Queensland Health

# MOCA7: Queensland Health's Response to Union Claims

## Without prejudice

Queensland Health's agreement on individual union claims is subject to union agreement on critical items for Queensland Health, as detailed in the Bargaining Agenda. There is no final agreement on any claim until a final certified agreement is agreed. Claims identified as cost items or potential cost items fall outside the scope of the Public Sector Wages Policy and therefore beyond Queensland Health's authority to agree to. However, where indicated, Queensland Health is prepared to explore items further in an effort to align positions and work towards an agreement in principle by the end of July.

| ASMOFQ | Workforce & Workloads Claims | QH Responses |
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| Safe Workloads & Staffing<br><br>Nurses and Midwives (Queensland Health) Award – State 2015: Part 11<br>EB11: clauses 7.2(a), 46<br><br>Workforce Planning<br><br>McKell Report: Operating without a plan<br>EB11: clause 64 | • 1.01: Reporting of workloads and staffing levels, with process to escalate<br>• 1.02: Regular reviews to assess staffing adequacy and safe doctor-to-patient ratios.<br>• 1.03: Reporting of overtime, fatigue, rostering metrics, leave balances, CST, staff attrition etc<br>• 1.04: Sufficient staffing levels to enable training the next generation of doctors to address future workforce shortages, not just current service provision<br>• 1.05: Refer to EB11 clause 64<br>• 1.06: Use data to make decisions and develop strategy in respect of recruitment, training, and retention.<br>○ *"How many doctors, and with what capabilities, do we need to provide safe, timely and effective care for patients?"* | 1.01 to 1.06: QH position is these are not matters for Enterprise Bargaining. QH workforce planning initiatives are continuing. QH is addressing workload issues through workforce planning and growing the medical workforce through the Easier Access to Health Plan. The QH Fatigue Review is addressing safe workloads and staffing, which includes reviewing reporting processes. |
| Medical Consultative Forums | • 1.07: Establish a local medical consultative forum at each HHS to discuss and address doctor issues, particularly those related to workloads | QH position is the current MOCA6 clause 3.4.1 wording is appropriate - if mutually agreed between union parties and the HHS a local medical consultative forum should be established. |

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| Permanency of employment | • 1.08: Convert temporary to permanent positions where possible & appropriate | QH will continue to review non-permanent employment and, where appropriate, convert to permanent in accordance with Part 9 of the *Public Sector Act 2022 (Qld)* and Public Sector Commission Directive 02/23: Review of Non-Permanent Employment. Note there is currently an RMO Long-term contracts projects in response to a MOCA6 commitment. |
| Proper backfilling of positions | • 1.09: To avoid excessive workloads or reduced access to leave, CST etc | This is not a matter for enterprise bargaining. These decisions are appropriately managed at the local level. |
| Administrative officer support<br><br>Support for Clinical/Medical Managers | • 1.10: Allocate an appropriate FTE of administrative officer support to medical officers to ensure that they are not spending time on administrative work and tasks unnecessarily<br>• 7.10: Administration officer support<br>• 7.11: Management training and support<br>• 7.12: Proper allocation of FTE for managerial work | These decisions are managed at the local level and are not considered matters for inclusion in the certified agreement. |

| ASMOFQ | Workplace culture, Psychosocial safety and Well-being Claims | QH Responses |
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| Psychosocial safety in the workplace<br><br>Safe Work Australia Model Code of Practice<br><br>Promotion of well-being | • 2.01: Reporting mechanism for psychosocial hazards<br>• 2.02: Identify risks, assess hazards, control risks and review control measures<br>• 2.03: Protection of medical officers from victimisation or reprisal when raising workplace concerns (including notifications without due process)<br>• 2.04: System design to promote well-being<br>• 2.05: Monitoring of workloads, rostering, overtime, fatigue, access to leave etc<br>• 2.06: Reporting of psychosocial hazards or unsafe situations<br>• 2.07: Well-being Medical Officer at each hospital (allocated FTE)<br>• 2.08: Exit interviews for departing staff by external party<br>• 2.09: Psychosocial rostering commitment (excessive weekends, or service terms) | System-wide support tools and resources are already available.<br>a) Reporting mechanism already exists through RiskMan. Recent updates have enhanced psychosocial hazard reporting categories, improving data capture and reporting capabilities. Local processes also ensure that psychosocial incident reports submitted through RiskMan are directed to HR teams in the first instance.<br>b) QH's Safety and Wellbeing Management System applies, including the Risk Management Standard and Guideline. The Managing the Risk of Psychosocial Hazards at Work Code of Practice 2022 has been communicated and implemented across the system to improve awareness and management of psychosocial risks.<br>c) QH will develop a new Psychosocial Risk Management Guideline in 2025 to provide further clarity on identifying risks, assessing hazards, and |

