FAIR WORK COMMISSION

AM2024/11

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION
Applicant

APPLICATION UNDER SECTION 157 OF THE FAIR WORK ACT 2009 (CTH) TO AMEND THE NURSES AWARD 2020

SUBMISSIONS OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

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PART A SCOPE OF APPLICATIONS AND OVERVIEW OF SUBMISSIONS

1. By a series of decisions and determinations issued over 2022–2025 in proceedings including AM2021/63 ("**Aged Care Proceeding**"),[1] the Fair Work Commission ("**FWC**") determined to increase the wages of (*inter alia*) Registered Nurses ("**RNs**"), Enrolled Nurses ("**ENs**"), and Assistants in Nursing ("**AINs**") working in aged care, and otherwise to make variations to classification structures.

2. As outlined below, the Australian Nursing and Midwifery Federation ("**ANMF**") regards certain issues raised in the Aged Care Proceeding as having been expressly not finally determined, and as expressly having been carried over for final determination into this proceeding. Specifically, these are:

   (1) "a wider review of the work, roles and rates of pay of ENs across the entire health sector" (*Nurses Decision* at [51]); and

   (2) "the position of NPs across the health sector … with the benefit of further and more focused evidence on the qualifications and role of NPs" (*Nurses Decision* at [61]).

3. Further, as long ago as 17 May 2021, when the ANMF filed its Form F46 in the Aged Care Proceeding it foreshadowed (see [7]–[8]) a further application the objective of which would be to bring the wages across all sectors covered by the *Nurses **Award** 2020* back into uniformity—*i.e.*, to bring the wages of workers in non-aged-care settings up to the aged-care levels. The foreshadowed application was made on 09 February 2024, commencing proceeding AM2024/11 ("**Nurses Proceeding**")—*i.e.*, while the Aged Care Proceeding was still ongoing. That Application again identified the ANMF's intention that the separate provision for aged-care employees in the Award be eliminated.[2]

4. Following without-prejudice discussions before Slevin DP, the parties filed "*position documents*,"[3] which reveal considerable, but not total, agreement as to the appropriate

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1 Most importantly in *Aged Care Award 2010* (2022) 319 IR 127; [2022] FWCFB 200 ("***Stage 1 Decision***"), Aged Care Award 2010 [2023] FWCFB 93 ("***Stage 2 Decision***"), *Aged Care Award 2010* (2024) 331 IR 137; [2024] FWCFB 150 ("***Stage 3 Decision***"), *Aged Care Award 2010* [2024] FWCFB 298 ("***Stage 3 Phasing Decision***"), and *Applications by Australian Nursing and Midwifery Federation* [2024] FWCFB 452 ("***Nurses Decision***").

2 Form F46 Application to make, vary or revoke a modern award, dated 09 February 2024, Annexure A at [9].

3 *ANMF's Position Document Identifying Variations Sought to the Nurses Award 2020*, 24 October 2025 ("**ANMF position document**"); *Healthscope's Response To ANMF's Position Document* ("**Healthscope**

disposition of the issues arising for decision. Set out on page 4 is a summary of the issues in dispute and those not in dispute, and set out on page 5 is a table showing remaining differences on rates and classifications.

position document"); *Australian Private Hospitals Association's Response to the Applicant's Position Document Identifying Variations Sought To Nurses Award 2020*, 14 November 2025 ("**APHA position document**"); *Response to the Applicant's Position Document - Catholic Health Australia*, 14 November 2025 ("**CHA position document**"); *Response To The Applicant's Position Document - Australian Business Industrial*, 14 November 2025 ("**ABI position document**"); *Response to the ANMF's Agitation of The Aged Care Decisions - Aged & Community Care Providers Association Ltd and Australian Business Industrial*, 14 November 2025 ("**ACCPA and ABI joint position document**") and

Summary of the issues arising for decision and the parties' positions

5. **Integration Issue**: The ANMF says that the result of this application should be a single, integrated structure, covering both aged-care and non-aged-care employees. That is, an EN working in (say) acute care and an EN working in aged care[4] should, *ceteris paribus*, have the same wages and conditions of employment. This would involve amendment to the aged-care structure, but this was expressly contemplated by the Full Bench in the *Nurses Decision* at [51] and [61], and it advances the modern awards objective. Other parties disagree, and maintain that there should be separate classification structures for aged-care workers and all other workers.

6. **Enrolled nurses**: All parties agree that the first EN payrate should be set at $1,419.40. The ANMF, APHA, and Healthscope are agreed as to other rates and structure. Catholic Health Australia, Australian Business Industrial and NSW Business Chamber Ltd ("**ABLA parties**"), however propose different rates and structure thereafter.

7. **Nurse Practitioners**: All parties agree that non-aged care NPs should have at least the 15 per cent increase awarded to aged-care NPs. The ANMF proposes, and all other parties oppose, a further increase so that all NPs (aged-care and non-aged care) maintain their existing relativity with non-aged-care RNs.

8. **RNs, Midwives, OHNs, AINs**: There is agreement as to rates and classification structure for RNs, Midwives, Occupational Health Nurses ("**OHNs**") and AINs.

9. **Progression Issue**: There is an issue whether casual and part-time employees should progress by reference to years in the role, or hours worked (the ANMF says the former).

10. **Phasing**: all parties agree to 5 annual increments, weighted equally (*i.e.*, each increment to be 20 per cent of the difference between the current award rate and any new award rate). There is an issue as to whether increments should start on 30 June, or 01 July, 2026. The ANMF's position is that it should be on 30 June.

11. **Award name change**: There is agreement that name of the Award in the title and at cl 1.1, be the *Nurses and Midwives Award 2020*.

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[4] Save that an EN working in aged care would have a higher minimum rate than an EN, other than in aged care, for the first four years by virtue of the existing "EN Aged Care" classification sitting above the "Introductory EN", "EN 1 – Completion of 6 months" and "EN 2 – Completion of 2 years" classifications on the structure proposed by the ANMF, APHA and Healthscope.

Classification structure showing differences on rates and classifications

Classifications	**Weekly rate ($)**	
Nursing assistant	*Note: all agreed*	
Less than 3 months	1182.80	
3 months or more	1248.50	
Experienced (certificate III qualification)	1314.20	
Student enrolled nurse	*ANMF / APHA / H/scope*	*ABLA parties*
Less than 21 years of age	1215.50	
21 years of age and over	1275.90	
Enrolled nurse	*ANMF / APHA / H/scope*	*ABLA parties*
Introductory Enrolled Nurse	1419.40	1419.40
EN 1 – Completion of 6 months	1445.00	N/A
EN 2 – Completion of 2 years	1470.00	N/A
EN – Aged care	1472.00	1472.00
EN 3 – Completion of 4 years	1495.00	N/A
EN 4 – Completion of 6 years	1521.74	N/A
Registered nurse/midwife	*Note: all agreed*	
Level 1		
1st year	1500.30	
Completion of 1st year (1 year plus)	1579.30	
Completion of 4 years (4 years plus)	1719.30	
Level 2		
1–3 years	1859.40	
Completion of 3 years	1953.10	
Level 3	1999.30	
Level 4	2282.00	
Level 5	2588.20	
Nurse practitioner	*ANMF*	*All other parties*
1st year	2381.90	2060.70
2nd year	2452.60	2121.90
Occupational health nurse	*Note: all agreed*	
Level 1	1719.30	
Level 2		
1–3 years	1859.40	
Completion of 3 years	1953.10	
Senior occupational health clinical nurse	1953.10	
Level 3	1999.30	

A-1 Structure of submissions

12. Part B-1 to these submissions addresses the legal principles relevant to the variation to the Award sought by the ANMF in this proceeding. Part B-2 addresses applicable findings from the Aged Care Proceeding and other relevant decisions.

13. Thereafter, the ANMF's submissions will address only the matters that remain in issue between the parties, in the order set out on page 4 above describing the issues. That is:

    (1) Part C addresses the Integration Issue;

    (2) Part D addresses Enrolled Nurses;

    (3) Part E addresses Nurse Practitioners;

    (4) Part F addresses the Progression Issue; and

    (5) Part G addresses Phasing.

A-2 Identification of the ANMF's evidence

(i) Evidence from experts and officials

14. The ANMF will rely on evidence from the following experts and officials:

    (1) Dr Lisa S. Heap, of Research Into Action (summarised in Part B-3);

    (2) Dr Noelleen Kiprillis, RN and "*Lead – Strategic Programs and Engagement*" within the ANMF Federal Office; and

    (3) Denise Lyons, President of the Australian Primary Health Care Nurses Association and an NP since 2012.

15. A summary of Dr Heap's evidence appears at Part B-3 of these Submissions.

(ii) Evidence from workers

16. The ANMF will rely on evidence from the following workers:

    (1) Nikki Johnston (NP), who practises palliative care and voluntary assisted dying in the Australian Capital Territory. She has been an NP for 15 years and has held clinical roles in inpatient, outpatient, community, cancer and ambulatory services.

    (2) Stephen Voogt (NP), who is a geriatric specialist with significant experience in residential aged care, who now practises in primary health in multiple regional communities in Victoria. He has been an NP for 15 years.

(3) Rose McCrohan (NP), who works in an acute residential drug and alcohol detox facility in Melbourne. She has been an NP for 15 years.

(4) Mary Fenech (NP), who worked in the Queensland Injectors Health Network for 8 years and who is now engaged in research in the School of Nursing at Queensland University of Technology. She had been an NP for 15 years.

(5) Kerrie Duggan (NP), who is the current owner and manager of the Cygnet Family Practice, a rural primary healthcare clinic that runs an after-hours urgent care clinic in Cygnet, Tasmania. She has been an NP for 14 years.

(6) Jason Moloney (NP), who has previously worked as a NP in emergency departments and now practises as a generalist NP in multiple rural and remote settings in Queensland and the Northern Territory. He has been an NP for 12 years.

(7) Samantha Beattie (NP), who practises primarily in diabetes and endocrine care and works in urgent care at Cygnet Family Practice, residential aged care by telehealth, pharmacy and in her own diabetes clinic in Tasmania. She has been an NP for seven years.

(8) Lesley Salem (NP), who practises as a remote-rural generalist in a number of locations in Queensland and New South Wales. She has been an NP for 23 years.

(9) Lachlan Timms (RN), who works in community nursing at Bolton Clarke in Victoria as a Care Manager supervising both ENs and RNs in the primary nurse role.

(10) Julie McGrath (EN), who works as an Anaesthetics Nurse at Mater Hospital and previously worked at Townsville Hospital and the Clarence Correctional Centre in Queensland. She has 19 years' experience in the role.

(11) Jade Barclay (EN), who works at St Andrews' Hospital in Queensland, at various times in medical and palliative care, endoscopy and surgical admissions. She has 12 years' experience in the role.

(12) Darren Wall (EN), who worked as a district nurse in community nursing at the Royal District Nursing Service for one year and as an EN at Flinders Private Hospital in South Australia, on the cardiac ward and in the cardiac emergency centre, for 12 years.

(13) Nicole Mackay (EN), who worked at St Andrews' Hospital in Queensland on the east ward for 11 years. Ms Mackay now works as an organiser at the Queensland Nurses and Midwives Union.

(14) Teresa Satalich (EN), who works in residential aged care and home care in Victoria. She has 10 years' experience in the role.

PART B MATTERS OF GENERAL RELEVANCE

17. Three matters are addressed in this part.

18. *First*, in Part B-1, legal principles relevant to disposition of the issues.

19. *Second*, in Part B-2, an overview of findings in earlier and other proceedings which are relevant to the issues requiring determination in the present case.

20. *Third*, in Part B-3, an overview of the expected evidence of Dr Lisa Heap.

B-1 Legal principles relevant to the Award Variation

(i) Scope of the issues requiring determination

21. The amendments to the Award sought by the ANMF require the FWC to be satisfied as to the relevant statutory prerequisites addressed in this Part.

22. The role of the FWC is not to determine a dispute between the parties; rather, it is to be satisfied as to the relevant statutory prerequisites relating to the variation of modern awards.[5] However, the variations to the Award sought by the ANMF are on the public record and have been notified to interested parties and stakeholders. There are a number of active, sophisticated, and well-represented parties. Where matters have been resolved between those parties by conciliation and are no longer in issue, the FWC may (and would) be comfortably satisfied that the statutory prerequisites have been met without requiring further evidence or submissions. That is especially so where the matters not in issue are consistent with the principles enunciated in previous decisions of the FWC.

