforce planning takes the guess work out of staffing. Which is vital in a sector as important as the public hospital system. Inadequate workforce planning can have serious and lasting consequences for patients, workers, and productivity. A failure to conduct workforce planning manifests as inadequate staffing. Understaffing causes stress and burn out for doctors and leads to long wait times and delayed procedures for patients which – in turn – leads to increased costs and reduced productivity.

In contrast, when enacted appropriately, medical workforce planning builds structural, economic, social, and technical resilience. It enables governments to attract the required medical workers in the immediate and medium term to ensure hospitals can meet the growing demand in the sector.

PATIENT IMPACTS

It has been widely accepted that patient care is heavily influenced by the wellbeing and capacity of the staff caring for them [10, 1]. In the UK, a number of reviews into care and treatment in the National Health Service (**NHS**) have identified workforce planning issues as central to hospital mortality, with inadequate levels of available staff, a reliance on locum or temporary staff, and the poor provision of weekend and night cover being identified as especially troubling [11, 12, 13].

Inadequate staffing can lead to the frequent implementation of escalation protocols, an increase in reported clinical incidents, extended wait times, delays to medical procedures and clinical mistakes [14, 1].

Increased workload brought on by inadequate staffing can also impact doctors' ability to fully discuss care with their patients and families, delay discharges, and impacts the quality of handovers and – ultimately - care [10].

STAFF AND TRAINING IMPACTS

Consistent and systematic understaffing can impact doctors' health and well-being in several ways ranging from feeling overworked and frustrated - to fatigue, burnout and mental illness. It contributes to, and exacerbates, staff attrition and makes it difficult to recruit and retain staff, further contributing to prolonged skills shortages. Protracted instances of understaffing and overwork can create serious psycho-social hazards.

Workforce planning is also necessary to ensure staff have adequate time for both service delivery (including administrative duties) and – vitally - trainee supervision. A failure to do so is deleterious in the long term, as the long-term efficacy and sustainability of the sector is sacrificed for the provision of immediate care [14].

Workforce planning requires a holistic engagement with the entire medical training system. The Group of Eight's workforce report identified that Australia's pipeline of medical professionals is a sovereign capability risk and called for *at least* 1,000 additional domestic graduates per year [16, p. 7]. In contrast, South Australia is expecting 261 commonwealth-supported students to graduate this year, down from 286 in 2017 [17].

PRODUCTIVITY IMPACTS

Workforce planning increases productivity by ensuring the right staff and skills mix. It assists with the attraction, attention, and retention of high performing staff and with the management of economic cycles and changes in market demand, including skills shortages and over supply.

Health workforce planning, specifically, builds resilience and agility to enable the sector to absorb shocks and adapt to change. It enables governments to plan and lobby the education sector to ensure the right graduates are being trained to meet workforce demands. And, in turn, ensure that when those graduates enter the hospital system there are adequate doctors available to supervise their training.

It plays a central role in identifying, monitoring, and managing risk, including by tracking variations in workforce trends like changing demographics (ageing, feminisation, cultural changes) [8]. Demographic changes can manifest in several ways for example through increased demands for flexible working arrangements, which in turn change the FTE composition of the work force [8].

1. These are distinct from 'workforce management planning' which responds to immediate and specific workforce issues – such as restructuring and recruitment.

Failing to Plan is Planning to Fail: A History of Medical Workforce Planning in (South) Australia

2008

In December of 2008 the Council of Australian Governments (COAG) signed a 'National Partnership Agreement on Hospital and Health Workforce Reform' to improve health workforce, hospitals and capacity nationally [15]. It laid out a reform agenda that included the establishment of a national agency that would improve health workforce capacity, efficiency and productivity in part by *"funding, **planning** and coordinating clinical training across all health disciplines"* and *"supporting health workforce research and **planning**"* [15, p. 16]. In doing so, COAG recognised that the creation of a new single body that could work across health, education, and jurisdictional borders was critical to effective workforce planning [15].

2009

That agency, Health Workforce Australia **(HWA)**, was established the following year in 2009 and its responsibilities included funding, planning and coordinating pre-professional entry clinical training across all health disciplines and supporting health workforce research and planning - including through a national workforce planning statistical resource [16].

2012

HWA produced their keystone plan 'Health Workforce 2025 — Doctors, Nurses and Midwives' in 2012. That report was a significant undertaking and marked the first time long-term, national medical workforce planning was conducted in Australia [9].

2014

Two years later in 2014, under the auspices of efficiencies, the Abbott Government and - then Minister for Health - Peter Dutton successfully passed the Health Workforce Australia (Abolition) Bill 2014 disestablishing both AWH and the milestone workforce plan [17].

2021

The abolition of HWA created a seven-year-long void in workforce planning until 2021, when the Federal Government release their new 'National Medical Workforce Strategy 2021 – 2031' which calls for – among a number of objectives – the formation of a national *"planning and advisory body with authority to inform and make recommendations to governments regarding the medical workforce"* [1]. The re-establishment of such an agency is also strongly supported by the Australian Medical Association, the peak body for professional doctors in the country [3].

2022

At a state level, in 2022, SA Health released their 'Workforce Strategic Directions 2022' report – 'Phase 3' of which is the *"development of the SA Health Strategic Workforce Plan 2022-2032"* -an *"integrated workforce model and a strategic workforce plan"* that would cover *"longer term strategies of up to five years"* [5].