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| Promotion of positive workplace culture | • 2.10: Commitment to provide a supportive workplace environment<br>• 2:11: Accountability by hospital executive & management for psychosocial well-being of staff | implementing and reviewing control measures.<br>d) A range of QH leadership programs are available targeted at multiple leadership levels which include promotion of psychosocial safety and positive cultures.<br>e) HR policies have been updated to include the Psychosocial Code of Practice and address protection from victimisation and mitigation of further harm in responding to staff concerns raised.<br>f) The Sexual Harassment Policy (HR Policy E5) specifically addresses protection from victimisation and reprisal and the Safety and the Wellbeing Policy (HR Policy W1) update in 2024 includes "permission to pause care" provisions.<br>g) Oversight of clinical training is already embedded within the existing responsibilities of Clinical Directors and Directors of Specialty Training at the facility level.<br>h) Existing legislation and QH policies / guidelines clarify management responsibilities in relation to psychosocial safety. |
| Parental Leave | • 2.12: Refer to ASMOF position statement on parental leave<br>• 2.13: Increase in spousal leave | Parental leave entitlements are managed at a whole-of-government level, and QH does not support increasing entitlements for specific classifications through certified agreements. Refer to Minister for IR Directive 08/24: Paid Parental Leave. |
| Promotion of medical leadership | • 2.14: For further discussion during bargaining<br>• Generally, but also leadership training and development pathways for RMOs | QH does not consider that a certified agreement is the best option for addressing this concern. Organisational Development teams within the Department and HHS are responsible for developing and promoting leadership courses and programs. |
| On-call rooms | • 2.15: Appropriate rooms for medical officers to rest and/or sleep | QH considers that current provisions in clause 12 of MOCA6 are sufficient (in particular clauses 12.23-6). |

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| Office space | • 2.16: Appropriate office space for medical officers (including RMOs) | |

| ASMOFQ | Rostering, Hours of Work, Overtime & Fatigue Claims | QH Responses |
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| Protection around "days off" (RMOs) | • 3.01: RMOs can still be rostered overtime on any of their four "days off"<br>• 3.02: Stronger protections around "days off" | QH agrees that RMOs should have sufficient rest, including four days off per fortnight in accordance with clause 19.1(d) of the Medical Officers (QH) Award – State 2015, as this supports wellbeing, reduces fatigue, and minimises associated health and safety risks.<br>However, claim 3.02 will restrict QH's flexibility in situations when it is necessary for RMOs to work additional hours to maintain service delivery and ensure patient safety. |
| Roster changes with short notice | • 3.03: Loading to be applied<br>• 3.04: Additional incurred costs such as parking, childcare to be reimbursed by the employer | Link with TQ claim 6.05. QH wishes to retain the flexibility in clauses 12.2 and 12.11 of MOCA6 that rosters should be provided four weeks in advance, and at a minimum two weeks in advance. However, changes to published rosters may be necessary in emergent situations—such as unplanned sick leave—to ensure service delivery and maintain patient safety. QH does not support penalties for rostering amendments made in emergent circumstances. |
| Reporting system for issues regarding workloads, rosters, overtime and fatigue | • 3.05: User-friendly, fit-for-purpose reporting system for doctors to notify issues and concerns | 3.05 Not a matter for inclusion in MOCA7. Workplace health and safety concerns can be reported via Riskman. A workload management kit was developed by the MOCA6 Oversight Committee. |
| Full recognition of work as overtime | • 3.06: Payment for additional hours of work performed eg prior to a shift, for discharge summaries | 3.06 MOCA6 clauses 12.14.4 (RMOs) and 12.15.2 (SMOs) already provide for unrostered overtime to be paid circumstances including patient admission/discharge. |
| Mitigation against Excessive Phone Calls | • 3.07: Develop protocols to reduce and manage excessive phone calls that disrupt rest periods, with a clear escalation process. | 3.07 Not a matter for inclusion in MOCA7. Protocol development can occur at the local level. |
| Night shift loading increase | • 3.08: Night shift loading increase - For further discussion during bargaining | 3.08 QH cannot support the cost implications, which may be at the expense of service delivery. |
| Clinical Support Time (CST) | • 3.09: Improve access to minimum CST entitlement (especially for RRR medical officers) | CST is implemented flexibly across facilities, making standardised reporting unfeasible. Not operationally viable to mandate rostering CST, particularly with flow-on effects. |