(ii) Statutory provisions – Work value reasons

23. Section 157(2) of the *Fair Work Act 2009* (Cth) ("**FW Act**") enables the FWC to make a determination varying modern award minimum wages if satisfied that:

    (1) the variation is justified by work value reasons (s 157(2)(a)); and

    (2) making the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective (s 157(2)(b)).

24. "*Justified"* in the context of s 157(2)(a) means that the "*work value reasons*" show the variation of modern award minimum wages to be just, right or warranted, or provide a

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5 *Stage 1 Decision* at [545].

satisfactory reason for the variation.[6] Whether a variation is justified by work value reasons requires the formulation of a broad evaluative judgment.[7]

25. Section 157(2A) defines work value reasons as being reasons justifying the amount that employees should be paid for doing a particular kind of work, being reasons related to: (a) the nature of the work; (b) the level of skill or responsibility involved in doing the work; and (c) the conditions under which the work is done. The Full Bench in the *Stage 1 Decision* identified the following propositions with respect to the assessment of work value reasons:[8]

(1) Section 157(2A) can be said to exhaustively define work value reasons in the sense that there are no other express provisions which inform the meaning of s 157(2A), though the objects of the FW Act will inform the interpretation and application of the concepts within s 157(2A).[9]

(2) The expression "*related to*" is one of broad import that requires a sufficient connection or association between the two subject matters; the connection must be relevant and not remote or accidental;[10]

(3) While not mandatory, where work value has previously been properly taken into account it is likely the FWC would adopt an appropriate datum point from which to measure work value change, as a means of avoiding double counting. A past assessment which was not free of gender-based undervaluation or other improper considerations would not constitute a proper assessment.[11]

(4) When dealing with applications to vary modern award minimum wages it is appropriate and relevant to have regard to relativities within and between awards. Aligning rates of pay in one modern award with classifications in other modern awards with similar qualification requirements will support a system of fairness, certainty and stability. The C10 Metals Framework Alignment

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6 *Stage 1 Decision* at [137] and [293].
7 *Stage 1 Decision* at [156] and [293].
8 For the full summary of relevant propositions see the *Stage 1 Decision* at [293].
9 *Stage 1 Decision* at [148] and [293].
10 *Stage 1 Decision* at [155] and [293]; *Re 4 Yearly Review of Modern Awards—Pharmacy Industry Award* (2018) 284 IR 121 ("***Pharmacy Award Case***") [165].
11 *Stage 1 Decision* at [175] and [293].

Approach[12] and the Australian Qualifications Framework ("**AQF**") are useful tools in this regard. However, such an approach has its limitations.[13]

(5) The meaning of "*work value reasons*" should focus on the text of s 157(2A), where elaboration will develop over time as the FWC determines particular issues as and when they arise.[14]

26. Amendments made to the FW Act by the *Fair Work Legislation Amendment (Secure Jobs, Better Pay) Act 2022* (Cth) ("**SJBP Act**") took effect on 7 December 2022 and are also important in the exercise of the powers of the FWC to vary modern awards.

27. It is now necessary, consistent with s 157(2B) of the FW Act, for the FWC to undertake a historical analysis of the development of the rates of pay in the award in question to ascertain whether there are any indicia of gender-based undervaluation.[15] The consideration required by s 157(2B) requires the making of findings or the statement of conclusions in respect of whether the FWC's consideration of work value reasons:

(1) are free of assumptions based on gender; and

(2) include consideration of whether historically the work has been undervalued because of assumptions based on gender.[16]

(iii) <u>The minimum wages objective and modern awards objective</u>

28. As identified above, s 157(2)(b) of the FW Act provides that the discretion of the FWC to vary modern award minimum wages is conditional upon it being satisfied that the making of the determination outside the system of annual wage reviews is necessary to achieve the modern awards objective.

29. Section 138 of the FW Act also provides that a modern award may include terms that it is permitted to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective in s 284(1).

30. Where a variation to award minimum wages is sought pursuant to s 157, the minimum wages objective in s 284 applies as well.[17] There is a substantial degree of overlap in

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12 Approach described in the *Stage 1 Decision* at [177]–[178]
13 *Stage 1 Decision* at [192].
14 *Stage 1 Decision* at [224] and [293].
15 *Stage 1 Decision* at [192] and [293]. *Stage 3 Decision* at [14]. See also *Gender-based undervaluation – priority awards review decision* [2025] FWCFB 74 at [67]
16 *Stage 3 Decision* at [21].
17 FW Act, section 284(2)(b).

the considerations relevant to the minimum wages objective and the modern awards objective, although some are not expressed in the same terms.[18]

31. The Full Bench in the *Stage 1 Decision* identified at [271]–[272] as follows:

(1) The obligation to take into account the matters in s 134(1) meant that each of these matters, insofar as they are relevant, must be treated as a matter of significance in the decision-making process.

(2) No particular primacy was attached to any of the s 134 considerations and not all of the matters identified will necessarily be relevant in the context of a particular proposal to vary a modern award.

(3) It is not necessary for the FWC to make a finding that an award fails to satisfy one or more of the s 134 considerations as a prerequisite to the variation of a modern award.

(4) Generally speaking, the s 134 considerations do not set a particular standard against which a modern award can be evaluated—many of them may be characterised as broad social objectives.

(5) In giving effect to the modern awards objective, the Commission is performing an evaluative function taking into account the s 134 considerations and assessing the qualities of the safety net by reference to the statutory criteria of fairness and relevance.

32. Sections 284(1)(aa) and 134(1)(ab) were added to the FW Act by the SJBP Act. They identify the achievement of gender equality as an overarching "*need*" which must be taken into account in the exercise of the Commission's modern award powers. Under s 284(1)(aa) "*ensuring equal remuneration for work of equal or comparable value*", "*eliminating gender-based undervaluation of work*" and "*addressing gender pay gaps*" are means by which this overarching need may be met. Section 134(1)(ab) likewise identifies the first two of these as means to achieve gender equality; the third means identified in s 134(1)(ab), "*providing conditions that facilitate women's full economic participation*", is concerned with terms of employment other than rates of pay.[19]

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18 *Stage 1 Decision* at [290]; and *2019-20 Annual Wage Review decision* [2020] FWCFB 3500 at [205].

19 *Annual Wage Review 2025* [2025] FWCFB 3500 at [55].

33. Determining a variation to modern award minimum wages to rectify gender-based undervaluation is a matter requiring the making of a value judgment based on the need to achieve the modern awards objective and the minimum wages objective, having regard to the mandatory considerations in ss 134(1) and 284(1) of the FW Act respectively. In the Commission's determination of this, the gender equality considerations in ss 134(1)(ab) and 284(1)(aa) are likely to have significant weight.[20]

B-2 Applicable findings from prior proceedings

34. By reason of the determination of the Aged Care proceeding and other proceedings involving the powers of the FWC under Part 2-3 of the FW Act, the FWC may take various matters as uncontroversial.

(i) Relevant rates in the Award are not properly fixed

35. In the *Stage 3 Decision* at [111]–[135] the Expert Panel conducted a detailed analysis of the historical development of the Award. That analysis identified that the model of award wage fixation which prevailed from the *National Wage Case August 1989* until 2006, when the *Workplace Relations Amendment (**Work Choices**) **Act** 2005* (Cth) took effect, embedded gender-based undervaluation in four fundamental ways,[21] namely:

(1) The use of the C10 tradesperson's rate as the lodestar for wage fixation across all awards entrenched masculinist assumptions about work value into the system. These rates were fixed on the basis of a male standard of work value that focused on traditional technical or "*hard*" skills in industry and was not apt to properly recognise or value the type of skills, including caring, "*soft*" or "*invisible*" skills, characteristic of feminised occupations and industries.

(2) As originally conceived in the *National Wage Case August 1989*, the C10 Metals Framework Alignment Approach was not intended to operate mechanistically so as to mandate that wages for employees with qualifications equivalent to C10 must be equal to the C10 wage rate, nor did it require equivalency of qualifications to be the only means for considering appropriate relativities.

(3) The C1 classification rate's relativity to the C10 rate for degree-qualified workers which formed part of the C10 Metals Industry Framework was never

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20 *Gender based undervaluation - priority Awards Review decision* [2025] FWCFB 74 at [71].

21 See also the summary of the analysis in the *Gender-based undervaluation – priority awards review decision* [2015] FWCFB 74 at [46].

implemented in practice since, for the most part, classifications for such workers were set at a significantly lower relativity.

(4) From the *National Wage Case August 1989* up until their disappearance in 2006 following the commencement of the *Work Choices Act*, the wage-fixing principles continued to restrict claims for higher wages based on work value to those based on changes to work value from a fixed datum point, being the completion of the structural efficiency exercise required for each award by that decision. That effectively foreclosed any *ab initio* consideration of whether the minimum wage rates in any award had been properly set in the first place based upon an assessment of work value free of gender-based assumptions.

36. The conclusion of that analysis set out at [135] of the *Stage 3 Decision* was that:

> "The rates of pay for degree-qualified nurses in the Nurses Award are not properly fixed minimum rates because the principles set out in the *Paid Rates Review decision* and the *ACT Child Care decision* (see paragraphs [82]–[83] above) were never properly applied. It is apparent that nursing has undergone a revolutionary transformation from an occupation which in 1958 was equated to a trade to a recognised profession for which a university degree is required for entry. However, the federal award system has failed to set minimum award rates of pay which properly recognise the addition to work value effected by this transformation and, in the context of this being a female-dominated occupation, this can only be characterised as historic gender undervaluation."
> (citations omitted)

37. That finding applies with equal force to the classifications the subject of the current application.

(ii) <u>The proper identification of invisible skills</u>

38. In the *Stage 1 Decision*, the Full Bench at [758] accepted the following propositions:

(1) The valuation of work is influenced by social expectations and gendered assumptions about the role of women as workers. In turn these social practices influence institutional and organisational practices.

(2) Undervaluation occurs when work value is assessed with gender-biased assumptions. The reasons for gender-based undervaluation in Australia include the continuation of occupational segregation, the weaknesses in job and work valuation methods and their implementation, and social norms, gender stereotypes and historical legacies.

(3) Gender-based undervaluation in the employment context occurs when work value is assessed with gender-biased assumptions which means the skill level of occupations, work or tasks is influenced by subjective notions about gender and gender roles in society. Skills of the job occupant are discounted or overlooked because of gender.

(4) Gender-based undervaluation of work in Australia arises from social norms and cultural assumptions that impact the assessment of work value. These assumptions are impacted by women's role as parents and carers and undertaking the majority of primary unpaid caring responsibilities. The disproportionate engagement by women in unpaid labour contributes to the invisibility and the under recognition of skills described as creative, nurturing, facilitating or caring skills in paid labour.

(5) The barriers and limitations to the proper assessment of work value in female dominated industries and occupations include:

(a) changes in the regulatory framework for equal pay and equal remuneration applications and the interpretation of that framework;

(b) procedural requirements such as the direction in wage-fixing principles that assessment of work value focus on changes in work value and tribunal interpretation of this requirement;

(c) conceptual considerations including the subjective notion of skill and the "*invisibility*" of skills when assessing work value in female-dominated industries and occupations;

(6) The approach taken to the assessment of work value by Australian industrial tribunals and constraints in historical wage fixing principles have been barriers to the proper assessment of work value in female dominated industries and occupations.

39. The Full Bench emphatically endorsed the proposition that the exercise of emotional intelligence, emotion management, empathy, communication and interpersonal skills, and flexibility and resilience in response to rapidly evolving and distressing work situations were work skills that needed to be assigned their proper value. In this latter respect, the Full Bench said at [848]:

> Indeed it seems to us the mischaracterisation of the so called 'soft skills' as personality traits or 'the simple cognitive activity of adults['] is at the heart of the gendered undervaluation of work.

