Keep Our Doctors Contract Guide – Senior Medical Officers

About this guide

This is a guide for members to assist in contract negotiation and to support collective activity in their HHS or department. It contains general industrial advice only. It does not contain nor take the place of individual legal advice in respect of a specific individual's contract of employment.

Individual preparation and actions

- Read the guide in full
- Read your contract and all schedules
- Review the previous remuneration guide from QH and your payslips and PAYG payment summaries.
- Identify any errors in the schedules that do not reflect your current work practices; pay etc and raise these with the local HHS contracts implementation team.
- If you wish to meet with management about your contract take one of your colleagues or a union delegate as a support person.
- Consider the duties listed in the contract; the KPI's being proposed and the proposed roster including for on call.
- Seek further information from the QH contracts website
- Ask questions or clarify industrial issues with your union: Together: health@together.org.au or 1800 177 244 or ASMOF: smocontracts@asmof.org.au or 1300 362 193.

Collective Preparation and Actions

- Talk to your colleagues and arrange a meeting within your hospital, HHS or craft group and ask these doctors to provide a summary of their concerns so that an industrial officer can review them with you. Contact your union office to coordinate attendance at the meeting to provide advice and support.
- With your colleagues and your industrial officer formulate a "claim" document that sets out what you are seeking to change about the contract schedules, implementation or local operational policies of your service or the HHS and plans to pursue them.
- If you do not already have a union delegate in your area or craft group, then elect one at the meeting.

- Seek a meeting (as a group) with the EDMS, CEO or person responsible for negotiating contracts.

Our advice is to wherever possible negotiate as a group. This will assist in setting a standard and maintaining the best possible outcomes for all members.

When you sign the contract you should also initial any changes or additions you have made to the contract and flag them for countersigning by the employer. You should also cross out any blank spaces, blank items or blank pages. Once you have signed the contract make a copy. When you receive a copy of the countersigned contract – make copies and keep in a safe place.

Contract Advice

Core Contract

The core contract is set by a "Health Employment Directive" and can only be negotiated or changed where the contract itself specifies that it can be. Further these changes only apply if they are not inconsistent with the HED and *Health and Hospital Boards Act*.

Provisions that allow negotiation or amendment will be brought to your attention below.

Preamble – this section is a 'warm and fuzzy" provision which sets out the context of the agreement and introduces the agreement itself.

It was added by Queensland Health to try and stem the anger of doctors about the insulting wording of the contract. Preambles are generally not considered to be part of the contract terms and therefore are typically not enforceable as terms of the contract.

However, the preamble can be used to interpret the contract and may be useful for providing context and assisting with dispute resolution.

1. ***Background***
   This sets out that contract must be entered into by the Health Service Chief Executive for an HHS employee or the Director-General of the Department of health for Department of Health employees. Check that this is the case in schedule 1 item 1.

2. ***Appointment***
   This specifies that you are employed in the position set out in schedule 2 item 6 and the employer is set out in schedule 2 part 4. This should be either the Department of Health or the HHS. It also sets out the continuity of your service and transfer of your entitlements.

3. ***Contract term*** **-** Includes that the Contract may be varied by written agreement between the parties. The HED states that any variation to an existing contract of employment must be consistent with the *Health and Hospital Boards Act* and the HED including its attachments.

4. **Relationship with other conditions**

This section sets out the other sources of rights and entitlements for an SMO.

The Queensland Employment Standards are contained in the *Industrial Relations Act 1999* and include minimum standards such as the minimum wage, annual leave, personal leave (sick, carer's, bereavement, cultural leave), parental leave, long service leave, jury service leave, public holidays, notice of termination and redundancy. These are minimum entitlements and the current more beneficial entitlements provided by Queensland Health in the instruments listed below will continue to apply (unless changed or removed by the Government).

If the QES and the contract have different entitlements, then the provision which is more favourable to the medical officer will apply.

Terms and conditions of employment and entitlements may also be found in the HHB Act; the Applied Public Service Law (the various legislation, directives and rulings); Health Employment Directives; and Policies of the Service and the Department. This is where currently the more beneficial long service leave, annual leave and redundancy entitlements are found.

