2026 Progress Report 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
Response rate to employee experience survey	16%
Contextual information	The RMH is committed to progressing gender equity within our organisation and further aspires to be a beacon of best practice across the health sector. Significant work has been undertaken in our journey toward achieving gender equity meaning that all actions within the plan have been commenced or completed. While working toward intersectional equity and inclusion remains a priority for the RMH, we continue to face a number of obstacles and challenges that are present across the health sector. Please note that throughout this document, we refer to data received in the 2025 People Matter Survey (PMS) which had a very low response rate resulting in flattened scores overall. The most recent PMS achieved a response rate of 50% and we are looking forward to getting access to the results to have a more indicative understanding of our workforce experience. In regard to the 2025 PMS, data collated by the Royal Children's Hospital (see Table 1 in the Appendix) highlights that our comparator hospitals experienced a similar decline in completion rates and a flattening of positive responses compared to 2023 and 2024. This was particularly marked in health services with lower response rates. As the PMS was run differently for the 2025 period, while it supplied us with important information, we do not believe that it is necessarily indicative of our workforce experience due to the low representation of respondents. Furthermore, it is important to note that in the weeks surrounding the 2025 PMS, the RMH was navigating an extremely rare and complex matter involving an incident of serious misconduct of a sexual nature, which gained significant media attention and impacted people's feelings of safety at work.
Location (metropolitan, regional or rural. If other, please specify)	Metropolitan – located over multiple sites

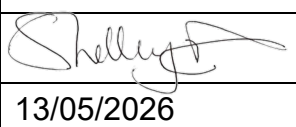
Attestation by head of organisation

I confirm that:

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

☒ I have reviewed and approved the submission of this progress report on behalf of my organisation (as named above). I attest to providing truthful and accurate information.

☒ I attest that my organisation has completed all relevant gender impact assessments under the Gender Equality Act 2020, or I have explained why not in the comment box below.

Any comments?	The RMH is committed to a continuous improvement journey toward gender equity. We welcome any feedback and recommendations to strengthen our work as we are aiming to be a leader in this space.
Name	Prof. Shelley Dolan
Role title	Chief Executive, RMH
Signed	
Date	13/05/2026

Step 1: Reporting on gender impact assessments (GIAs)

Section 1.1 Confirming GIA exemptions

If you have not listed any GIAs, please choose one or more permitted reason:

☐ Reporting on the GIA(s) would make the progress report an exempt document. This is within the meaning of the *Freedom of Information Act 1982*.

☐ Reporting on the GIA(s) would result in a disclosure prohibited by a different Act.

☐ Reporting on the GIA(s) would reveal confidential information.

☐ Your organisation had no policies, programs or services requiring a GIA. This is under the parameters of the *Gender Equality Act 2020.*

☒ None of these apply (**go to 1.2**).

Section 1.2 Describing policies, programs and services subject to a GIA

Ref #	A: Title & lead staff member (required)	B: Subject (required)	C: Description of the policy, program or service (required)	D: Status (required)	E: Description of gendered impacts (recommended)
1.	ED wait time dashboard (Ben Smith)	Service	Development of a dashboard that shows live ED wait times	New	
2.	Medical intern guest presenter invitation (Lynne Ticehurst)	Policy	Invitation template that shapes the education given to interns weekly	Up for review	Sex/gender differences in health, healthcare, and health outcomes are often ignored which can leads to poorer outcomes.
3.	Telehealth wait room messaging (Barbara Ioppi)	Service	Content shared with patients in telehealth wait room	Up for review	Women – more likely to be in caring roles, supporting children or family members. Trans and gender diverse people often feel unsafe accessing healthcare.
4.	Telephone on-hold message (Hannah Driscoll)	Service	Messaging heard while people calling the RMH are on hold	Up for review	Women are more likely to be in caring roles, supporting children or family members therefore more likely to contact hospital. Trans and gender diverse people often feel unsafe accessing healthcare.
5.	635 Building design (Rob Rothnie/Sue Rice)	Service	Design of facilities for staff and patients/visitors at new site	New	Feeding parents needing access to safe spaces to feed or express to reduce impact on work. Trans and gender diverse people often feel unsafe accessing healthcare. They also often feel unsafe accessing bathroom facilities.
6.	Inclusive design principles document (Sue Rice)	Policy	Design guidelines for developers	Up for review	Feeding parents needing access to safe spaces to feed or express to reduce impact on work. Trans and gender diverse people often feel unsafe accessing healthcare spaces. They also often feel unsafe accessing bathroom facilities.
7.	All gender toilet project (Michael McCambridge)	Program	Update bathroom signage to indicate all gender use/access	Up for review	Non-binary/gender diverse and trans people often feel unsafe in gendered spaces. They often feel unsafe in clinical settings too and may avoid much needed healthcare as a result.
8.	New Human Resources Information System (John Mizzi)	Service	Introduction of new HRIS with updated DEI information	New	Old system collected binary sex data, limited DEI data and some outdated language re sex, gender and disability and other social identities. This may leave people feeling

					unsafe, unwilling to disclose information, and excluded. Also made gender analysis difficult and meeting our requirements under the Gender Equality Act.
9.	IRIS dashboard (clinical data) (Rebecca Reed)	Service	Clinical data dashboards	Up for review	If sex and gender differences are not considered then differences in care provided, and health outcomes could be missed. This information will enable to RMH to continue to improve care.
10.	Flag Flying Policy and Practice (Amanda Armstrong)	Policy	Outline of what flags fly when and where at RMH	Up for review	Trans and non-binary staff and patients face greater barriers to employment and healthcare, including discrimination. They may feel less safe in public spaces. This could lead to not showing up for appointments or not being able to contribute fully at work. Having a visual representation of the flag out the front of our buildings could improve safety.

Section 1.3 Describing actions taken as a result of a GIA

Ref #	F: Were actions taken as a result of the GIA? (required)	G: Describe the actions taken as a result of the GIA in order to: • Meet the needs of people of different genders; and/or • Promote gender equality; and/or • Address gender inequality. If you did not take action, write N/A here and explain why in (H). (required)	H: If you did not take action, explain why. If you did take action, describe it in (G) and write N/A here. (required)	I: Describe: How and why intersectionality was considered (or not) (required)	J: Describe any actions taken specifically designed to address intersectional inequalities (compounded gender inequalities)? (recommended)
1.	Yes (go to column G)	Undertook a bias assessment of our machine learning model which demonstrated that there was no material difference in waiting times based on gender.	N/A	Intersectionality is difficult with our current data systems, however, in this project we looked beyond gender. Waiting times for First Nations people was considered as well as LGBTIQ+ patients. There was not enough data in our model to demonstrate longer waiting times for these groups, however First Nations people have a higher rate of leaving without being seen.	We reviewed the signage in the ED waiting room and posters that are specific for First Nations consumers about waiting times.
2.	Yes (go to column G)	Speaker invitation now requires presenters to include some information about different cohorts based on sex, gender age etc.	N/A	Presenters asked to consider sex, gender and other intersecting factors.	Presentations now have a lens that encourages thought, discussion and learning about gender equity and intersectionality.
3.	Yes (go to column G)	Added messaging around hospital commitment to gender equity and DEI, information about support available including Family violence, rolling promotion of DEI dates of celebration	N/A	Factors that intersect with sex and gender were considered	Messaged included various intersecting identities which has been used as a learning opportunity, promotion of supports and support of intersectional communities
4.	Yes (go to column G)	Added messaging around hospital commitment to gender equity and DEI, info about support available including for Disability, First Nations and LGBTIQA+ communities and translation and interpreter service.	N/A	Factors that intersect with sex and gender were considered	Messaged included various intersecting identities aiming at supporting all members of our community to feel safe in receiving care at the RMH
5.	Yes (go to column G)	All gender bathrooms allocated on each floor and end of trip facilities area updated to ensure lockers not just in male/female spaces.	N/A	Considered the needs of our staff (predominantly women) who live with	Also discussed access for staff (predominantly women) to accessible

		Feeding space and prayer room with separation for genders.		disability, practice various faiths, or need to feed or express milk.	bathrooms, to feeding spaces for those who don't identify as women, and prayer space. This is influencing the way we update our facilities.
6.	Yes (go to column G)	Many updates throughout document reflecting current knowledge and practice, including updating language to be more contemporary and specificity in design requests	N/A	Intersecting identities beyond sex and gender were considered	Various updates were made to the document and will influence our redevelopment briefing into the future
7.	Yes (go to column G)	New signage installed. Mapping undertaken and promoted externally and internally. Improved signage clarifies spaces for safe access and subtly challenges ideas about binary genders. Signals of inclusion, safety and respect.	N/A	Considers the experiences of people from different cultures in sharing bathrooms and people with disability.	Wayfinding and signage in a hospital can be crowded and complex meaning the clutter can make it hard to read and understand. We are looking at better ways of signposting across the service to make it easier for everyone, including those with a disability or ESL patients.
8.	Yes (go to column G)	Built fields to align with GE reporting. Much more inclusive language, multiple gender options to allow people to better identify their gender.	N/A	Considered the needs of our staff (predominantly women) with intersecting identities.	Updated wording around disability, cultural heritage and sexuality and other identities was included.
9.	Yes (go to column G)	Filters added for age, First Nations, Sex, Gender, top 10 languages to two dashboards. This data will soon be utilised regularly in reporting.	N/A	Intersecting identities were considered. Some dashboards now allow for intersectional data slicing and there are plans to continue this work.	Filters added for age, First Nations, Sex, Gender, top 10 languages to 2 dashboards. Next steps is to ensure this data is utilised regularly in reporting.
10.	Yes (go to column G)	Decision made to fly the progress pride flag permanently at city campus and Royal Park which supports intersex, trans and non-binary communities.	N/A	Intersecting identities were considered.	No additional action taken; however, we are continually looking for opportunities to communicate inclusion and safety at the RMH.

