2026 Gender Equality Action Plan (GEAP) for: The Royal Melbourne Hospital

Cover page

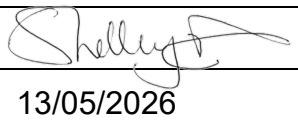
Organisation name (required)	The Royal Melbourne Hospital (Melbourne Health)
Total number of employees (and full time equivalent FTE), as at 30 June 2025	Total employees: 10569 Total FTE: 8595.33
Location (metropolitan, regional or rural. If other, please specify)	Metropolitan – located over multiple sites

Attestation by head of organisation

I confirm that:

☒ I am the head of organisation (CEO or equivalent)

☒ I have reviewed and approved the submission of this gender equality action plan (GEAP) on behalf of my organisation (as named above), and I attest that the implementation of the GEAP will be adequately resourced as required under the Gender Equality Act (2020).

Any comments?	The Royal Melbourne Hospital is committed to being a leader in gender equity through understanding the impacts of systemic power, normalised paradigms the hinder equity and the increasingly turbulent geopolitical climate. By considering intersectionality, the RMH is aiming to be a beacon, showing what is possible, in the Victorian health sector.
Name	Prof. Shelley Dolan
Role title	Chief Executive, RMH
Signed	
Date	13/05/2026

A) Planning your GEAP

Section 1: Use insights from your previous gender equality work

The RMH is proud of the progress we have made to date, enabling us to establish strong foundations on our journey toward gender equity. Our current Gender Equality Action Plan (the Plan) had 27 targeted actions articulated and all have been achieved or are in progress toward completion. In addition to the actions stated, additional work has been undertaken, such as the Menopause Working Group and the development of an overarching Diversity Equity and Inclusion Policy, a first for the RMH. We have also strengthened the profile of gender equity both at the RMH and across the Precinct through events (particularly around IWD) and a targeted media plan.

LEARNINGS

Engaging with stakeholders early
While work regarding men taking parental leave did begin during the reporting period, a number of key activities were delayed. A planned partnership with Melbourne University to run focus groups has not yet gone ahead however, this strategy will be carried over into the next plan. In addition to the targeted focus groups, a communication campaign to highlight the benefits of men taking parental leave will also be delivered.

Focus on creation AND implementation
While significant work has been undertaken to create tools, collectives and resources, we now need to turn our attention to embedding these new systems. For example, in this next period we need to support a stronger and more consistent approach to recruitment and promotion. New tools and resources have been developed for hiring managers through the last plan, and now we need to turn our attention to training and integration.

Invest in continuous improvement
Following a maturity model, the RMH will build on the foundations laid through the first Action Plan. Equity and belonging efforts have gained great visibility at the RMH, and stakeholders from a diverse range of social and professional identities have engaged in the projects. Ongoing efforts will continue to address systems and structures for sustained impact. The RMH approach will continue to include:

- Platforming visible leadership
- Connecting the top-down and bottom-up drivers of change
- Highlighting data & evidence
- Elevating lived experience
- Building awareness, skills and confidence
- Embedding equity lens into systems and processes

Strengthen governance
We recognise the need for targeted approaches within distinct workgroups and will elevate this into the next Action Plan. For example, we understand that, from a gender lens. our medical clinicians experience significant obstacles in their career. As such, we can look at strengthening representation through the Gender Equity in Medicine Committee.

Data means better insights
We will continue to build our ability to undertake intersectional analysis, through improved data collection and reporting. We need to continue to build psychological safety for people to feel comfortable to disclose information so that we can build programs that will have meaningful impact. We also need to improve our data capture ability through our Human Resource Information System and other core systems such as the EMR and Riskman.

Ultimately, we know that for gender equity to be achieved, it cannot just be one teams responsibility. We will continue to support leaders across the RMH to understand the value of workforce equity efforts, and how they can support stronger outcomes for people of all genders and identities.

Section 2: Processes, record keeping and governance

Governance
A working group of the Gender Equity Committee (the Committee) was formed to support the development of this Action Plan. With Executive sponsorship, the Committee will support the development of the Plan through participation on specific projects, providing advice, and receiving updates from project leads. The Committee ensured a consultation plan was developed and working group members supported these where possible. Bi-annual reports will be provided to the People, Culture & Communications Executive Committee to provide insights on outputs and outcomes, as well as barriers or amendments to the Plan. Further, more in-depth deep dive discussions and workshops are held with the executive to ensure engagement, knowledge sharing and accountability.

The Plan progress is included in updates to the Board and reports are provided to the Board People Culture and Remuneration Committee on a regular basis.

Processes & record keeping
To note, each action within the Plan has an Executive Sponsor who is accountable for the delivery of the work and is provided a lead team/role to ensure the actions are visible and delivered. Further, the P&C team meet with the Executive Sponsor on a regular basis to ensure progress. In these meetings the DEI Consultant helps the Executive Sponsors with decision making, resource allocation, monitoring of progress, and address any issues as early as possible. Executive will show visible support through activities, where appropriate – for example emceeing events or inviting participation in working groups.

A shared action tracker is live and will be created for the next iteration of the Plan. The DEI Consultant ensures that project leads update this tracker on a quarterly basis and that oversight (including escalation where necessary) is reported.

Audit results, interim PMS results, and action outcomes will be communicated widely across the organisation through a variety of methods to maintain visibility and engagement.

Section 3: Leadership commitment

The RMH has a strong commitment to striving toward gender equity.

As a first step in developing the Action Plan (the Plan), the Executive Committee met to explore their vison for equity and belonging and the RMH, including articulating their appetite to drive positive, meaningful change. Across two workshops, the Executive indicated a strong desire to be leaders in gender equity, including in the areas of highlighting the real-world health equity impacts of workforce efforts, meaning that there is an executive commitment to be brave in the face of potential backlash considering our current geopolitical climate.

The Executive endorsed our first overarching Diversity Equity and Inclusion Policy and embedded equity as a key concept into a revised Clinical Governance Framework; two key documents that provide a clear, systemic commitment to progressing gender equity. The position statement in the new policy summarises the position championed by leadership.

"The RMH acknowledges the Kulin Nation as the Traditional Custodians of the lands on which our services are located and supports principles of self-determination. As a leading health service, we have a responsibility to address health equity for First Nations peoples, especially if we are to meet the RMH's purpose of advancing health for everyone, every day.

In line with our values of People First, Lead with Kindness and Excellence Together, we embrace and celebrate the diversity of our community. As a leader in healthcare, we recognise the need to foster a culture of equity, inclusion, and belonging — a space where every individual is empowered to be their authentic self, contributing meaningfully to both their own health journey and the collective well-being of our community.