The HED states the contract can't validly contain a higher amount of an entitlement than is set out in the Terms and Conditions document. So, for example the employer can't contract to give you additional annual leave or a higher on call rate. If they do then the lower amount in the Terms & Conditions document is considered to be what is actually in the contract.

Further, if an additional benefit not contemplated in the T&C document at all is offered in the contract, then it is as if it has not been included, and does not form part of the contract.

This means that any "special deal" or inducement that the employer makes to you will only have effect if it fits into the T&C document which is Attachment 2 to the HED. Check this carefully if the employer is offering you an incentive or additional entitlement or seek specific advice from your union office.

If there are other benefits provide by the HHS locally through policy, these cannot be included in the contract. Let your union know about these arrangements so we can seek for these to be confirmed in writing or authorised by the D-G to be included in the contract.

Other written commitments may be given by HHS CEOs.

5. ***Location*** - Schedule 2 item 5 sets your initial location. Ensure that this is accurate and specific. The specific consultation and reasonable refusal processes set out in this clause apply to being relocated outside this location. However within the specified location, these processes may not apply.

6. ***Medical Officer responsibilities and functions*** are set out in clause 6. This includes to perform the Duties of the role as prescribed in Schedule 1 of this Contract and any other duties for which they are registered in the State that are within the Medical Officer's skills,

qualifications and competencies as reasonably required by the Service from time to time. Check the duties in **Schedule 1** carefully and ensure that they accurately reflect the duties you currently do, or are reasonable to your role and classification level, and that you agree to perform them. These duties may be negotiated with the HHS and most usually directly with your supervisor.

Other duties include "engaging in and/or facilitating the ongoing teaching and training of both medical and non-medical staff". It may be useful to raise this when discussing Clinical Support Time (see below).

The contract provides that the Medical Officer is subject to the reasonable directions of the Service, and that the Service respects the Medical Officer's professional ability to exercise clinical autonomy within their scope of practice. This is an ongoing area which will require monitoring and vigilance by members. If your craft group or hospital has a strong network of active members then this can mitigate the risks of inappropriate management intervention in clinical decision making and allow continuing campaigning for patient safety and patient rights.

There is a paragraph about secondary appointments, which is assumed to refer to more than one appointment with the same HHS. It is assumed that appointments at multiple HHS would require separate contracts. Members should seek specific advice about secondary appointments or multiple contracts from your union.

9. *Grievance/ Dispute Resolution*

The contract provides that the method of dispute resolution (e.g., mediation or binding arbitration or a combination) will be at the choice of the medical officer, that the employer must agree to this process and the outcome will be binding. There will be opportunities and pitfalls to navigating this process and your union office will provide further general advice about the process in due course. Any member who is involved in a dispute with management about an industrial issue or their contract can seek advice from your union by calling 1800 177 244. If a member is considering formal dispute resolution processes under the contra tot is strongly recommended that the member contact your union office for advice and assistance before lodging a formal grievance or dispute or electing a dispute resolution mechanism.

Attachment 4 to the HED to the Contract contains the Dispute Resolution provisions as negotiated.

10. *Remuneration*

The Medical Officer's Total Remuneration Framework, including Base Salary, is set out in Schedule 2. It is very important that you understand and agree to the remuneration amounts set out in Schedule 2 and understand and accept the calculations. The T&C document and the "Total remuneration framework conditions" document are attachments to the HED and provide more information.

(a) Base Salary – this should be annual amount listed in both the T&C document (appendix 1, page 14) and Schedule 1 of MOCA3 commensurate with your level, which is also set out in item 8 of Schedule 2.

(b) Tier 1 is made up of motor vehicle and professional development allowance and should be the sum of the vehicle allowance as set out in the QH policy and the Remuneration Framework for your classification level and fulltime or part time status and the PD allowance. For full time employees this should be either $41,000.00 or $45,500.00 depending on classification level. The part-time amounts are $10,200 or $11,800 based on classification level and paid pro rata.

The provision of a vehicle allowance to a part-time employee is discretionary and is less likely to have been paid in the past to Medical Officers on a fraction of less than 0.5FTE. If you currently receive an allowance the contract should include the appropriate amount. If you do not receive it the employer has the discretion to pay the allowance even if you are below an 0.5FTE. The level of on-call and out-of-hours responsibilities, nature of service provided and geographic area covered by the service are also relevant.