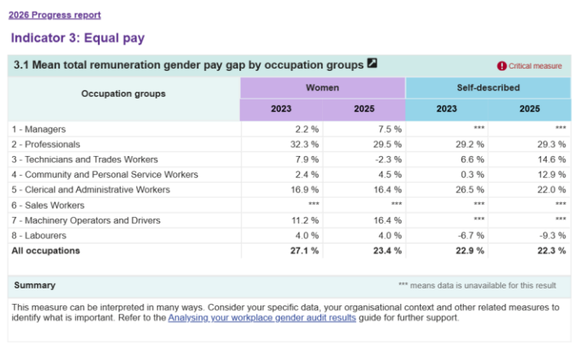
Step 2: Reporting on progress against the indicators

Section 2.1 Describing progress against the workplace gender equality indicators

K: Indicator *	L: Progress data (required)	M: Additional progress data (recommended)	N: Has progress been made? (required)	O: Explain how the data does (or does not) demonstrate progress. (required)
1	**Critical performance measures** <u>Gender composition of the duty holder organisation:</u> • 2023: 71% women, 27% men, 1.5% non-binary • 2025: 71% women, 28% men, 1% non-binary <u>Gender composition of part time workers in the duty holder organisation:</u> • 2023: 52% of women, 37% of men, and 46% of non-binary • 2025: 59% women, 42% men, 63% non-binary	**Casual workers by gender:** • 2023 - 14% women, 11% men, and 15% of non-binary staff were casuals. • 2025 – 7.5% women, 8% men and 7% non-binary were casuals	Yes	**Progress summary** We have increased representation of non-binary staff across the organisation, most pleasingly in more senior roles. Further, we have increased job security for women and non-binary staff with a significant reduction in casual work; halving the proportion on these contracts since 2023. We have also seen a rise in female representation in senior medical staff positions to 20% in 2025. Considering the feminised workforce, from a composition perspective, large scale change is not necessarily the primary driver in healthcare, therefore we have focused on gap areas and opportunities for impact such as job security and intersectionality. Progress has been recorded across all areas for indicator 1, except for senior leaders which has seen stronger equality yet less women in these roles.

	<u>Gender composition of senior leaders in the duty holder organisation:</u> • 2023: 79% women, 21% men, 0% non-binary • 2025: 60% women, 40% men, 0% non-binary			**Composition - women** Like most healthcare organisations, the RMH remains a feminised workforce at 71% women. Though we are less feminised than the state average of 77%[1]. In a feminised industry a key focus is to support women in senior roles, and in higher paid specialities. 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 reflects a shift in composition to higher paid career pathways. When examined by level to CEO, we see some mixed patterns. Our most junior support roles increased in proportion of women from 68 to 79% women. However, our junior nursing, allied health and corporate roles decreased in proportion (nursing and allied health 74 to 65% women, corporate 83 to 77% women). **Senior leaders** Clarification of our definition of 'Senior Leader' as well as some shifting structures has reduced the number in this category from 19 to 15 people, comprising the CEO, Executive, and General Managers. This resulted in a slight decrease in women at this level, yet there remain more women than men in executive positions at the RMH. This decrease means that there is a more equitable gender split of senior leaders in 2025 than 2023, however, no senior leaders identify as non-binary. While greater equality has been achieved in this area, the RMH is assessing what equity measures may be our target for the next period as for a feminised organisation, we are considering if senior leadership should also be feminised. Further, senior leadership may extend beyond executive positions in future reporting, specifically as our main target areas are within senior leadership of the medical workforce. **Composition non-binary** Our number of known non-binary staff sits around 1% which is up from 2021 but down from 2023. In the 2023 audit we saw a significant jump in existing staff sharing their non-binary identity, and new staff joining us. This dropped slightly in the 2025 audit. This may be because other hospitals are emulating our pioneering work in the LGBTIQA+ space (e.g. the LGBTIQA+ Liaison service and branded pronoun pins) or be reflective of community rhetoric making people feel less safe to share their identity with employers. Junior doctors and Registered Nurses have slightly higher representation than other groups. Seniority and job security has improved for non-binary staff. In 2021 none of our non-binary staff were in permanent, full-time roles, and they were represented in the lower-level positions in the organisational hierarchy. In 2023 that shifted significantly, and we had three non-binary staff in the top 5 levels. In 2025 we have seven non-binary staff represented in the top 5 levels, 30% are permanent, and 16% are full time and permanent. Interestingly, PMS data showed that 33% of people who indicated they live with disability are also non-binary. The additional barriers to success for this group should be considered by the RMH in the next action plan – for example, consideration of accessibility of training and event venues. **Contract type** Part time work is common in healthcare. For example, standard Graduate Nurse positions at the RMH are offered at 0.8EFT and many medical staff work part time across two or more organisations. Across all genders the rate of part time work has increased, but women and non-binary staff continue to be more likely to work part time than men at the RMH. The number of staff on permanent contracts has increased for all genders, and there is now greater parity in these figures. Similarly, there is greater parity for the proportion of staff on casual contracts. Non-binary staff in particular are more secure in their employment at the RMH. Over 30% of non-binary staff were on casual contracts in 2021, this is now 7%. **Diversity and Intersectionality** Our Human Resources Information System (HRIS) was updated to better capture diversity data. An initial communication campaign was held to encourage staff to update this information. To date this

[1] CGEPS Insights Report, 2023 Public Healthcare data

				data remains limited. It is hoped this data will be more detailed to support future audits and improved intersectional analysis.
2	**Critical performance measures** <u>Gender composition of the duty holder organisation's governing body:</u> • 2023: 56% women, 44% men, 0% non-binary • 2025: 63% women, 38% men, 0% non-binary		Yes	**Progress summary** Women remain well represented on the RMH Board. **Board appointment and composition** Board appointments are the responsibility of the Victorian Government. Women are well represented on the Board. No non-binary board members have been appointed. Recently appointed board members also have intersectional lived experience. Board members will be encouraged to provide diversity data for future audits so this can be formally reported. Gender equity is stable for indicator 2.
3	**Critical performance measures** <u>Mean total remuneration gender pay gap by occupation group</u>  2026 Progress report Indicator 3: Equal pay 3.1 Mean total remuneration gender pay gap by occupation groups — Critical measure Occupation groups / Women 2023 2025 / Self-described 2023 2025 1 - Managers 2.2 % 7.5 % *** *** 2 - Professionals 32.3 % 29.5 % 29.2 % 29.3 % 3 - Technicians and Trades Workers 7.9 % -2.3 % 6.6 % 14.6 % 4 - Community and Personal Service Workers 2.4 % 4.5 % 0.3 % 12.9 % 5 - Clerical and Administrative Workers 16.9 % 16.4 % 26.5 % 22.0 % 6 - Sales Workers *** *** *** *** 7 - Machinery Operators and Drivers 11.2 % 16.4 % *** *** 8 - Labourers 4.0 % 4.0 % -6.7 % -9.3 % All occupations 27.1 % 23.4 % 22.9 % 22.3 % Summary — *** means data is unavailable for this result This measure can be interpreted in many ways. Consider your specific data, your organisational context and other related measures to identify what is important. Refer to the Analysing your workplace gender audit results guide for further support. <u>Mean total remuneration senior leader gender pay gap:</u> • 2023: NA • 2025: 10.6% women **Supplementary measures** <u>Mean base salary pay gap:</u> • 2021: women 31.7%, 56.2% non-binary • 2023: women 26.1%, 22.8% non-binary • 2025: women 22.3%, 21.9% non-binary <u>Median total remuneration pay gap</u>: • 2021: women 18.6%, 70.5% non-binary • 2023: women 10%, 14.9% non-binary 2025: women 7.6%, 9.2% non-binary <u>Median base salary pay gap:</u> • 2021: women 3.8%, 100% non-binary • 2023: women 8.7%, 13.4% non-binary • 2025: women 6.3%, 9.1% non-binary	**Mean total remuneration gender pay gap:** • 2021: women 31.1%, 78.8% NB • 2023: women 27.1%, 22.9% NB • 2025: women 23.4%,22.3% NB **Pay gap by contract type:** • Pay gaps continue to be highest for those on part-time, fixed term contracts. They vary from 30-40% for women and 30-50% for non-binary staff depending on the metric. • Pay gap for casual staff varies greatly. It varies from 14% in favour of women to *5, and 6% in favour of non-binary staff to 24% depending on the metric	Yes	**Progress summary** On all indicators regarding gendered pay gaps have reduced and progress has been made. **Pay gap by occupation – ANZCO codes** When mean total remuneration pay gaps are considered via ANZCO occupation groups, the data shows mixed outcomes. The pay gaps for women are small (<10%) for 4 of the 7 groups represented (managers, technicians and trades, community and personal services, and labourers). They have reduced for technicians and labourers. Gaps are wider for machinery operators and clerical and administration workers and are highest for professionals. This pattern is replicated for non-binary staff members though the pay gaps are higher for clerical and administrative workers. This data provides limited insights within a hospital context, where segregation and hierarchies are structured differently as per enterprise agreements. Further analysis using levels to CEO is provided below. **Organisation-wide pay gaps** Organisation wide pay gaps have reduced for women on multiple measures: mean base salary, median total remuneration, and median base salary. Pay gaps have also reduced for non-binary staff on all metrics. Mean pay gaps are much higher than median, which tells us that outlier salaries are the main driver of our current pay gap. Given that a relatively small number of medical salaries contribute greatly to our organisation-wide pay gap, this is unsurprising. 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 in base salary and a further 169 in included in total remuneration this can be complex and quickly changing so requires further investigation at the local level. Staff on part-time, fixed term contracts continue to show a larger pay gap than staff working full time, permanent or other contract types. In 2023 this was driven by the high proportion of men in this category who were doctors. Further investigation is required to see if that is still the case. Interestingly the pay gap now favours women for casual employees on most metrics, though it varies greatly. Further investigation is required to understand and address this. **Pay gap by level to CEO** When looking at pay gaps for women by level, across the mean, median, base salary and total remuneration categories there are 60 points of data to consider. Of these 60 indicators, 32 are 5% or less, whereas in 2023 only 23 indicators were 5% or less. This is a significant improvement. Executive and non-clinical staff and managers are the workgroup with the highest pay gaps (23.9% is the highest gap recorded). Further investigation is required to inform action.