We are committed to creating a healthcare environment that prioritises health equity for all individuals, regardless of their background, identity, or circumstances. Good healthcare relies on each person, whether staff, consumer, or community member, feeling valued, welcomed, respected, safe, and included.

This begins with acknowledging that systemic power imbalances underpin social and economic inequality. It extends to advocating with and for marginalised communities to address inequities, and all forms of oppression and social exclusion.

Our organisation's accountability to DEI is not an individual responsibility. It is a shared commitment woven into the fabric of the RMH's operations."

The Gender Equity Committee has an Executive Sponsor (outside of the People & Culture portfolio to show a broader organisational commitment to gender equity) and is chaired by a clinical General Manager. Further Executives have agreed to once again sponsor each action within the plan. The RMH Board Chair and Chief Executive are very committed to enabling gender equity outcomes at the RMH.

B) Consult on your audit results and strategies

Section 4: Confirm consultation groups

You must consult with your…	**Confirm yes or no**	**If no, why not?**
Governing body (if your organisation has one)	Yes	
Employees:	Yes	See section 5 for more detail.
Employee representatives, including relevant trade unions	Yes	All unions were contacted, only one responded – see section 5 for more detail.
You might consult with…	**Confirm yes or no**	**Please describe additional people and/or groups**
Other relevant people	Yes	All relevant equity and belonging committees including: - First Nations Governance Group - Disability Working Group - LGBTIQA+ Steering Committee - Anti-Racism/Racial Discrimination Working Group -
Senior leaders	Yes	Executive and General Managers All managers
Parkville Local Health Service Network (LHSN) partners	Yes	The creation of the Parkville LHSN provides opportunities for shared projects. This aims to strengthen impacts and maximise resources, and benefits staff who work across multiple organisations.

Section 5: Document your consultation process

A full-scale consultation was deployed in the creation of this Action Plan with the aim of hearing diverse voices, using engagement as a learning opportunity and providing an opportunity for feedback on our areas of strengths and need for improvement. As such a range of avenues were offered to enable people to provide feedback on the audit findings and draft actions.

Engagement Approach

- Presentations were scheduled at a range of meetings, as well as virtual drop-in consultation sessions open to all.

- A survey developed for people to share their thoughts on draft actions and propose amendments or additions.
- A slide pack was developed containing data insights and proposed actions for each indicator.
- Four sets of large foam boards were used to present the draft actions. These were moved around the RMH sites with stickers and pens for staff to provide feedback in less formal ways. (The image below is a photo taken early in the consultation phase and used to promote to staff.) This range of opportunities was shared widely and promoted using internal communication channels such as the intranet, internal social media platform, and regular CEO communications.

Formal Focus Groups

Formal consultation meetings were held, including targeted presentations, which sought to ensure staff from a range of craft groups were involved including nursing, medical, allied health, mental health, administration and support services. A snapshot is provided below.

- Executive and General Managers meeting
- Board – People Culture and Remuneration Committee
- Managers Forum
- Gender Equity Committee
- First Nations Governance Group
- Disability Working Group
- LGBTIQA+ Steering Committee
- Anti-Racism/Racial Discrimination Working Group
- Intersectionality Community of Practice
- Home First and Community Care Leadership
- Office for Research

Further, the following 14 unions were given the opportunity to provide feedback:
CFMEU, Plumbing and Pipe Trades Employees Union (PPTEU), Australian Manufacturing Workers' Union (AMWU), Electrical Trades Union (ETU), Professionals Australia, Health and Community Services Union (HACSU), Health Services Union of Australia Victoria (HSU), Victorian Psychologists Association Inc (VPA), Association of Hospital Pharmacists (AHP), Medical Services Association Victoria (MSAV), Victorian Allied Health Professionals Association (VAHPA), Health Workers Union (HWU), Australian Nursing and Midwifery Federation (ANMF), Australian Medical Association (AMA). Unfortunately, only the ANMF engaged in this opportunity. However, their feedback was incredibly valuable.

Section 6: Findings from your consultation

Consultation findings showed that people were largely supportive of the proposed actions and were pleased with efforts to date.

Priority Areas

- Actions around sexual harassment received strong support, though increased visibility of organisational responses was suggested and added improving our recording and monitoring of flexible work and workplace adjustments was popular, with the need for manager education suggested and added.
- Actions around recruitment, promotion and leadership opportunities were well received though several people suggested more strategic intent and oversight is required. An action regarding business plans was added in response.
- An action proposed auditing past policies to see if Gender Impacts Assessments were undertaken and how effective they have been in impacting positive change. It was suggested that the future focus on embedding the process across the organisation rather than looking backward. This action has been amended.

Resistance Areas

- Some of the less popular actions were those which are required to meet legislative obligations, such as tracking professional development opportunities and encouraging people to update their identity data. While these were kept in the Action Plan, it did highlight that some employees are resistant to data being captured about them. As such, we need to investigate ways of building psychological safety and trust in the way that data is used.
- The proposed action regarding pay gap education was not well supported. However, a further analysis of the commentary revealed a poor understanding of how the pay gap is measured, and what the drivers are. For that reason, that action was kept.

C) Consider the gender equality and the gender pay equity principles, and intersectionality

Section 7: Consider the gender equality principles

The ten gender equality principles were pivotal to the development of the Action Plan. Specifically, the principles were used in developing our vision, refining our case for change, communicating the need for focusing on gender equity with staff, and gathering feedback. While the RMH is committed to addressing all ten principles, throughout consultation and data analysis there were five that were deemed particularly critical for our workforce, and sector, and as such we have highlighted these areas below.

Areas of focus

Principle 4
In particular, the link to health outcomes were regularly highlighted given its alignment to both the purpose of our organisation and the motivation of the majority of our workforce. As indicated by the statement highlighted above, we intent to carry the principle of gender equity throughout our organisation as we know it not only makes a difference to our employees, but it also positively impacts the quality of care for our community.

Principle 6
The RMH view gender equality as a shared responsibility and this is evident in the fact we sought to have actions allocated to teams across the organisation (not just in the P&C team) and that there is whole of Board and Executive leadership engagement throughout the process. Further, the connections maintained with our broader LHSN, consumers and our intersectional communities show this integration approach. This is clearly described in our Diversity, Equity and Inclusion Policy.

Principle 8

The Committees consulted included our various diversity, equity and inclusion committees to ensure we considered compounding forms of disadvantage. This is critical in a feminised workforce, to ensure we understand the differing experiences of women based on other aspects of their social identities.

Principle 9
We have used stories, data, and other evidence throughout to highlight the impact of current and historical discrimination of women and non-binary people working in or receiving healthcare. This principle will be a driving factor in the development of our communications, advocacy and learning programs.

Principle 10
We have also defined equity measures, and understand the need to clearly, consistently and vocally take action to work toward gender equity.