2024

Two years on, in 2024, there is no evidence any workforce planning has been undertaken for doctors in the South Australian public hospital system for more than a decade. The national workforce planning agency has not been established and the SA workforce plan has not been released. This has created an entirely predictable crisis for medical staff and patients in South Australia.

Note: Clause 38 - Right of entry, deals with comparable provisions contained within the Act. In order to ensure the currency of existing legal requirements parties are advised to refer to Chapter 9, Part 1, Division 5 of the Act as amended from time to time.

PART 11 - Workload Management

39. Workload management - Business Planning Framework (BPF)

39.1 Overview

(a) The Business Planning Framework: a tool for nursing workload management (BPF), and any agreed variations, is the tool for managing nursing and midwifery resources and workload management. The BPF is the agreed methodology for the resolution of disputes regarding workload and safe staffing levels. The parties also recognise that professional judgement is a valid criterion for deeming a definitive staffing level of nurses and midwives as being safe.

(b) The business planning approach to nursing/midwifery resource management focuses on achieving a balance between service demand and the supply of nursing resources necessary to meet the identified demand.

(c) The service profile will detail hours per patient day (or occasions of service where relevant) in each clinical unit and will be varied in accordance with changing acuity and activity. Notional, ward/unit based nurse:patient ratios will be defined. Patient safety and sustainable workloads will be the guiding principles in defining the nursing/midwifery hours required.

(d) The BPF will be used daily to identify minimum, consistent and enforceable nursing/midwifery hours per patient day (or per occasion of service) for clinical units on a shift by shift basis.

(e) A maximum number of available beds per clinical unit will be calculated by reference to the rostered productive hours and the Nursing Hours per Patient Day (NHPPD) for the clinical unit on any particular day.

(f) Bed availability will be defined at the clinical unit level in accordance with the productive nursing hours available.

(g) Any bed closure will occur within the context of the integrated bed management arrangements of the facility.

(h) Training in the application of the BPF will be provided to develop specialists in the application of the tool across all facilities under the guidance of a dedicated project officer.

39.2 Nursing Workload Committee

The Department and each hospital and health service will establish a joint employer/Union workloads committee (a Steering Committee or Nursing Consultative Forum can be agreed alternatives) to deal with issues of nursing/midwifery workload management. The committee or consultative forum will provide specialist advice, training and workload management review in relation to the local application of the tool and with grievances or disputes relating to its application.

39.3 Workloads management concern escalation process

(a) This is the process for the resolution of workload concerns including those that may impact on patient and staff safety. Any nurse, midwife, employer or union representative may raise a workload concern.

(b) Where a workload concern creates an immediate and substantial risk to the safety of patients or staff, the parties will work together to address the concern as a matter of urgency by immediate escalation to stage 3.

(c) **Stage 1**

(i) Where a nurse/midwife identifies a workload concern, it will be raised immediately at the service level with the line manager responsible for ensuring the BPF has been correctly applied.

(ii) The parties will engage to resolve the concern within 24 hours.

(iii) The line manager or after-hours nurse/midwife manager is responsible for immediately investigating the workload concern identified and implementing actions (including implementing service agreed low priority strategies) to resolve the identified concern, mitigate risk to patient safety and/or prevent reoccurrence.

(d) **Stage 2**

(i) If the workload concern is not resolved at the service level at Stage 1, it may be escalated for discussion between the nurse/midwife, union representative and Nursing/Midwifery Executive team (that is Nurse Grade 9 and above depending on the nursing executive structure of the facility).

(ii) The parties will review the identified workload concern and determine and implement further actions to resolve the concern, mitigate risk to patient safety and/or prevent re-occurrence, within seven days of the workload concern being referred to Stage 2.

(e) **Stage 3**

(i) If the workload concern is not resolved at Stage 2, the nurse/midwife, employer and/or union representative party may escalate for resolution.

(ii) Resolution will be by discussion between the Executive Director of Nursing/Midwifery, or when a workload concern is within the Department the professional lead equivalent, and union representative.

(iii) Discussions will be held within seven days of the concern being escalated to Stage 3 by any party to the concern.

(iv) The workload concern should also be tabled for reporting purposes to the next immediate Workload Management Committee / Nursing Consultative Forum.

(f) **Stage 4**

(i) If the workload concern is not resolved at Stage 3, a specialist panel must be convened by the Hospital and Health Service Executive Director of Nursing/Midwifery or Department equivalent within seven days (or longer as agreed by the parties) of the concern being escalated from Stage 3 by a party to the concern.

(ii) The specialist panel will be made up of the following nominees:

(A) Employer nominees:

- Hospital and Health Service Executive Director of Nursing/Midwifery or Department equivalent
- External Executive Director of Nursing peer (optional)

- Hospital and Health Service /Department BPF expert
- External BPF expert - other Hospital and Health Service or Office of Chief Nurse and Midwifery Officer
- Hospital and Health Service /Department HR/IR representative

(B) QNMU nominees:

- Industrial Officer
- Professional Officer
- Organiser
- QNU Workplace representatives

(iii) The specialist panel will review the identified workload concern and jointly recommend actions to resolve the concern, mitigate risk to patient safety and/or prevent re-occurrence of the identified concern. The recommendations should include timeframes for implementation.