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| | • 3.10: Data collection of CST allocated to individual medical officers | QH considers clause 12.22 of MOCA6 provides appropriate support to enable the allocation of CST in a manner which is responsive to local service delivery needs. |
| Term allocation and rostering outside ordinary hours | • 3.11: Limit the allocation of RMOs to "service terms"<br>• 3.12: Limit the number of after-hours & weekends shifts that RMOs can be rostered to in a given period | 3.11 Exposure to a variety of clinical settings—including those with higher service demands—is a critical part of medical training and workforce development. Limiting term allocation in this way would affect both training quality and the capacity of services to meet clinical demand.<br><br>3.12 QH does not support imposing rigid limits on after-hours and weekend shifts. Such limits would reduce operational flexibility and service delivery, particularly in smaller or regional facilities. Existing MOCA6 provisions and local rostering practices are designed to promote RMOs receiving adequate rest. |

| ASMOFQ | • Training & Professional Development Claims | • QH Responses |
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| Access to professional development leave (PDL) | • 4.01: Access to out-of-core hours PDL for both RMO & SMOs<br>• 4.02: Use of PDL for studying for exams | 4.01 Clause 7.6.5 already allows SMOs to access their accrued PDL balance to undertake professional development activities outside of their ordinary rostered hours. As RMO hours may be scheduled at any time across a 24/7 roster, there is no defined "out-of-core" hours equivalent. Requests to use PDL for training occurring on weekends are currently permitted, with time off provided elsewhere in the fortnight to ensure the RMO does not exceed the 76-hour rostered fortnight. QH needs this flexibility, as it supports fatigue management and promotes regular days off in the interests of health and safety.<br><br>4.02 and 5.07 QH is prepared to discuss use of existing entitlement of PDL subject to final agreement on all claims reached. |
| Career progression for PHOs & CMOs<br><br>National Medical Workforce Strategy 2021-31: page 41-42 | • 5.01: Career progression for PHOs & CMOs -To be discussed further<br>• 5.02: Better protections and training/education for PHOs to avoid exploitation and career non-progression. | 5.01-5.04 QH is prepared to discuss career progression for PHOs, subject to final agreement on all claims reached.<br><br>5.02 QH supports assisting PHOs in meeting their Continuing Professional Development (CPD) requirements through |