Section 8: Consider the gender pay equity principles

Gender pay equity principles have shaped our work throughout each audit, progress report and in the development of this Action Plan. To note, we run educations sessions to explain the gender pay gap and the drivers of it, including a fireside chat with the CEO, and will continue to do so to build the knowledge of as many staff and leaders as possible. Specifically:

- Principle A: As our remuneration is tightly controlled by Enterprise Agreements, this principle is taken into account. However, the recruitment projects in the Action Plan will support reviews of equity and fairness.
- Principle B: as above
- Principle C: We share the gender pay gap data widely across the organisation, both high level and detailed versions. Further, we plan to develop a remuneration procedure to build accountability, transparency and consistency in decisions about pay.
- Principle D: We know that parental leave uptake by men is an issue in our organisation and we will build upon our previous efforts in this space. In nursing, sector-wide structural barriers prevent part-time leadership, which is why we are looking at job-share as an avenue to strengthen leadership pathways. Through the People Matter Survey, we have seen that carers of frail adults and people with disability have lower scores when asked about the support provided and opportunities to progress at RMH, a focus articulated in our Action Plan.
- Principle E: The Action Plan was developed in consultation and has executive endorsement.
- Principle F: We consulted widely in the development of our actions, which aligns with all the pay equity principles.

We know from analysis that the biggest driver of our organisation-wide gender pay gaps is the disproportionate composition of men in medicine in comparison with the organisation as a whole, especially in senior medical roles. We also know there are gender pay gaps between medical specialities, a sector wide issue and are actively working to be a leader in this area.

Section 9: Consider intersectionality

As the RMH provides care to a very diverse community, and we know seeing a whole person impacts care outcomes, everything we do must consider intersectionality.

To note, the RMH highly feminised workforce, however, we acknowledge that experience of women across our organisation will be different, complex and nuanced. To gain strong insights, we must ensure that we have accurate and appropriate data – something which we will focus on trying to establish through the next phase of our work. We continue to see underreporting in gender identity, First Nations identification, disability and sexual orientation. However, we can assess windows of intersectionality through information obtained in our People Matter Survey data.

For instance, we know that staff with disability, or who care for someone with disability, are less satisfied with their access to flexible work. This may be further compounded by knowing that women often carry the burden of caring responsibilities.

We have seen that younger woman, and women with disability, experience sexual harassment at higher rates than other staff, something which we take into account in sexual harassment training and will weave that throughout all our sexual safety efforts.

Active Bystander Training, which began in the last reporting period and will continue in this action plan, explicitly addresses the fact some communities experience bullying, harassment and microaggressions at higher rates than others. It uses real-life case studies to build skills and confidence for staff to recognise and address these behaviours.

A reason we have prioritised strengthening governance throughout the Plan is that much of the work to support diverse communities is driven by separate (but linked) Committees and Action Plans. For example, the First Nations Governance Committee, LGBTIQA+ Steering Committee, and Disability Working Group each have an Action Plan. An Intersectionality Community of Practice also exists to ensure an intersectional approach is applied wherever possible.

An area for improvement is that our previous Human Resources Information System was not set up to adequately capture data about diverse social identities. Over the life of the last Action Plan, a new system was developed and built to align with reporting requirements. Additional effort is required to encourage more staff to update their diversity data in the system. Further work will also explore opportunities to support less manual, and more meaningful, reporting and analysis of this data, outside of the Commission portal.

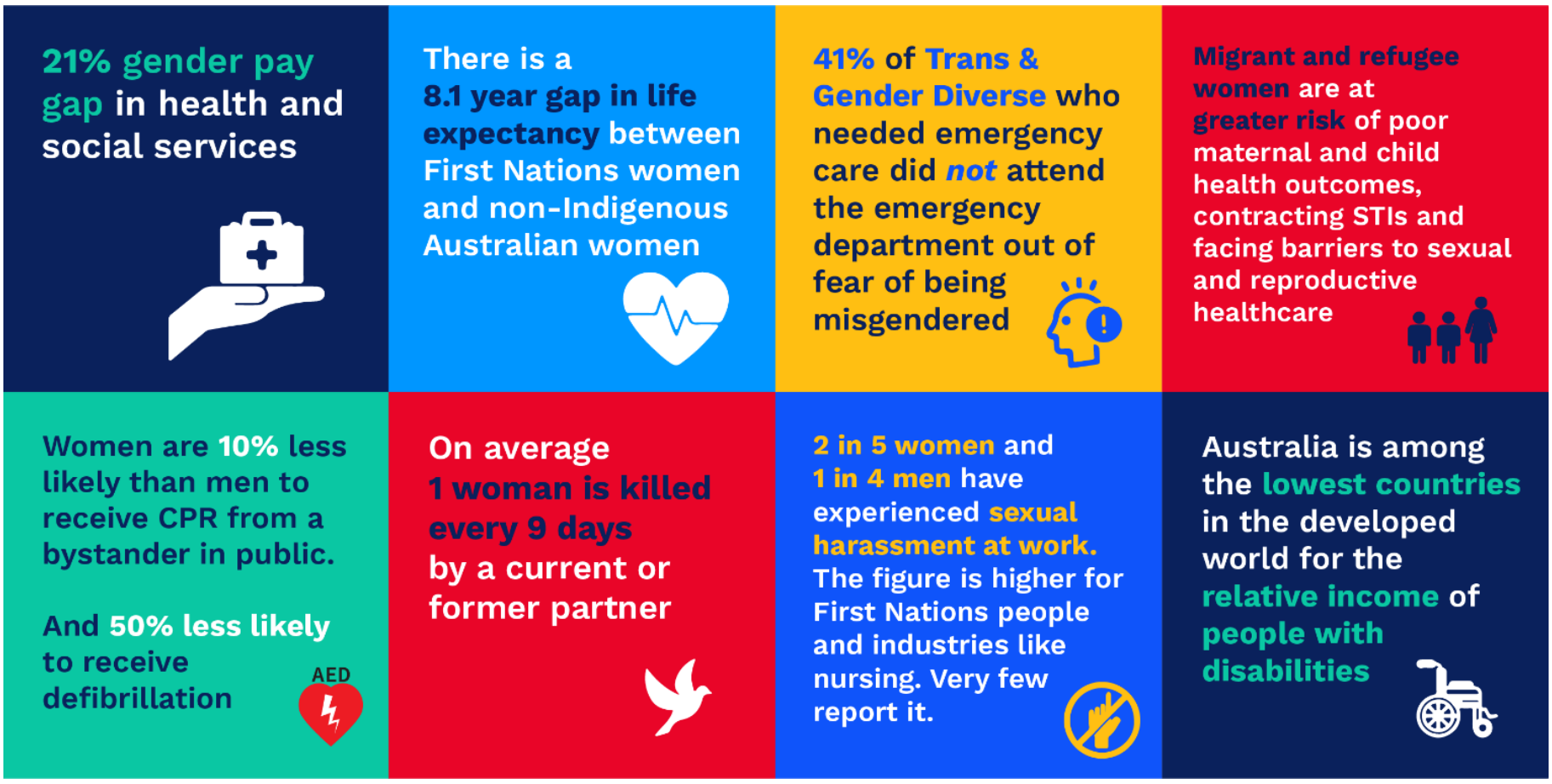
D) Making a case for change

Section 10: Make a case for change and create a vision (recommended)

Everyone deserves to feel safe, supported, and included in their communities. We all want equitable opportunities to succeed at work, to receive effective care, and live healthy lives.