(iv) The recommendations of the specialist panel meeting must be published and feedback on the actions taken and those actions to be taken must be provided to staff affected by the identified workload concern within three days of the conclusion of the panel's deliberations.

(g) **Stage 5**

(i) If the workload concern is not resolved at stage 4, a party to the concern may refer the matter to the QIRC for conciliation and if necessary arbitration.

(ii) For the purposes of this stage, an unresolved concern may include but is not limited to instances where the specialist panel is unable to reach an agreed position or the recommendations of the specialist panel are not implemented or are only partly implemented.

7. Purpose of Agreement

7.1 The purpose of this Agreement is to:

(a) advance and recognise nursing and midwifery through a positive practice environment; and

(b) provide simple, easily understood and easily applied conditions of employment within a co-operative and consistent industrial relations framework.

7.2 A positive practice environment for nursing and midwifery promotes safe quality care is established when the following standards are met:

(a) Nurses and midwives must have safe workloads. Minimum safe staffing and skill mix is essential for safe workloads in nursing and midwifery practice. Nurses and midwives have a process in place within the organisation to escalate workload issues.

(b) Nurses and midwives must practice in a physically, psychologically and culturally safe environment that delivers safe, high-quality health and aged care within a just culture.

(c) Nurses and midwives must work in an environment that promotes autonomous and collaborative practice. The autonomous practice of registered nurses and midwives working to their full scope must be recognised and respected by all. The nursing and midwifery professions require collaborative practice to deliver safe quality care for all.

(d) Nurses and midwives must be actively included in organisational governance and decision-making. Nurses and midwives within the practice environment are accountable for their own practice; and registered nurses and midwives have the authority for decision making for their professions with an organisation.

(e) Nurses and midwives must lead and/or participate in research and innovation. Nurses and midwives conduct evidence-based practice research; lead and contribute to health and aged care service research and innovation; participate in innovative quality improvement and accreditation processes; develop health policies, practices, systems, products and technologies.

(f) Nursing and midwifery leadership must be recognised at all levels. Transformational leadership underpins the nursing and midwifery profession.

8. International Labour Organisation (ILO) Conventions

(a) The employer accepts obligations made under international labour standards. The employer will support employment policies which take account of:

(b) Convention 100 – Equal Remuneration (1951);

(c) Convention 111 – Discrimination (Employment and Occupation) (1958);

(d) Convention 122 – Employment Policy (1964);

(e) Convention 142 – Human Resource Development (1975); and

(f) Convention 156 – Workers with Family Responsibilities (1981).

8.1 The parties to this Agreement will monitor the extent to which policies and practices match relevant obligations under these conventions. Any real or perceived deficiencies will be the subject of discussions between the parties to develop agreed strategies to address any problems.

9. Renewal or Replacement of Agreement

Negotiations for a replacement Agreement will commence at least six months prior to the expiration of this Agreement.

10. Co-operative Resolution of Disputes

10.1 The parties agree to a co-operative and consistent approach to resolving industrial issues and disputes

NMBA, the employee will be classified under this Agreement and the job will have "nurse" or "midwife" included in the title.

46 Workload management

46.1 Workload Management and the Business Planning Framework (BPF)

(a) In conjunction with legislated minimum ratios, the BPF is affirmed as the agreed and industrially mandated methodology to ensure safe and sustainable workloads for nurses and midwives. In addition, the BPF addenda have been developed to clarify the application principles of the BPF and improve consistency and transparency of business planning practices in particular specialty services. The parties also recognise that professional judgement is a valid criterion for deeming a definitive staffing level of nurses and/or midwives as being safe.

(b) The calculation of the annual operating budget incorporates the following steps:

(i) Calculate total annual productive nursing/midwifery hours required to deliver service.

(ii) Determine skill mix/category of nursing/midwifery hours.

(iii) Convert productive nursing/midwifery hours into full-time equivalents.

(iv) Calculate non-productive nursing/midwifery hours based on the Award entitlements, as relevant.

(v) Convert non-productive nursing/midwifery hours into full-time equivalents.

(vi) Add productive and non-productive full-time equivalents together and convert into dollars.

(vii) Allocate nursing/midwifery hours to meet service requirements.

(c) It is acknowledged that since its inception the BPF has been, and will continue to be, enhanced and refined and its application improved. This gives confidence within the nursing and midwifery workforce and management that this will deliver safe staffing and effectively match workforce supply and service demand.

46.2 BPF Resources

(a) Each Hospital and Health Service will continue to have a minimum of one full time permanent BPF coordinator position, who is a nurse or midwife, classified at no less than Nurse Grade 7. This position is a dedicated BPF role which will provide expertise in the BPF, support the BPF Steering Committee and participate in the state-wide BPF co-ordinators network co-ordinated by OCNMO.

(b) OCNMO will have a permanent dedicated BPF position to provide BPF expertise and co-ordinate state- wide BPF activities including BPF education and training. The state-wide BPF co-ordinators network will report through OCNMO to NaMIG quarterly on matters to be agreed.

(c) The BPF resource co-ordinators will be responsible for reviewing the ongoing utility of the BPF addenda through the BPF Resource Network coordinated through NaMIG.

