VMP EB 2024 LOG OF CLAIMS

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BETTER RECOGNITION BY THE AGENCY OF THE VALUE OF SERVICE PROVIDED BY VMO'S
PAY INCREMENTS ON-CALL AND CALL-BACKS

1. **Pay Increases in line with SMP Agreement** to ensure value of VMP does not decline over the period of the agreement.
   Annual Salary and Hourly Rate to be based as a percentage of the new SMP agreement with indexation in line with SMP. First increment to be backdated to July 1st, 2023, irrespective of date the new agreement is signed.

2. **New senior classification structures -** The collapsing of VMO/ VMS levels would act as an incentive to keep younger people in the system, noting we are competing against QLD which has collapsed their structure for Rural Generalist doctors.

3. **Cost of Living / Retention Payment of $1000** flat rate increase to the base salary with effect from ffppcooa 1 July 2023 paid at full rate despite fractional hours.

4. **Non-Clinical time:** VMO's perform some duties outside of clinical duties for which they are not paid. The principle of being paid for the work performed is fundamental whether that be for administrative duties, teaching, or supervising duties or for ward rounds when not on call. We need to find a way to ensure VMOs are paid for all work performed.

5. **On call allowances** to be automatically given CPI increments whenever there is a change in CPI applied to the agreement.

6. **Differential On call Allowance:** consideration be given to providing a higher on-call allowance for those with onerous on-call requirements and/ or statewide on call requirements this could be as a higher allowance or higher hourly rate.

7. **2nd on-call** for rural hospitals to supervise registrars. – on-call allowance, remote on-call and electronic recall and physical recall

8. **Remote on call/ Disturbance allowance:** Inclusion of hours providing telephone advice as fully paid call-back hours to reflect increases in responsibility, risk and accountability in providing such advice. NB: wording of the SMP Disturbance Allowance:

> **14 DISTURBANCE ALLOWANCE WHEN ON CALL**
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> 14.1 Medical Practitioners covered by this agreement who are required, by telephone call or other electronic communications, to undertake duties without returning to the workplace will be entitled to payment at the base salary rate for a minimum period of one hour.
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> 14.2 Any further requirement to undertake duties without returning to work that occurs within one hour of the commencement of the first requirement in accordance with sub-cl 14.1 of this clause, for which a minimum payment is to be made, does not attract any additional payment until the time actually worked exceeds one hour.
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> 14.3 Provided that payment beyond the minimum period of one hour is to be calculated on the cumulative hours worked and be rounded up to the nearest half an hour.
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> 14.4 Provided further that 'duties' under this Clause means that action must be taken by the Medical Practitioner such as providing advice.

9. **Increase permanent appointments** and remove the requirement that all VMP positions are Fixed-term contracts, with a minimum engagement of five years.

10. **Continuing Professional Development allowance** paid pro-rata based on the SMP Allowance.

11. **Management Allowance**

To be eligible for payment of this allowance, the additional management responsibilities will include direct line responsibility for a unit department, a division or area/ statewide service and involvement in a number of, but not necessarily all, of the following:

(i) Participation in planning and policy development,
(ii) Responsibility for the co-ordination of research, training, or teaching programs,
(iii) Membership and participation in senior executive management teams.
(iv) Human resource management responsibilities
(v) Quality improvement and clinical governance activities

This Allowance will commence at 5% going up to maximum of 30%. Based on local negotiations and applied to rural facilities/district hospitals.

This Allowance is not payable for any periods of leave that are without pay.

This Allowance does not apply for the calculation of any other entitlements.

VMPs can be appointed to management positions.

REWORDING OF WORK AGREEMENTS WITH SUFFICIENT HOURS THAT REFLECT THE TIME REQUIRED TO ATTEND TO INCREASING THS BUREAUCRACY AND INCLUSION OF THE BUREAUCRATIC TASKS IN THE AGREEMENTS

12. New VMP Hours of Work Clause that in addition to the work required takes into account the following requirements;
    I. Direct Public Patient Care and Related Activities
    II. Management/Administrative Responsibilities
    III. THS meetings
    IV. Participation in Quality Assurance Activities as required by the THS
    V. Teaching and research as required by the THS and not directly funded by the University
    VI. Practice in a Distant Location (where an allowance is not being paid)
    VII. Requirements to undertake Employer-directed mandatory education

    The clause must allow for 25% non-clinical time, to comply with increasing Employer mandated bureaucracy and accreditation requirements.

13. **Fatigue Payment:**
    VMPs who have a significant component of on-call work may be on call for the night with the THS but then expected to participate in private practice work the following day. As such, there must be a mechanism for compensation from the THS and incentive for the practitioner to prevent working through fatigue the following day if the on-call shift has resulted in less than adequate rest between shifts.