(c) Tier 2 provides an annualised amount to compensate for on call and standby on call as well as overtime (if agreed).

Tier 2S provides annualised compensation for working non-standard hours within contracted hours (e.g., extended hours, weekends, public holidays). These are not paid while on leave but QH have advised that the rate/multiplier has been calculated to compensate for this so overall there is no disadvantage.

Hours in excess of Core Hours (overtime) will be paid on an exception basis or as an additional component of an annualised salary (in tier 2), where agreed and recorded in Schedule 2. Recall will be paid on an exception basis.

These amounts are based on a projected roster to be discussed with your supervisor. It is important that this roster is one that you agree to and is fair and reasonable and that it matches up with the Tier2 payments in the contract. If possible it should be agreed in writing or even attached to the final contract so that it can be relied upon later.

The contract states that "*where there is an on-going and significant change to work patterns, Tier 2 benefits will be reviewed and changed to accord with the changed work patterns*".

(d) Tier 3 is 25% of base for both existing "Option A" and "Option B" doctors. This amount will be guaranteed until 30 June 2016, whilst key performance indicators (KPIs) are refined, reviewed and systems to measure the KPIs are established. Agreed KPIs for financial year 2015/16 will be measured and outcomes may impact remuneration for the 2016/17 financial year.

For current "Option A" Doctors this is a translation of approximately half of Option A, and (subject to performance reviews) "continued payment of this benefit will be maintained during the course of employment within Queensland Health" including when accepting a new position in a different HHS. ***Item 11, Schedule 2 should record the term of the tier 3 agreement as perpetual.***

For current "Option B" Doctors this is an additional payment that will compensate for some of the decrease in retention model income due to proposed facility fee increases.

This payment can be reviewed and adjusted by agreement. Keep Our Doctors suggests that a perpetual term be sought. Further advice for "Option B" doctors can be sought from your union office.

(e) Tier 4 includes compensation for recruitment, attraction, retention for geographic or speciality issues.

Existing area loadings to Option A rural and remote and inaccessibility incentive scheme payments and location allowance should be translated into the various parts of tier 4A. The terms recorded in Schedule 2, item 12 should read perpetual however continued payment of these benefits during the course of employment will be subject to an eligibility test (e.g. Does the SMO still work in a locality that they should receive an allowance?). ***If the employer does not agree to this being perpetual, then consider requesting it read perpetual subject to eligibility requirements***, and seek further advice from your union office.

All existing SMOs receiving the clinical manager allowance (CMA) or medical manager allowance (MMA) as at 3 August 2014 will continue to receive their existing allowance. Continued payment of management and leadership incentive benefits for translating SMOs will be subject to ongoing eligibility during the course of employment. If you believe you should be receiving the allowance then seek it to be included according to the criteria contained in the Remuneration Framework.

The speciality recruitment incentive is available to the service to attract new specialists or retain existing specialist staff that are critical to or enhance the capability of the service to deliver its service requirements to the community.

For existing SMOs translating to individual employment contracts, it is expected that use of this tier will not extend beyond those currently receiving the ED25% incentive other than in exceptional circumstances.

Translating SMOs in receipt of the ED25% will continue to receive the ED25% for the course of employment within Queensland Health provided that they continue to meet the criteria

to receive the ED25%.

Pathologists are an example of a group of doctors who will be significantly disadvantaged financially by the introduction of contracts. Your union office is working with Pathology members to seek compensation for this disadvantage in this tier.

The remaining portion of the Option A allowance will translate to Tier 4d for existing doctors. ***The term for this tier 4d agreement should be recorded as perpetual.***

Where a term is set for a Tier 4 benefit, it will not be amended during the term, except by written agreement between the parties.

Senior Medical Officer's employed as such after 4 August will not be automatically entitled to many of these tier 4 components and in particular the 25% in 4d. It will be at the discretion of the employer. Your union encourages members to clearly convey to management the depth and strength of their views about the operation of this discretion in the future and the potential effects on patients and the health system of a reduction in remuneration to future doctors. Union members may also seek to convey these views in writing to the HHS CEO or D-G.