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| Improved access to leave for examination purposes<br><br>College exam reimbursement<br><br>Clarity on importance of professional development for RMOs | • 5.03: Establish framework to develop skills and capabilities (optimise scope of practice)<br>• 5.04: Pathway for doctors not on a formal training program to become CMOs to address workforce shortage (MOCA 6 claim)<br>• 5.05: Allow PHOs or those waiting for entry into a training program to progress up to Level 9 (on par with Registrars)<br>• 5.06: To be available for specialty primary/entrance examinations as well<br>• 5.07: PDL able to be taken for the purpose of studying for exams<br>• 5.08: Reimbursement of college examination fees upon successful completion, acknowledging the high financial burden and benefit to QH<br>• 5.09: Amend/clarify relevant MOCA6 clauses (7,3, 7.5) | structured feedback via their individual learning plans. It is also noted that supervision requirements for PHOs are the same as for all other employees.<br><br>5.05- 5.08 The cost implications of these claims may impact service delivery.<br><br>5.09 QH is prepared to discuss this claim, subject to final agreement on all claims reached. |
| Clinical Supervision Time | • 5.10: Ensuring high-quality clinical supervision is fundamental to developing and maintaining a highly skilled medical workforce.<br>• 5.11: Protected, rostered time for senior clinicians (SMO and registrars) to provide structured teaching, feedback, and mentorship, without compromising service delivery.<br>• 5.12: Aim to enhance training outcomes and improve safety and quality, as well as foster a culture of excellence and support | QH is concerned with the potential impact upon service delivery, however, may consider these claims depending upon the final package of agreed claims. |

| ASMOFQ | Regional, Rural and Remote Claims | QH Responses |
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| MSPP/MOPP review | • 6.01: Review and consider MSPP/MOPP terms and conditions of employment to align with SMO entitlements and achieve parity. | SMO and MPPP are different models of employment and accordingly remunerated differently. The cost implications of remunerating MPPPs as SMOs are noted. |
| FRACGP and FACRRM | • 6.02: Recognition of FRACGP and FACRRM as specialties | As per TQ claim 10.01. |

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| | | Rural Generalists: Queensland Health understands this claim relates, in part, to the anticipated national recognition of Rural Generalist medicine as a field of practice within the specialty of General Practice medicine. Queensland Health does not support amending MOCA in advance of a formal national decision, as the outcomes of the recognition process are not yet confirmed. Depending on cost implications, QH can work with unions to review relevant industrial provisions once the new registration and qualification frameworks are finalised.<br><br>General Practitioners: Queensland Health maintains that, as a provider of secondary (hospital-based) care, General Practitioners employed within Queensland Health are not operating in a primary care setting or practicing to the full scope of general practice. For these reasons, Queensland Health does not support classifying General Practitioners as staff specialists under MOCA. |
| Attraction & Retention Allowance<br><br>Rural Generalist (RG) Incentives<br><br>Staffing Models at Rural Regional & Remote locations | • 6.03: Specialist medical practitioners including specialist general practitioners should receive an A&R allowance of 50% of base salary (and Rural Generalists)<br>• 6.04: Adjustments to current RG incentives, to align with the actual location of work rather than the base appointment site<br>• 6.05: Loading for advanced skills in remote practice<br>• 6.06: Increase headcount at hospitals to address excessive workloads, fatigue and burnout as well as access to entitlements<br>• 6.07: Rural Generalists should be paid as such, at their correct level | 6.03 QH does not support General Practitioners receiving staff specialist allowances (50% A&R) under MOCA.<br><br>6.04 QH understands this claim relates to the application of the Inaccessibility Incentive Scheme, Locality Allowance, and Regional and Rural Attraction Allowance to employees who temporarily work in eligible locations for short periods (e.g. one or two days) but are based elsewhere.<br><br>Incentives are intended for employees who are employed in (i.e. based at) eligible locations—not for those undertaking short-term placements (i.e. less than two weeks) where travel and accommodation are provided.<br><br>6.05 and 6.07 QH does not support amending MOCA until it can consider the formal decision and outcomes of the national recognition of Rural Generalist medicine as a field of practice within the specialty of General Practice medicine<br><br>6.06 Not a matter for enterprise bargaining. It is noted that QH has workforce planning strategies to grow the |