				Scores are more variable when considering non-binary pay gaps. Low staff numbers make the data less reliable. For example, level 4 (non-medical senior leaders) shows the highest pay gap (in favour of non-binary) at but there is only 1 person at this level. **Diversity and Intersectionality** Our Human Resources Information System (HRIS) was updated to better capture diversity data. An initial communication campaign was held to encourage staff to update this information. To date this data remains limited. A concerted campaign will be undertaken to ensure data will be more detailed to support future audits and improved intersectional analysis. Addressing this gap in our data collection is included in our 2026 Action Plan.
4	**Critical performance measures** <u>Anonymous experience rate of sexual harassment (PMS Survey):</u> • 2021: 10% overall • 2023: 14% overall. 17% women, 6% men, 23%NB • 2025: 17% overall. 19% women, 10% men, 0% NB <u>Number of formal reports of sexual harassment: via RiskMan, or to People and Culture</u> • 2023: 211 overall, 123 women, 11 men, 1 NB, 4 other • 2025: 440 overall, 348 women, 52 men, 2 NB, 8 other **Supplementary measures** PMS respondents who said they submitted a formal report: • 2023: 12% overall, 13% women, 12% men, 0% NB • 2025: 17% overall, 13% women, 5.3% men, 0% NB <u>Reasons for not making a formal sexual harassment complaint:</u> 2023: • **Overall**: 52% “I didn’t think it was serious enough”, 33% “I didn’t think it would make a difference”, 20% no longer on contact, 15% made it stop • **Women**: 53% “I didn’t think it was serious enough”, 33% “I didn’t think it would make a difference”, 20% no longer in contact, 15% made it stop. • **Men**: 56% didn’t think it was serious enough, 26% didn’t think it would make a difference, 23% negative consequences 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%	**Behaviours reported via PMS**: In both 2023 and 2025 the most common behaviours reported were suggestive comments or jokes (58-59%) and intrusive questions (54-55%). For men this order was reversed. **Source of harassment**: In 2023 68% experience from a patient or, 33% from a colleague[2] and 13% from a visitor. Women were more likely to experience from a patient (73%) than men (39%) who were more likely to experience from a colleague (37%) than women (24%). Men were more likely to experience sexual harassment from their supervisor (10%) then women (3%). In 2025 64% experience by patient, 33% from a colleague(s) and 19% visitors. Women most likely to experience from patient (67%) than men (42%). Men were most likely to exp from colleague (47%) than women (30%). Men were also more likely to experience it from their supervisor (18%) than women (6%) **Response:** 2021: Overall 43% told the person not ok. 41% tried to laugh it off, 39% pretended it didn’t bother them. 2023: Overall 49% told the person it was not ok, 38%	Yes	**Progress summary** While we have seen a rise in anonymous reports of sexual harassment, we are confident this is indicative of improvements in understanding of what constitutes sexual harassment rather than simply an increase in number of incidents. Internal research and monitoring confirm this analysis. We have also seen increased formal reporting, increased satisfaction of handling of complaints and a reduction in people thinking incidents weren’t serious enough to report. We believe that efforts over recent years to provide education to staff and encourage reporting across all areas has produced significant progress. **Increased reporting** Anonymous reporting via People Matter Survey (PMS) continues to increase, up to 17% in 2025 from 14% in 2023 and 10% in 2021. Of these, there is also in increase in the number of people who said they formally reported sexual harassment – up to 17% in 2025 from 12% in 2023. Pleasingly there was a marked increase in captured formal reports up from 211 to 440. The majority of these are captured via RiskMan (428), meaning the incident involves a patient or visitor, rather than being between colleagues. Health has historically had significant underreporting of sexual harassment incidents, especially those involving patients. Internal research projects are underway in areas such as Mental Health – and early qualitative data from focus groups indicates that sexual behaviours from patients towards staff were historically described as simply ‘inappropriate’ and reporting wasn’t encouraged. Additionally, audits of reporting data post educational intervention in clinical areas demonstrated correlating spikes in reporting. This all provides evidence that the increase in RiskMan reporting reflects improvements in awareness and understanding, as well as improvements in confidence to report. Formal reports captured by People & Culture have increased but remain low (12), and do not reflect actual numbers expected based on PMS data. Many people ‘report’ to their manager, who may choose to deal with this locally and not engage P&C. In such a large organisation it can be hard to navigate this issue, which is recognised as an organisational risk, and efforts continue to encourage managers to engage with P&C as general process and upskill capability at the local level Pleasingly the percentage of formal reports of submitted by bystanders has increased. In 2023, 6 formal reports of sexual harassment were made by bystanders (2.8%) In 2025, 32 formal reports of sexual harassment were made by bystanders (7.8%) This is likely to due to the efforts of our Sexual Safety Nurse Consultant and the rollout of bystander training which includes sexual harassment case studies. This work also highlights that even microaggressions or “minor” incidents should be taken seriously and could account for the reduction in people not thinking it was serious enough to report, which has dropped for all genders.

[2] This figure does not include other relevant categories – a manager or supervisor, a group of colleagues, senior leader. The survey design allows people to select more than one category, so we cannot determine an overall proportion of harassment stemming from a staff member.

	• **Men**: not serious enough 36%, not make a difference 39%, negative consequences 22% <u>Satisfaction with handling of workplace sexual harassment complaints (PMS data):</u> • 2021: 53% overall • 2023: 72% overall, 73% women no data for men • 2024:66% overall, 66% women, 60% men • 2025: 60% overall, 65% women no data for men <u>Satisfaction with handling of formal workplace sexual harassment complaint:</u> • 2023: Data not yet captured • 2025: Data not yet captured	pretended it didn't bother them. 36% told a colleague or tried to laugh it off. Men - 24% tell person it was not ok. They were more likely to pretend it didn't bother them. Women - tell them it was not ok (53%) and tell a colleague 2025: Overall 48% told the person it was not ok, 38% pretended it didn't bother them, 34% told a colleague. Men – 47% pretended it didn't bother 34% laugh it off 26% told them not ok Women – 53% told them not ok 38% told a colleague 36% laugh it off **Org encourages respectful behaviours:** 2021: Overall, 85%, 87% women, 84% men, 72% non-binary 2023: Overall, 87%, 89% women, 87% men, 85% non-binary 2024: Overall, 85%, 89% women, 88% men, 76% non-binary 2025: Overall, 80%, 81% women, 86% men, 82% non-binary **Org takes steps to eliminate bullying harassment and discrimination:** 2021: Overall, 69%, 71% women, 88% men, 41% non-binary 2023: Overall, 73%, 74% women, 76% men, 60% non-binary 2024: Overall, 71%, 73% women, 75% men, 60% non-binary 2025: Overall, 67%, 68% women, 77% men, 59% non-binary **I feel safe to call out inappropriate behaviour at work:**		**Gendered insights - experiences** Women remain much more likely to experience sexual harassment (19% of PMS and 348 formal reports) than men (10% of PMS and 52 formal reports). PMS data captured no reports from non-binary staff, though 2 formal reports to P&C were from non-binary staff. Women were more likely to experience harassment from patients than men, and less likely to experience it from colleagues according to PMS data. Men were also more likely to experience it from a manager or supervisor (10%) than women (3%). When this data was filtered for sexuality, the number dropped which indicates heterosexual identifying men are experiencing this harassment. Formal reports show that most harassment was perpetrated by men (384) rather than women (49). **Gendered insights - responses** It is positive that now close to 50% of people who experience sexual harassment feel confident to tell the person it was not ok, up from 43% in 2021. While we are working to ensure this number rises further, it is not always the safest response. Our education includes messaging that we respond in different ways, including laughing it off in the moment, and safety is the most important factor. Interestingly, women seem more empowered to speak up in the moment than men, who are more worried about negative consequences of reporting. This is counter to the responses to "I feel safe to call out behaviour" where men scored higher than women. This is likely correlated to the data showing men experience the harassment from colleagues and supervisors more frequently than women. The third highest reason for women not reporting was "other" and we are so far unable to access this free text data from VPSC. **Satisfaction with complaints handling** We currently have no satisfaction data for formal complaints. We aim to have this in place by the 2027 audit. We can, however, review the PMS data which includes anyone who believe they made a formal complaint but does not necessarily align with the actual formal reports (see previous commentary). We can see that there is an increase in satisfaction from 2021 to 2025, with a very large spike in 2023. This spike is likely because the Sexual Safety Nurse Consultant initially spoke to every person who submitted a complaint via RiskMan as part of building insights. This level of involvement was unsustainable, especially as reporting increased. **Perceptions of organisational culture and approach** PMS questions related to this indicator show that perceptions remain largely positive, the gender differences in scores have reduced over time. Pleasingly non-binary perceptions have improved most significantly. A drop in scores for women related to this indicator would likely have been influenced by a significant sexual safety matter coming to light just prior to the survey, as well as the overall flattening of scores across the sector in 2025. **Diversity and intersectionality** Certain groups experience sexual harassment at higher rates than others. For example: • 35% disability, women with disability 43% • 25% diverse sexualities, 29% women from this group • 21% of Aboriginal and Torres Strait Islander staff (intersectional analysis not available due to low numbers) These communities also tend to have less favourable perceptions of RMH culture, though they are trending positive over time, especially for diverse sexualities See for example Table 2 and Figure 1 in the appendix which show poorer scores for those groups but overall positive trends.

		2021: Overall, 68%, 69% women, 78% men, 59% non-binary 2023: Overall, 73%, 73% women, 78% men, 68% non-binary 2025: Overall, 72%, 72% women, 83% men, 68% non-binary		
5	**Critical performance measures** <u>Gender composition of recruited employees:</u> • 2023: 69.5% women, 28% men, 3% non-binary • 2025:68.5% women, 31% men, 0.6% non-binary <u>Gender composition of employees who were promoted:</u> • 2023:NA • 2025: 69% women, 29% men, 2% non-binary <u>Perceptions of recruitment, by gender:</u> • 2021: 59% positive overall, 61%women, 65% men, 65% NB • 2023: 71% positive overall, 72%women, 74% men, 65% NB • 2024: overall 67% fair, 70% women, 70% men, 32% non-binary • 2025: overall 60% fair, 60% women, 69% men, 68% non-binary <u>Perceptions of promotion, by gender:</u> • 2023: 56% overall, 58% women, 59% men,50% NB • 2024: overall 53% fair, 54% women, 57% men, 68% non-binary • 2025: overall 46%, 46% women, 57% men, 55% non-binary	**Gender composition of exits:** 2023: 69% women, 29% men, 2% non-binary 2025: 67% women, 31% men, 2% non-binary **Higher Duties awarded by gender**: 2025: 75% women, 24% men, 1% non-binary **Internal secondments awarded by gender:** 2025: 82% women, 16% men, 2% non-binary **Satisfied with opportunities to progress:** 2021: Overall, 63%, 66% women, 65% men, 55% non-binary 2023: Overall, 62%, 36% women, 63% men, 55% non-binary 2024: Overall 59%, 60% women, 62% men, 44% non-binary 2025: Overall, 54%, 55% women, 62% men, 50% non-binary **Perception re equal chance of promotion:** 2023: Overall, 58%, 59% women, 62% men, 55% non-binary 2024: Overall 52%, 53% women, 58% men, 27% non-binary 2025: Overall, 47%, 47% women, 60% men, 45% non-binary **Satisfied with Learning and Development:**	Yes	**Progress summary** Figures for recruitment, exits and promotion roughly align with current composition. Higher duties and internal secondments have been given to proportionately more women than men. Perceptions of recruitment, learning and development have improved for all genders. However, perceptions of promotion and opportunities to progress have not. Progress demonstrated through improved data collection, proportionate access to development opportunities for women, and improved perceptions. This can be a difficult indicator to define progress in for the health sector. As a feminised organisation, in a feminised industry, gender equity challenges and successes differ fundamentally to those in male-dominated workforces. While progress has been made across most facets, we continue to aim for better data so that insights can become more sophisticated. **Recruitments, exits and promotions by gender** Audit data includes promotions for the first time in the 2025 audit, building transparency and accountability. When considering if progress has been made in this facet of the indicator, the feminised nature of the industry must be considered. A focus is on ensuring women and gender diverse staff given I internal progression and promotion opportunities at a level equal to or greater than their gender representation in the workforce. Recruitment, exits and promotion are proportionate to the current workforce composition of the organisation – with around 70% of each being women. When analysed by 15 levels to CEO we see that non-binary staff are being recruited largely into junior roles. We also see an increasing number of staff who do not wish to share their gender identity. Further, when net loss/gain (recruits minus exits) is examined, we see we greater net losses of women in senior roles. More senior women than men have exited the organisation, though numbers are small overall. Female nurses with extra responsibilities, and enrolled nurses exited at, slightly, disproportionately higher rates. **Higher duties and internal secondments by gender** Audit data includes higher duties and internal secondments for the first time in the 2025 audit. Overall, women were awarded more higher duties than men. At 75% this is slightly higher than overall workforce composition. This pattern is seen across most levels of the organisation. Medical staff are the exception. While medical figures roughly align with composition, this does not address the underrepresentation of women in leadership roles.