This is an ongoing area which will require monitoring and vigilance by members. If your craft group or hospital has a strong network of active members then it is more likely that you will be able to successfully influence the decision maker to provide these allowances and maintain reasonable wages and working conditions to future senior doctors and preserve the quality of our medial workforce.

11. Superannuation

The contract provides for superannuation to be paid as required by the QSuper deed. There is a QH factsheet which provides advice on the superannuable components of the remuneration framework: Super factsheet.

14. Hours of work

This sets out that there are core hours (80 per week or less part time) but work may be rostered and required outside of these hours, including to work shift work. The maximum rostered hours of duty for a Medical Officer is 12 hours 30 minutes. Hours of work, whether worked or on call, will be monitored and managed in accordance with the fatigue provisions of this Contract. The consultation and right of refusal provisions for shift work are set out in this clause.

It is recommended that as well as core hours, roster patterns, agreed on call and other hours of work arrangements are recorded in item 15 of Schedule 2, or otherwise agreed in writing and preferably attached to the signed contract.

15. *Part time work*

Hours of work should be carefully recorded in item 15 Schedule 2 including the pattern of days or hours of work. Overtime applies to hours in addition to core hours, but core hours can be increased by agreement.

During negotiations with the Director-General of Health a commitment was made to allow SMOs with small fractions, who may be more appropriately employed as VMOs to be employed under a VMO contract. This appears to have now been arbitrarily limited to "one day a week SMOs" or those on a 0.2 FTE fraction. Members are reporting that HHSs are now actively refusing to honour this commitment from the D-G. Similarly SMOs are being prevented from reducing their fractional appointments or going part time.

If your craft group or hospital has a strong network of active members then you will be better able to influence this local decision.

18. *Fatigue-related matters*

The Service is required to have an open and transparent fatigue management strategy in place for Medical Officers. Keep Our Doctors advises you to seek a copy of the policy and discuss with your fellow members. If the local policy is not open, transparent or adequate to ensure adequate patient care and provide a safe workplace, your union office can assist members to take action in their workplace to improve the policy.

21. *Review of performance*

This clause sets out the tier 3 performance arrangements and progression arrangements.

Payments under Tier 3 will be guaranteed until 30 June 2016, whilst key performance indicators (KPIs) are refined, reviewed and systems to measure the KPIs are established. Agreed KPIs for financial year 2015/16 will be measured and outcomes may impact remuneration for the 2016/17 financial year.

Given the contractual provision above Keep Our Doctors office advises members to seek to remove the KPIs from the contract at this stage (or cross them out), on the basis that they are not complete and require review and refinement and the development of measurement systems. KPIs can only be changed by mutual agreement, so the employer may insist on any incomplete and unrefined KPIs agreed now, remaining in place indefinitely. If the employer refuses this request, then members may consider collective or industrial action to influence the decision maker. Please contact your union office for advice and assistance.

Incremental progression will occur as per the structure in the T&C document. All progression must be accompanied by a satisfactory annual review, however, where the Service does not

conduct the review and there are no documented performance concerns, progression will occur.

22. *Policies and procedures*

The contract requires the medical officer to comply with policies and procedures, which can be changed by the employer. The Service will give the Medical Officer notice of the changes and the Medical Officer will be required to follow the changed policies and procedures. This is an ongoing area which will require monitoring and vigilance by members. If your craft group or hospital has a strong network of active members then you will be able to influence the policy makers in the interests of your patients and your own working conditions.

23. *Privacy*

This clause is not a major departure from the current responsibilities of medical officers. However during negotiations it has come to your unions' attention that the practices in various HHS may not be strictly in accordance with legislative requirements in regards to privacy and in particular electronic transmission of information, and this creates risk for the Queensland Health and our members. Keep Our Doctors recommends that members seek for the HHS to develop clear policies and procedures in regards to these obligation and provide appropriate training to doctors.

24. *Confidential Information and Intellectual Property*

Subsection (5) - This clause limits the employer's ownership of intellectual property (IP) to that which is produced, invented or conceived by them *in the course of their employment* or *in connection with the Medical Officer's Duties* ***performed for the Service***. This union office understands this to mean that the employer is only likely to be able to claim ownership of intellectual property produced outside of work and work time where part of your duties for the employer are related to invention, research or production of IP. If this is the case then you make wish to seek individual legal advice about IP rights.