Unfortunately, we know this isn't always the case. The barriers to health equity are multiple, and often linked to factors like gender, cultural background, ability, and socio-economic status. We know, for example, that some groups, in particular women and girls, people with a disability, and trans and gender diverse people, are still more likely to experience harassment, discrimination and violence.

Further, we know that driving health equity, means driving workplace equity. We serve a diverse community; a community reflected in our workforce. To provide the best care and to create the best culture, we need to be an organisation where people of all backgrounds, identities and abilities feel safe, welcome and included to fully contribute.



So, for the RMH equity and belonging must be part of our core business.

That's why at the RMH we are committed to taking clear and meaningful steps to support better outcomes for people of all genders, backgrounds and identities. We regularly audit our organisation and engage with staff to understand their experiences, especially those who face additional barriers. We share the insights we gain from listening to people, celebrate improvements, and acknowledge the work that we still need to do. Our work is intentional and ongoing. Our vision is bold and strong.

The Action Plan outlines some of the work we are doing to drive change and is supported by other plans like our Disability and LGBTIQA+ Action Plans.

Our equity and belonging vision:

"At The RMH, we acknowledge First Nations' sovereignty and support self-determination. In line with our values of People First, Lead with Kindness and Excellence Together, we embrace and celebrate the diversity of our community. As a leader in healthcare, we recognise the need to foster a culture of equity, inclusion, and belonging — a space where every individual is empowered to be their authentic self, contributing meaningfully to both their own health journey and the collective health and well-being of our people."

E) Analysing your data to identify forms of gender inequality AND developing your strategies

Section 11: Identifying underlying causes of gender inequality

Historical systems of gender imbalance

Historical gender segregation is a key driver of inequity in healthcare. This is compounded by historical undervaluing of "women's work" within the system, and the embedded hierarchies including systems of power.

While data suggests the RMH is less feminised than other health organisations, 70% of our staff are women. Nursing staff are our biggest workforce and highly feminised, along with allied health. Our highest paid workforce, medical staff, is not feminised. Women enter at similar rates to men but are not proportionately represented in senior roles. This is a key factor in our organisation wide pay gaps, and although we have seen recent improvements, there is still significant work to be done.

Pay gaps when broken down by level to CEO are concentrated in medical and administrative roles. Legacy contracts negotiated salary increases, historical academic appointments and above award payments – where men are advantaged – influence this trend.

Both the gender segregation and gender pay gaps reflect historical gender bias.

Exposure to trauma

A growing body of research shows sexual harassment against healthcare workers is common and often perpetrated by patients/consumers, and their visitors. This type of violence disproportionately impacts women and non-binary people. Because direct care frequently requires staff to prioritise the needs of patients and often involves long periods of contact without other colleagues present, healthcare workers face an especially high risk of gendered violence. These risks are further intensified by factors such as staffing shortages, gender stereotypes, unequal power dynamics, and historical acceptance of such behaviours[1].

[1] Work-related gendered violence against Victorian healthcare workers.pdf

Industrial relations landscape

The RMH is required to comply with nine separate Enterprise Agreements. The agreements are negotiated between the Victorian Hospitals Industrial Association (VHIA) (who represent the Health Services) and the relevant Unions (who represent the Employees). The Victorian Government, as the funder of the enterprise agreements, is heavily involved and present during the negotiations, and a key influencer of what can be agreed between the parties. While efforts are being made to increase consistency across the awards, many discrepancies still exist. Some relate to entitlements that underpin gender equity efforts such as parental leave, professional development and leadership opportunities.

Parental leave uptake by men is very low at the RMH. Enterprise Agreement entitlements historically used gendered language, preventing men from taking leave. As these are updated, gendered language is removed and replaced with primary and secondary carer leave. However, the primary carer leave must still be taken at the time of birth or adoption, which remains a barrier. Furthermore, given a large proportion of men at RMH are medical staff, it is likely they are the highest money earner in their family, creating a financial barrier.

Enterprise Agreements vary in the level of paid education stipulated. For example, medical staff have greater access to reimbursement for Professional Development than other clinicians and non-clinical staff. In a budget constrained environment this proves a challenge for equitable access to paid PD. Additionally, Enterprise Agreements for medical staff often protect education and training time for doctors but this protection is not extended to other workforce groups.

Flexibility

Sex and Gender were not identified as barriers to success at the RMH. However, flexible working and caring responsibilities were identified as obstacles, which do have a gendered element. This is a challenge in nursing where leadership EFT is stipulated in the enterprise agreement, making part-time leadership roles rare.

Intersectionality

First Nations people have long experienced racism and harm in healthcare settings. Further, healthcare has a history of pathologizing the experiences of trans, non-binary, and disabled people. Additionally, migrant and refugee people face barriers to healthcare and employment. These factors compound gender inequality and must be considered concurrently.

Section 12: Analysing your data and documenting your strategies

Indicator 1: Gender composition of all levels of the workforce

Describing the problem

Analyse audit data	**Critical performance measures:** • Gender composition of the duty holder organisation in 2025: 71% women, 28% men, 1% non-binary • Gender composition of part time workers in the duty holder organisation in 2025: 59% women, 42% men, 63% non-binary • Gender composition of senior leaders in the duty holder organisation in 2025: 60% women, 40% men, 0% non-binary Senior leadership should represent the demographics of the organisation, so it could be expected that there are more senior women than men, reflective of a feminised workforce. The RMH has more senior women than men, but at slightly lower proportion than the organisation as a whole so there is opportunity for improvement Healthcare is largely a feminised industry where part time work is common in clinical roles. For example, graduate nurses are appointed at 0.8EFT and many doctors work across multiple organisations. Over the life of the last Action Plan, the RMH reduced the number of staff of all genders on casual contracts, maintaining that this is important for job security and economic gains. Key focus areas for the RMH include: • increasing representation of women in senior medical roles • supporting job-share arrangements (the nursing EA requires 1EFT for Nurse Unit Manager roles) • building staff data to support more nuance and interactional analysis and thus strategies