46.3 BPF Improvement

46.3.1 Electronic BPF

(a) The parties agree that every Hospital and Health Service should have access to a standardised/NaMIG endorsed electronic BPF tool to capture its BPF.

(b) Hospital and Health Services currently using the eBPF should continue using the program. Those Hospital and Health Services that have not adopted the eBPF should consider the analysis undertaken under the *Nurses and Midwives (Queensland Health and Department of Education) Certified Agreement (EB10) 2018* (NMEB10) with a view to adopting an eBPF.

(c) The parties will conduct a workshop within six months of certification of this Agreement with key stakeholders to consider the cost benefit analysis undertaken in NMEB10 and consider next steps to

provide education and endorsement of a standardised state-wide eBPF.

46.3.2 Timely resolution of workload concerns

(a) The parties acknowledge the importance of ensuring workload concerns are resolved in a timely manner. To assist with the timely resolution of Stage 3 and Stage 4 workload concerns using an interest-based problem-solving approach, the parties will create a guidance note in the first 12 months following certification of this Agreement.

(b) NaMIG will continue to oversee system monitoring of the implementation of the escalation process, particularly specialist panels, to ensure effective and timely resolution of workload concerns.

(c) The parties agree the Environmental Analysis section of the BPF 6th Edition will be updated to prompt the consideration of the cultural factors that affect the role and functions of a service and the result impact, or potential impact, on the workload of Aboriginal and Torres Strait Islander employees in that service.

46.4 **BPF Governance**

(a) Each Hospital and Health Service will establish a BPF Steering Committee (or equivalent as agreed), to ensure transparency in the development and sign-off of the BPF service profiles, including direct links to the budget setting process.

(b) The BPF Steering Committee will be a source of expertise and support for the effective implementation and monitoring of the BPF and build local sustainability across each Hospital and Health Service.

(c) The BPF Steering Committee in each Hospital and Health Service will operate in accordance with the jointly developed terms of reference.

46.5 **BPF Application**

(a) Correct application of the BPF and allocation of resources includes:

(i) A joint BPF sign off process involving the Executive Director of Nursing and Midwifery and the Chief Finance Officer.

(ii) Use of joint employer and QNMU BPF documents/processes including the display of notional nurse or midwife to patient ratios for each unit and the prioritisation notice/process; and the display of legislated ratios where they apply.

(iii) Monitoring the workload concern escalation process; and BPF compliance.

46.6 **BPF Promotion**

(a) The parties commit to joint promotion, education and training in the BPF, targeted at:

(i) nurses and midwives, particularly NUMs/MUMs and DONs; and

(ii) other stakeholders, including non-nursing senior managers, Hospital and Health Service Executive members and Boards, and Human Resources staff to cultivate an understanding of the importance and benefits of the BPF.

47 Identified Aboriginal and Torres Strait Islander nursing and midwifery positions

47.1 Wherever possible, where an identified Aboriginal and Torres Strait Islander nursing or midwifery position is vacant, it will be filled or backfilled with an employee who identifies as Aboriginal or Torres Strait Islander.

47.2 Where an identified Aboriginal and Torres Strait Islander nursing or midwifery position is unable to be filled or backfilled with an employee who identifies as Aboriginal or Torres Strait Islander, the position should not be left vacant. In these circumstances it is reasonable to employ a person who does not possess the relevant attribute, if it assists the continuity of a critical program or activity which could not otherwise be continued if the position was not filled.

63 Scope of Practice Project

63.1 The Chief Executive is committed to enabling system change that ensures Nurses and Midwives are able to work to full scope of practice.

63.2 NaMIG will establish a joint working group with a dedicated funded project officer for the life of the Agreement to investigate system change required to allow nurses and midwives to work to their full scope of practice.

63.3 The project will develop a strategy to overcome structural barriers that inhibit nurses and midwives working to their full scope to optimise health outcomes and achieve efficiencies in the Health system.

63.4 The project will include, but not be limited to, consideration of the following:

(a) a definition of full scope of practice;

(b) investigation of opportunities for criteria led discharge;

(c) mapping opportunities for own source revenue;

(d) mapping where nurses and midwives are not currently working to full scope of practice;

(e) investigation of how full scope of practice applies for enrolled nurses and enrolled nurses advanced skills;

(f) investigation of the process for credentialling of nurse practitioners and endorsed midwives with a view to developing recommendations for best practice;

(g) the role of endorsed midwives;

(h) innovative models of care currently being utilised and how they could be expanded or duplicated.

64 Nursing and Midwifery Workforce Planning

64.1 The parties agree the focus of ongoing collaboration relevant to nursing and midwifery workforce planning continues to be in the priority areas of:

(a) Attraction, recruitment and retention of nurses and midwives;

(b) Effective management of workloads and workforce planning;

(c) A consistent approach to models of contemporary nursing and midwifery practice;

(d) Nursing education and development frameworks;

(e) Work-life balance strategies for nurses and midwives;

(f) Promoting an effective, efficient and value-based health system that is affordable and meets the growing needs of Queenslanders;

(g) Improving accountability, innovation and responsiveness through realising policy commitments to better meet community needs; and

(h) Optimising the opportunities to access all sources of health care funding.

64.2 The role of NaMIG in workforce planning

(a) The Chief Executive recognises that NaMIG is the peak consultative forum for the advancement of the industrial and professional interests of the Queensland Health nursing and midwifery workforce.