		2021: Overall 61%, 64% women, 66% men, 52% non-binary. 2023: Overall 68%, 70% women, 70% men, 55% non-binary 2024: Overall 71%, 73% women, 74% men, 59% non-binary 2025: Overall 67%, 69% women, 77% men, 55% non-binary		Women were also overrepresented in internal secondments, with 82% going to women. This pattern consistent at all levels that reported secondments. **Perceptions of recruitment**, **promotion and opportunities to progress** When considering the PMS questions related to recruitment and promotion, we note the low overall scores. These remain some of our lower scores from the survey, though we sit slightly higher than our comparator organisations[3]. However, there is a positive trend over time for perceptions of recruitment, excluding 2025 as per previous commentary. It rose from 59% of respondents seeing our processes as fair in 2021 to closer to 70% in the following two years, with men's and women's scores better aligning. However, First Nations and disabled staff reported lower scores of 37% and 53%, respectively (43% and 54% for First nations and disabled women). Perceptions of promotion and opportunities to progress have trended down, particularly for women and non-binary respondents. This may be due to perceiving a gap between the expressed intent of the organisation, and their own experiences. These scores may be linked to perceptions of discrimination. Nearly half (44%) of PMS respondents who said they had experienced discrimination, said they were denied an opportunity for promotion. No gender differences were found. This is the first audit where such data has been collected and can be shared. It will be interesting to see if people perceptions change as a result of greater transparency of promotion, secondment and higher duties data. While progress has not been made in this area, the plans in place will give us greater insights to target areas that may make a meaningful impact. **Perceptions of learning and development** Trend is positive over time for all genders, excluding 2025 as per previous commentary. This is strongest for women who rose from 64% satisfaction in 2021 to 73% in 2024. Our scores are 4-5% higher than comparators which is also pleasing. **Diversity and intersectionality** When PMS scores are considered by diversity groups (See for example Table 3 and Figure 2 in the appendix) it shows lower scores for First Nations and disabled staff, and also those with caring responsibilities. Scores are trending positive over time. Intersectional analysis is not available for non-binary staff due to low numbers. Detailed intersectional analysis for women is affected by the fact that most respondents are women. However, it does show that women with disability, caring responsibilities other than children have lower scores.
6	**Critical performance measures** <u>Average weeks of parental leave, by gender</u>: 2021: • Women - 14.3w paid, 28.9 w unpaid. • Men - 1.7w paid, 2.5w unpaid. • Non-binary – none taken 2023: • Women 32 weeks total,7.65 weeks paid, 24.07 w unpaid. • Men 3 weeks total, 2.14w paid, 0.55w unpaid. • Non-binary 15 weeks total, 9.71w paid, 5.29 unpaid. 2025: • women 21wks total, 14 paid, 7 unpaid • men 13.5wks total, all paid • non-binary no leave taken	**Parental Leave Exits:** 2021: 48 voluntary women 2023: none 2025: 2 involuntary women, 1 involuntary man **Family Violence Leave taken:** 2021: 14 total, 12 women, 1 man, 1 non-binary 2023: 60 total, 55 women, 3 men, 2 non-binary 2025: 28 total, 24 women, 4 non-binary	Yes	**Progress summary** Progress has been made around parental leave exits, carers leave access, perceptions of and access to family violence leave, and perceptions of and access to flexible work. While progress has been made for men accessing paid parental leave, we have not seen progress in men accessing unpaid parental leave. This will be a focus for the next reporting period. **Parental Leave** Men are taking more weeks of parental leave overall than in previous audits. However, it is in the area of paid parental leave, which can largely be attributed to improved Enterprise Agreement entitlements. However, the increase in paid leave available has likely contributed to the drop in unpaid leave taken. No men took unpaid leave in 2025and as such, this an area that needs further attention.

[3] VPSC PMS dashboard

	Uptake of flexible work, by gender: • 2023: no data available • 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: • 2021: Overall, 64%, 68% women, 68% men, 52% non-binary • 2023: Overall, 68%, 69% women, 70% men, 68% non-binary • 2025: Overall, 71%, 71% women, 73% men, 84% non-binary **Supplementary measures** Gender composition of parental leave takers: • 2021: Of all staff to take parental leave, 87% were women, 13% were men, and no non-binary. • 2023: Of all staff to take parental leave, 82.5% were women, 17% were men, and 0.5% non-binary. • 2025: Of all staff to take parental leave, 97% were women, 3% were men, and 0% non-binary. Gender gap in carer's leave: • 2023: 19% of women took carers leave, 16.5% of men and 9% of non-binary staff • 2025: 20% of women took carers leave, 17% of men and 12% of non-binary staff	**Org would support a FV leave request:** 2021: Overall 75%, 79% women, 72% men, 72% non-binary 2023: Overall, 81%, 83% women, 78% men, 75% non-binary 2025: Overall, 79%, 81% women, 81% men, 86% non-binary **PMS reports of utilising Flex Work** 2021: Overall 64%, (part time and shift swap most common) 68% women, 58% men, 59% non-binary 2023: 73% (part time and shift swap most common) 76% women, 66% men, 72% non-binary 2025: Overall 73% (part time, working from alternate location, shift swap and flex start/finish times) most common 77% women, 68% men, 77% non-binary **Manager supports working flexibly**: 2023: Overall, 77%, 79% women, 79% men, 73% non-binary 2024: Overall, 77%, 79% women, 80% men, 64% non-binary 2025: Overall, 74%, 75% women, 78% men, 82% non-binary		While we had some non-binary staff utilise parental leave in the 2023 audit, none were recorded in the reporting period. With the small numbers overall, this is not necessarily a cause for concern, and we are aware of non-binary staff who began parental leave just after 30 June 2025. The gender composition of parental leave takers trended positive between 2021 and 2023, with men moving from 13 to 17% of staff who took parental leave. However, 2025 showed a significant backward shift with only 3% being men. That's only 11 men compared to 96 in 2021, and 110 in 2023. We do know that many men use other leave entitlements, such as long service leave, to cover parental leave absences, which would be missed in this audit. While gendered language is being removed from Enterprise Agreements, the requirements for primary carers leave to be utilised at the time of birth or adoption remains a barrier for many men. **Parental leave exits** Pleasingly, numbers of people exiting during parental leave have significantly decreased, from 48 people in 2021 to 3 in 2025 following a proactive campaign to support the return to work of new parents. **Carers Leave access** Carers Leave use remains relatively consistent between men and women, with women taking slightly more in both years. Non-binary staff have increasingly accessed carers leave which is positive. **Family Violence Leave access** We saw a significant increase in the uptake of Family Violence Leave, especially in 2023 which was after a review of the procedure and a targeted communications campaign. While it has reduced slightly in 2025, usage remains double to that of 2021 which is a positive sign. Similarly, perceptions of organisational support for taking Family Violence Leave have increased for all genders, and most significantly for non-binary employees increasing from 72% in 2021 to 86% in 2025. **Flexible work** Flexible work and leave data remain areas where current system capability limits the precision of reporting. Formal flexible work arrangements are incompletely captured in the HRIS in a structured way. This gap will be addressed in the 2025 Action Plan. For the purpose of the 2025 Audit and this report, formal flexible work arrangement data was compiled through a manual review of Flexible Work Arrangement application forms held in employee files. Most recent PMS responses regarding flexible work provide additional information in regard to uptake of flexible work. These responses show that uptake of flexible work has increased from 64% in 2021 to 73%, with working part-time and shift work being the most common. While women do utilise flexible work more than men, the use has increased for all genders from 2023 - 2025. Peoples' confidence that a flexible work request would be considered fairly has increased over time for all genders, and their belief that their manager supports flexible work has remained steady. **Diversity and intersectionality** When PMS scores were considered by diversity we see a reduction in differences over time, but with lower scores remaining for First Nations. See for example Table 4 and Figure 3 in the Appendix. Intersectional analysis is not available for non-binary staff due to low numbers. Detailed intersectional analysis for women shows that women with disability have lower scores.
7	**Critical performance measures** Occupational gender segregation:	**Org uses respectful images and language**: 2021: Overall, 85%, 88% women, 85% men, 74% non-binary	No	**Progress summary** The RMH can demonstrate an inclusive culture, with high relative scores, and scores improving for people with intersecting identities. Maintaining an inclusive culture is strength, and something the RMH is proud of and continues to proactively build upon.

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%**

2023: Overall, 88%, 89% women, 89% men, 73% non-binary
2025: Overall, 85%, 87% women, 88% men, 86% non-binary

My org does not tolerate improper conduct:
2021: Overall, 80%, 83% women, 84% men, 68% non-binary
2023: Overall, 87%, 89% women, 87% men, 65% non-binary
2024: Overall, 75%, 77% women, 80% men, 64% non-binary
2025: Overall, 78%, 81% women, 81% men, 59% non-binary

Feel culturally safe at work:
2021: Overall, 80%, 83% women, 84% men, 68% non-binary
2023: Overall, 87%, 89% women, 87% men, 65% non-binary
2025: Overall, 78%, 81% women, 81% men, 59% non-binary

Workgroup treat each other with respect:
2021: Overall, 76%, 78% women, 75% men,
2023: Overall, 84%, 85% women, 85% men, 78% non-binary
2025: Overall, 77%, 77% women, 84% men, 86% non-binary

Manager treats employees with respect:
2023: Overall, 86%, 88% women, 88% men, 80% non-binary
2025: Overall, 80%, 81% women, 85% men, 82% non-binary

Work allocated fairly by gender:

While there is relative stability in this indicator, with some improvement, progress is not consistently demonstrated.

Occupational gender segregation – ANZCO codes
The analysis of data based on ANZCO codes provides limited insight for a healthcare workforce as it does not align to the sectors workforce composition or Enterprise Agreements. When the RMH roles are aggregated into ANZSCO occupation groups, critical detail about internal hierarchies disappears for example Nurse Unit Managers seem to be classified as professionals, while a Director of Clinical Services is classified as a 'Manager'.

The RMH data shows women most highly represented as managers and professionals, and men as machinery operators and drivers. The biggest shifts since the 2023 audit is a 5% increase in men in the manager and machinery operators and drivers' categories. Further analysis by level to CEO is provided below.

Occupational gender segregation in craft groups via 15 levels to CEO
The levels utilised for 'Level to CEO' analysis categorises our workforce into four craft groups: nursing medical, allied health and administration.