Setting metrics

Measures	**Critical performance measures:** • Gender composition of the duty holder organisation • Gender composition of part time workers in the duty holder organisation • Gender composition of senior leaders in the duty holder organisation **Additional measures (optional):** • Gender composition casual workers (2025 – 7.5% women, 8% men and 7% non-binary) • Number of job-share arrangements (2025 - 1) • Gender composition of senior medical roles (2025 – 31% Med Direct, Dep & HoU and 32% SMS with additional responsibilities, no no-binary)
Target/s (recommended)	• Increase in number of job-share arrangements in place • Maintain less than 10% causal contracts for all genders • Increase in 5% women in senior medical roles

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Use insights from RMH research and LHSN partners to develop and promote job-share tools and guidelines.	Chief Nursing Officer	Hollie Prescott/Laura Zeeman DEI Consultant LHSN partners	2027	Leave and Flexibility Gender Segregation Gender Pay Gap
Engage with carers of frail adults and people with disability that reduce barriers to employment advancement	Chief Nursing Officer	DEI Consultant Disability Working Group	2027-8	Leave and Flexibility Gender Segregation Gender Pay Gap
Review exit data with an intersectional gender lens and share relevant insights with leaders	Chief People and Communications Officer	Director Leadership Culture and Learning & Director P&C	2027	Gender Segregation Gender Pay Gap
Apply DEI lens in the development of Talent Strategy – incl targeted recruitment and succession planning	Chief People and Communications Officer	Director Recruitment	2027-2029	Gender Segregation Gender Pay Gap Recruitment and Promotion
Review approach to annual business planning, ensuring we have a gender equity lens on our priority strategy areas	Chief Strategy Officer	Executive General Managers		Gender Segregation Gender Pay Gap Recruitment and Promotion

Indicator 2: Gender composition of the governing body

Describing the problem

Analyse audit data	**Critical performance measures:** • Gender composition of the duty holder organisation's governing body in 2025: 63% women, 38% men, 0% non-binary The RMH Board represents the community in our governance, so should reflect the community. Given that, it could reasonably be expected to be more gender balanced than the organisation and pleasingly it has achieved this goal. The Board is appointed by the Victorian State Government based on required skills identified by the Chair. Recent efforts by the Chair aimed at broadening diverse perspectives, intersectionality and experiences beyond gender have been successful. Efforts in this indicator are focused on maintaining a representative Board, and ensuring the Board are aware of Gender Equality obligations.

Setting metrics

Measures	**Critical performance measures:** Gender composition of the duty holder organisation's governing body. **Additional measures (optional):**
Target/s	Maintain stable gender composition

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Continue to educate Board members about gender equity obligations	Chief Executive Chief Legal Officer	Chief People and Communications Officer DEI Consultant	2026-2029	All indicators
Encourage Board members to update their diversity data in SuccessFactors	Chief Legal Officer	Chief Legal Officer	2026	Gender composition

Indicator 3: Equal remuneration for work of equal or comparable value across all levels of the workforce, irrespective of gender

Describing the problem

Analyse audit data	**Critical performance measures:** • Mean total remuneration gender pay gap by occupation group in 2025: all occupations 23.4 % women, 22.3 % non-binary. Although demonstrating a downward trend this remains our highest pay gap, see commentary below. • Mean total remuneration senior leader gender pay gap in 2025: 10.6%. This is the first time we have measured senior leader pay gap. It is a relatively low pay gap, though further reduction is sought. **Supplementary measures:** • Mean base salary pay gap in 2025: women 22.3%, 21.9% non-binary • Median total remuneration pay gap in 2025: women 7.6%, 9.2% non-binary • Median base salary pay gap in 2025: women 6.3%, 9.1% non-binary Our organisation-wide pay gaps are driven largely by the disproportionate representation of men in senior medical roles compared to the workforce overall, particularly in senior medical roles. Mean figures are much higher than median, which tells us that outlier salaries are the main driver of our current pay gap. Given that medical salaries contribute greatly to our organisation-wide pay gap, this is unsurprising. Legacy contracts rely on attrition for change which may limit our ability to demonstrate significant change in the short term. Total remuneration pay gaps are a little higher than base salary, suggesting differences in payments such as overtime and shift penalties. Given that there are 132 wage types applied in base salary calculations and a further 169 included in total remuneration this can be difficult to understand and requires further investigation at the local level. For example, in administrative roles it is likely that above award payments are a driver, while differences clinical roles may be due to certain shift penalties. The legislated pay rise for nurses will go some way to addressing pay gaps, as will other enterprise negotiations, though internal efforts must also continue.

Setting metrics

Measures	**Critical performance measures:** • Mean total remuneration gender pay gap by occupation group. • Mean total remuneration senior leader gender pay gap. **Supplementary measures:** • Mean base salary pay gap. • Median total remuneration pay gap. • Median base salary pay gap. **Additional measures (optional):**
Target/s (recommended)	Reduce org-wide pay gaps by 2%

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Build knowledge and awareness of pay gap drivers in staff and leaders	Chief Corporate Officer	DEI Consultant People & Culture Business Partners Finance Business Partners	2026-2029	Leave and Flexibility Gender Segregation Gender Composition Recruitment and Promotion
Instigate a Gender Equity in Medicine Committee to identify and monitor key actions and metrics	Chief Medical Officer	DEI Consultant & Director Medical Workforce	2026-2029	Gender Composition Gender Segregation Recruitment and Promotion Leave and Flexibility
Develop and promote a Remuneration Procedure	Chief Corporate Officer	Director Recruitment Director Payroll Director, P&C	2027	Gender Segregation Gender Composition Recruitment and Promotion
Advocate for greater consistency in Enterprise Agreements	Chief People Communications Officer	Director P&C	2026-2029	Leave and Flexibility Gender Segregation Recruitment and Promotion Sexual Harassment

Indicator 4: Sexual harassment in the workplace

Describing the problem

Analyse audit data	**Critical performance measures:** • Anonymously reported rate of sexual harassment in 2025 (PMS data): 17% overall. 19% women, 10% men, 0% NB • Number of formal reports of sexual harassment (directly to the organisation through Riskman) in 2025: 440 overall, 348 women, 52 men, 2 NB, 8 other We have seen both anonymous and formal reports of sexual harassment increase. We are clear that this is a positive outcome, indicative of an increased understanding of sexual harassment, and confidence in the RMH to respond. Most of the harassment comes from patients and community members. Some areas of the hospital deal with such behaviours frequently, such as wards with patients with cognitive impairment or mental ill-health. We expect this number to increase further before reducing, as we continue to educate our large and disparate workforce. **Supplementary measures:** • 2025 PMS participants who said they reported sexual harassment in 2025: 17% overall, 13% women, 5.3% men, 0% NB Reasons for not making a formal sexual harassment complaint in 2025: • Overall: 41% not serious enough, 41% didn't think it would make a difference 20% other – please specify. • Women: not serious enough 46%, not make a difference 42%, no longer in contact 14% • Men: not serious enough 36%, not make a difference 39%, negative consequences 22% • From our 2025 People Matter Survey satisfaction with handling of workplace sexual harassment complaint in 2025: 60% overall, 65% women, no data for men. These scores have improved over time, and we are working so that they continue to do so. Women's satisfaction is higher than the overall score, indicating that women are more satisfied with the handling of their complaint than other genders. Data is not yet available on the satisfaction score on the outcome of formal workplace sexual harassment complaint in 2025. We aim to have this in place by the next progress report as we resolve technical and process challenges.