    - If a VMP has less than an eight-hour continuous break between the end of their previous day's work at 6pm and commencement of work in private (specialist or general) practice the following morning at 8am, because of a recall to the hospital or disturbance, a fatigue payment will be paid by the THS to the VMO.
    - This payment will be $1,040 for a half day to establish a minimum 4-hour break, and $1,560 for a full day, as required, to establish the eight-hour break.

RURAL RETENTION OF VISITING SPECIALISTS' NORTH WEST REGION – TWO SEPARATE ALLOWANCES TO ALSO INCLUDE DISTRICT HOSPITALS

14. We want a commitment by THS to invest in local specialists and minimise use of locums in the North West. Recognising the ongoing recruitment and retention difficulties in the North West as well as for visiting doctors in rural facilities, we want VMP contracts to align better with staff specialist contracts in the North West. Therefore, we want to remove the legacy North West allowance and apply the following allowance to all VMPs in the North West as well as Rural Facilities with public beds.

    I. Replace with 55% (35% legacy allowance (in lieu of PPS) plus NW retention allowance 20%) for NW and Rural Facilities with public beds

And, introduce a new allowance for the LGH, which is also struggling to recruit VMPs.

    II. 20% Retention Allowance for LGH – private practice for VMPs

INCORPORATING RURAL MEDICAL PRACTITIONERS IN DISTRICT HOSPITALS INTO THE VMP AGREEMENT

Rural medical practitioners in district hospitals will move across from the Rural Medical Practitioner Agreement (which is to be retired) to the Visiting Medical Practitioner Agreement.

Principles:

- Rural doctors in Tasmania need and deserve an agreement that fairly and appropriately remunerates doctors in rural facilities for the integral part they play within the Tasmanian health service, including direct patient care, afterhours service, administrative work, training and quality control.

- Rurally based career paths are recognised and valued

- The ability to work across hospital and general practice facilities to provide coordinated care is supported

- The viability of existing rural general practice is enhanced

- Clinical leadership capability is recognised, enhanced, encouraged, and supported

- That agreement needs to have capacity for recognition of the different recruitment landscape that exists in rural sites (importantly, this needs to include a framework for remuneration for emergency medical cover in lieu of THS recruited locums).

- Acknowledging the many differences in the structure that rural medical practitioners must work with in district hospitals compared with the four larger hospitals in Tasmania, there are several inclusions that should be written into the agreement to apply to the district hospital medical VMOs.

Rural Visiting Medical Practitioners:

15. Inclusion of a "Daily Rate" option for VMPs in rural facilities to facilitate remuneration for short term and urgent cover.
    - The VMO would be paid the daily rate instead of their regular hours and call backs.
    - The daily rate should be the equivalent of the agreed number of daily regular hours for that day plus two "call backs".
    - The daily rate option should be only available for short term periods to provide urgent cover when required (regular rural hospital VMOs should be remunerated under the usual VMO payment arrangement).

16. **Rural hospital hours of work**
    - The "facility hours" in the previous Rural Medical Practitioners be replaced by a system of agreed "regular hours" depending on the workload required in each facility, with VMPs paid based on the hours worked.

- Regular hours would include ward rounds, compulsory training, weekly meetings and administrative work required on and off the ward
    i. For rural hospitals the number of regular hours each require will be different for each facility. The calculation of "Regular Hours" for district hospital medical staff should be based on an 80% occupancy for the facility
        1. Calculation could be based on a similar method to calculating the previous "facility hours" + clinical documentation/training hours
        2. Regular hours would then be divided between VMPs each day as required, depending on local needs and systems.
    ii. Extra hours are paid for any planned hours of work that are clinically necessary outside of the "regular hours" (e.g. a planned review for a patient who requires twice daily medical reviews, or unexpectedly extended requirement for clinical work beyond the regular hours)
- Calls backs to apply to when employer calls back the doctor for an inpatient, outpatient or emergency patient requiring face-to-face consultation **OR** where a VMP recognises a clinical need for an <u>unplanned</u> urgent review and attends without being called in (e.g. receipt of urgent blood results not yet seen or recognised by nursing staff and requiring immediate attendance).
    i. This is an important clarification. In rural hospitals there are not generally any medical staff on site, so urgent patient deterioration or the need for an urgent review may be identified by the VMO from afar and there is a clear need to allow for remuneration for urgent reviews that are clinically necessary but may not be noted by nursing staff on the ward.

17. **Sign on payment** – in preference to a HECS fee reduction
    - If a GP VMP signs a contract and actively participates in the hospital medical roster the following is payable:
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	At contract commencement	At completion of 12 months and re-signing of contract
MMM 3	$10,000	$5,000
MMM 4	$20,000	$10,000
MMM 5	$30,000	$15,000
MMM 6	$40,000	$20,000
MMM 7	$50,000	$25,000

    - Notes:
        i. IF doctor withdraws from service within 6 months of initial contract being signed, 100% of retention payment is to be re-paid to THS.
        ii. *IF doctor withdraws from service within 6-9 months of initial contract being signed, 50% of payment is to be re-paid to THS.*