Subsection 6 provides that where the employer is undertaking or involved in research activities participated in by the medical officer, any IP produced by the Medical Officer in the course of those activities is owned by the employer unless there is a prior written agreement. This clause applies whether or not the activities are funded by the Service and/or grants obtained by the Service or a third party.

If there are existing research activities being undertaken or likely to be undertaken at the time of signing the contract, for which the medical office wishes to IP rights it is highly advisable for members to seek legal advice and seek written agreement to retain rights in regards to these activities.

In the future, where a medical officer is contemplating research activities in which they are seeking to retain IP rights it is highly advisable to seek legal advice and written agreement from the employer in relation to these rights. If there are common arrangements for research in particular disciplines please advise the union office so we can investigate the possibility of the preparation of template forms or advice.

25. Termination of employment

There are a variety of notice periods that apply to termination of your employment by you or the employer. For medical officers with at least five years' continuous service you may elect - six months' notice in writing, or three months' notice in writing. Make sure you make this choice in Item 18 of Schedule 2. Remember that this is reciprocal, so a shorter notice period for you also means less notice or payment on termination by the employer.

By written agreement between the parties, the notice period may be reduced. This can be negotiated at the time of signing or at another time in the future.

26. Consent to deduction from termination pay

The contract provides that the employer can deduct money owing to them from your termination pay. This is very similar to the rights they have now in QH policy and the *Industrial Relations Act*. The union office advises all doctors with outstanding overpayments to initiate (or in many cases – follow up once again) on any identified overpayment and seek to have it resolved as it is much more difficult to reclaim it during a termination process. Union members can contact your union office for assistance with overpayment disputes.

27. Indemnity

The contract provides that indemnity is provided as per QH policy. This policy is set by the Department and not by the individual HHS but can be amended from time to time. This is the same as currently. If the policy is changed to the detriment of doctors or interpreted inappropriately by an HHS, then doctors will need to take action at a state-wide or local level to influence this decision. If your craft group or hospital has a strong network of active members then you will be better able to influence the policy makers.

There has also been legislative change that provides increased legal indemnity to public employees more broadly and this protection extends to public service, ambulance service and health service employees within the Department of Health and to health service employees engaged in or by a Hospital and Health Service (HHS).

28. Clinical support time

In the contract your employer acknowledges medical education, teaching, training and research are part of its core business and that, as part of Core Hours, a Medical Officer may have access to clinical support time in accordance with operational requirements, *at the discretion of the Service*. **Specific provisions for clinical support time may be included in Schedule 1.**

The Director-General of Health agreed in negotiations that while CST decisions rest with the HHS, he would write to each CEO and require them to consider CST and to document this depending on the current activities of the doctor. He went on to say that he expected that doctors would receive, in Schedule 2 of their contract, their existing CST entitlement, except where they were not currently utilising their notional allocation for CST tasks.

The best chance of strong CST outcomes across your HHS or agency is collective negotiation and action. ● Talk to your colleagues about their CST time negotiation. ● Arrange a meeting of union members within your hospital, HHS or craft group. ● If you do not already have a union delegate in your area or craft group, then elect one at the meeting. ● Put a joint claim to management about CST team, with assistance from your union office. ●Consider what action you are prepared to take if your claim is not met.

***30*. Private practice**

Private practice arrangements are detailed in Schedule 3. (This is not the case for MSPP/MOPP).

The department has suggested that not signing this page is not signing the contract.

The contract further states that except where clinical priorities require otherwise, if there is a potential conflict between the Medical Officer's public practice duties and their private practice commitments, the Medical Officer must first comply with their public practice duties. This clause may be useful in discussion with the HHS bureaucracy around competing priorities.

32. Amendments

Any variation to this Contract may only be made by written agreement between the parties to this Contract.

33. Entire agreement

This clause provides that it is only the contract document itself that forms the contract and that other statements, representation or promise made in any negotiation or discussion ***have no effect*** except if it is expressly set out or incorporated by reference in this Contract.

This means that any “special deal”, inducement or local arrangement that the employer makes to you will only be enforceable if it is written in or referred to in the contract itself. Be

wary of promises that are not referenced in the contract and seek advice from your union office.