Setting metrics

Measures	**Critical performance measures:** • Anonymous experience rate of sexual harassment. • Number of formal reports of sexual harassment. **Supplementary measures:** • Participants who said they reported sexual harassment. • Reasons for not making a formal sexual harassment complaint. • Satisfaction with handling of workplace sexual harassment complaint. • Satisfaction with handling of formal workplace sexual harassment complaint. **Additional measures (optional):** Positive response to PMS questions: • My workplace puts a stop to unacceptable behaviour • I feel safe to call out unacceptable behaviour
Target/s	• 15% increase in number of formal reports of sexual harassment • Increased satisfaction of handling of formal sexual harassment complaints (baseline set in 2027 – increase in 2029) as reported through PMS.

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Develop and implement satisfaction survey for sexual harassment complaints that will meet audit requirements (in cooperation with LHSN).	Chief Legal Officer	Director Digital Innovation Director P&C Sexual Safety NC, Manager Quality & Improvement LHSN colleagues	2026-2027	Gender Composition Gender Segregation
Improve P&C sexual harassment data collection to support reporting and risk management	Chief People and Communications Officer	Director P&C	2026-2027	Gender Composition Gender Segregation
Advocate for changes to RiskMan to improve reporting and confidentiality	Chief Information Officer	Sexual Safety NC, Director Safety Culture	2026-2029	Gender Composition Gender Segregation

		Manager Quality & Improvement		
Strengthen imbedding and utilisations of anonymous reporting pathways through the introduction of the 'Virtual Ombuds'	Chief Legal Officer	Director P&C	2026-2027	Gender Composition Gender Segregation
Build skills and confidence to respond to sexual harassment and support those reporting it including: • continued education • centralised resources / options • internal communication and promotion • opportunities for shared learning an action	Chief People and Communications Officer	Sexual Safety NC Director Communications Medical Education Unit Nursing Education Allied Health Education OVA Staff Consultancy and Education	2026-2029	Gender Composition Gender Segregation
Build visibility of organisation wide sexual harassment reporting and response (i.e. guest speakers at Leadership Meetings)	Chief People and Communications Officer	Sexual Safety NC, Director P&C OVA Staff Consultancy and Education	2027	Gender Composition Gender Segregation

Indicator 5: Recruitment and promotion practices in the workplace

Describing the problem

Analyse audit data	**Critical performance measures:** • Gender composition of recruited employees in 2025: 68.5% women, 31% men, 0.6% non-binary • Gender composition of employees who were promoted in 2025: 69% women, 29% men, 2% non-binary • Perceptions of recruitment, by gender in 2025: overall 60% fair, 60% women, 69% men, 68% non-binary • Perceptions of promotion, by gender in 2025: overall 46%, 46% women, 57% men, 55% non-binary Recruitment and promotion data is roughly proportionate to the workforce composition and is not concerning. In fact, the proportion of non-binary staff who were promoted in 2025 is slightly higher than may be expected. This is positive to see for a group who have historically faced barriers to employment and progression. This similar pattern is replicated across higher duties and internal secondments, suggesting women are being given opportunities to progress. Promotions, higher duties and internal secondment data has not been available in previous audits. Sharing this data with staff may help improve perception of recruitment and promotion processes which remain relatively low, through perceptions regarding recruitment have improved over time. Perceptions of learning and development are also improving over time.

Setting metrics

Measures	**Critical performance measures:** • Gender composition of recruited employees. • Gender composition of employees who were promoted. • Perceptions of recruitment, by gender. • Perceptions of promotion, by gender. **Additional measures (optional):** • Exits by gender: 2025 67% women, 31% men, 2% non-binary (Including Exits by reason of 'Career opportunity (career advancement & job security) and 'To seek further education' - by gender) • Higher Duties by gender: 2025 75% women, 24% men, 1% non-binary • Internal secondments by gender: 2025 82% women, 16% men, 2% non-binary Positive response to PMS questions: • In the last 12 months, I've worked with my direct line manager to plan what I want to do to develop my career • I develop and learn in my role • My direct line manager supports me when I need it • I can talk about problems with my direct line manager • My direct line manager gives me feedback that helps me do my job better • My direct line manager recognises when I do good work • In the last 12 months, have you experienced any barriers to your success: • In the last 12 months, have you seen any barriers to the success of people you work with
Target/s (recommended)	• Maintain proportionate higher duties and secondments • Improved scores for PMS questions related to recruitment, promotion and development – baseline in 2027 – improved by 2029

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Develop and implement training for hiring managers about contemporary recruitment practices including bias and equity considerations – based on updated tools and resources	Chief People a**nd** Communications Officer	Director Recruitment Capability and Culture Manager	2026	Gender segregation Gender composition Pay Equity
Audit attraction and recruitment data with a gender and diversity lens to identify opportunities for improvement	Chief Legal Officer	Director Recruitment	2028	Gender Composition Gender Segregation Pay Equity
Explore providing shared medical leadership capability development opportunities (e.g. masterclasses, networking, mentoring, secondments) across the Local Health Service Network – in order to expand offerings available	Chief Medical Officer	Manager Culture & Capability	2026-2029	Gender Composition Gender Segregation Pay Equity
Increase leadership roles available to people from any professional background (e.g. nursing, allied health & administration)	Chief Operating Officer	General Managers Director Recruitment	ongoing	Gender Composition Gender Segregation Pay Equity
Embed equity and inclusion into the new Capability Framework, including implementation strategies and succession framework	Chief People and Communications Officer	Manager Culture & Capability	2026	Gender Composition Gender Segregation Pay Equity
Audit training and event spaces for accessibility	Chief Redevelopment Officer	Director Redevelopment Director Facilities Management	2028	Gender Composition Gender Segregation Recruitment and Promotion
Refine & consolidate tracking systems for professional development to support improved visibility, address gaps and aid reporting.	Chief Information Officer	Director People Systems Director Medical Education, Director Nursing Education, Director Allied Health Education Manager Capability and Culture	2027	Gender Composition Gender Segregation Pay Equity