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| | | clinical workforce including in rural, regional and remote locations. |
| Rural Accommodation | • 6.08: Provision of a defined standard of accommodation<br>• 6.09: Support for accommodation where not currently provided | Not Supported. Service wide design principles for staff accommodation are based on the Government Employee Housing (GEH) standards, which are used as the foundational framework for the provision and management of employee housing across Queensland. Within QH, the Staff Accommodation Program is delivered by Health Infrastructure Queensland (HIQ), in combination with individual Hospital and Health Services (HHSs). Each HHS is responsible for determining arrangement of accommodation, cleaning services, dispute resolution, and other operational matters. As these matters are managed in alignment with established statewide processes, QH does not support increasing entitlements for specific classification groups or diverging from whole-of-government provisions. |
| Relocation volumes | • 6.10: Align relocation volumes with teachers/police (e.g. 36 $m^3$ plus an additional 10 $m^3$ per dependent). | HR Policy D4 (Transfer and Appointment Expenses) already provides 36$m^3$ for RMOs, with discretion to approve additional volume in reasonable circumstances. Directive 11/11 already provides SMO's with 50$m^3$ or 8 tonnes per employee (+ up to 254 kg or 1.15 cubic metres for professional library). |
| Clarification/consistency around employment arrangements for secondment/rotation | • 6.11: For further discussion during bargaining - D4/D8 policies | QH will review HR Policies D4 and D8 in collaboration with both union parties, with the aim of clarifying and simplifying entitlements. |

| ASMOFQ | Fair Pay, Remuneration and Allowances Claims | QH Responses |
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| Wage increases and cost of living adjustment (7.01)<br><br>No disadvantage to medical officers if negotiations extend past 30 June 2025 (7.02) | • 7.01: For further discussion during bargaining<br>• 7.02: For further discussion during bargaining<br>• 7.04: Pay parity for GPs and RGs<br>• 7.05: PHOs to Level 9<br>• 7.06: For further discussion during bargaining<br>• 7.07: Extend allowance to RMOs as well as SMOs | No wages claim has been provided. Unions have been advised of the Government's Public Sector Wages Policy covering wage increase of 3% in the first year, followed by 2.5% per year in the next two years. In addition, a Consumer Price Index Uplift Adjustment (CUA) of up to 0.5% in the first year and up to 1% in each of the following two years may apply.<br>7.04 Refer to response to AMOFQ claim 6.02 |

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| Pay parity (7.04 and 7.05)<br><br>Allowances (eg PDA, VTS, inaccessibility, clinical/medical managers, on-call) (7.06)<br><br>Regional and Rural Allowance (clause 12.28.2) (7.07) | | 7.05 and 7.07 QH does not support due to cost implications which may impact service delivery.<br>7.06 QH may have further discussion with unions about the effectiveness of listed allowances. |
| Review of incentive schemes (including replacement for WAIS)<br><br>Retention: incentives for continued employment with QH | • 7.03: For further discussion during bargaining<br><br>• 7.08: Introduce incentives for SMOs and RMOs for continued service with QH<br>• 7.09: eg allow long-standing SMOs to continue progression to MO3 and MO4, introduce further levels for SMOs and RMOs to progress | 7.03 QH may have further discussion with unions about the effectiveness of existing incentive schemes.<br><br>7.08 Recognition of service and incentives for ongoing employment are already embedded within the classification structures, where progression through pay points and classification levels reflects experience and/or service.<br><br>7.09 MO3 and MO4 levels should only be obtained by demonstrating eminent or pre-eminent status through defined criteria. |
| Preservation of accrued entitlements while away (eg secondment/rotation or break) | • 7.13: For further discussion during bargaining | Continuity of service provisions are outlined in section 3.2 of HR Policy B65 (Engagement of Resident Medical Officers), which allows RMOs undertaking vocational training outside of QH to maintain their temporary engagement for up to 24 months. These provisions already support the preservation of accrued entitlements while on rotation or secondment. Additionally, where a medical officer has a break in service, clause 3 of HR Policy C55 (Recognition of previous service) applies—medical officers may request recognition of previous service for long service and sick leave purposes if the break is less than five years. |
| Granted Private Practice (GPP): Retention | • 7.14: Revision of cap and indexation | QH is of the view that this is not a matter for MOCA7. Matters relating to the indexation of the earnings cap can be raised with the Private Practice Governance Board (PPGB) or via the Director General. |