When examining segregation by Levels to CEO we see relative stability. The biggest changes are the reduction of women at the Executive and General Manager levels, counterbalanced by an increase in women in the senior (non-medical) managers roles, and an increase in women in the entry level support services.

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.

Further analysis at local levels is required to understand and address concerning gender segregation.

Efforts have successfully increased gender balance in security at the RMH. Since 2023 the number of women working security has doubled from 4 to 8, which is a small but significant difference in a team of around 50. Future efforts will include looking at medical units to identify opportunities to improve gender representation.

Bullying
Reported experiences of bullying have increased in 2025 for men and women. Like sexual harassment this is can in some part be aligned with education and awareness raising about appropriate workplace behaviour. Pleasingly, non-binary rates have decreased over time, likely in response to efforts around LGBTIQA+ inclusion.

As in previous years, the vast majority (69%) name incivility as the bullying behaviours experienced, this was consistent for all genders. Only 23% of those who made a formal report were satisfied with its handling, a drop from 27% in 2023, comparison by gender were unavailable. 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 and build capability of local leadership.

Discrimination
Reported experiences of discrimination have increased in 2025 for both men and women but remain low. Like sexual harassment this 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%). Satisfaction of handling of formal reports has significantly increased from 7% in 2023 to 40% in 2025.

Perceptions of inclusive culture and organisational response

		2021: Overall, 81%, 84% women, 83% men, 74% non-binary 2023: Overall, 82%, 83% women, 83% men, 75% non-binary 2025: Overall, 76%, 78% women, 80% men, 82% non-binary **I can be myself at work:** 2021: NA 2023: Overall, 84%, 85% women, 84% men, 73% non-binary 2025: Overall, 79%, 80% women, 84% men, 59% non-binary **I feel like I belong at RMH:** 2023: Overall, 84%, 81% women, 80% men, 60% non-binary 2025: Overall, 73%, 75% women, 77% men, 59% non-binary **Experienced bullying:** 2023: Overall, 14%, 14% women, 12% men, 25% non-binary 2024: Overall, 14%, 13% women, 20% non-binary 2025: Overall, 20%, 20% women, 15% men, 18% non-binary **Experienced Discrimination:** 2023: Overall, 6%, 5% women, 6% men, 20% non-binary 2024: Overall, 6%, 5% women, 4% men, 15% non-binary 2025: Overall, 8%, 8% women, 8% men, 14% non-binary **Witness barriers to success:** 2023: 74% not witnessed any. Highest groups reported were flex work (10%) and caring resp (8%) 2025: 70% not witnessed any. Highest groups reported were flex work (12%) and caring resp (10%) **Experienced barriers to success:**		Several PMS questions inform this indicator, and the RMH looks at questions beyond those stipulated by CGEPS. Questions regarding our inclusive culture and willingness to address poor behaviours are consistently our highest survey scores and higher than our comparators. However, there has been a small decline in scores between 2023 and 2025. Like our efforts around sexual safety, education around appropriate workplace behaviours could account for an increase in reporting of bullying and discrimination, and an increase of expectations of the organisation to act. Also as mentioned there has been a general flattening of PMS scores across the health sector in 2025. **Organisational response to inappropriate behaviour** In 2022-3 one staff member was terminated for unsafe behaviours such as bullying, discrimination, sexual harassment and other violence. Nine resigned during an investigation. In 2024-5 three staff members were terminated and 14 resigned during an active investigation. This demonstrates a strengthened response to reports. Visibility of this shift remain low across the organisation, something the RMH will seek to address in the next reporting period. **Barriers to success** Experienced: 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, age is highlighted here, when the question around opportunities to progress is examined by age no strong patterns are identified. Witnessed: Most PMS respondents had not witnessed any barriers to success. For those that did, sex/gender 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. **Disability inclusion** PMS data shows that many staff with disability do not share that information with their manager, often out of fear that it will have a negative impact. Efforts to address the stigma around disability will continue. • 2023 PMS 4% w disability, 38% not shared the info, 27% felt it would reflect negatively on me • 2024 PMS 5% w disability, 44% not shared the info, 32% felt it would reflect negatively on me • 2025 PMS 7% disability 7% (rest of data not available) A new Disability Action Plan will be developed this year and will consider this issue. **Diversity and intersectionality** When PMS scores are considered by diversity groups (see for example Table 5 and Figures 4 & 5 in the appendix) it shows lower scores for First Nations and disabled staff. Scores are trending positive over time. Intersectional analysis is not available for non-binary staff due to low numbers. Intersectional analysis shows that First Nations women, and those with disability, or caring responsibilities other than children have lower scores.

		2023: 73% not exp any. Highest groups reported were age and caring resp and flex work (both 7%) and mental health (6%) 2025: 70% not exp any. Highest groups reported were age and caring resp (both 8%) and flex work (7%)		

*Indicators (column K)

1. Gender composition of all levels of the workforce
2. Gender composition of the governing body
3. Equal remuneration for work of equal or comparable value across all levels of the workforce, irrespective of gender
4. Sexual harassment in the workplace
5. Recruitment and promotion practices in the workplace
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
7. Gendered segregation within the workplace

Section 2.2 Describing factors limiting and contributing to progress

1 (gender comp)	☐None ☐ a ☒ b ☐c ☒d ☒e ☐f ☒g	**Nature and circumstances** Like most health organisations, the RMH has a predominantly feminised workforce, and the workforce pipeline has a similar composition, particularly across nursing and allied health. This is a sector wide characteristic, which is difficult for a single organisation to shape. Addressing this aspect of gender equality is not considered a priority currently. **The organisations resources & competing priorities and obligations** The RMH operates in a resource constrained environment, where funding is largely tied to healthcare provision outputs, accordingly clinical care, staffing constraints and managing other unexpected issues must be prioritised, which can impact and sometimes delay gender equity initiatives. For instance, the pandemic impacted many proactive initiatives. However, the RMH remains committed to prioritising gender equity and intersectional inclusion, including ensuring appropriate resourcing is allocated. **Genuine attempts** In this indicator we have focused on attracting and retaining non-binary staff, retaining senior women, especially in medicine, attracting women into traditionally male dominated roles like security, and increasing job security. Our entry level roles support many women who face additional barriers to employment. We support them to build skills, gain qualifications, and increase economic outcomes. Efforts that support progress across the gender equality indicators also relate to this indicator. They include building skills and knowledge around intersectional gender equity, elevating and empowering lived experience, and enhancing policies and procedures, and enabling flexible working arrangements where possible.	• Undertook several communication campaigns to engage staff and leaders in understanding the case for change and raise awareness of the steps they can take to promote equity in the workplace. • Hosted a range of events that celebrate our diverse workforce and community such as IDAHOBIT, NAIDOC week and more. • Precinct wide International Women's Day (IWD) series. In 2025, 11 events were held focused on varied topics relevant to healthcare. Wherever possible event recordings were made available for those unable to attend live. • New IWD scholarship to support RMH staff to lead gender equality locally. • Diversity considered and monitored for participation in The Melbourne Way Leadership Program. • Reviewed leadership development offerings to enhance inclusive leadership skills including leadership masterclasses on topics such as inclusive leadership and gender pay gaps as well as weaving key principles into all leadership fundamental programs. • A new online resource library is supported by SMEs from across the RMH to support ongoing and informal learning • Updated policy and procedure templates to include consideration of equity, provided training to policy review committees. • Reviewed staff orientation processes to embed inclusion. This included providing pronoun pins, considering speakers and content, and building visibility of key roles and services such as the LGBTIQA+ Liaison service. • Supported existing staff voice committees and their associated Action Plans, for example: Aboriginal Governance Committee and the LGBTIQA+ Steering Committee. • Increased representation of staff with lived experience on the Disability Working Group and included actions related to staff experiences in the action plan. • Supported placement and pathways programs for young people of all genders with disability and supported school placements. • Reviewed recruitment procedures and templates for inclusive language and practice, updated tools and resources. • Developed and promoted an Inclusive Communications Guide.

			• Strengthened diverse representation of the RMH in external communications, including specific gender focused campaigns • Created a new website with strong accessibility features and improved content regarding support for diverse patients/consumers and job seekers. • Reviewed Flexible Work procedure and undertook a communication campaign to raise awareness of the various types and benefits of flexible work to staff and leaders. • Actively promoted Parental Leave for people of all genders. • Updated Gender Affirmation in the Workplace procedure to support trans and non-binary staff members. • Reviewed the Leave Procedure to increase support available to Aboriginal and Torres Strait Islander and multifaith staff. • Reviewed the Family Violence Leave procedure with staff with lived experience and promoted it and other supports available. • Hosted a '*Men as Allies'* event to increase men's confidence and competence in addressing gender-based violence. • Introduced the external, anonymous Virtual Ombuds service and acted on insights • Hosted several forums and webinars to build skills and knowledge regarding menopause for employees and patients. • Appointed Sexual Safety Nurse Consultant who has led significant pieces of work to enhance sexual safety. • Partnered with diverse staff to review complaints handling process to build a trauma informed and equitable approach. • Reviewed gendered language in security position descriptions and job ads. • Increased job security for junior medical staff. • Working group created to update data collection and reporting to align with CGEPS requirements and improve analysis. • Developed an overarching DEI Policy, a first for the RMH.
2 (board com)	☐None ☐ a ☒ b ☒c ☐d ☐e ☐f ☒g	**Nature of organisation and requirements under another act** The RMH Board is appointed by the Victorian Government, as with all public hospitals. **Genuine attempts** Within these constraints, we have built Board understanding of the value of gender equity and intersectional inclusion. The Chair and broader board is very supportive of the RMH being a leader in achieving gender equity.	The Board were supported to explore opportunities to influence board attraction and increase diverse representation, within the constraints of it being led by the Victorian Government. • The Gender Equality Act was added to the board induction/orientation. Equity considerations were also added. • The Board receives regular briefings and updates on the progress of the Gender Equity Action Plan. • The Board participates in events that promote and support gender equity initiatives. • The Board is actively seeking members who have intersectional life experience.
3 (pay equity)	☐None ☐ a ☒ b ☐c ☒d ☒e ☐f ☒g	**Nature and circumstances of the organisation, competing priorities**, **and practicality and cost to the organisation** The largest driver of our overall gender pay gap is the fact that 70% of our overall staff are women, but 60% of our doctors (our highest paid staff) are men. This reflects the long-standing gender segregation seen across the health sector. There are also higher mean pay gaps that are due to a small number of outlier salaries. A key driver of this is legacy contracts. It is not feasible or appropriate use of constrained funding to simply raise other salaries to match, nor is it possible to reduce existing contract salaries. This will rely on attrition. There are also sector relativities which are difficult for a single organisation to address. This includes relativities between medical craft groups, some of which also are gender segregated. **Genuine attempts** Education, additional data analysis, salary reviews, and work in all the other indicators have impacted progress.	• Reviewed process to record and access data to improve accuracy and support stronger analysis. • Workforce data was analysed at 29 levels to the CEO to allow for more nuanced scrutiny, and leaders were encouraged to explore their own team's data. Salary reviews have been completed in key areas and adjustments made. Actions have been taken to support better representation of women in senior medical roles and more consistency in remuneration. The next Action Plan will include the finalising of a Remuneration Procedure and further investigation of problem areas for the pay gap. This includes a specific focus on the medical workforce • Education sessions on the gender pay gap have been facilitated. • A specific gender focus committee for medical staff has been established to understand the issues in more detail. • Proactive engagement with unions regarding historical inequity in enterprise agreements • Efforts in all other indicators are relevant to this indicator.