(iii) Proper application of the C10 Metals Framework Alignment Approach

(A) C1(a) benchmark rate

40. At [204] of the *Stage 3 Decision*, the Expert Panel considered the proper application of the C10 Metals Framework Alignment Approach in a manner free from gender assumptions and consistent with the principles stated by the Full Bench in the *Teachers decision*.[22] The Expert Panel determined that a four-year degree qualified RN in aged care would be aligned with the benchmark rate calculated on the basis of alignment with Level C1(a) in the C10 Metals Framework ("**C1(a) benchmark rate**"), with this becoming the benchmark rate for the fixation of minimum wages for RNs in aged care.

41. At [44]–[47] of *Nurses Decision*, the Expert Panel determined that the C1(a) benchmark rate should apply equally to a three-year and four-year degree qualified RN. However, the Expert Panel also identified an entry-level rate applicable during the first year of nursing employment, set below the C1(a) benchmark rate.

42. In the *Gender-based undervaluation – priority awards review decision* it was further recognised that the C1(a) benchmark rate identified in the *Stage 3 Decision* should, as a minimum, apply to any classification for which a university degree is required (except at the entry level) absent evidence justifying a different outcome.[23]

(B) Approach to fixing rates for ENs and diploma-qualified employees

43. Having regard to the work value reasons identified in the *Stage 1 Decision* and the *Stage 3 Decision*, the Expert Panel in the *Stage 3 Decision* determined that the rate for an EN in aged care who has responsibility for supervising personal care workers ("**PCWs**") should be set at the same rate as a Level 6 direct care employee (Team Leader) with supervisory responsibilities.[24] That classification is fixed at 112 per cent of the Caring Skills benchmark rate (discussed below).[25]

44. In the *Gender-based undervaluation – priority awards review decision* an Expert Panel considered appropriate award variations to rectify gender-based undervaluation of Children's Services Employees ("**CSE**") in the *Children's Services Award 2010*. The

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22 *Independent Education Union of Australia* [2021] FWCFB 2051.
23 *Gender-based undervaluation – priority awards review decision* at [71]
24 *Stage 3 Decision* at [205].
25 *Stage 3 Decision* at [194].

Expert Panel there expressed a provisional view that a CSE whose primary role is to work directly with children and who has completed a diploma-level early childhood education and care qualification or an equivalent approved qualification for out of school hours care, would be fixed at 108 per cent of the Caring Skills benchmark rate.

(C) Caring Skills benchmark rate

45. At [170]–[172] of the *Stage 3 decision* the Expert Panel identified the benchmark rate for Certificate III-qualified employees engaged as PCWs, aged care home care workers ("**HCWs**") and AINs, ("**the Caring Skills benchmark rate**"). That rate was determined to be the minimum weekly wage rate established by the *Social, Community, Home Care and Disability Services Industry Award 2010* operating in conjunction with the *Social, Community and Disability Services Industry Equal Remuneration Order 2012* for a Certificate III-qualified social and community service employee.

46. The Expert Panel at [173] of the *Stage 3 Decision* expressly contemplated that the Caring Skills benchmark rate would provide appropriate guidance as to the rectification of historic gender undervaluation in respect of female-dominated "*caring*" work. It further identified that the adoption of such a benchmark rate for work of this nature, in replacement of the C10 rate, would provide a stable anchor point for a modern award system which ensures gender equality in the valuation of work.

47. At [194]–[195] of the *Stage 3 decision* the Expert Panel applied the Caring Skills benchmark rate to the structure for PCWs (and AINs)[26] under the *Aged Care Award 2010*. In that classification structure, Level 3 is the classification for Certificate III-qualified employees and is aligned with the Caring Skills benchmark rate. Additionally:

(1) Level 1 was identified as an entry-level classification with a relativity of 90 per cent of Level 3; and

(2) Level 2 applied to direct care employees who have no relevant AQF qualification but who have more than 3 months' industry experience as a direct care employee. Level 2 has a relativity of 95 per cent of Level 3.

48. In the *Gender-based undervaluation – priority awards review decision* at [71], the Expert Panel further observed that:

> … in respect of work of a 'caring' nature involving the exercise of 'soft' or 'invisible' skills, the Caring Skills benchmark rate (currently $1269.80 per

[26] *Stage 3 Decision* at [191].

week) established in the Stage 3 Aged Care decision for a Certificate III-qualified employee indicates the upper end of the range of potential outcomes. This is because the aged care work considered in the Stage 3 Aged Care decision was found to have involved the constant exercise of the identified 'invisible' skills in a manner entirely integrated with all other aspects of the work.

(iv) Classification structure for RNs and midwives

49. The basis for the classification structure for RNs in aged care was discussed at [52]–[60] of the *Nurses Decision*.

(v) Additional findings from the Aged Care Proceeding

50. Throughout the Aged Care Proceeding, the Full Bench and Expert Panel made various findings about work value reasons and relevant to the minimum wage objective and modern award objective. This includes findings regarding:

(1) The "*Uncontentious Propositions*";[27]

(2) Application of the "*Spotlight tool*" by Associate Professor Junor including that:

(a) the skill, responsibility and effort required in the RN, EN and AIN/PCW classifications is under-recognised in current rates of pay;[28]

(b) Spotlight skills identified for RNs, ENs and AIN/PCWs in aged care are skills and should be taken into account in the assessment of work value;[29]

(c) the evidence of Associate Professor Junor was cogent, probative and relevant to assessment of whether a variation of modern award minimum wages was "*justified by work value reasons*";[30] and

(3) Permanent changes in respect of infection prevention and control resulted from the aged care sector's experience of the COVID-19 pandemic. These changes encompassed the exercise of additional skills and responsibilities, requirements for additional training and changes to the working environment and constituted an increase in the work value of direct care employees covered by the Award which is not comprehended by current rates of remuneration.[31]

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27 *Stage 1 Decision* at [551] – [739].
28 *Stage 1 Decision* at [829].
29 *Stage 1 Decision* at [847].
30 *Stage 1 Decision* at [856].
31 *Stage 3 Decision* at [137] – [146].

B-3 The evidence of Dr Lisa Heap

51. Dr Lisa Heap has produced a "*Spotlight Skill Recognition Report*," being a report into the work of nurses and midwives that identifies, names, and classifies the invisible skills used by those workers. The ANMF will rely on Dr Heap's report in support of the variations it seeks. Detailed submissions as to the findings that ought to be made on the basis of Dr Heap's evidence will come after her oral evidence and any cross-examination. But, as the ANMF did in the Aged Care Proceeding, via its opening submissions it will provide a roadmap to use of Dr Heap's report.

(i) The nature of Dr Heap's report

52. Dr Heap has produced what could be called a "*Spotlight Report*," based on application of the "*Spotlight Tool*" to classifications in the Award.

53. The Spotlight Tool is a job and skills analysis tool designed as an aid in identifying, naming and classifying "invisible skills" used in undertaking service work processes that are not directly observable.[32] "*Invisible*" means "*hidden*", "*under-defined*", "*under-specified*" or "*under-codified*."[33] To illustrate each of these, a skill might be:[34]

(1) hidden because it is diplomatically kept unnoticed, or downplayed because it is "*behind the scenes*";

(2) under-defined because it is hard to pin down in words, is non-verbal, or is applied in rapidly-changing situations;

(3) under-specified because it is 'soft' or 'natural' and is misdescribed as something innate and personal rather than as a skill;

(4) under-codified because it is integrative, or involves interweaving one's own activities with others' activities.

54. The Spotlight Tool measures skill in two dimensions: skill content and skill level.[35] The content dimensions are:[36]

(1) "awareness" of contexts and situations; of reactions and ways of shaping them; and of impacts;

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32 *Stage 1 Decision*, [43], [410]; Dr Heap's report, pt 1.4.
33 *Stage 1 Decision*, [43], [410]; Dr Heap's report, pt 1.4.
34 *Stage 1 Decision*, [410]; Dr Heap's report, pt 1.4.
35 *Stage 1 Decision*, [411].
36 *Stage 1 Decision*, [411]; Dr Heap's report, pts 1.6, 2.1.

(2) "communication and interaction" — managing boundaries; verbal and non-verbal communication; intercultural communication and inclusion

(3) "coordination"— of own work; interweaving one's own line of work with those of others; maintaining and restoring workflow.

55. The skill levels, from lowest to highest, are:[37]

(1) orienting;

(2) fluently performing;

(3) problem-solving;

(4) solution-sharing; and

(5) expertly system-shaping.

56. Dr Heap's report is in the nature of opinion evidence. It is adduced on the basis that Dr Heap has specialised knowledge, based on her training, study, or experience, and will therefore be of assistance to the FWC. The area of specialised knowledge is gender and inequality at work, including gender pay inequality.[38] The Commission has already identified that expert application of the Spotlight Tool is capable of being "cogent, probative and relevant to [an] assessment of whether a variation of modern award minimum wages is 'justified by work value reasons'."[39] Dr Heap's report will be, the ANMF submits, of the same assistance.[40]

(ii) Structure of Dr Heap's Report

57. Dr Heap's report is structured in the following way.

58. In Part 2, she sets out her research approach.

59. In Part 3, she sets out an overview of the nursing and midwifery professions in Australia.

60. In Parts 4–7, she sets out the product of the application, by her, of the Spotlight Tool to each of the RN, Midwife, EN, and NP classifications in the Award.

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37 *Stage 1 Decision*, [412]; Dr Heap's report, pts 1.6, 2.1.

38 Dr Heap's report, pt 1.2.

39 *Stage 1 Decision*, [856].

40 There is information as to the development of the Spotlight Tool in Part 2.1 of the report. Given that application of the tool is now, however, a recognised area of specialised knowledge in the Commission, it is submitted that there is no need, again, to consider the basis and history of the tool.

61. In Part 8, drawing on the analysis in Part 4–7, she names, identifies, and classifies the invisible skills brought to bear by workers in each of the classifications, and expresses overall conclusions.

62. In view of the fact that, as outlined above, the rates and pay and classifications for RNs and midwives are generally not the subject of controversy, Parts 4 and 5 (RNs and midwives respectively) are of contextual rather than direct relevance. In particular, they are contextually relevant in two ways.

63. *First*, where one of the controversial issues is (in effect) the relativity that should apply as between RN and NP classifications, a report which identifies and enables comparison of the invisible skills brought to bear at each classification will assist the Commission in identifying the proper relativity.

64. *Second*, likewise, where there is some controversy as to the classification structure relevant to ENs, a report that identifies skills that ENs may develop with experience in the role that are hidden or undervalued will be of assistance.

(A) Part 2—research approach

65. Dr Heap's approach to the Spotlight Tool was, in broad terms, the same as Assoc Prof Junor's in *Aged Care Proceeding*.[41] Workbooks were completed by participants, and used as triggers for conversation in interviews that occurred as between members of the research team and participants. The interviews, each lasting about 1.5–2 hours, were transcribed and then coded. There were several rounds of coding to cross-check results. The coded interviews were then used to prepare the analyses in Parts 4–8.

66. 57 possible participants were referred by Gordon Legal to Dr Heap. Of those, Dr Heap selected 30, of whom 29 participated. Dr Heap outlines the basis upon which she satisfied herself that the group of 29 provided her with adequate demographic representation in order to express opinions that will assist the Commission, in Pt 2.3.

67. The process of data gathering (*i.e.*, workbooks and interviews) is described in Pt 2.4. The process of coding those interviews is described in Pt 2.5. These codes were, as with Assoc Prof Junor's approach, used to generate "heat maps," showing the skills used in each skill content and level.

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41 See *Stage 1 Decision* at [761]–[763].

(B) Part 3—overview of nursing and midwifery in contemporary Australia

68. Part 3 of Dr Heap's report is a useful overview, based on identified secondary material (academic and other literature) as to the history and nature of the nursing profession, and how these contribute to gender-based undervaluation and the invisibility of skills.

69. Part 3.1 sets out demographic matters concerning nursing overall, and within the relevant classifications. Of particular relevance given the matters in issue in this proceeding are the summaries of "*core EN activities*" at [142], and the overview of "*core NP activities*" as including RN activities and in addition the matters listed under [144]. Those additional matters include:

(1) advanced health assessment that includes ordering and interpreting diagnostic tests (pathology and medical imaging);

(2) diagnosing and treating acute and/or chronic physical and mental health conditions;

(3) independent prescribing of scheduled pharmacological and non-pharmacological interventions;

(4) independent referral to general practitioners, medical specialists and allied health practitioners;

(5) establishing healthcare delivery;

(6) strategic role to improve, manage or prevent health issues;

(7) support meeting the need of community health using contemporary research to provide evidence-based care; and

(8) policy development initiation and quality improvement activities.