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| ASMOFQ | Miscellaneous Claims | QH Responses |
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| Public Holidays | • 8.01: Stronger protections against rostering practices that restrict public holiday entitlements | As per TQ claim 6.01 - clause 12.19 of MOCA6 adequately clarifies that rosters should not be amended to avoid or reduce an employee's access to public holiday entitlements. |
| Climate Change Mitigation and Sustainability | • 8.02: Refer to clause 15A in Victoria Health/ASMOF/AMA EA 2022-2026 | Not a matter for MOCA7. Health Protection Branch prepared Queensland Health's Climate Risk Strategy 2021-2026. |
| Special leave arrangements | • 8.03: Being called in early<br>• 8.04: Unable to leave work safely | QH has already prepared FAQ guidance documentation in relation to recent severe weather events. Advice provided is dependent upon the local situation and the medical officer's discussion with their line manager about their circumstances. It is noted that special leave provisions currently exist under QH HR Policy C7 (Special Leave) and the whole-of-Government Special leave Directive. |
| Overseas travel approvals | • 8.05: Clarity and/or simplification of approval process in situations such as when may be perceived to be representing QH | Not a matter for MOCA7. It is noted there are whole-of-Government guidelines about the processes required in relation to overseas travel in an official capacity. |
| FBT notification | • 8.06: Clarity provided to the doctor in respect of what type of fringe benefit is being provided (such as relocation assistance, housing, motor vehicle or any allowance) | This is a taxation matter. Guidance material exists and medical officers can speak with HHS Finance teams in relation to their individual circumstances. |
| | • 8.07: No reduction in existing MOCA 6 terms and conditions | QH recognises that In-Principle Agreement will represent a final agreement reached on all claims made by both parties. QH's agreement on individual union claims is subject to union agreement on critical items for Queensland Health. |
| pending submission on ASMOFQs final log of claim - QH requested 26.06.25 | • 99.01: Add a no loss of show day clause to MOCA7<br>• 99.02: Imminent Risk to Safety - A medical officer may cease, or refuse to carry out, work if they have a reasonable concern that performing the work would expose them to a serious risk to their health or safety arising from an immediate or imminent exposure to a hazard. | QH waiting to receive details of these claims formally from ASMOFQ. |

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| TQ | Claims | QH Responses |
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| Leave and PDL | • 1.01: Professional Development Leave to be available for exam study<br>• 1.02: Increase Professional Development Leave to 2 weeks for RMOs<br>• 1.03: Examination Leave to be available for entrance exams<br>• 1.04: Introduce Examiner's Leave | 1.02-1.04 These claims have large cost implications which may impact service delivery.<br><br>1.01 QH is prepared to discuss use of PDL subject to final agreement on all claims reached. |
| Defence Leave | • 1.05: Include Defence Leave in preserved entitlements schedule | Defence Leave entitlements are provided under Minister for IR Directive 12/24: Special Leave. These matters are managed at a whole-of-government level, and QH does not support duplicating these provisions within MOCA. |
| Professional Development Allowance | • 1.06: Indexation of PDA | QH does not support the indexation of SMO PDA due to cost implications, which may impact service delivery. |
| Extra Annual Leave | • 1.07: Extra 3 days leave for MM3+ for travel time and access | Annual/Recreation leave entitlements are provided for under sections 30-38 of the *Industrial Relations Act 2016 (Qld)* and Minister for IR Directive 11/24: Recreation Leave. These matters are managed at a whole-of-government level, and QH does not support increasing entitlements for specific classification groups or diverging from whole-of-government provisions. |
| Clinical Support Time | • 1.08: Mandatory training and training that is deemed essential by employer for performing job will not be deducted from PDL<br>• 2.01: Increase and better protect Clinical support time, noting AMA recommends 20% and Nurse Practitioners have 20% | 1.08 May consider depending upon the final agreement reached on all claims.<br><br>2.01 Not supported due to the cost and service delivery implications. |
| Employment Security | • 3.01: Long Term employment contracts for RMOs | Clause 1.17.1 of MOCA6 already facilitates this entitlement. Operational solutions to support broader use of the provision are being progressed by the Junior Medical Officer Employment Team via the RMO Employment Security Project. |