4 (sex harass)	☐None ☒ a ☒ b ☒c ☒d ☐e ☒f ☒g	**Size of the organisation** The scale of the organisation and speed of patient flow can make it is very difficult to respond appropriately in a moment. With close to 13000 employees, it is challenging to ensure key messages reach everyone who needs to hear then. Similarly, the visibility and oversight required to ensure consistent approaches is difficult. However, we are improving our communication channels, seeking better ways to ensure visibility and are proactively working to reach our frontline staff with these important messages. **Nature and circumstance of organisation, and practicability and cost to the organisation** The healthcare setting has unique complexities and barriers both in the clinical and staff space in the management and prevention of sexual harassment. Most of the sexual harassment experienced by our staff originates from people receiving care and members of the public. These behaviours can often appear in the context of complex clinical situations (delirium, dementia, brain injury, influence of drug/alcohol) and have historically been minimised or ignored, with patient care prioritised. Being a large public trauma hospital, we can never eliminate the risk that these behaviours will occur. And once they do, our duty of care requirements mean we often cannot simply remove the hazard. Instead, we need to create and refine a plan of care that provides for medical needs whilst minimising harm to staff. In some areas of the hospital sexual harassment is common, with data showing some work groups experience this regularly. Reporting of clinical incidents is done via a safety incident reporting system shaped by state government and utilised across all public health services. It is time consuming and not fit for purpose. Many staff complete these reports in their own time, as time and access to computers is limited. Staff report that it can feel like further punishment to spend 20 mins doing so after a long shift. Regarding sexual harassment occurring between staff, barriers to progress include the strongly embedded hierarchies and power structures. Many junior staff, such as junior doctors, are on short term/annual contracts, and rely on senior staff to recommend them for their desired speciality. They are understandably cautious and worried about what speaking up might mean for their future career. **Requirements under other legislation** The RMH has requirements under the *Health Act*, *Mental Health and Wellbeing Act*, and the *Australian Charter of Healthcare Rights*. All these underpin the prioritising of patients' rights and needs that can impact our ability to prevent and address sexual harassment. For example, the mental health and wellbeing act requires the minimisation and elimination of use of restraints, meaning staff are more exposed to sexualised touching in some cases. This legislation also shapes some of the data collection challenges as outlined above. Additionally, the current legislative landscape in healthcare can make addressing concerning staff behaviour difficult, for example board involvement is required to terminate doctors creating another hurdle in the system. There are also mandatory requirements relating to clinician registration and reporting with the Australian Health Professionals Regulation Authority (AHPRA) that may influence some staff in their willingness to report. New changes will mean any findings against a doctor will be on their permanent record which may act as a deterrent to both the perpetrators and the reporters. **The organisations resources** & **genuine attempts** The RMH continues to invest in the Sexual Safety Nurse Consultant role, a unique role that reflects the commitment to reduce harm from sexual harassment. This role has worked	• Appointed and embedded Sexual Safety Nurse Consultant. They undertook a review of sexual harassment in the workplace, met with complainants and their managers, reviewed literatures, systems and process. • The Sexual Safety Nurse Consultant has worked extensively across campuses to was used to build the understanding of our staff and challenge historical and sector-based attitudes to behaviours from patients, managing internal hierarchies, and understanding the range of responses to trauma. • The Sexual Safety Nurse Consultant codesigned a guideline for how to respond to sexual behaviours from patients in collaboration with clinical staff. Thei guideline has clear information to support all staff, including managers to consistently respond in a trauma informed way while continuing to deliver patient care. This initiative has been shared with other public hospitals and has been recognised by WorkSafe (finalist in one of their 2026 awards) • Sexual safety education is routinely delivered by Sexual Safety Nurse Consultant, OVA team, P&C Business Partners. Over 150 education sessions have been facilitated with teams across the RMH over the reporting period. • Sexual safety education has also been embedded into existing and complimentary trainings – e.g. sexual safety examples included in Speaking up for Safety and Active Bystander trainings. • Educational series have been run with leadership and other staff groups (such as clinical assistants) to highlight and discuss Respectful Behaviours in the Workplace. These have been developed and delivered as a collaboration between Sexual Safety Nurse Consultant and P&C Business Partners. • . The DEI Consultant and Sexual Safety Nurse Consultant initiated and facilitated the planning and delivery of a statewide forum on '*Sexual Safety in Healthcare*' through the VHOGEN forum. This was attended by the DEI stakeholders from across Victorian Public Hospitals and included presentations from leading researchers and Dr Nikki Vincent. This initiate has generated multiple inter-hospital conversations sharing insights and strategies for improvement. • Sexual Safety Nurse Consultant partnered with leaders and educators in the RMH Emergency Department to progress a sexual safety quality improvement project – included a staff survey to highlight barriers of reporting and an education intervention. • Sexual Safety Nurse Consultant collaborated with senior psychologist to undertake a formal research project into staff experiences of sexual safety in the mental health setting. Initial findings have been presented to senior leadership, and formal writing for publication is underway). • Engaging senior leaders and investing in education of student/junior staff – help improve perceptions of safety – to hopefully help with reporting. • Establishment of SASH Prevention Discussion Group – bring ideas for socialisation and discussion of key ideas, challenges and considerations – with feedback to OVA and Partnership in Care Committees. • Sexual Safety Nurse Consultant attends multidisciplinary team meetings and safety huddles to support specific efforts when staff are caring for high-risk consumers. • Collaboration with WorkSafe, the Unions and specialist sexual assault services when high risk consumers are requiring care • Other efforts such as work in indicators 1 and 7 also shape this work.

		closely with the Occupational Violence and Aggression team to enhance support following any sexual safety incident. The response guideline was developed with input from across the organisation. Training sessions have been rolled out across the organisation to build skills and knowledge around sexual safety. Sexual Safety case studies are included in other education such as Active Bystander Training. People and Culture continue to work to improve responses to sexual harassment complaints.	
5 (recruit & pro)	☐None ☒ a ☒ b ☐c ☐d ☐e ☒f ☒g	**Size of the organisation** With close to 13000 employees, it is challenging to ensure key messages reach everyone who needs to hear then. Similarly, the visibility and oversight required to ensure consistent approaches to recruitment and promotion is difficult. Also, much professional development is locally managed and not centrally recorded or reported at the RMH. We are continuing to improve our systems and communication channels. **Nature and circumstance of organisation, and practicability and cost to the organisation** The centralised allocations of graduate staff in medicine and nursing reduces the ability of the RMH to determine junior recruitment. Attraction and recruitment data routinely reflects gendered educational pipelines, that we have little ability to influence, or to drive visible change in a short time. Clinical colleges and registration bodies set progression requirements and hold data about professional development. Clinical staff must meet strong minimum requirements around Continuing Professional Development. Under the Commission definition, this does not count as Professional Development but leaves little space for additional education. This education is tracked by external bodies not the RMH, so if it were to be included data collection and reporting would remain a challenge, making it difficult for us to demonstrate progress. Ongoing sector wide budget reductions have impacted internal funding for additional education. Combined with the high demand for clinical services, this has resulted in education workshops and study days being postponed or cancelled to prioritise patient access and flow through the healthcare system. 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. **Genuine attempts** As highlighted opposite, much work was undertaken to try to improve outcomes in this indicator. This includes attraction, recruitment, orientation, leadership development, and data availability.	• Undertook a literature review, internal practice review, and benchmarking process to inform a understand opportunities to improve recruitment. • Updated recruitment tools and resources. • Developed and promoted an inclusive communications guide. • Strengthened diverse representation of the RMH staff and consumers in external communications. • Created a new website with strong accessibility features and improved content regarding support for diverse patients/consumers and job seekers. • A new Human Resources Information System was built to align with CGEPS reporting requirements and supports confidential capture of diversity data. Promoted to staff. • Diversity considered and monitored for participation in The Melbourne Way Leadership Program. • Reviewed leadership development offerings to enhance inclusive leadership skills – this included leadership masterclasses on topics such as inclusive leadership and gender pay gaps as well as weaving key principles into all leadership fundamental programs. • Reviewed staff orientation processes to embed inclusion. This included providing pronoun pins, considering speakers and content, and building visibility of key roles and services such as the LGBTIQA+ Liaison service. • Other efforts such as work in indicators 1 & 7 also shape this work.
6 (leave)	☐None ☐ a ☒ b ☐c ☒d	**Nature and circumstances of the org, org resources, practicability and cost to the org** Victoria's Public Health workforce is covered by 11 Enterprise Agreements totalling 23 Awards. The RMH is required to comply with nine of these 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).	• Promoted parental leave for people of all genders and highlighted the link between parental leave and the gender pay gap. • Reviewed Gender Affirmation in the Workplace procedure to support trans and non-binary staff members, including leave provisions beyond enterprise agreement entitlements.