70. There are also helpful summaries of regulation in nursing and midwifery,[42] education, training, qualifications, and professional recognition[43] (including CPD),[44] and contemporary issues impacting on nursing and midwifery.[45] These contemporary issues, aligning with many of those raised in evidence and considered in the aged care work value proceeding, include:

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42 Dr Heap's report, [156]–[163].
43 Dr Heap's report, [164]–[197].
44 Dr Heap's report, [189]–[197].
45 Dr Heap's report, [209]–[354].

(1) attraction and retention in nursing and midwifery;[46]

(2) increases in number and complexity of patient presentations, including chronic illness and multimorbidity;[47]

(3) the move to a person-centred care model;[48]

(4) a move to digital technology (including AI) in health service delivery;[49] and

(5) particular challenges for nurses and midwives working in different contexts, *e.g.*, in rural or remote settings, with Indigenous people, with culturally and linguistically-diverse communities).[50]

71. Dr Heap also provides an overview of advanced practice nursing (including leadership in nursing and information relevant to nurse practitioners),[51] and on matters pertaining to nurse and midwife health and wellbeing (including the social perception of their roles, and their own perceptions of themselves).[52]

72. Part 3.3 provides an overview of secondary literature relevant to the undervaluation of female-dominated areas of work.

(C) Parts 4 and 5—Registered Nurses and Midwives

73. Although, as outlined above, the material relevant to RNs and midwives is contextually rather than directly relevant, the structure of each of these parts, as well as parts 6 and 7, is more or less the same. Accordingly, the approach taken here is to provide an overview of the structure and basic content of parts 4 and 5 together.

74. These parts commence with an introductory part (Parts 4.1, 5.1), and a profile of the classification in Australia (Parts 4.2, 5.2). For RNs, for example, there is information about the number of persons holding the relevant registration as well as dually-registered nurses, the education and qualification prerequisites for the classification, and the core duties and activities of the role. There is then (Parts 4.3, 5.3) a demographic overview of the participants in Dr Heap's investigation. That is, again for RNs, there is a breakdown by state, by metro/regional context, by setting of care, by years of

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46 Dr Heap's report, [211]–[234].
47 Dr Heap's report, [235]–[250].
48 Dr Heap's report, [251]–[273].
49 Dr Heap's report, [274]–[282].
50 Dr Heap's report, [282]–[300].
51 Dr Heap's report, [301]–[321].
52 Dr Heap's report, [322]–[348].

experience, by field of nursing work, by qualification and endorsement, and by leadership role.

75. Parts 4.4 and 5.4 then commence with a heatmap, or a "*skills profile*". These set out the number of coded Spotlight skill elements by skill content and level. For the RN, for example, one sees (in Table 4.4) real concentrations of skills at levels A3–4, B3–4, and C3–4. These are then the subject of considerable detail in the parts that follow so as to give content to exactly what is being measured.

76. First, in Table 4.5 (again for the RN), one sees one-sentence summaries of each of the combinations of skill contents and levels. Picking one example, there was a concentration of skill for the RN at level A1.4. Table 4.5 gives two examples of that kind of skill:

> "L4 Use techniques for exchanging rapid situational updates with colleagues (UD)
> L4 With colleagues share approaches to solving problems relating to patients or technology (UC)"

77. Here, "*UD*" is under-defined, and "*UC*" is under-codified.

78. Every combination of skill content and level is then exemplified by examples from the coded interviews, in Part 4.5. Again, taking level A1.4, that appears starting at [430]. The summary of the skill content and level is as follows:

> "The skills involved at level 4 involve sharing new approaches when interpreting and understanding contexts. This may involve activities such as exchanging rapid situational updates and exchanging information with colleagues. Sharing approaches to solving problems relating to patients or technology may also be work activities at L4. Activities at this level also include maintaining internal and external networks, keeping up with developments relevant to RNs work. …"

79. Various quotations are then given from interviews of the kind of skill just described. For example, Fatima (RN) gave an example, quoted at length at [434], of maintaining network and contacts with community nursing, aged care, agencies, and mediating care for particular patients via care plans, healthcare assessments and the like through those various networks and connections.

80. The same exercise is done for every combination of skill content and level.

81. Parts 4.6 and 5.6 then contain "*case studies*" of skill clusters. The process and object of each case study is as follows. A particular work activity is described, and is quoted.

Using the Spotlight framework, there is then a tabular analysis with coding applied to particular tasks and matters, with Dr Heap's observations in the right-hand column indicating, in effect, why each of the tasks and matters warrant the allocation of a particular Spotlight code. The effect is to show that a particular work task or event will require the utilisation or deployment of a variety of Spotlight skills all at once, in combination one with another.

82. As Dr Heap explains, the significance of "*clustering*" is as follows (from [592]):

> "Interweaving, or deploying clusters of skills requires a complex combination of thinking feeling and acting. Further, the capacity to apply several skills at the same time is itself an 'under-codified higher level skill'; increasing the effort required to perform the role and adding to work intensity."

83. Deploying skills in clusters has characteristics that Dr Heap describes at [593], drawing on the work of Dr Junor, and helping to illustrate the value of the skills in combination:

> "a) It enables jobholders to bring together a range of other skills, and integrate their use into their work activities
> b) It is the 'thinking' element of multi-tasking
> c) It relies on prior learning of some action sequences that no longer require much conscious attention, so that the jobholder can pay attention to new challenges
> d) Routines are always likely to break down and need rebuilding, and this requires a clustering of other visible and invisible skills with problem-solving thinking and thinking ahead, while continuing to rebuild and work on."

84. In Parts 4.7 and 5.7, there are then conclusions. Again, not surprisingly (and consistently with what the parties in this proceeding agree is the historical undervaluation of RN and midwife work), there is "*substantial incidence of the use of Spotlight skills across the 9 Skill Elements of the Spotlight framework*" ([621]). Dr Heap goes on to discuss matters of particular significance, and the centrality of the various skills identified to RN and midwife practice in practical terms.

(D) Part 6 and elsewhere—Enrolled Nurses

85. The part on ENs (Part 6) follows the same structure as Parts 4 and 5. It is not necessary to go through it in detail in these submissions. In part, that is because the contest as to ENs is limited. All parties are in agreement as to the entry-level rate. That logically, legally, inheres agreement as to the work value of that entry-level work. The question,

accordingly, is one of identifying the degree to which work value increases over time in the EN role, so as to justify pay increments and levels of classification.

86. There is material in Dr Heap's report that is relevant to the EN progression question, and it is identified in this part of the submission.

87. Within Part 6.5, there are many references to skills being developed with time in the role. For example, at [811], Jessica (EN), an EN with 30 years' experience, is quoted as saying the following:

> "The more experience you have because you've been through some stuff, and you know what can happen. And you just pick things up a lot quicker. Guess you're a lot more situationally aware."

88. At [817], Jessica (EN) makes further observation as to the difference between experienced and newer ENs:

> "Once you have a lot of experience, and you pick up things that you never would have picked up as a new person, because you have the experience. And you've been through, you know some things, and you're very aware of what situations can crop up. And so you're scanning and observing and watching the patient and the anaesthetist all the time."

89. At [820], Jacinta (EN) makes a similar observation:

> "So you have to be able to recognize when your patient is deteriorating, and that is not something that just comes to you, you do have to learn and recognize about. If your patient is deteriorating or not. You're looking at the rise and fall of the chest. You're looking at the colour of the patient. You're looking before you even look at your machine. You are looking at all of these."

90. Dr Heap's assessment of this observation, at [821], is it involves description of progression in knowledge and skill development with time in the role. These skills are under-codified, being integrative skills that enable a workflow to continue. In a similar way, based on discussion of a quote at [828], Dr Heap observes at [828] that awareness of how one's communications affect other people is a skill that develops over time, as is becoming more "*tolerant*."

91. Further examples include those of Tamara (EN) having developed skills that an EN colleague had not yet developed including emotion management to control her own responses when others are volatile in an operating theatre, being under-codified and under-specified skills developed with training ([835]).

92. At [865], Dr Heap analyses a quote from Nina (EN) who describes adapting her communication for paediatric patients, those without fluency in English, and people without the ability to speak. This involves use of non-verbal communication, "*through facial expressions and emotions*," which involved "*development of skills and knowledge through her years of experience*."

93. Another part of Dr Heap's report that is of particular relevance in this connection is Part 8.5, addressing the acquisition of skills on the job. Dr Heap there makes the following points of relevance:

(1) based on the evidence set out in Parts 4–7, there is considerable evidence of nurses and midwives developing their practice through the acquisition of skills through on-the-job experience and further training and education (formal and informal);

(2) but, at least often, these increases in skill are not formally recognised via credentialling or a qualification;

(3) the fact that in female-dominated industries skills are not (or may not be) recognised by formal credentials or qualifications is itself something that tends to render those increases in skills invisible, hence to be undervalued.

94. There are extensive CPD requirements for nurses and midwives ([1256]), and in fact nurses commonly exceeded statutory requirements ([1257]–[1258]). Further, nurses are involved in the formation of professional bodies that publish standards of practice (*e.g.*, the Australian College of Perioperative Nurses), and take seriously what is seen to be the professional responsibility to share leanings with colleagues via informal learning networks ([1265]). There are structured education roles, individual learning programmes, and reflexive practice ([1266]–[1278]).

95. All of this evidence strongly supports a conclusion that a flat, or a too-flat, classification structure would itself contribute to the gendered undervaluation of work. The fact is that ENs develop skills—valuable skills—on the job, and via ongoing training through formal, less formal, and informal networks and structures. They recognise, and Dr Heap opines, that these skills develop with time on the job. A classification structure which fails adequately to account for that development is one that undervalues the work of ENs who have developed those additional skills. It undervalues work if it proceeds on

an assumption that, absent some formal additional qualification or credential, work being performed is of the same value.

96. There is further relevant material in Part 8.6, dealing with evolution of practice. The main topic addressed there is the "*extensive evidence of the skills of nurses and midwives extending and deepening with experience and the application of these skills in context*" ([1279]). These skills, which go beyond formal training, are identified as including ([1280]):

> "a) the application of skills and knowledge in context
> b) the ability to assess patients through observation and active listening
> c) the capacity to have multiple contingencies if a treatment plan needs revision
> d) the ability to anticipate and avoid problems
> e) capacity to act with fluency, maintaining emotional control under high pressure
> f) high level problem-solving and solution sharing skills."

97. Examples are then given to support the opinion expressed.

(E) Part 7—Nurse Practitioners

98. The part of the case concerning NPs is the closest to a pure work value case, in the sense that there is no agreement (unlike all other classifications) as to the entry level rate. That inheres, logically and legally, absence of agreement as to the value of the work being done by the NP. Accordingly, Part 7 of Dr Heap's report is, out of Parts 4–7, the Part that requires the closest attention by the Commission.

99. Its structure is the same as previous parts. That is, there is an introduction and then a profile of NPs generally, and as a cohort investigated. Four NPs participated in Dr Heap's investigation. They had between 35–48 years of experience in nursing, and 11–22 years working as an NP specifically. They were highly qualified people (see at [950]).

100. Table 7.1 is the skills profile (or heatmap) for the NP. It is also relevant to look to Table 8.1 , which compares the average incidence for each skill element across occupational classifications, and in particular the incidence between RNs and NPs. From that table, the following even denser calculation can be made:

	RN	NP	NP as % of RN
A: Contextualising	57.8	78	135%
B: Connecting:	39.5	55.5	141%

C: Coordinating	43.2	42.8	99%
Total	140.5	176.3	125%

101. It would, of course, be a mistake to draw the conclusion from this table that the NP entry rate should be (say) 125 per cent of the RN benchmark rate. That is for (at least) two reasons.