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| Establish Career Medical Officers Employment Arrangements | • 4.01: Employ Career Medical Officers who have general registration as a medical practitioner with minimum 6 yrs experience including 3 years as a PHO<br>• 4.02: They are to be under the supervision of an appropriate SMO<br>• 4.03: No admitting rights or similar of a SMO<br>• 4.04: Establish an appropriate pay scale for CMOs<br>• 4.05: CMOs to have access to appropriate Professional Development Leave<br>• 4.06: CMOs to have access to Professional Development Allowance<br>• 4.07: Provide CMOs with an attraction allowance and retention allowance | 4.01-4.04 May consider depending upon the final agreement reached on all claims.<br><br>4.05-4.07 Cost implications noted. |
| Wages | • 5.01: Wage increase to enable the living standards of employees to be improved. | No wages claim has been provided. Unions have been advised of Government's Public Sector Wages Policy covering wage increase of 3% in the first year, followed by 2.5% per year in the next two years. In addition, a Consumer Price Index Uplift Adjustment (CUA) of up to 0.5% in the first year and up to 1% in each of the following two years may apply. |
| Public Holidays | • 6.01: Strengthen provisions to ensure rosters are not amended to reduce or avoid public holiday entitlements<br>• 6.02: Staff rostered on public holidays + public holiday standby should be the same as the number normally rostered on the day if it was not a public holiday<br>• 6.03: Allocation of paid holiday stand down shall be done fairly and equitably and subject to audit on request | 6.01 aligns with ASMOFQ claim 8.01 - clause 12.19 of MOCA6 adequately clarifies that rosters should not be amended to avoid or reduce an employee's access to public holiday entitlements (noting that SMOs who accrue 5 weeks of annual leave per year do so because they are expected to work on public holidays).<br><br>6.02 While QH supports the principle that rosters are not amended for the purpose of avoiding or reducing employees' access to public holiday entitlements, rosters are required to meet clinical operational need. Where service demand is reduced, it is reasonable for staffing levels to reflect that reduction. Conversely, increased service demand requires a higher staffing presence. |

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| | | 6.03 Not supported as 'public holiday stand down' is not an award or agreement entitlement. QH supports fair and equitable rostering practices based on operational need. Where medical officers have concerns about favoritism or inequity, local audit and grievance resolution processes may be utilised. |
| Hours of Work and Rostering | • 6.04: Roster changes for emergent reasons to require consultation with employee<br>• 6.05: Where less than 2 weeks' notice has been provided for a roster change, the aspect of the roster that is changed is to be paid at overtime rates, excluding changes initiated by the employee<br>• 6.07: Unless requested by an employee, annual leave and long service leave is not to be rostered to commence on the day on which night shift finishes or on call finishes<br>• 6.08: Improve night shift loadings for RMOs<br>• 6.10: If 10 hr break not provided for SMOs a loading of 25% of base rate is to be paid until a 10 hr break. | 6.04 – MOCA6 clause 12.2 specifies that roster changes require consultation. May consider suggested wording changes depending upon final agreement reached on all claims.<br>6.05 aligns with ASMOFQ claim 3.03 – MOCA6 clauses 12.2 and 12.11 specify that rosters should be provided four weeks in advance, and at a minimum two weeks in advance. However, changes to published rosters may be necessary in emergent situations—such as unplanned sick leave—to ensure service delivery and maintain patient safety. QH does not support penalties for reasonable amendments made to address emergent issues.<br>6.07 May consider depending upon the final agreement reached on all claims.<br>6.08 and 6.10 - QH cannot support the cost implications, which may be at the expense of service delivery. |
| Meal Breaks | • 6.06: Meal breaks to be paid | Not supported. MOCA6 clause 12.12 already provides that medical officers are entitled to overtime rates when required to work through their lunch break. |
| Reasonable Overtime | • 6.09: Provide issues to be considered to determine if overtime is reasonable | Section 26 of the *Industrial Relations Act 2016* addresses overtime as well as the Department of Health's Overtime Policy (HR Policy C60). QH does not support duplicating these provisions within MOCA. |