Indicator 6: Availability and utilisation of terms, conditions and practices relating to: family violence leave, flexible working arrangements, and working arrangements supporting employees with family or caring responsibilities

Describing the problem

Analyse audit data	**Critical performance measures:** Average weeks of parental leave, by gender in 2025: • women 21wks total, 14 paid, 7 unpaid • men 13.5wks total, all paid • non-binary no leave taken • Uptake of formal flexible work, by gender in 2025: Overall only 0.64% of the workforce have a formal flexible work arrangement recorded in our systems. Of these records – 91.5% accessed by women, 7.3% men, 1.2% non-binary • Perceptions of flexible work culture, by gender in 2025: Overall, 71%, 71% women, 73% men, 84% non-binary **Supplementary measures:** • Gender composition of parental leave takers in 2025: 97% women, 3% men, 0% non-binary • Gender gap in carer's leave in 2025: 20% women, 17% and 12% non-binary Men take longer paid parental leave than they previously have, now at similar length to women. This is largely due to improved entitlements in Enterprise Agreements. However, they took no unpaid leave in this reporting period, and very little in previous years. This requires ongoing attention and effort. While the gender balance in people who take carers leave is pleasing, the gender composition in parental leave takers is concerning, and has worsened since the last audit. Increasing the number of men taking parental leave will again be a focus for the RMH in the coming years.

	Current system limitations have limited the precision of reporting of formal flexible work arrangement; however, this is proposed to be rectified for the 2027 audit enabling more comprehensive reporting and analysis. PMS data suggests 73% of all staff work flexibly, with men sitting 10% lower than women and on-binary respondents. Pleasingly, perceptions of flexible work and family violence leave remain high.

Setting metrics

Measures	**Critical performance measures:** • Average weeks of parental leave, by gender. • Uptake of flexible work, by gender. • Perceptions of flexible work culture, by gender. **Supplementary measures:** • Gender composition of parental leave takers. • Gender gap in carer's leave. **Additional measures (optional):** Ability to record and report on formal flexible work and workplace adjustments arrangements Utilisation of Family Violence Leave Improvements in positive response to PMS questions: • My workplace would support me if I needed to take family violence leave • My direct line manager lets me work flexibly if I need to Proportion of staff who report working flexibly in PMS survey
Target/s (recommended)	• Develop a baseline number of formal flexible working arrangements by 2027 • Increase number of formal flexible working arrangements by 2029 • Develop a baseline number of workplace adjustments arrangements by 2027 • Increase number of workplace adjustments arrangements by 20295% increase in composition of men taking parental leave

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Implement a communications campaign to promote men's utilisation of carers and parental leave	Chief Operations Officer	Director Communications DEI Consultant	2026	Gender Composition Gender Segregation Pay Equity
Engage with men to understand current barriers to utilising carers and parental leave and develop recommended actions in responses	Chief People and Communications Officer	DEI Consultant Gender Equity Committee	2026-2027	Gender Composition Gender Segregation Pay Equity
Implement process to record formal Flexible Work Arrangements and Workplace Adjustments in SuccesFactors for monitoring and reporting – and educate managers on both	Chief Information Officer	Director People Systems Director P&C	2026	Gender Composition Gender Segregation Pay Equity
Family Violence Contact Officers and Family Safety Team help build awareness of supports available and encourage managers to complete relevant training	Chief Allied Health Officer	Director Safety Culture & Family Safety Team	2026-2029	Gender Composition Gender Segregation

Indicator 7: Gendered segregation within the workplace

Describing the problem

Analyse audit data	**Critical performance measures:** Occupational gender segregation in 2025:

Occupation groups	Women		Men		Self-described	
	2023	2025	2023	2025	2023	2025
1 - Managers	90.5%	85.3%	9.5%	14.7%	***	***
2 - Professionals	72.0%	72.5%	26.4%	26.4%	1.6%	1.1%
3 - Technicians and Trades Workers	53.6%	50.9%	45.6%	48.8%	0.8%	0.3%
4 - Community and Personal Service Workers	69.4%	63.8%	28.4%	34.1%	2.2%	2.2%
5 - Clerical and Administrative Workers	76.4%	74.9%	22.7%	24.7%	0.8%	0.4%
6 - Sales Workers	***	***	***	***	***	***
7 - Machinery Operators and Drivers	21.4%	15.4%	78.6%	84.6%	***	***
8 - Labourers	58.3%	61.9%	40.6%	37.5%	1.1%	0.7%
All occupations	**71.2%**	**70.9%**	**27.3%**	**28.1%**	**1.5%**	**1.0%**

When the RMH roles are aggregated into ANZSCO occupation groups, critical detail about roles and internal hierarchies disappear. For example, Nurse Unit Managers seem to be classified as professionals, while a Director of Clinical Services is classified as a manager.

Using level to CEO data we can see that in 2023 18% of our women were medical staff, which rose to 20% in 2025. Conversely, in 2023 62% of women were nursing which dropped to 60%. This shows a small shift in gender segregation.

Efforts have successfully increased gender balance in security at the RMH. Future efforts will include looking at medical units to identify opportunities to improve gender representation across specialities.

Reported experience of bullying has increased in 2025 for men and women, in part due to education and awareness raising about appropriate workplace behaviour and greater trust in responsiveness. Pleasingly, non-binary rates have decreased over time, likely in response to efforts around LGBTIQA+ inclusion.

Only 23% of those who made a formal report were satisfied with its handling, a drop from 27% in 2023. Formal complaints may be handled locally without P&C support, which can result in inconsistent or poor processes. Efforts are underway to increase P&C oversight.

Reported experiences of discrimination have increased in 2025 for both men and women but remain low. Like sexual harassment this increase, can in some part be attributed to education and awareness raising about appropriate workplace behaviour. Pleasingly, non-binary rates have decreased over time, likely in response to efforts around LGBTIQA+ inclusion.

Low rates of formal reporting remain (7%), though satisfaction of the handling of formal reports has significantly increased from 7% in 2023 to 40% in 2025.

PMS questions regarding our inclusive culture and willingness to address poor behaviours are consistently our highest survey scores.

There has been an increase in the number of staff who have been terminated, or chosen to leave, during an active investigation for behaviours like bullying and harassment including in non-traditional areas such as medicine

Most PMS respondents had not experienced barriers to success. For those that did age, caring responsibilities, and flexible work were the most common reasons indicated. All of these can be gendered in nature, yet sex/gender was not selected as a reason. Interestingly, though age is highlighted here, when the question around opportunities to progress is examined by age no strong patterns are identified.