102. *First*, Dr Heap's report identifies, and identifies only, hidden skills. As the other NP evidence will show, there are also visible, clinical, skills deployed by NPs that are not deployed by RNs because of (*inter alia*) differences in scope of practice and legal frameworks (*i.e.*, there are things that NPs may do that RNs simply cannot do, like diagnose, refer and prescribe).

103. *Second*, Dr Heap's comparison is not between benchmark RNs and entry-level NPs. On the contrary, the largest category of RNs participating in Dr Heap's report was those with 31+ years of experience (see Figure 4.4, under [393]).

104. Nevertheless, the point is that even on a comparison between experienced NPs and experienced RNs, there is a significant difference in the quantum, and level, of hidden skills brought to bear by RNs and NPs. Dr Heap makes the point that there were significant instances of skills being used by NPs to "*create systems*" (*i.e.*, the level 5 skill level—[931]). These were demonstrated by NPs at the highest rate of all classifications interviewed ([954]). The types of skills contemplated there include things like:

(1) changing the palliative care system across a whole region ([978]);

(2) working through a systems change approach with multidisciplinary teams to bring about change for homeless people and in correctional facilities ([979]);

(3) introducing innovations as to how clinics respond to after-hours medical requests ([995]);

(4) developing an evaluation process for health programmes for those with alcohol and drug addictions ([1007]);

(5) leading a GP practice through a review cycle for accreditation including policy development and review ([1008]);

(6) participation in expert advisory panels ([1017]);

(7) pursuing a change in regulations about scope of practice and funding policies to enable improvements in the delivery of health services in remote communities ([1040]).

105. Dr Heap's conclusions concerning NPs contain further useful opinion at [1093]–[1117] as to the value of the skills deployed. That will be the subject of further submission in closing. For the present moment it is enough to refer to Dr Heap's opinion that NPs are "*a group of nurses working at the highest level of their profession*" ([1093].

(F) Part 8—Documenting dimensions

106. Part 8 sets out Dr Heap's findings and conclusions drawing on early parts of her report, and in particular on the detailed investigation in Parts 4–7. Higher-level opinions, the reasons for which are set out in detail in Part 8 drawing on earlier Parts, are as follows.

107. *First*, there was significant evidence of nurses and midwives utilising all nine Spotlight skills and that these skills and the way they are utilised are likely "*invisible*" ([1122]). The deployment of these skills was at a high level of proficiency (levels 3 and 4, and sometimes 5 especially for NPs) ([1123]. Each classification investigated engages all Spotlight skills and elements ([1128]).

108. *Second*, the case studies provide evidence of the way that nurses and midwives utilise those skills in practice, described as "*articulation work*" ([1130]). Articulation work is plainly valuable work, as appears from the description quoted by Dr Heap at [1130]:

> "[It is] attending and sequencing simultaneously a range of different competing demands; responding to contingencies, and working around obstacles. It involves negotiating relationships within and across authority lines, organisational boundaries and cultural groups; interweaving team members' own activities into overall work-flow; and keeping work processes on track."

109. *Third*, deployment of skills in a clustered way (of which examples were given via case studies for all classifications) increases job size. It adds to work intensity and increases effort required. Deploying clustered skills is itself an <u>under-codified</u> skill ([1131].

110. *Fourth*, as outlined in detail in Parts 4–7, the hidden skills are integrated with other aspects of nurses' and midwives' work. In fact, the invisible skills, so integrated, "*are at the heart of what makes nursing and midwifery what they are*" ([1133]).

111. Dr Heap goes on to express conclusions and analysis about each of the four classifications she considered.

112. Of particular relevance given the matters in issue in this proceeding, further discussion and conclusion concerning ENs is in Part 8.3. There, Dr Heap analyses in particular the following features of EN work:

(1) interpersonal and contextual awareness ([1191]–[1201]);

(2) dynamic workflow management ([1202]–[1207]);

(3) negotiating boundaries and relating ([1208]–[1217]);

113. The conclusion ([1218]) is that the work of ENs in this study requires intensive use of Spotlight skills across the 9 Spotlight Skill Elements, and that a substantial volume of the work required use of skills that are invisible, and therefore likely to be under-valued on gender grounds.

114. And, further discussion and conclusion concerning NPs is in Part 8.4. Dr Heap describes a "very high level of operation on the Spotlight framework" ([1222]). She analyses in particular the following features of NP work:

(1) interpersonal and contextual awareness to shape systems ([1222]–[1226]);

(2) advocating for change in marginalised communities ([1227]–[1232]) ;

(3) negotiating boundaries, including with patients and with doctors ([1233]–[1240]);

(4) dynamic workflows ([1241]–[1243]);

(5) innovating systems ([1244]–[1249]).

115. Dr Heap's conclusion at [1250] is again that the work of NPs involved intensive use of Spotlight skills, including at the highest level of proficiency. A substantial volume of the work required use of skills that are invisible, and therefore likely to be under-valued on gender grounds.

116. Parts 8.5–8.6 (acquisition of skills on the job, evolution of practice) have already been addressed above in the context of discussing ENs. Part 8.7 contains further analysis of the way in which nurses and midwives build relationships to implement person-centred care. Part 8.8 addresses the increasing contextual complexity of work, which is to say that the circumstances in which the skills are developed and deployed are growing increasingly difficult. These include, as Dr Heap addresses:

(1) greater diversity in those seeking care ([1313]–[1316]);

(2) the manner of delivery of services to First Nations people ([([1317]–[1324]]);

(3) increasing chronic illnesses and co-morbidities ([[1325]–[1332]);

(4) the aging Australian population ([1333–1339]).

117. Dr Heap expresses her overall conclusions from [1346]–[1352]. Her opinions are that evidence is provided of extensive and intensive use of skills in the Spotlight taxonomy ([1348]). She refers to her discussion of further issues that bear upon undervaluation, including (saliently to the EN debate), "*the lack of recognition of both the extensive development of nursing and midwifery skills 'on the job', and through the extensive ongoing learning (formal and informal) that nurses and midwives undertake that is not credentialled*" ([1350]). She likewise refers to the "*significant contextual factors*" bearing upon the difficulty, skill, and value of the work, and changes in these factors ([1351]).

118. Dr Heap concludes by saying the following ([1352]):

> "The work of nurses and midwives is of high impact and is extremely important to the Australian community. This work engages a depth and range of skills that have been brought to light in this study using the Spotlight framework. I consider that the Primary Materials, set out in chapters four–seven, and further in this chapter, contain evidence of the intensive, and extensive use of Spotlight skills which are—and which are utilised in ways that mean—they are under-recognised (because they are 'hidden', 'under-defined', 'under-specified' or 'undercodified) and are therefore invisible."

PART C THE INTEGRATION ISSUE

C-1 The parties' positions

(i) The ANMF's position

119. The ANMF applies to vary the Award such that the separate provision for aged care employees would be eliminated. That is, there would be a single classification structure for all employees covered by the Award, albeit that one classification will only apply to employees currently identified as "*aged care employees*" (namely EN – aged care) and some classifications only to employees currently identified as "*other than aged care employees*" (namely AINs and OHNs).[53]

120. The ANMF seeks an integrated classification structure and minimum rates of pay:

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53 ANMF position document at [6].

(1) for RNs, Midwives and OHNs, mirroring the outcome for RNs – aged care employees in the *Nurses Decision*;[54]

(2) for ENs, incorporating a classification of EN working in aged care who may be required to supervise other direct care employees (see further Part D below);[55]

(3) for NPs, maintaining existing relativities to RNs outside aged care (see further Part E below).[56]

(ii) The other parties' positions

121. Catholic Health Australia ("**CHA**") does not oppose a single set of classification definitions applying to RNs (including those working in aged care) and midwives,[57] but does appear to oppose that course for ENs.[58]

122. Healthscope Operations Pty Ltd and the Adelaide Community Health Care Alliance Incorporated ("**Healthscope**") has not expressed a position with respect to the Integration Issue and so ought to be taken either to agree with the position of the ANMF or not to have an interest in that position.[59]

123. The Australian Private Hospital Association ("**APHA**") is opposed to the proposal to integrate the aged care and non-aged care classification structures.[60] It says that the combined EN classification structure proposed by the ANMF is likely to cause confusion as to the correct structure and rates that apply to ENs in aged care.[61]

124. The Aged & Community Care Providers Association Ltd ("**ACCPA**") and Australian Business Industrial ("**ABI**") oppose changes to classifications pertaining to Aged Care employees, and to that extent presumably would oppose an integrated classification structure to the extent that such integration would require or involve changes to aged care classifications.[62]

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54 ANMF position document at [8].
55 ANMF position document at [9].
56 ANMF position document at [10].
57 CHA position document at [15].
58 CHA position document at [23(c)].
59 Healthscope position document at [5].
60 APHA position document at [4].
61 APHA position document at [5].
62 ACCPA and ABI joint position document.

C-2 Evidence relevant to integration

(i) Registration and Accreditation Scheme and evidence

125. The National Registration and Accreditation Scheme for each of ENs, RNs (including OHNs), Midwives and RNs is established under the *Health Practitioner Regulation* National *Law Act 2009* ("**National Law**").[63] To become an EN, RN, Midwife or NP, a person must have successfully completed a program of study accredited by the Australian Nursing and Midwifery Accreditation Council ("**ANMAC**") and approved by the Nursing and Midwifery Board of Australia ("**NMBA"**) before being registered or endorsed by the NMBA.

126. The objectives of the National Registration and Accreditation Scheme established under the National Law include:

> "… to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are registered."[64]

127. That is, a registered EN, RN and Midwife will possess a minimum level of training, qualifications and skill such as to ensure they are able to practice in a competent and ethical manner. Likewise, a person endorsed as a NP will also possess the necessary skills and competence to competently and ethically perform the role of NP.

128. The National Registration and Accreditation Scheme established under the National Law make no distinction between the registration of EN and RNs working within or outside of aged care.

129. As identified above, the ANMF will also rely on the evidence of Dr Kiprillis. Having had recent experience overseeing ENs in both an aged-care and an acute setting, Dr Kiprillis observes that ENs have transferrable skills that enable them to transfer between these areas of practice.[65]

C-3 Argument as to why the ANMF's position should be preferred

130. The position of the ANMF in the Aged Care Proceeding, consistent with its industrial position for decades, was that "*a nurse is a nurse is a nurse*". That is, there is a single

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63 *Health Practitioner Regulation National Law Act 2009* (Qld) sch Health Practitioner Regulation National Law (**"National Law"**).

64 National Law, Section 3(2)(a).

65 Statement of Noelleen Kiprillis, 17.03.26, [62].

regulated profession, with a uniform pathway to registration and maintenance thereof, and uniform educational standards.[66]

131. In that proceeding, the ANMF sought the creation of a new schedule to the Award for aged care employees to enable an increase in minimum wages in respect of those employees. The Full Bench in the *Stage 1 Decision* at [998] acknowledged that it was "*less than ideal*" that some workers covered by the Award, *i.e.*, those working in aged care, would have had their wages properly assessed under s 157, and others would not. However, the Full Bench rejected a submission that proposed the expiration of the new schedule of rates for aged care employees after 4 years, noting that the situation could be remedied by the ANMF simply making an application to vary the Award.

C-4 Conclusion

132. Aged care is but one of the numerous areas of practice in which ENs, RNs and NPs work. Save for the position of entry level aged care ENs (addressed below at [133(5)]), there is no basis to differentiate between the work value of an EN, RN or NP by reason of their area of practice. In recognition of this, to facilitate nurses transferring to and from aged-care and other settings and to promote "*a stable … modern award system*" (s 134(1)(g)), the Expert Panel would adopt the integrated classification structure sought by the ANMF.

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66 See for example, *Submissions in Relation To Issue Regarding Removing Aged-Care Workers from the Nurses Award 2020*, 30 August 2022 at [38] – [39].