(b) It is acknowledged that NaMIG will continue to advance the interests and issues of the nursing and

midwifery workforce through:

(i) strategic consideration of current and emerging nursing and midwifery workforce issues in Queensland Health; and

(ii) providing strategic advice to the Chief Executive and the Executive Management Team on issues affecting nursing and midwifery.

(c) Given the current and emerging workforce challenges, this will be a particular focus for NaMIG for the life of this Agreement.

65 Nursing and Midwifery Clinical Education roles

65.1 The parties recognise the essential role of nursing and midwifery clinical education services (nurse and midwife educators, facilitators and coaches) in leading and supporting nursing and midwifery professional practice through workforce capability development.

65.2 In recognition of the integral role that learning has to the provision of quality health care, each Hospital and Health Service must undertake appropriate planning to ensure that there are sufficient nurse and midwife clinical education resources to support both professions educational demands each financial year and/or where changes to nursing and midwifery service delivery occurs.

65.3 Nursing and midwifery clinical educators, facilitators and coaches must not be used to fill roster vacancies or leave, except in exceptional circumstances.

66 Nurse Practitioners

66.1 Nurse Practitioners will have 20% of their rostered hours allocated away from direct clinical duties to support them to work to their full scope of practice.

66.2 The parties recognise that Nurse Practitioner Candidates must be provided with the necessary academic and clinical support consistent with the regulator and academic requirements.

67 Nursing and midwifery governance

67.1 The parties acknowledge the value of a nursing and midwifery voice in governance at both the strategic and operational level within the health system, including:

(a) the leadership role of Executive Directors of Nursing and Midwifery, and participation in decision-making within the Hospital and Health Service;

(b) the Executive Directors of Nursing and Midwifery having responsibility for professional standards and practice for nursing and midwifery;

(c) the relationship between the employer and the QNMU at central and local facility level;

(d) the leadership role of Executive Directors of Nursing and Midwifery Forum, NaMIG and NaMCFs;

(e) the strategic policy directions and governance for nursing and midwifery provided by OCNMO;

(f) the authority of nurses and midwives at all levels over their own professional practice;

(g) relationship with other consultative forums;

(h) health service planning;

(i) workforce planning including recruitment and retention, skill mix and staff profile;

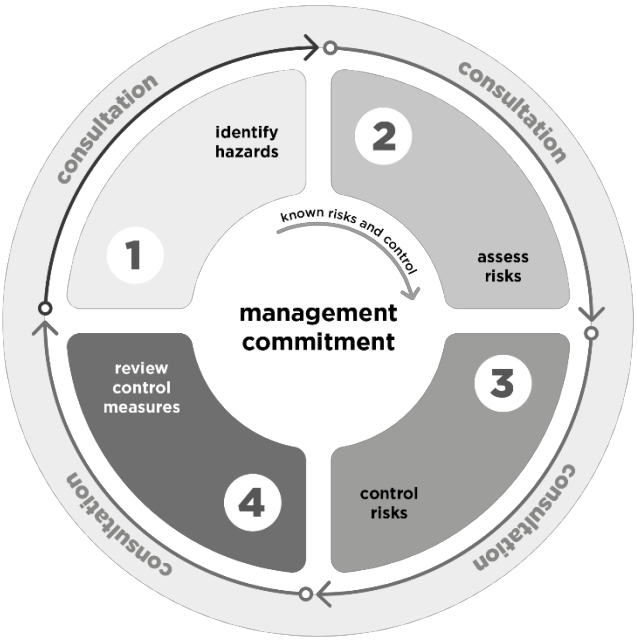
(j) effective, efficient and responsible resource management including nursing and midwifery budget;

(k) future and emerging funding options;

(l) nursing and midwifery input into Hospital and Health Services;

2 Overview of the process to manage psychosocial risks

To meet your duties to ensure health and safety, you must eliminate or minimise psychosocial risks so far as is reasonably practicable. To achieve this, just as for any other hazard, you can apply the risk management process described in the Code of Practice: *How to manage work health and safety risks*.



The risk management process involves four steps:

1. **Identify hazards** - find out what could cause harm (Chapter 3).
2. **Assess risks**, if necessary - understand the nature of the harm the hazard could cause, how serious the harm could be and the likelihood of it happening. This step may not be necessary if the risks and controls are known (Chapter 4).
3. **Control risks** - implement the most effective control measures that are reasonably practicable in the circumstances and ensure they remain effective over time. This means:
   - you must eliminate risks, if reasonably practicable to do so
   - if it is not reasonably practicable to eliminate the risks, implement the most effective control measures to minimise the risks so far as is reasonably practicable in the circumstances, and
   - ensure those control measures remain effective over time (Chapter 5).
4. **Review control measures** to ensure they are working as planned and make changes as required (Chapter 6).

All of these steps must be supported by consultation (see Section 1.3 of this Code).

Risk management requires planning and is an ongoing process. However, considering risks early prevents costly changes later and allows for more effective control measures to be used, resulting in less harm to workers. For example, you should consider psychosocial hazards at the design phase when planning an organisational restructure.

The risk management process may be implemented in different ways depending on the size and nature of your business or undertaking. Larger businesses and those in sectors where workers are exposed to more or higher risks are likely to need more complex, sophisticated risk management and consultation processes.