Most PMS respondents had not witnessed any barriers to success. For those that did, sex was not commonly identified, however, flexible working and caring responsibilities give the highest scores, which do have a gendered element to them. This is a challenge in nursing where leadership EFT is stipulated in the enterprise agreement, making part-time leadership roles rare.

Setting metrics

Measures	**Critical performance measures:** • Occupational gender segregation. **Additional measures (optional):** • Segregation by craft group (via level to CEO) • Exit survey – reason for leaving ‘Discrimination, bullying, harassment’ and ‘Work environment and team culture’ by gender Data from People Matter Survey • Number of staff who report experiencing bullying • Satisfaction with handling of bullying complaints • Number of staff who report experiencing discrimination • Satisfaction with handling of discrimination complaints Positive responses to PMS questions: • I can be myself at work • I feel culturally safe at work • I feel safe to call out unacceptable behaviour • My workplace uses respectful words and pictures • Work is given out fairly to people in my team, no matter their gender • My direct line manager treats people with respect

	• My workplace puts a stop to unacceptable behaviour • I feel safe to call out unacceptable behaviour • My workplace acts to stop bullying, harassment and discrimination • The people I work with respect human rights in the way they work and treat others • Senior leaders view the mental health of staff as just as important as getting work done • At work, there is good communication about psychological safety issues that affect me • People in my team can bring up problems and tough issues
Target/s (recommended)	• Increase in proportion of medical staff who are women or non-binary • Increased satisfaction with handling of bullying complaints • Increased satisfaction with handling of discrimination complaints

Strategies

Strategy	Exec Sponsor	Responsible (recommended)	Timeline (recommended)	Related to other indicators? (recommended)
Continue to celebrate key dates of significance – explore opportunities to do so as a LHSN	Chief People and Communications Officer	DEI Consultant Director, Communications	2026-2029	
Develop and promote an inclusive events guide	Chief People and Communications Officer	Director, Communications	2027-2028	Gender composition Recruitment and Promotion
Enable the voices of lived experience to shape efforts through committees including: - Gender Equity - First Nations - Disability - LGBTIQA+ - Racial Discrimination -	Chief Nursing Officer	Committee Chairs	2026-2029	All indicators
Continue to roll out Active Bystander Training and embed approach, specifically in medical workforce. Seek support to evaluate the program.	Chief Medical Officer	Manager Culture & Capability	2026-2029	All indicators
Support Intersectionality CoP and explore opportunities for intersectional analysis and approaches to equity and inclusion	Chief Quality Officer	DEI Consultant	2026-2029	All indicators
Consult with staff to develop the RMH plan to address psychosocial safety	Chief People and Communications Officer	Director Safety Culture	2026-2027	All indicators

Additional areas of focus (optional):

Describing the problem

Analyse audit data	RMH had insufficient data to do intersectional analysis on our workforce data. Despite good intent, reported number of GIAs remain low, and reporting and accountability challenges remain.

Setting metrics

Measures	**Performance measures:** • Number of staff who have added diversity data into SuccessFactors. • Number of GIA/EIAs completed. • Research forms updated • Procurement practices reviewed **Additional measures (optional):** • Clarity of governance mechanism for Equitable Impact Assessments

Target/s (recommended)	• Minimum 3000 staff have answered at least one question in the diversity data section • 20 Impact Assessments are reported in the 2025-2027 reporting period.

Strategies

Strategy	**Exec Sponsor**	**Responsible (recommended)**	**Timeline (recommended)**	**Related to other indicators? (recommended)**
Continue to encourage diversity data inclusion in Success Factors, including clarity around confidentiality	Chief Information Officer	DEI Consultant Director Communications	2026-2027	Gender segregation Gender composition Gender pay gap
Strengthen understanding of link between workforce efforts and healthcare outcomes	Chief Quality Officer	DEI Consultant Director Quality and Improvement DEI Committee Chairs	2026-2029	All indictors
Continue to embed application of equity lens into organisation practices and approval processes (aligned with GIA reporting requirements)	Chief Quality Officer	Director Quality Improvement Director Projects	2026-2027	All indicators
Enhance gender equality in research through: • Adopting standardised terminology around sex/gender across clinical and research activities wherever possible to allow harmonisation of data sets and inclusion in standard documents • Adding sex/gender questions to research review forms (Ethics and/or Research Governance) • Continue building skills and knowledge of research workforce, as well as ethics committee and research advisory committee members • Explore opportunities to strengthen alignment with Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research | Australian Government Department of Health and Aged Care, and other relevant NHMRC guidelines •	Chief Research and Innovation Officer	Director Office for Research	2026-2029	
Continue to build skills and knowledge around menopause in healthcare.	Chief Nursing Officer	DEI Consultant GE Committee	2026-2029	Gender Composition Gender Segregation Leave and Flexibility
Review procurement practices with a gender and equity lens	Chief Corporate Officer	Director Procurement and Supply Chain	2027-2028	

F) Resourcing your GEAP

Section 13: Identifying current and required resources (recommended)

Implementing, monitoring and reporting on this Action Plan requires people to:

- Participate in various Committees
- Lead projects
- Provide advice and insight into projects
- Plan and host events
- Promote projects
- Monitor progress of actions
- Report on progress of actions
- Collect and analyse data on progress against the indicators
- Report on progress against the indicators
- Develop accessible communication materials on progress
- Work with our partners and stakeholders

Much of this work sits with the DEI Consultant, with support from executive, senior leaders, Committee members and other stakeholders as outlined in Section 14.

Section 14: Developing a resourcing plan

The DEI Consultant was made full time in 2025. While this is less EFT than some similar organisations, there is strong senior leadership and organisational engagement which support these efforts and ensure accountabilities are embedded into the service. As such, all actions have executive sponsors, and responsible teams/roles from across the organisation.

The DEI Consultant will meet with executive sponsors quarterly to review progress against each action and provide bi-annual reports to the Executive Committee. These will provide an opportunity to determine if additional and adjusted resourcing is required.

There has been strong investment in patient facing roles such as the First Nations Health Unit and the LGBTIQA+ Liaison team which also support hospital wide equity and inclusion efforts. As do the various Committees and Working Groups such as the Gender Equity and Disability Committees.

The Gender Equity Committee has an executive sponsor, and a senior leader is Chair.

The RMH also supports a part-time Sexual Safety Nurse Consultant who leads much of the work in the sexual safety space, a key issue in healthcare. People & Culture has recently restructured, and both the DEI Consultant and Sexual Safety Nurse Consultant now sit within the People Operations portfolio, alongside Business Partners and the Capability team. This change provides an opportunity to review accountabilities, integration and how the gender equity lens is embedded and supported across operational roles.

Any other additions or comments (optional)

Annual reports will be provided to the Board. Regular updates are provided to the People, Culture and Remuneration Board Committee.