PART D ENROLLED NURSES

D-1 The parties' positions

(i) The agreed position as between the ANMF, APHA, and Healthscope

133. The ANMF seeks a revised classification structure and rates for ENs incorporating the following principles:

(1) A minimum rate for an Introductory EN of $1,419.40 per week, being the rate identified for a diploma qualified early childhood educator, Advanced Educator under the *Children's Services Award* identified in the *Gender-based Undervaluation – Priority Award Review Decision* at [557];

(2) A structure that provides progression through levels after the completion of 6 months' (EN1), 2 years' (EN2), 4 years' (EN3) and 6 years' (EN4) practical experience in providing nursing care and/or services and completing professional development as required by the NMBA or its successor;

(3) Minimum rates for levels EN1 to EN4 where EN4 has a relativity of 107.21 per cent of the Introductory EN rate;

(4) A classification of "*EN – aged care*" based on the classification identified at [205] of the *Stage 3 decision*, [51] of the *Nurses decision* and Schedule A.4.6 but amended in accordance with the submissions of the ANMF and Joint Employers dated 13 December 2024.[67] This recognises that the term "*direct care employees*" is not defined in the Award. The amendment to the title ensures ENs in aged care who may not (or may not yet) be required to supervise other direct aged care employees are not excluded from the classification;

(5) Provision for ENs in aged care to progress from "*EN – aged care*" to the classifications of EN 3 after the completion of 4 years', and to EN 4 after the completion of 6 years', practical experience and the completion of required professional development;

(6) The modernisation of existing classification descriptors for ENs;[68] and

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67 *Submission Commenting on the Draft Determination - Aged & Community Care Providers Association Ltd and Australian Business Industrial*, 13 December 2024; *ANMF Comments of a Technical Nature in Respect of the Draft Determination Accompanying the Decision [2024] FWCFB 405*, 13 December 2024.

68 See, ANMF position document at Annexure 2.

(7) Retaining classifications for Student ENs who are less than 21 years of age, or 21 years of age and over and the existing relativity of these classifications to the Introductory EN classification.[69]

134. Healthscope has indicated that it does not have an interest in the ANMF's proposal as to aged care nurses. It otherwise agrees with the position of the ANMF (with respect to ENs) as set out in the ANMF position document.[70]

135. Subject to opposing the integration of aged care and non-aged care classification structures, APHA does not oppose the ANMF's proposed revised classification structure and rates for ENs.[71]

(ii) The ABLA parties' position

136. CHA agrees to the proposed minimum rate for an EN outside of aged care being $1,419.40 per week, but otherwise does not agree to the pay or classification structure for ENs as proposed by the ANMF.[72]

137. CHA says that classification definitions in clause A.4 (relating to ENs) will require amendment and that there is scope to materially simplify the wording.[73] However, it does not substantively respond to the ANMF's proposed set of EN classification descriptors set out at Annexure 2 to the ANMF position document.

138. ACCPA and ABI oppose any change to the classification structure for aged-care ENs. That position is put on the basis that the Aged Care Proceeding has been finalised[74] and that the Expert Panel in the *Nurses Decision* determined that the single classification for ENs in the aged care sector was not to be disturbed or abandoned by any subsequent change to the classification structure for ENs.[75] ACCPA and ABI also say that the inclusion of "*new rates*" or "*progression*" for ENs in aged care would be contrary to the *Nurses decision*.[76]

139. ACCPA and ABI oppose any amendment to the title or description of the classification "*enrolled nurse supervising other direct care employees*".[77]

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69 ANMF position document at [17].
70 Healthscope position document at [5].
71 APHA position document at [7].
72 CHA position document at [21] – [23].
73 CHA position document at [24].
74 ACCPA and ABI joint position document at [2].
75 ACCPA and ABI joint position document at [3.9].
76 ACCPA and ABI joint position document at [3.10].
77 ACCPA and ABI joint position document at [1.2(a)] and [3.11] – [3.13].

D-2 The job of the EN, and its work value

(i) Registration and Accreditation Scheme and evidence from experts and officials

140. As identified in the Enrolled Nurse Standards for Practice,[78] the EN works with the RN as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice generally requires the EN to work under the direct or indirect supervision of the RN. At all times, the EN retains responsibility for his/her actions and remains accountable in providing delegated nursing care.[79]

141. The qualification / program of study for ENs involves obtaining a Diploma of Nursing (AQF 5) involving a minimum of 18 months education and training. The Diploma is delivered within the vocational educational training sector and approved by the NMBA. Students must also complete a minimum of 400 hours of clinical placement in a variety of settings and complete a number of core competencies in, amongst others, clinical assessment, wound management and intravenous therapy.[80]

142. Dr Kiprillis's evidence will be that the EN is a valuable and viable alternate career path to that of an RN which has a place in providing nursing care across a range of settings.[81]

143. The ANMF relies on the Evidence of Dr Heap at Part 3 and Part 6 of her report and the summary of that evidence discussed at Part B-3(ii)(B) and Part B-3(ii)(D) above as to the role of the EN across the health sector.

(ii) Evidence from workers

144. The ANMF will rely on a body of evidence from EN workers and their supervisors to demonstrate the nature of the work of an EN, the level of skill and responsibility involved in doing the work and the conditions under which the work is done. A number of common examples and pertinent themes emerge from the lay witness statements:

(1) ENs are skilled workers who perform the following clinical tasks:

(a) ENs conduct regular observations of the patient and are responsible for recognising and reporting patient deterioration and any other concerns.[82]

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78 Enrolled Nurse Standards for Practice, Nursing and Midwifery Board of Australia, 1 January 2016, p 2; Statement of Noelleen Kiprillis, 17.03.26, "NK-3".

79 Enrolled Nurse Standards for Practice, Nursing and Midwifery Board of Australia, 1 January 2016; p 2; Statement of Noelleen Kiprillis, 17.03.26, "NK-3".

80 Nursing and Midwifery Board, Ahpra, "Fact Sheet – scope of practice and capabilities of nurses – Updated May 2024" (**"NMBA fact sheet"**), p 2; Statement of Noelleen Kiprillis, 17.03.26, "NK4".

81 Statement of Noelleen Kiprillis, 17.03.26, [49].

82 Statement of Nicole Mackay, 18.03.26, [15]-[16]; Statement of Jade Barclay 17.03.26, [7]-[11]; Statement of Julie McGrath, 19.03.26, [10].

(b) ENs administer certain medications alone and, in so doing, apply safe administration of medication procedures. ENs are permitted to administer medications chartered in a medication plan set by a doctor or NP or all other drugs not classified Schedule 4 or Schedule 8 under applicable *Drugs, Poisons and Controlled Substances* legislation. In the case of the later, the EN administers this medication together with an RN. In safely administering medication, the EN performs an assessment of the patient and applies critical thinking skills, escalating care where necessary.[83]

(c) ENs administer varying levels of wound care. All ENs are competent at basic wound care and some ENs excel in the use of advanced techniques like vacuum dressing.[84]

(d) ENs provide direct patient care (*e.g.*, showering, toileting and generally assisting the patient) in a skilled manner, taking the time while performing these tasks to assess the patient's physical and emotional state. The EN follows an individualised care pathway, also known as a care plan, set in respect of each patient.[85]

(e) Certain ENs in particular settings, once approved by a supervising RN to do so, administer intravenous medication and perform procedures like inserting cannulas, removing sutures, and inserting and replacing catheters alone.[86]

(2) The EN's primary role is patient care, enabling the EN to devote time in practising holistic patient-centred care. As Samantha Beattie (NP and former NUM) observes,

> "It was apparent to me, as the NUM overseeing the Endocrine Out-patient Clinic, that everything ran smoother and was generally more

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83 Statement of Nicole Mackay, 18.03.26, [11]-[14]; Statement of Darren Wall, 18.03.26, [16] and [19]-[21; Statement of Teresa Satalich, 17.03.26, [6(a)] and [7]-[10]; Statement of Jade Barclay 17.03.26, [12]-[14]; Statement of Lachlan Timms, 17.03.26, [29] and [40(b)].

84 Statement of Nicole Mackay, 18.03.26, [9]-[10]; Statement of Darren Wall, 18.03.26, [23]; Statement of Teresa Satalich, 17.03.26, [6(e)] and [15(d)]; Statement of Lachlan Timms, 17.03.26, [30] and [53]; Statement of Stephen Voogt 18.03.26, [16(b)].

85 Statement of Nicole Mackay, 18.03.26, [8]; Statement of Teresa Satalich, 17.03.26, [6(b)-(c)]; Statement of Jade Barclay 17.03.26, [10].

86 Statement of Darren Wall, 18.03.26, [26], [30] and [39(d)]; Statement of Jade Barclay, 17.03.26, [13]-[14]; Statement of Lachlan Timms, 17.03.26, [27] and [40(c)]; Statement of Julie McGrath, 19.03.26, [17(b)].

> comfortable for patients as a result of this initial meeting with an EN. I often observed that patients loved seeing ENs because ENs had the time to sit down and have a conversation with the patient, a holistic conversation, about their health care needs."[87]

(3) While ENs are subject to the supervision of an RN, many ENs perform many duties independently. ENs can manage their own patient load, complete medication rounds alone and prepare their own patient notes.[88] ENs working in home care community nursing attend on clients alone in their homes.[89]

(4) In home care, both the EN and an RN can occupy the primary nurse role.[90]

(5) The EN is the most qualified nursing team member to whom the RN may delegate care tasks. The work of an EN provides critical support to the RN, who is often occupied with other duties. An experienced EN can be called on to fill in for the NUM(RN) in respect of certain duties while the NUM is on break.[91]

(6) ENs play an important role in educating new nurses on the ward/unit, in particular new ENs, graduate RNs and other care workers.[92]

145. Many ENs, particularly ENs working in aged care settings, have advanced skills in identifying and responding to signs of acute deterioration. ENs in aged care know their residents well, are constantly observing them, identifying issues and changes in their presentation, and performing small non-pharmacological interventions to assist them.[93]

D-3 Progression in the EN role

(i) Registration and Accreditation Scheme and evidence from experts and officials

146. As identified above, the objectives of the National Registration and Accreditation Scheme established under the National Law include to provide for the protection of the public by ensuring that only health practitioners who are suitably trained and qualified to practice in a competent and ethical manner are permitted to practice. This objective is achieved by a system whereby registration as an EN requires a person to complete a

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87 Statement of Samantha Beattie, 19.03.26, [25]-[26].
88 Statement of Nicole Mackay, 18.03.26, [12] and [19]; Statement of Darren Wall, 18.03.26, [40].
89 Statement of Darren Wall, 18.03.26, [16]-[18] and [24]; Statement of Lachlan Timms, 17.03.26, [24]-[33].
90 Statement of Lachlan Timms, 17.03.26, [34]-[40(e)] and [60].
91 Statement of Nicole Mackay, 18.03.26, [20]; Statement of Jade Barclay 17.03.26, [41] and [43]; Statement of Darren Wall, 18.03.26, [45]-[46].
92 Statement of Nicole Mackay, 18.03.26, [23]; Statement of Jade Barclay 17.03.26,[42]; Statement of Lachlan Timms 17.03.26, [66].
93 Statement of Teresa Satalich, 17.03.26, [6(g); Statement of Stephen Voogt 18.03.26, [16(a)].

ANMAC accredited and NMBA approved EN program of study and apply for registration with the NMBA. The Enrolled Nurse Accreditation Standards identify that professional accreditation is part of the broader process of assuring that:[94]

> "Beginning practitioners have achieved professional outcomes to practice in a safe and competent manner because they are equipped with the necessary foundation knowledge, professional attitudes and essential skills."