Before you start the process:

- explain the process
- get commitment and engagement from senior leaders and managers
- identify who needs to be involved, for example managers, workers, HSRs and subject matter experts, and
- decide how the process and its outcomes will be recorded and communicated.

Matters to consider when controlling risks

How long (**duration**), how often (**frequency**) and how significantly (**severity**) your workers are exposed to psychosocial hazards impacts the level of risks. Hazards **interacting** or **combining** with each other may also change the risks.

As you work through the risk management process you must consider things that may give rise to hazards, influence the level of risks workers are exposed to, or could be changed to help control those risks, including:

- **the design of work, including job demands and tasks involved**

  Considering how the work is designed will support you to eliminate hazards at the source and at the organisational level.

  Your workers should have an appropriate amount of work to match their skills and experience. For example, a job designed with too much work for a worker of that skill level to complete with the resources provided, or tasks that do not match that worker's skillset will create hazards. Matching tasks to workers' skills and scheduling non-urgent tasks for times of lower demand may assist to control risks.

- **systems of work, including how work is managed, organised and supported**

  Systems of work are organisational rules, policies, procedures and work practices used to organise, manage and carry out work. These systems can introduce psychosocial hazards, but if carefully considered can also help control them.

  For example, a system of work that does not allow workers to seek assistance from supervisors, or that allocates tasks without regard for other work demands may introduce hazards. A system of work which provides for support and manages job demands may assist to control risks.

- **the design and layout and environmental conditions, of the workplace, including safe means of entering and exiting the workplace and welfare facilities**

  A poor physical working environment can be a psychosocial hazard, however the way a workplace is set up can also control other psychosocial hazards.

  For example, ensuring workers can get away from aggressive customers or can observe when another worker may need assistance.

- **the design and layout, and environmental conditions of workers' accommodation**

  Like the working environment, accommodation provided for workers can introduce or control psychosocial hazards.

  For example, worker accommodation which does not provide adequate privacy or security can contribute to the risk of violence or harassment. Well-designed accommodation can help control these risks.

- **plant, substances and structures at the workplace**

  Plant (e.g. machinery, equipment, appliances and tools), structures and substances used at work can introduce psychosocial hazards where they create a physical hazard that is not adequately controlled. For example, plant can create loud noises, dust and vibrations which creates poor physical environments and contributes to psychosocial risks.

  Well-designed and maintained plant can prevent these hazards but can also be used to control other psychosocial hazards. For example, safe plant that allows work to be performed more efficiently can reduce high work demands.

- **workplace interactions or behaviours**

  The way workers interact with each other and other persons in the workplace, their behaviour and relationships can introduce psychosocial hazards. However, supportive leadership, positive relationships and professional and respectful interactions can help to minimise a range of psychosocial hazards.

  Poor organisational culture can hamper efforts to improve work health and safety by preventing workers seeking and providing support and discouraging workers from reporting hazards and participating in consultation. Leaders demonstrating poor behaviour are likely to contribute to poor organisational culture.

- **information, training, instruction and supervision provided to workers**

  Information, training, instruction and supervision may be necessary to implement control measures effectively (see Section 5.2 for further information and relevant duties). They may also assist in controlling some psychosocial risks, for example where low role clarity is creating a risk, information and training on the worker's role will assist in controlling the risks.

Leadership and management commitment

Genuine commitment by the PCBU, officers, and other organisational leaders is essential. These leaders, through their governance arrangements and resourcing decisions, actively shape the organisation and the way work is undertaken. These decisions will, directly and indirectly, impact how effectively you can control psychosocial risks.

This commitment can be built by ensuring leaders understand their duties under WHS laws, the risk management process these require, the business case for effectively managing psychosocial hazards, and the roles of various organisational leaders (e.g. human resources and WHS managers).

Consulting workers throughout the risk management process

At each step of the risk management process you must consult workers who are, or are likely to be, directly affected by a work health and safety matter and any HSR(s). For example, on proposed changes affecting work health and safety such as:

- new policies, procedures and systems of work
- organisational restructures, changes to staffing levels, new reporting arrangements and work locations
- changes to tasks, workload, duties and working arrangements, including rosters
- new technology, plant, equipment, substances, structures and production processes
- the redesign of existing workplaces, or
- changes to the way information, training, instruction and supervision are provided.

Consultation on changes that may affect work health and safety should occur as early as possible.

See Section 1.3 for more information on consultation.

Further guidance on the risk management process is available in the Code of Practice: *How to manage work health and safety risks*.

AUSTRALIAN SALARIED MEDICAL OFFICERS FEDERATION

POSITION STATEMENT

RECOMMENDED MINIMUM PARENTAL LEAVE ENTITLEMENTS FOR SALARIED MEDICAL OFFICERS

The ASMOF Gender Equity Working Group (the 'Group') has identified a need for key recommendations to be developed in respect of parental leave and other entitlements for medical practitioners with parenting responsibilities across all federal, state and territory public health systems.

The vocational training requirements of medical practitioners can extend for up to a decade or more following the completion of prevocational training. Doctors in Training (DiTs) may have little say about where they are directed to complete specialist training and may find themselves moving between public health system employers with little choice or notice.