35. Notices

Formal notices and other communication under the terms of this contract must be in writing and send to the address specified in items 16 and 17 of Schedule 2 or as notified from time to time.

If you want to receive formal notices to a postal address only for example then make sure that this is the only address recorded at item 17. Similarly if you want to receive notices by email, then ensure this is recorded.

Note the terms specifying when a notice is deemed to have been received.

Schedule 1

This schedule sets out the duties of the medical officer. It begins with a list of requirements that include the following:

- Implement and support clinical models of care and patient safety initiatives as required
- Supporting alternative revenue sources and maximise funding for the delivery of service (where appropriate);

  Doctors have an important role in advocating for their patients, quality healthcare and safe and appropriate models of care. There may be occasions where in the doctor's opinion their ethics comes into conflict with this duty, however the interaction between professional ethics and contractual obligations is complex. If your craft group or hospital has a strong network of active union members then you will be better able to influence models of care, and less likely to be placed in a situation, as an individual, where you are compromised industrially or ethically. Union members are committed to an ongoing campaign for quality health policy in Queensland.

- Access clinical support time (where appropriate).

  This duty may help you to negotiate CST allocation in your contract. If you have duties to undertake clinical support activities, training etc then it follows that accessing clinical support time is appropriate and therefore is also part of your duties.

  Conversely, if any of your KPI's or duty statements refer to clinical support activities and you have not been allocated sufficient CST then

  If you are forced to sign a contract where your CST is unreasonable with respect to duties and KPI's then you may be able to use the dispute resolution procedure to seek additional CST allocation, however it is much safer to lock fair CST in at the time of signing.

Outside Practice and Other Business Activities

There is a contractual obligation to notify the service of all other work that you do, whether as an employee, contractor or business owner. Delegates in negotiations considered this to be an horrendously onerous obligation with little or no justification. It is clear that this is not genuinely a fatigue measure due to the lessening of other fatigue provisions. The D-G maintains that this is a recommendation from the Qld Audit Office second report, which has been accepted by parliament and therefore is now required by law. Keep in mind that the report found approximately 8 people out 3500 had done anything wrong. Also keep in mind for the future that better management of fatigue was another recommendation that has gone, it appears, unaddressed.

Complying with this clause is difficult because members' outside work and private practice hours may vary extensively and the contract requires these changes to be provided to the employer. The following are some suggestions to deal with this clause. Specific industrial advice may be obtained from your union office.

Option 1: Provide very broad information

A medical officer could take a number of different approaches such as the following (these are not exhaustive):

Exhaustively set out separately every single outside activity you can think of in a separate entry. The advantage of this is that it means you have covered yourself by reporting everything and made a small point about how ridiculous it is, however, it creates a high burden of constantly updating the information and the associated risk of not keeping the information up to date and therefore breaching a term of the contract.
Alternatively you could report generally - all of the possible locations, employers or business activities and all times that they *may* participate in other work, for example list all non-work days, or all outside work hours etc. This helps to ensure that you haven't not reported any activity, but may lead the service to question whether all of this activity interferes with your job.

You could also list everything as variable but not interfering your job e.g.,

1. Nature of engagement - present private practice arrangements [known to the Service]
2. Location - [name of facility] or variable but does not interfere with Service Core hours
3. Working times - variable, but does not interfere with Service Core hours
4. Duration of work - variable, but does not interfere with Service Core hours
5. On call commitments - variable, but does not interfere with Service Core hours

The other alternative would be for all doctors across the state or in a service to refuse to fill in this detail and instead make a statement such as the following:

"*To the extent that I engage in private practice or other activities outside of my employment with the Service, I will, as has been my practice to date, manage these external activities to ensure that I can discharge my duties as required pursuant to the contract. I consider this request to be unnecessary and a gross intrusion into my privacy.*"

This will only be effective if all or the strong majority of doctors do so. If individuals or small groups do so then there is a much higher risk of individual contracts not being signed by 31 May and doctors losing private practice benefits or the service seeking to take action against an individual or group of individuals for breach of contract. This is another area where strong union membership in your area will be an advantage.

Duty Statements

The next section is devoted to duty statements or in some cases services are attaching Position Descriptions. Check these carefully, and ensure that they accurately reflect the duties you currently do, or are reasonable to your role and classification level, and that you agree to perform them. These duties may be negotiated with the HHS and most usually directly with your supervisor.