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| Overtime for RMOs | • 6.11: For RMO add to clause 12.14.4 completion of required paperwork which cannot be left to the following shift | MOCA6 Clause 12.14.4 already facilitates overtime without prior approval for activities related to clinical handover. |
| On Call | • 7.01: Ensure employees are not on call for excessive periods of time<br>• 7.02: Provide compensation for phone calls occurring during on call periods | 7.01 On-call rosters are managed locally, with the expectation that on-call responsibilities are shared equitably among available employees. QH does not support introducing an arbitrary cap on on-call shifts, as rostering requirements vary significantly across specialties and locations. A cap would not account for the diversity of service models or adequately address fatigue risks, which are more directly influenced by factors such as the frequency of sleep interruptions rather than the number of on-call shifts alone.<br><br>7.02 MOCA already compensates medical officers for being on call and receiving phone calls via the on-call allowance. More significant work undertaken while on call but not recalled to the workplace is compensated by digital recall. QH may consider wording changes to the definition of digital recall, depending upon the final agreement reached on all claims. |
| Rural and Regional | • 8.01: Increase Rural Generalist attraction and retention allowance<br>• 8.02: Increase Inaccessibility Allowance by 25% and index increases for future | Not supported due to the cost implications which may impact service delivery. |
| Principal House Officer | • 9.01: Will be entitled to the same supervision and education entitlements as per the accreditation requirements of the relevant specialty college for a first-year registrar | As per ASMOFQ claim 5.02 - The educational framework and structured term assessments in place for RMOs on accredited training pathways do not currently exist for PHOs and cannot be replicated in the same way. QH also supports assisting PHOs in meeting their Continuing Professional Development (CPD) requirements through structured feedback via their individual learning plans. It is also noted that supervision requirements for PHOs are the same as for all other employees. |

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| Specialty recognition | • 10.01: FRACGP and FACRRM to be recognised as specialist | Rural Generalists: Queensland Health understands this claim relates, in part, to the anticipated national recognition of Rural Generalist medicine as a field of practice within the specialty of General Practice medicine. Queensland Health does not support amending MOCA in advance of a formal national decision, as the outcomes of the recognition process are not yet confirmed. Depending on cost issues, QH can work with unions to review relevant industrial provisions once the new registration and qualification frameworks are finalised.<br><br>General Practitioners: Queensland Health maintains that, as a provider of secondary (hospital-based) care, General Practitioners employed within Queensland Health are not operating in a primary care setting or practising to the full scope of general practice. For these reasons, Queensland Health does not support classifying General Practitioners as staff specialists under MOCA. |
| No loss of entitlements | • 11.01: There shall be no diminution of conditions including but not limited to conditions that are in an industrial instrument or a Health Employment Directive | QH recognises that In-Principle Agreement will represent a final agreement reached on all claims made by both parties. QH's agreement on individual union claims is subject to union agreement on critical items for Queensland Health. |
| Pending submission on TQs final log of claim - QH requested 26.06.25 | • 99.01: Add HR Policy D9 to Schedule 3 protected policies.<br>• 99.02: Define 'Evening shift' in MOCA<br>• 99.03: Clarification that enrolment in another Fellowship Is Not Required for Senior Registrar Classification<br>• 99.04: Progression from Registrar to Senior Registrar | 99.01 In line with Queensland Health's common clauses claim, QH is seeking to remove HR policy protections from all certified agreements and does not support introducing additional HR policies.<br><br>99.02 QH MOCA7 Bargaining Agenda seeks to remove reference to 'evening shift' in clause 5.8.3 of MOCA6 as the term not defined which creates confusion. For further discussion between the parties.<br><br>99.03 and 99.04 QH waiting to receive these claims formally from TQ. However, clause 12.1 of the Medical Officers' Award and clause 2.6.3 of MOCA6 define a senior registrar as a medical practitioner with specialist registration who is appointed as such. Clause 2.10 of MOCA6 also allows a registrar to be paid at the senior registrar rate while |

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| | | undertaking accredited training towards another fellowship. QH does not consider these provisions to be unclear or regularly misinterpreted and does not support amending either clause. |

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