This lack of autonomy or flexibility occurs during the stage of life where many medical practitioners become parents and can detrimentally impact an employee's capacity to access paid parental leave entitlements. This is a matter that has been recognised in the Australian Medical Association Position Statement "Medical parents and prevocational and vocational training" issued in 2020.

The Working Group also notes and supports the call from the Royal Australian and New Zealand College of Obstetricians and Gynaecologists for Federal and State governments to introduce 26 weeks of paid parental leave for all DiTs that is fully transferable and available with no qualifying period.

Noting the above and following a review of parental leave entitlements across the various state and territory public health system employers, the Working Group makes the following recommendations with regard to the employment conditions of all salaried medical officers. The Working Group further recommends that such entitlements be included in enforceable collective industrial instruments such as awards and enterprise agreements.

Paid Parental Leave

The ASMOF Gender Equity Working Group recommends that industrial instruments applying to salaried medical officers should provide for Paid Parental Leave:

1. of not less than 26 weeks, payable in addition to any entitlement to Parental Leave Pay under the Federal Government Paid Parental Leave Scheme;

2. that is fully available without an initial qualifying period;

3. that is transferable between public health system employers;

4. that extends beyond the conclusion of a fixed term contract, or otherwise transfers to a subsequent public health system employer;

5. that is recognised as service for all employment purposes; and

6. that is equally accessible to either parent.

Additional Matters

The ASMOF Gender Equity Group recommends that industrial instruments applying to salaried medical officers contain the following additional entitlements:

A. Non-gender specific language and entitlements;

B. Superannuation contributions to be paid during periods of both paid and unpaid parental leave;

C. Access to flexible work arrangements for each parent;

D. The recognition of service and continuity of service between different state and territory public health system employers;

E. The provision of adequate facilities to support working parents such as access to affordable childcare, childcare assistance and lactation facilities;

F. The provision of paid reproductive leave for the purpose of accessing:
   i. fertility and IVF treatment;
   ii. preventative screening and treatment associated with reproductive health;
   iii. treatment or absence due to chronic reproductive health conditions; and
   iv. miscarriage, pregnancy loss and other pregnancy related illness.

Position Statement developed by ASMOF Gender Equity Working Group on 8 October 2024 and endorsed by ASMOF Federal Council on 26 November 2024.

The Strategy recognises that IMGs form an important part of the medical workforce, but that there are risks in continuing our heavy reliance on them. While the total number of IMGs working within the public hospital system is unknown, international border closures in response to COVID-19 have highlighted vulnerabilities in a system that relies on temporary and permanent international migration. The Strategy supports working towards an agreed definition of national self-sufficiency, the first step of which is understanding and modelling the domestic supply through the Data Strategy. Australia, like many other countries, will likely always benefit from some IMGs, and some doctors may choose to migrate or gain experience overseas, but the ability to deliver care without a significant reliance on IMGs is important. The Data Strategy will ensure that our view of the domestic workforce is informed by Commonwealth, state and territory data, and that any adjustments that need to be made to improve supply can be made.

Restructuring the service registrar medical workforce

A longstanding expectation is that all medical students will start as junior doctors, then train as registrars, and finally Fellow as specialists. However, this progression no longer fits the workforce needs of specialties that provide 24/7 acute care, as more doctors are needed in 'middle-grade' roles than as specialists.

Advances in diagnosis and treatment have increased the range and volume of services provided 24/7 in acute hospitals. This increased workload, and important reductions in excessive working hours, means that more middle-grade doctors, who have sufficient skill and experience to provide acute care under specialist supervision, are needed. Hospitals have logically increased the number of registrar positions to provide the middle-grade workforce they need.

Seeking accreditation from specialist colleges for these to be training positions increases the attractiveness of positions to doctors wanting to specialise, and ensures these doctors are supervised and are part of an educational program. So, the number of training positions has increased separately from consideration of the number of specialists needed.

From the perspective of filling rosters, accreditation can have downsides as colleges set limits for on-call and night duty out of concern for their trainees' welfare and education. Registrar positions in units or hospitals that do not seek accreditation, or cannot fulfil the requirements for accreditation, are called 'unaccredited registrar' or 'service registrar' positions. Unaccredited registrars usually perform the same tasks as training registrars, but without the same college requirements for supervision, education and limits on overtime and on-call work.

Thus the need for middle-grade workforce in acute care specialties has created two major issues, namely an increase in accredited training positions, which has led to an oversupply of specialists, and an increase in unaccredited registrars at risk of overwork, career uncertainty and professional isolation.

The increased numbers of junior doctors resulting from the expansion of medical school places has exacerbated this situation, by increasing competition and bottlenecks for training places. Junior doctors may reluctantly take service registrar positions hoping to gain a training position in time. This creates frustration and, for some, dissatisfaction at their career prospects.

The importance of service registrars in providing care is not always matched by recognition and respect by medical and other health professional colleagues, nor by professional or educational support, which puts them at greater risk of overuse and exploitation. For a health service, maintaining patient care and ensuring sufficient staff is the primary goal. This should be achieved while providing service registrars with a safe, structured and more supported place in the medical workforce.