147. Put another way, ENs graduate from a competency-based education framework with essential knowledge to manage and complete nursing care under the supervision of an RN, NP or midwife.[95]

148. However, once registered, the skills possessed by ENs, their responsibilities and the nature of the work does not remain static. Indeed, the EN Standards for Practice require an EN to engage in ongoing development of themselves as a professional.[96] The indicators for this standard include:

(1) Recognising the need for and participating in, continuing professional and skills development in accordance with the NMBA's Continuing professional development registration standard;[97] and

(2) Identifying learning needs through critical reflection and consideration of evidence-based practice in consultation with the RNs and the multidisciplinary healthcare team.[98]

149. Dr Kiprillis has a breadth of experience working as an EN, RN (including as a DON) as well as spending a lot of time as the Associate Director of Teaching and Learning at Eastern Health working with her team in managing new EN graduates. This included ENs in both acute and aged-care settings. Based on that experience, Dr Kiprillis's evidence will be that she recognises the benefit in providing progression for ENs through classification levels in both aged-care and acute care.[99] She identifies a career pathway that recognises the increase in competence, skill and knowledge gained over time working, as an important way to support the role of the EN. Whereas some ENs

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94 Enrolled Nurse Accreditation Standards 2017, Australian Nursing and Midwifery Accreditation Council, (**EN Accreditation Standards**) p 2, Statement of Noelleen Kiprillis, 17.03.26, "NK2".
95 NMBA fact sheet, p 2.
96 Accreditation Standards 2017, Standard 10, p 7.
97 Accreditation Standards 2017, Standard 10.2, p 7.
98 Accreditation Standards 2017, Standard 10.3, p 7.
99 Statement of Noelleen Kiprillis, 17.03.26, [47].

will go on to become RNs, some will not want to do so, and the time and cost involved will make it unviable for others.[100]

150. Dr Kiprillis identifies that the completion of a Nursing Diploma will prepare the EN with the knowledge and skills needed to work as an EN, and that new ENs need support to successfully move into the workforce as part of the nursing care team.[101] However, she observes a difference between theoretical knowledge and its application in practice. Starting out in the EN role involves a steep learning curve with critical on-the-job skills developing with improvements in skills identifiable in formative assessments at three, six and 12 months.[102]

151. Dr Kiprillis also draws a comparison between the work value of an experienced EN and an early career RN in an acute setting. An experienced EN may not have the same understanding of the framework that underpins why they do what they do (as would be obtained through the completion of an undergraduate degree in nursing), but they typically have superior clinical skills and "*know how to do the job*".[103]

152. Dr Kiprillis draws a distinction between the work of an EN entering aged care and an EN in acute care. Consistently with findings in the Aged Care Proceeding, Dr Kiprillis identifies that ENs entering aged care will have immediate responsibility in leading and supporting care.[104]

153. In addition, the ANMF will here again rely upon the evidence of Dr Heap at Part 3 and Part 6 of her report and the summary of that evidence discussed at Part B-3(ii)(B) and Part B-3(ii)(D) above as to the role of the EN across the health sector.

(ii) Evidence from workers

154. The evidence of the lay witnesses will demonstrate that the EN role is a career pathway and a valuable nursing role in and of itself. Outdated conceptions of the EN as "*just an EN*" have no place in modern day nursing.[105]

155. Any suggestion that the EN role is but a mere stepping stone to the RN role is not supported by the lay evidence and would be rejected. Many ENs remain in the EN role

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100 Statement of Noelleen Kiprillis, 17.03.26, [51].
101 Statement of Noelleen Kiprillis, 17.03.26, [35].
102 Statement of Noelleen Kiprillis, 17.03.26, [36] and [41].
103 Statement of Noelleen Kiprillis, 17.03.26, [45].
104 Statement of Noelleen Kiprillis, 17.03.26, [38] – [39]. See *Nurses Decision* at [48].
105 Statement of Darren Wall, 18.03.26, [55]; Statement of Teresa Satalich, 17.03.26, [1] and [21]; Statement of Jade Barclay 17.03.26, [43] and [45]; Statement of Lachlan Timms, 17.03.26, [61]; Statement of Stephen Voogt 18.03.26, [17(d)].

for the entirety of their nursing careers.[106] Many factors personal to the EN, but common to this cohort of primarily women balancing familial care responsibilities alongside work, explain why going to university to become an RN is not a viable option.[107]

156. The lay evidence will demonstrate that the nature of the work of the EN, the skills and responsibilities exercised and the conditions within which the work is done change significantly over many years, and across multiple settings.

(1) ENs hone knowledge and skills acquired in the EN Diploma with time in the role. As Stephen Voogt (NP) explains, by reference to the work of ENs in residential aged care conducting and interpreting observations,

> "This is an important clinical skill that takes time to develop. Anyone can do observations but being able to connect the dots is the key to the skill. ENs take time to develop that skill. Usually, after three to four years, ENs will start to develop the skills of joining those dots and knowing the cause of why most observations are not normal. ENs I worked alongside were very good at reviewing patient's progress charts, fluids, and treatment given to date, in order to identify those patients in need of triage. It takes skill, and is a significant responsibility, to identify that a patient is stable. The EN in aged care is the nurse conducting regular observations of the resident and identifying those patients who need escalation to the RN, NP or Doctor."

(2) ENs gain new clinical skills throughout their careers. Darren Wall (EN), Teresa Satalich (EN), Jade Barclay (EN) and Julie McGrath (EN) document the many additional clinical skills they have gained over their years working in multiple settings. Their individual development of increasingly advanced nursing skills is chartered by reference to months and/or years in the EN role. [108] Likewise, Samantha Beattie (NP and former NUM) documents her observations of the fundamental and increasingly specialist skills her ENs working in endocrine and diabetes assessment acquired over many years.[109]

(3) This clinical skill development is fostered by a commitment to ongoing education and training – even where on occasion accreditation is overlooked and

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106 Statement of Darren Wall, 18.03.26, [1]; Statement of Teresa Satalich, 17.03.26, [21]-[23].

107 Statement of Darren Wall, 18.03.26, [58]-[60]; Statement of Nicole Mackay, 18.03.26, [25], [27]-[28]; Statement of Teresa Satalich, 17.03.26, [20]-[21]; Statement of Jade Barclay 17.03.26, [44]; Statement of Lachlan Timms, 17.03.26, [71].

108 Statement of Darren Wall, 18.03.26, [31]-[33] and [38]-[39]; Statement of Teresa Satalich, 17.03.26, [13(a)-(c)]; Statement of Jade Barclay 17.03.26, [15], [16], [24], [27]-29] and [33]; Statement of Lachlan Timms, 17.03.26, [49]-[53]; Statement of Julie McGrath, 19.03.26, [17].

109 Statement of Samantha Beattie, 19.03.26, [28].

deemed beyond the EN's scope – in order to advance their skills and be "*the best nurse I can be*" for their patients.[110]

(4) EN witnesses consistently observe that their development of critical "soft skills" in their roles took time. Throughout their careers, they developed:

(a) new strategies in making patients feel at ease in stressful situations;[111]

(b) additional knowledge and skill in managing and deescalating violent and/or aggressive patient behaviours;[112]

(c) skills in effectively communicating with and managing patient's families;[113]

(d) strategies in managing the vicarious trauma inherent to their work;[114] and

(e) better skills in liaising effectively with doctors and other multi-disciplinary staff.[115]

(5) ENs practice with greater level of independence and responsibility, with the support of their employer and NUM, upon demonstrating competency at an advanced level.[116]

(a) Darren Wall (EN) speaks of being approached to work as one of only two nurses in a cardiac emergency unit, under challenging conditions, in recognition of his advanced practice nursing.[117]

(b) Nicole Mackay (EN) and Jade Barclay (EN) were, at an appropriate time and as required, both allocated their own patient loads.[118] Julie McGrath (EN) met one-on-one with patients in a correctional setting assessing them, ahead of their referral to a doctor.[119]

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110 Statement of Darren Wall, 18.03.26, [47], particularly [47(d)]; Statement of Teresa Satalich, 17.03.26, [14]-[18]; Statement of Julie McGrath, 19.03.26, [15].

111 Statement of Darren Wall, 18.03.26, [48]-[53]; Statement of Jade Barclay 17.03.26, [39].

112 Statement of Teresa Satalich, 17.03.26, [13(d)-(e)]; Statement of Lachlan Timms, 17.03.26, [55]-[57]; Statement of Stephen Voogt 18.03.26,[16(e)-(g)].

113 Statement of Teresa Satalich, 17.03.26, [13(l)]; Statement of Jade Barclay 17.03.26, [30]-[31]; Statement of Lachlan Timms, 17.03.26, [55]; Statement of Stephen Voogt 18.03.26, [17(c)].

114 Statement of Jade Barclay 17.03.26, [32].

115 Statement of Jade Barclay 17.03.26, [37]-[38]; Statement of Stephen Voogt 18.03.26, [16(i)]; Statement of Julie McGrath, 19.03.26, [16].

116 Statement of Darren Wall, 18.03.26, [40]-[41].

117 Statement of Darren Wall, 18.03.26, [43]-[46].

118 Statement of Nicole MacKay, 18.03.26, [19]; Statement of Jade Barclay 17.03.26, [25].

119 Statement of Julie McGrath, 19.03.26, [18]-[21].

(c) Jade Barclay (EN) was classified "*On Call*" after a year and a half in the endoscopy unit (and eight years into her career as an EN), indicating she could be called to perform all the advanced clinical skills required in that unit (including assisting in a number of specialist procedures) independently.[120] She is also "*the de-facto team leader*", taking all incoming and outgoing calls, anytime all the RNs on shift are new in the role.[121]

(d) Stephen Voogt (NP, geriatrician) has observed that "*ENs with 5 years' or so experience manage entire wings of aged care facilities with minimal oversight of the RN*".[122]

(6) Critical aspects of the job – managing time between patients, effective notetaking and handover, and anticipating what equipment is required when assisting in different procedures – take time to develop[123]. New ENs, in particular, need significant support in learning how to concisely and accurately complete patient notes.[124]

(7) With time, Lachlan Timms (RN) observes that ENs in community nursing move away from "*a task focused approach to delivering care in a holistic manner*".[125] Likewise, Teresa Satalich (EN) reflects that *"[n]ew nurses are often task oriented*" but that with experience in aged care nursing she has learnt how to "*approach tasks from that which is most critical to the resident*".[126]

(8) The skill and confidence required to respond to emergency situations is also established over time.

(a) Nicole Mackay (EN) details how it took her four years before she would confidently press the Medical Emergency Team ("*MET Call*") button, having identified signs of rapid deterioration in a patient, without deferring to an RN first to confirm her assessment.[127]

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120 Statement of Teresa Satalich, 17.03.26, [18].
121 Statement of Jade Barclay 17.03.26, [23(a)].
122 Statement of Stephen Voogt 18.03.26, [17(c)].
123 Statement of Teresa Satalich, 17.03.26, [13(h)]; Statement of Jade Barclay 17.03.26, [21]-[22] and [26].
124 Statement of Lachlan Timms, 17.03.26, [45]-[48 and [59]; Statement of Teresa Satalich, 17.03.26, [13(c)].
125 Statement of Lachlan Timms, 17.03.26, [58].
126 Statement of Teresa Satalich, 17.03.26, [13(d)].
127 Statement of Nicole MacKay, 18.03.26, [18].

(b) It took Teresa Satalich (EN) one to two years to pick up common non-verbal cues of agitation in dementia patients, and four to five years to develop a deep understanding of the underlying causes behind these behaviours and learn how to effectively manage behavioural incidents.[128]

(c) Likewise, Jade Barclay (EN) notes that she has spent her entire career learning "*how to assess what is normal and what isn't normal for a patient and when to escalate care*".[129]

(9) Darren Wall (EN) observes that "*over the years, the gap between the work I was doing as an experienced EN and the work of junior RNs working alongside me got smaller and smaller*".[130] The lay witness ENs are routinely asked by junior RNs how to perform tasks and manage competing tasks. The evidence from these workers and their supervisors establishes that experienced ENs play a critical role in supporting the broader team of nurses and carers.[131]

157. All lay witnesses identify financial progression through multiple pay points as an important part of recognising the EN career pathway and the EN's development of skills and progression of responsibility over time. Additionally, financial progression affords job satisfaction and supports the retention of this critical workforce.[132]

D-4 Argument as to why the agreed position should be preferred to the ABLA parties' position

158. The revised EN classification structure and rates sought by the ANMF reflect an agreed position between the ANMF, Healthscope and APHA. That consent position has involved compromise by those parties and the Expert Panel would give significant weight to that position.

159. It is submitted that this outcome best reflects the work value of ENs and would eliminate the historical gender-based undervaluation of the EN. This proposal recognises and rewards increases in work value throughout the career of an EN. It provides for career

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128 Statement of Teresa Satalich, 17.03.26, [13(i)-(k).

129 Statement of Jade Barclay 17.03.26, [36].

130 Statement of Darren Wall, 18.03.26, [42].

131 Statement of Darren Wall, 18.03.26, [36]; Statement of Nicole MacKay, 18.03.26, [22]-[23]; Statement of Teresa Satalich, 17.03.26, [12(b)], [19]-[20] and [26]; Statement of Jade Barclay 17.03.26, [19], [23(b)], [42].