	☐e ☒f ☒g	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 Agreements, many discrepancies still exist. Some relate to entitlements that underpin gender equity efforts. Agreements differ in entitlements such as parental leave, carers leave, gender affirmation leave, and cultural and ceremonial leave. As highlighted above, the RMH operates in a resource constrained environment where consistency across the sector is important. As highlighted in the pay equity section, men are most represented in our medical workforce. It is likely these men are the highest earners in their families and therefore less likely to take unpaid leave. This is a wider structural issue for the community. Flexible work and leave data remain areas where current system capability limits the precision of reporting. Formal flexible work arrangements are not presently captured in the HRIS in a structured way. For the purpose of this report, flexible work data was compiled through a manual review of Flexible Work Arrangement application forms held in employee files. While this approach allowed the organisation to include relevant information in the dataset, it is a manual process and may not fully capture all arrangements. **Genuine attempts** The RMH has committed to provide gender affirmation leave, and cultural leave beyond base agreement entitlements. We worked with staff to enhance our approach to family violence leave and flexible work and undertook a range of activities as outlined opposite.	• Reviewed the Leave Procedure to increase support available to Aboriginal and Torres Strait Islander and multifaith staff. • Reviewed the Family Violence Leave procedure with staff with lived experience and promoted it and other supports available. • Hosted a *'Men as Allies*' event to increase men's confidence and competence in addressing gender-based violence. • Hosting a range of event during 16 days of Activism Against Gender Based Violence. • Promoting a broader understanding of flexible work in a healthcare context. • Providing support, advocacy and coaching for individual matters
7 (gender segregation)	☐None ☒ a ☒ b ☐c ☐d ☐e ☐f ☒g	**Nature and circumstances of the org** The ANZCO codes provide little insight in the hospital context, so the focus is on craft group and Level to CEO analysis provides more relevant information. Like most health organisations, the RMH has a predominantly feminised workforce, and the workforce pipeline has a similar composition, particularly across nursing and allied health. This is a sector wide characteristic which the RMH cannot meaningfully influence in isolation. **Genuine attempts** A key focus has been on supporting people of all genders who work with us to feel safe, supported and empowered to thrive at the RMH. We have also targeted medical and security as areas to increase the representation of women.	• Efforts in all other indicators are relevant to this indicator. A selection is listed below. • Hosted a '*Men as Allies*' event to increase men's confidence and competence in addressing gender-based violence. • Implemented an external anonymous reporting pathway, the Virtual Ombuds Service. • Appointed Sexual Safety Nurse Consultant who has led significant work to enhance sexual safety. • Developed LGBTIQA+ Liaison Service, a first in Australia. • Expanded the First Nations Health Unit including the introduction of a Workforce role. • Partnered with diverse staff to review complaints handling process to build a trauma informed and equitable approach. • Reviewed gendered language in security position descriptions and job ads. • Increased job security for junior medical staff. • Embedded equity in our revised clinical governance framework. • Developed an overarching DEI Policy, a first for the RMH.

*Factors (column Q):

a. the size of the organisation, including the number of employees
b. the nature and circumstances of the organisation, including any barriers to making progress
c. requirements that apply to the organisation under any other Act, including an Act of the Commonwealth
d. the organisation's resources
e. the organisation's operational priorities and competing operational obligations
f. the practicability and cost to the organisation of making progress; and
g. genuine attempts made by the organisation to make progress.

Step 3: Reporting on GEAP strategies

Section 3.1 Explaining incomplete strategies

Work regarding men taking parental leave did begin during the reporting period, but key activities were delayed. A planned partnership with Melbourne University to run focus groups did not go ahead. These important actions will be carried over into the next plan, including a communication campaign to highlight the benefits of men taking parental leave.

Section 3.2 Describing achievements, challenges and learnings (recommended)

The RMH approach could be summarised as follows:

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

Our overall strategies include:

- Auditing and reporting
- Recognising and celebrating key dates
- RMH-wide committees, action plans and online communities
- Learning and development
- Policy, procedure & guideline development and review
- Health equity as part of quality improvement.
- Dedicated roles and services

Success highlights include:

- Creative staff engagement approaches.

For example,

  - Enabling frontline staff to provide immediate feedback on the gender equality action plan by using interactive initiatives
  - Building awareness of disability inclusion by visible engagement opportunities in high traffic employee areas
  - Drawing attention to the challenges of sexual safety in the clinical space by co-creating a video amplifying staff voices of lived experience

- Sector leaders in sexual safety.

The establishment of specific sexual safety role within RMH is unique and groundbreaking. It has enabled us to listen to our staff in a person-centred way and ensured that this important issue remains front and centre. The establishment of this role has been crucial in building confidence and trust amongst staff groups. Our sexual safety specialist is often invited to speak at events run by other organisations in the sector on the impact of work being undertaken at the RMH. Our new response guideline has challenged the historic normalisation of sexual harassment, and is currently being emulated by other hospitals, as well as recognised by WorkSafe as an important contribution to staff safety.

- LGBTIQA+ safety and inclusion.

Visibility and engagement of this community and their experiences have grown over the last 4 years. PMS scores for LGBTIQA+ staff have steadily improved in response. The development of an LGBTIQA+ Liaison Service is further evidence of RMHs commitment to ongoing improvement in this area.

- Active Bystander Training.

At the time of reporting over 2300 staff have been trained, by a group of champions from across the organisation. This has built trust and confidence and increased formal reporting of sexual harassment by bystanders.

Learnings

- Tying workforce equity efforts to patient outcomes has proved the most effective way to build engagement and commitment to equity efforts.
- Health is a sector comprising of multiple distinct workforces. Success for one professional group, often doesn't easily translate to another. Targeted, tailored approaches are required, which is resource intensive but necessary. This has worked in the bystander action efforts, and a specific Gender Equity in Medicine Committee has been created to drive change in this workforce.

Section 3.3 Providing other updates on implementation (recommended)

Many actions are ongoing, such as work in the parental leave space, or the work to elevate and build consistency in recruitment practices. Driving cultural change is long term, complex work. The RMH is committed to continuing to focus on our progress.

Embedding GIAs is an ongoing focus for the RMH, and training has been provided to key stakeholders. Further, the new Clinical Governance Framework includes equity as a key component, which provides an opportunity to strengthen oversight and accountability.

Section 3.4 Describing resourcing allocation

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 supports progress.

All actions have executive sponsors, such as the Gender Equity Committee has an executive sponsor, and a senior leader is Chair. This is the same for and other relevant committees such as the First Nations and Disability groups. The DEI consultant meets regularly with these champions to discuss progress.

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 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.

Any other additions or comments

As highlighted earlier, People Matter Survey response rates and results were lower for this reporting period when compared to previous years. We are mindful that the results do not enable a representative, statistically significant sample to provide accurate insights. The most recent PMS achieved 50% completion rate so data moving forward will be much more reliable and insightful.

Appendix 1 – Audit Data Tables

Table 1: 2025 PMS completion rates and score changes compactor health organisations

Organisation	Headcount	2025 Response rate	2024 Response rate	Average Change	# Questions Declined	# Questions Same	# Questions Improved
Melbourne Health (RMH)	11,239	16%	48%	**-4.3%**	20	1	2
Royal Women's Hospital	2,066	20%	50%	**-6.9%**	21	3	0
Royal Children's Hospital	5,475	7%	50%	**-5.6%**	20	1	2
Peter MacCallum Cancer Centre	750	20%	58%	**-4.2%**	21	1	1
Royal Eye and Ear Hospital	1,102	34%	34%	**-2.8%**	18	3	2
Oral Health Victoria	648	62%	40%	NP	17	3	3
Northern Health	8,570	11%	32%	**-5.3%**	22	0	1
Monash Health	22,000	9%	24%	**-4.8%**	19	4	0
Western Health	1,1000	22%	17%	**-1.3%**	19	0	4
Austin Health	11,000	8%	22%	NP	19	4	1
Alfred Health	12,000	4%	20%	NP	14	3	7

Table 2: 2025 PMS responses for recruitment and promotion questions by diversity groupings

Responses to Recruitment and Promotion Questions

Survey Questions	RMH	First Nations	Men	Women	Non Binary	Disability	LGBA	Born OS	Language	Non Christian	Caring for Children	Caring for Disability / Illness	Caring for Aged	15-34 years	55+ years
Satisfied w/ learning & development support	67	42	77	69	55	64	70	74	70	69	72	65	71	70	73
Satisfied w/ career progression opportunities	54	42	62	55	50	39	56	61	59	61	57	50	51	57	58
Fair recruitment processes	60	37	69	60	68	53	64	68	63	57	64	58	54	62	68
Fair promotion processes	46	21	57	46	55	36	48	55	51	47	50	46	42	44	54
Equal chance at promotion	47	26	60	47	45	37	52	56	51	49	52	40	46	47	54
Experienced barriers to success	30	68	24	30	59	62	34	25	27	21	33	39	29	34	18
Witnessed barriers to success	30	63	26	29	50	53	33	26	24	19	30	41	33	35	14

Figure 1: PMS responses to "Satisfied with learning and development" question over time, by diversity groupings

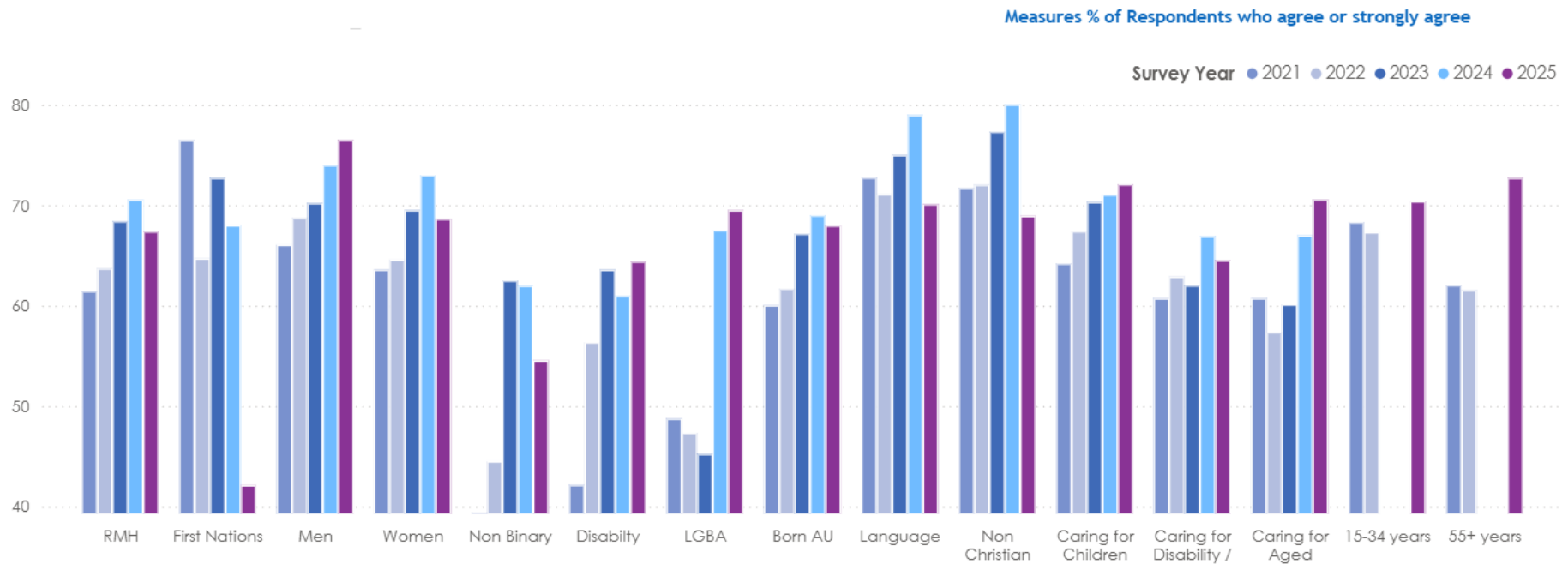


Table 3: 2025 PMS responses for sexual harassment questions by diversity groupings