Unaccredited or service registrars are not a homogenous group. Their interest in entering specialist training varies, as do their interests or preferences for working in specific specialties, or across hospital units as generalists. Doctors may not want to train as specialists for a number of reasons, including lifestyle, carer's responsibilities and wanting to combine medical work with other interests and opportunities. Their titles are similarly varied between states and territories, and public and private employers, and include hospitalist, service registrar and Career Medical Officer (CMO).

During consultations, three pathways for service registrar roles were discussed:

1. A junior middle-grade role (PGY3+) which was limited to three years – accredited prevocational role, with intention to pursue Fellowship.
2. An unlimited senior middle-grade role (PGY5+) without intention to pursue Fellowship.
3. A Fellow with an area of interest, an unlimited part-time role in addition to scope of practice – for example, a GP working under supervision in orthopaedic surgery, or a general paediatrician working as a CMO in a neonatal intensive care unit.

Consultation participants agreed on the importance of service registrars and the need to strengthen their roles to meet the service needs of hospitals, and to train the right number of specialists. Views differed on how much detail a national strategy should include on employment conditions that are determined by state and territory governments. There was consensus that the Strategy could support the collaborative development and implementation of a service registrar framework. A working group will develop this framework for trialling and evaluation in different jurisdictions. The framework will explore the following principles:

- Flexibility for doctors to enter training or other middle-grade hospital roles
- Recognition of prior learning for entry into training
- Provision of safe and collaborative rostering with clear job plans and expectations
- Options for flexible work arrangements where patient safety is maintained
- Safe supervision standards and supervision
- A reduction in inefficient administrative tasks currently performed by doctors in training.

Service registrars need an affirming name that reflects their importance in the health system. Possibilities include Clinical Associate and Senior Clinical Associate, which can be associated with a specialty or function, for example, Surgical Associate or Emergency Medicine Associate, and/or Hospitalist or Career Medical Officer.

Formalising roles, career pathways and progression opportunities, alongside positive titles for service registrars will provide them with a recognised and respected place in Australia's medical workforce. This will improve their wellbeing and job satisfaction. Some will choose this level of work long term, whereas others will select the value of worthwhile, supervised work as a short-term match with their other life commitments.

Evidence-based career choices

Highlighted across all of these areas of imbalance is a need for better access to information and support to enable doctors to plan their careers, so that they may choose to train in specialties that are undersupplied and practice in locations that are viable and sustainable.

Medical students and junior doctors report receiving career information informally. There is a lack of information on success rates of applications to specialist medical colleges, and often limited visibility of the route to Fellowship. There is also no simple way to compare specialty programs and future job prospects. There are nearly twice as many doctors enrolled in the basic training program of the Royal Australian College of Physicians as places available for advanced trainees; basic physician trainees pay training and exam fees and sit exams without knowing whether they will gain an advanced training post. As cited above, expansion in the numbers of accredited training places in other acute care disciplines, such as intensive care and emergency medicine, means that these registrars provide valuable service, and study and train in their specialty, but may not find employment once qualified.

New South Wales and Queensland are leading the way with their 'Map My Career Tool' and 'Medi-Nav' systems. Both tools are interactive and can be used to compare specialties based on supply and demand data, including data from the *National Health Workforce Data Set*, the Medical Education and Training Reports, specialist medical colleges and local recruitment campaigns. Having a national tool that synthesises data from multiple sources would enable junior doctors and medical students to make more informed career decisions, taking into consideration community need.

position). Such an arrangement will terminate on expiry of the specified term, or when the Doctor ceases to perform the specified role, unless terminated earlier on notice or by agreement.

15A. Climate Change Mitigation and Sustainability

15A.1 Acknowledgment

The parties acknowledge that:

(a) the climate is changing and this affects the health and wellbeing of Victorians:

(b) Health Services use significant amounts of energy and water and generate large volumes of waste;

(c) the *Climate Change Act 2017* has a long-term emissions reduction target for Victoria of net zero greenhouse gas emissions by the year 2050 with a series of interim targets to achieve that goal; and

(d) Doctors and Health Services have a role to play to support the achievement of that target, which includes through discussion, information sharing and cooperation.

15A.2 Continuous improvement

(a) Doctors and Employers support continuous improvement to improve environmental sustainability including:

(i) At an industry level through the Best Practice Employment Commitment term at clause 63;

(ii) At a local workplace level through:

A. the WIC (see subclause 62.10) where it is in operation; and/or

B. a local body established for the purpose of consulting over environmental sustainability and climate change (however described).

(b) Doctors and Employers support the development of local processes to:

(i) integrate climate and environmental considerations into the evidence-based decision-making process;

(ii) engage with Doctors to consult over matters of environmental sustainability including possible mitigants such as:

A. recycling and waste reduction;

B. better use of technology;

C. healthy sustainable buildings, infrastructure and materials; and

D. the delivery of health services;

(iii) implement change at the workplace level to achieve environmental sustainability objectives including through local action plans as Health Services seek to move to 100% renewable energy by 2025.

15A.3 Education

(a) It is acknowledged that education concerning to climate related health topics may be directly relevant to a Doctor's role within the meaning of clause 59 (Continuing Medical Education.

(b) The Health Service will encourage and support the inclusion of climate-related health topics as part of education provided to Doctors.

15A.4 Discussions with Association

(a) Upon request, a Health Service will meet the Ambassador or other representative of the Association to discuss the sustainability report of the Health Service.