Also consider the IP clause and look at any clauses that refer to research, invention or creation of original ideas or content. Consider whether these are actually part of your job as they may affect your rights to IP. If you have duties related to invention or production of IP or current IP rights you may wish to seek individual legal advice.

Schedule 2 - Checklist

1. Is the HS Chief Executive or DG appropriately recorded with the correct name and title?
2. Is your name recorded and correct?
3. Date the contract takes effect
    a. Is your current employment anniversary date accurately recorded, e.g., the date when you currently progress through increments etc?
    b. Is the end date marked as N/A or otherwise indicates the contract is ongoing?

5. Is your location accurate and specific?
6. Is your position title or description recorded correctly?
7. Is your medical specialty recorded accurately – QH is using the AHPRA designation
8. Is your classification level accurate? (The level no. is most important)
    a. Is your base salary correct as per MOCA3 and the Remuneration document?
9. Are the car and PD allowances consistent with what you currently receive and the criteria in the policy / T&C document?
10. Do the rates and multipliers of the Tier 2 components appear correct ?
    Do they reflect agreed rosters, and number and roster of hours of work and on call?
    Are these agreed in writing?

Consider noting them in the contract or attaching them to the final document as evidence.

Is the basis for Overtime (annual or exception) recorded as you have chosen?

11. Is the Tier 3 Benefit 25% and is the term perpetual?
12. Are the Tier 4A locality, Option A area supplement and other benefits consistent with what you currently receive and the criteria in the policy / T&C document?

    Are the CMA/MMA amounts consistent with what you currently receive and the criteria in the policy / T&C document?

    If you are an ED doc is the ED25% supplement included in Tier 4C?

    Has your specialty group considered seeking an 4C benefit (note that QH's position is not to provide this, however some groups such as Pathologists are being disadvantaged).

13. Does the total amount reflect the above and is it consistent with your current annual income?

14. Have you sought to remove the KPIs on the basis that they are not complete, require review and refinement and are not yet accompanied by policy or processes to in regards to how they will be implemented and assessed?
    Have you reviewed the KPI individually and as a group and sought to amend them so that they are appropriate, reasonable and clinically sound?

15. Are your core hours of work listed as 80 or per fortnight or the appropriate fraction?

17. Have you recorded your preferred Addresses for service?

18. Have you discussed any special condition or other items, not recorded elsewhere? These may be recorded here if agreed with the employer. However, note that benefits not contained in the T&C document or other attachments to the HED have no effect.

Schedule 3

This schedule sets out the arrangements for and contractual obligations for private practice. The former right of private practice (ROPP) is now styled as a "grant" of private practice, however appears to be mandatory. If members do not want to undertake private practice then they could seek for this to be recorded as NO. However, it would be at the employers discretion in the future to grant private practice and this may also bring the employers attention to the lack of KPIs or duties related to private practice and prompt them to seek to include these.

Advice

Members may seek individual advice in relation to your contract and related issues by calling your union. Together: 1800 177 244, health@together.org.au. ASMOF: 1300 362 193, smocontracts@asmof.org,.au

Signing

When you sign the contract you should also initial any changes or additions you have made to the contract and flag them for countersigning by the employer. You should also cross put any blank spaces, blank items or blank pages. Once you have signed the contract make a copy. When you receive a copy of the countersigned contract – make copies and keep in a safe place.

Legal Advice

Union members may seek individual and specific legal advice about their contract. For Together members there is a panel of three excellent law firms that offer a free initial consultation to Together members. These are Hall Payne Lawyers, who have provided legal advice and representation to the Keep Our Doctors Industrial Campaign, Slater and Gordon Lawyers and Maurice Blackburn Lawyers. Additional advice or representation beyond the initial consultation may be subject to additional costs to be borne by the member. ASMOF members should contact Hall Payne Lawyers.

To access a free legal consultation please call the firm below. Please note that you may be required to provide confirmation of your current financial membership status which can be by calling Together on 1800 177 244.

Hall Payne Lawyers	1800 659 114
Slater & Gordon Lawyers	1800 555 777
Maurice Blackburn Lawyers	1800 309 443

Authored by the Together Union