Responses to Sexual Harassment Indicator

Survey Questions	RMH	First Nations	Men	Women	Non Binary	Disabilty	LGBA	Born OS	Language	Non Christian	Caring for Children	Caring for Disability / Illness	Caring for Aged	15-34 years	55+ years
Safe to challenge behaviour	72	58	83	72	68	69	72	79	74	73	78	69	72	69	86
Takes steps to eliminate bullying/harass	67	53	77	68	59	62	67	77	72	73	72	66	70	66	80
Experienced sexual harassment	17	21	10	19	18	35	24	11	12	10	12	13	16	30	4

Figure 2: PMS responses to "safe to challenge behaviour" question over time, by diversity groupings

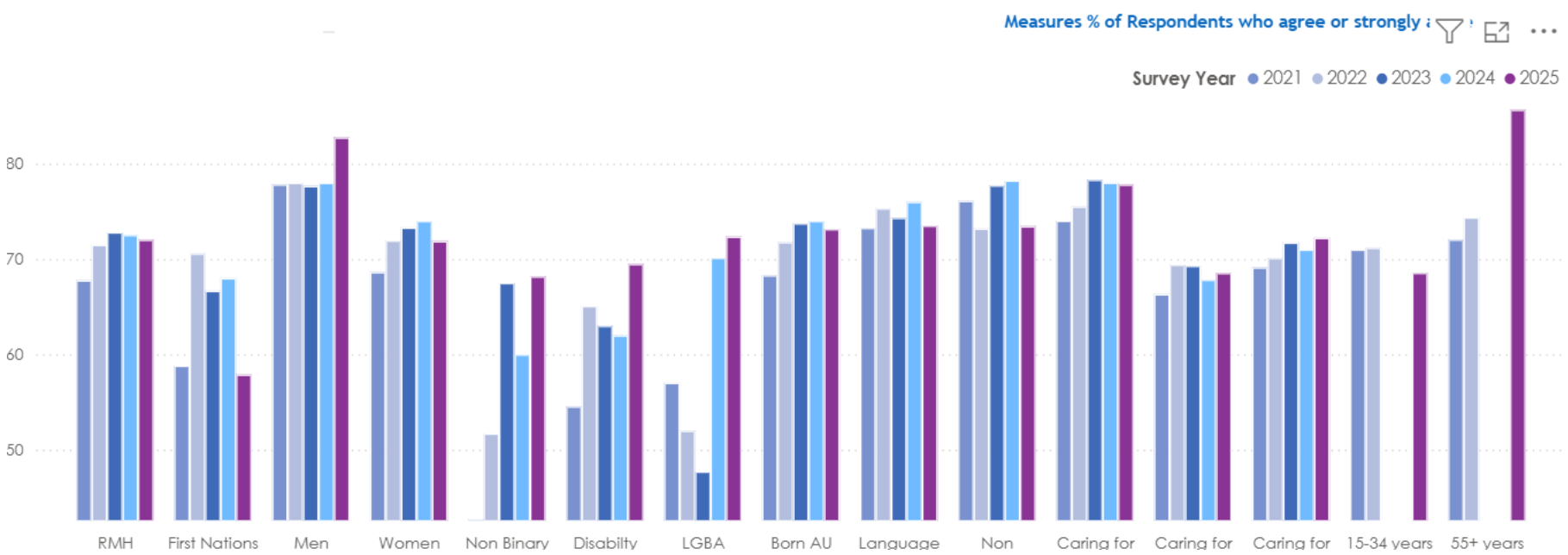


Table 4: 2025 PMS responses for leave and condition questions by diversity groupings

Responses to Terms, Conditions and Leave Questions

Survey Questions	RMH	First Nations	Men	Women	Non Binary	Disabilty	LGBA	Born OS	Language	Non Christian	Caring for Children	Caring for Disability / Illness	Caring for Aged	15-34 years	55+ years
Flexible work requests considered	69	58	73	71	86	68	68	77	74	73	77	68	69	63	81
Support for FV leave	79	84	81	81	86	78	78	82	81	78	82	75	81	82	86
Manager supports flexible working	74	63	78	75	82	67	70	78	79	75	79	78	76	75	81

Figure 3: PMS responses to "fair consideration of flexible work requests" question over time, by diversity groupings

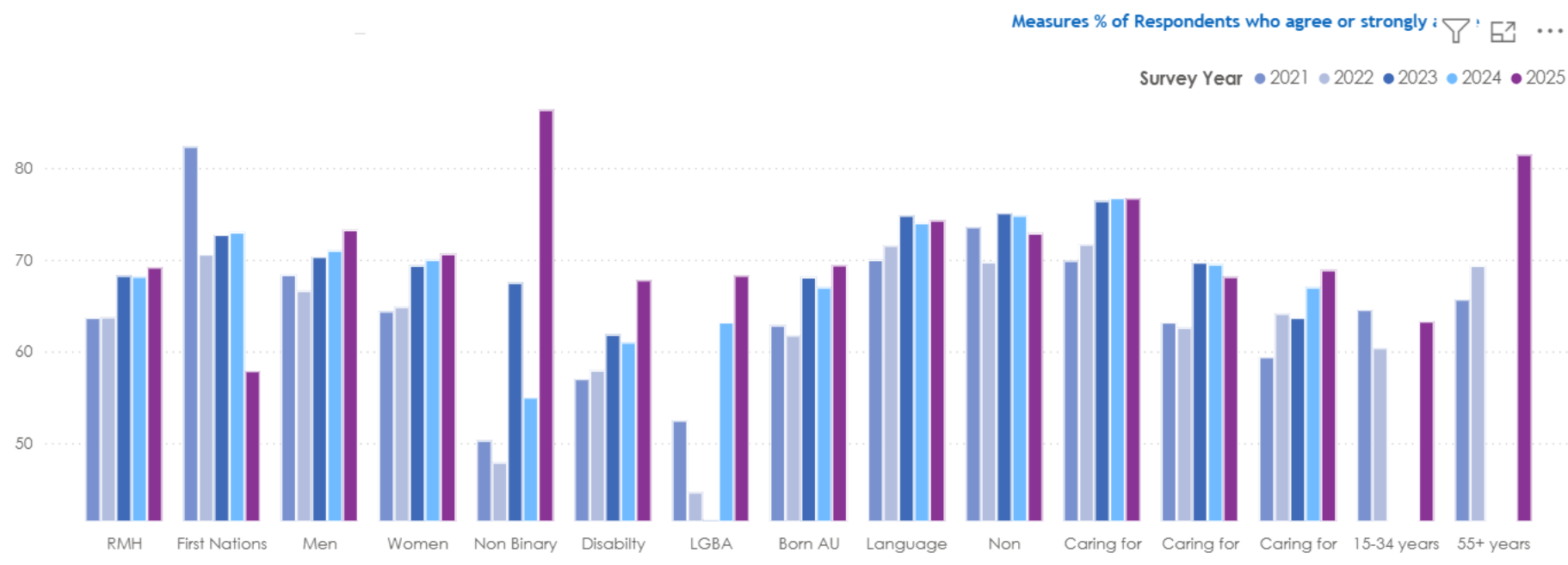


Table 5: 2025 PMS responses for gender segregation questions by diversity groupings

Responses to Gender Segregation Index Questions

Survey Questions	RMH	First Nations	Men	Women	Non Binary	Disabilty	LGBA	Born OS	Language	Non Christian	Caring for Children	Caring for Disability / Illness	Caring for Aged	15-34 years	55+ years
Feel culturally safe	78	53	81	81	59	67	73	84	79	76	82	73	78	79	85
Feel as if I belong	73	42	77	75	59	63	71	79	77	73	78	74	71	74	81
Inclusive, respectful comms	85	68	88	87	86	83	85	89	86	83	88	83	82	89	90
Fair allocation of work (regardless of gender)	76	79	80	78	82	77	77	82	77	74	83	74	73	76	84
Manager treats staff w/ dignity & respect	80	79	85	81	82	81	79	86	84	79	83	80	81	84	86
Workgroup treats with respect	77	79	84	77	86	79	78	82	78	79	81	73	77	80	83

Figure 4: PMS responses to "feel culturally safe at work" question over time, by diversity groupings

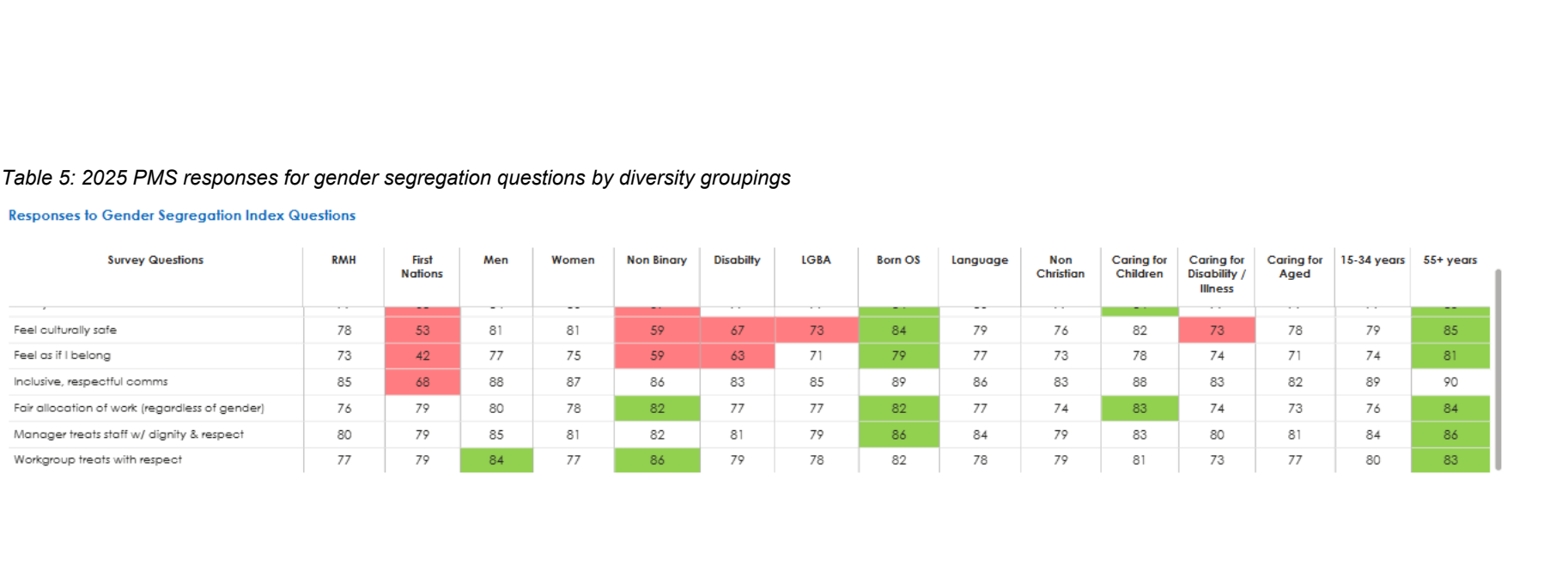


Figure 5: PMS responses to "RMH doesn't tolerate improper conduct" question over time, by diversity groupings