132 Statement of Darren Wall, 18.03.26, [57]; Statement of Teresa Satalich, 17.03.26, [24]-[25] and [28]; Statement of Jade Barclay 17.03.26, [40]; Statement of Lachlan Timms, 17.03.26, [67]-[70]; Statement of Samantha Beattie, 19.03.26, [30]-[31].

progression for an important cohort within the nursing profession and broader health sector.

160. All parties are agreed on the minimum rate for an Introductory EN, reflecting the outcome for a diploma qualified early childhood educator in the *Gender-based Undervaluation – Priority Award Review Decision* at [557].

161. The Expert Panel in the Aged Care Proceeding recognised that, with any employment, an initial period of experience is necessary before an employee becomes fully competent.[133] The evidence makes clear that this is the case for ENs. This increased work value justifies higher minimum wages and is also necessary to provide a viable career path for ENs.

162. The ABLA parties do not propose an alternate classification structure or rates for ENs. The ANMF proposal (as supported by Healthscope and APHA) provides for modest but tangible minimum rate increases across the career of an EN of 7.21 percent. The consequence is that the highest classification of "EN (EN 4 – Completion of 6 years)" would have a minimum rate between that of an "RN 1st year" and an "RN Completion of 1st year (1 year plus)". This accords with the evidence (identified above) of an experienced EN exhibiting similar work value to an early career RN.

163. It may be accepted that there are no bright lines that delineate work value increases in the career progression of ENs. ENs work value does not progress in a linear manner by the acquisition of qualifications. However, it is plain that the work value of ENs does increase with experience. A failure to recognise that increased work value would be a failure to recognise hidden skills and would perpetuate the historical gender-based undervaluation of their work. The passage of time represents a clear, simple and objective way of measuring that experience and increased work value. The time periods of 6 months, 2 years, 4 years and 6 years represent appropriate milestones reflecting that increased work value.

164. The amendments to the EN descriptors are also necessary to meet the modern awards objective. The modernisation of those descriptors is consistent with s 134(1)(g) of the FW Act. Items A.4.1, A.4.2 and A.4.6 of Schedule A describe holding registration as an EN in terms that are no longer relevant. The references to "in-service training, subject to its provision by the employing agency, from time to time" do not reflect the current

133 *Nurses Decision* at [47]

obligation of all ENs to complete a minimum of 20 hours of continuing professional development per registration period (whether employed on a full time basis or not).[134] As noted above, the other amendments to item A.4.6 are consistent with the earlier submissions of both the ANMF and the Joint Employers, and they are also consistent with s 134(1)(g) of the FW Act.

D-5 Conclusion

165. For the reasons set out above, the amendments to the EN classification structure and rates of pay identified in the ANMF position document are justified by work value reasons and necessary to achieve the modern awards objective.

[134] Nursing and Midwifery Board of Australia "Registration Standard: Continuing Professional Development", 1 June 2016 (**CPD Registration Standard**); Statement of Noelleen Kiprillis, 17.03.26, "NK5".

PART E NURSE PRACTITIONERS

E-1 The parties' positions

(i) The ANMF position

166. The ANMF seeks a single classification structure and increased minimum rates for all NPs that would:

(1) apply to all NPs, whether working in aged care or outside of aged care;

(2) retain the existing two levels of NP, being first year and second year;

(3) retain the existing definition of NP at Schedule A.7; and

(4) retain existing relativities as between RNs and NPs outside of aged care.[135]

(ii) The other parties' positions

167. Healthscope does not agree that NPs should maintain their existing relativities to RNs. Healthscope's view is that all NPs should be paid the rate determined by the Expert Panel for NPs in aged care.[136]

168. Likewise, APHA opposes the changes in relation to NPs proposed by the ANMF[137] and says that the minimum rates for Nurse Practitioners should be those set by the Expert Panel for NPs in aged care.[138]

169. CHA does not agree to the ANMF proposal for the NP pay rates.[139] It says the minimum award rates should be aligned to the NP pay structure in the aged care stream.[140]

170. ACCPA and ABI oppose any increase in the rates for NPs working in aged care.[141]

E-2 The job of the NP, and its work value

(i) Registration and Accreditation Scheme and Evidence from experts and officials

171. The ANMF will rely on the Evidence of Dr Heap at Part 3 and Part 8 of her report and the summary of that evidence discussed at Part B-3(ii)(B) and Part B-3(ii)(E) above in respect of the role of the NP across the health sector.

172. NPs are autonomous clinicians. They provide advanced clinical assessment, make diagnoses and undertake investigations. They provide care co-ordination and refer

135 ANMF position document at [21].
136 Healthscope position document at [2].
137 APHA position document at [8].
138 APHA position document at [9].
139 CGA position document at [25] – [26].
140 CGA position document at [27].
141 ACCPA and ABI joint position document at [1.2(c)] and [4].

patients to other medical specialists. They have legal authority to diagnose and treat patients within their scope of practice.[142]

173. As identified in the NMBA Nurse Practitioner Standards for practice:[143]

> "As part of providing care, NPs can independently request and interpret any diagnostic and/or screening investigations within their scope of practice to facilitate diagnosis and/or screening processes. This informs diagnosis and care planning. Care can include nursing interventions that involve initiation, titration or cessation of any medicines in their scope. NPs practice encompasses technical and procedural skills that are applied as part of their responsibility in initiating and managing complex healthcare requirements. NPs take responsibility for following-up on any components of care initiated. They are accountable for care provided and self-monitor their work."

174. To be endorsed by the NMBA as an NP, a person must:

(1) hold a general registration as an RN without restrictions;

(2) be able to demonstrate clinical experience equivalent to three years (5,000 hours) at an advanced practice level;[144]

(3) hold a masters – Nurse Practitioner degree or equivalent qualification; and

(4) comply with the Standards of Practice for an NP.[145]

175. The role of an NP in the broader health sector is still relatively new. The introduction of the NP in Australia began under different state regimes in the 1990s. Their initial role was particularly focused on addressing gaps in the health system, particularly in remote and regional areas where there was a shortage in the delivery of specialised care[146] and due to the growing demand for health care due to aging populations and chronic disease.[147] That initial focus is still reflected in the domains in which NPs

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142 Statement of Noelleen Kiprillis, 17.03.26, [100].

143 Nursing and Midwifery Board of Australia, "*Nurse Practitioner standards for practice, 1 March 2021*" (**NP standards for practice**), p 8; Statement of Denise Lyons, 17.03.26, "DL4".

144 "Advanced practice" is defined by the NMBA to be "*where nurses incorporate professional leadership, education, research and support of systems into their practice. Their practice includes relevant expertise, critical thinking, complex decision-making, autonomous practice and is effective and safe. They work within a generalist or specialist context and they are responsible and accountable in managing people who have complex healthcare requirements. Advanced practice in nursing is demonstrated by a level of practice and not by a job title or level of remuneration.*". See **NP standards for practice,** p 8; Statement of Denise Lyons, 17.03.26, "DL4".

145 Nursing and Midwifery Board of Australia, "*Registration Standard: Endorsement as a Nurse Practitioner, 1 June 2026*" (**NP Registration Standard**); Statement of Denise Lyons, 17.03.26, "DL2", p 2. Statement of Noelleen Kiprillis, 17.03.26, [88].; Statement of Denise Lyons, 17.03.26, [20].

146 Statement of Noelleen Kiprillis, 17.03.26, [78] and Statement of Denise Lyons, 17.03.26, [12].

147 Statement of Denise Lyons, 17.03.26, [12].

operate today, where they commonly work in settings where access to care is limited or demand is high, including primary care, urgent and after-hours services, rural and remote communities, aged care and telehealth.[148]

176. In 2010, national registration and accreditation of NPs by the NMBA under the National Law commenced.[149] Around this time, funding was also provided to allow eligible NPs to access the Medicare Benefits Schedule ("**MBS**") and the Pharmaceutical Benefits Scheme ("**PBS**").[150]

177. The role played by RNs in the delivery of patient care was expanded as a part of the Australian Government's health reforms in around 2015.[151]

178. Since November 2024, NPs have been recognised as independent practitioners for the purpose of the MBS and the PBS.[152] There is no longer a requirement for an NP to have a collaborative agreement with a doctor in order for patients or health providers to access MBS and PBS subsidies.[153] Critically, the legislative change served to recognise NPs as autonomous professionals who deliver high quality care to patients within their scope of practice.

179. Denise Lyons is the President of the Australian Primary Health Care Nurses Association (the peak body representing nurses working in primary health care in Australia). In that role she represents primary health care nursing at a national level in respect of health-system reform.[154] She has been an NP since 2012.[155] Her clinical, leadership and policy experience enable her to address the role of the NP and its work value.

180. Denise Lyons will describe the work of NPs having expanded and intensified over the past six to ten years. The work of NPs has shifted from being supplementary or service specific to being core, frontline clinical care in many settings.[156] She also identifies that the level of skill and responsibility required of NPs has increased materially. NPs are now managing patients with greater complexity, and clinical decision-making has

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148 Statement of Denise Lyons, 17.03.26, [58].
149 Statement of Denise Lyons, 17.03.26, [19], [42].
150 Australian Nursing and Midwifery Accreditation Council "Nurse Practitioner Accreditation Standards 2015" (**NP Accreditation Standards**), [1.4], p 5; Statement of Denise Lyons, 17.03.26, [47].
151 NP Accreditation Standards; Statement of Noelleen Kiprillis, 17.03.26, "NK6".
152 NPs are eligible to apply to the Commonwealth Health Minister as a "*Participating nurse practitioner*" under the *Health Insurance Act 1973* (Cth).
153 Statement of Denise Lyons, 17.03.26, [52] - [53].
154 Statement of Denise Lyons, 17.03.26, [1].
155 Statement of Denise Lyons, 17.03.26, [3].
156 Statement of Denise Lyons, 17.03.26, [76] - [77].

become more risk laden. Overall, NP work has become more complex, more autonomous and more central to health service delivery.[157]

181. A NP's scope of practice describes the clinical services they are educated, authorised and competent to provide. In practical terms, this includes:

(1) independently assessing patients;

(2) diagnosing health conditions;

(3) prescribing medicines;

(4) ordering and interpreting pathology and imaging;

(5) initiating and managing treatment plans;

(6) referring patients to other health professionals; and

(7) providing ongoing management of acute, chronic, and complex conditions.[158]

182. The expansion of an NP's scope of practice is self-regulated. However, as identified by the AHPRA Safety and quality guidelines for NPs:[159]

> "The scope of practice for an NP may change over time. If an NP decides to expand or change their scope of practice to meet the needs of their client group, then the NP must make sure they have the appropriate skills, knowledge and education to ensure they remain safe and competent to practise at the advanced practice level. This may include further postgraduate education and skill development.
>
> NPs planning to change scope are required to use the NMBA's Decision-making framework for nursing and midwifery. This will ensure that NPs are competent in their proposed expanded or new scope of practice. It is the responsibility of the NP, and where employed, an employer, to ensure that, should an NP be required to expand or change their scope of practice to meet the needs of a client group, they are educated, authorised and competent to perform their role."

183. In her role as Deputy Director of Education at the School of Nursing and Midwifery at Monash University, Dr Kiprillis has been involved in providing education assistance to the course coordinator for the Masters of Nurse Practitioner.[160] She also has experience as the Acting Director of Nursing at Eastern Health which involved, *inter alia*,

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157 Statement of Denise Lyons, 17.03.26, [76] - [79].

158 Statement of Denise Lyons, 17.03.26, [30].

159 Nursing and Midwifery Board AHPRA Safety and quality guidelines for nurse practitioners, Updated November 2024 (**NP Safety and quality guidelines**), p 1; Statement of Denise Lyons, 17.03.26, "DL7".

160 Statement of Noelleen Kiprillis, 17.03.26, [66].

mentoring a NP candidate seeking endorsement as an NP.[161] This, together with her broader experience in the health sector and her role as Lead – Strategic Programs and Engagement of the ANMF Federal Office, enables her to speak to the role of the NP in the health sector.

184. Dr Kiprillis will describe RNs and NPs as being "*poles apart*" in terms of experience and scope of practice[162] with the NP possessing greater skills.[163] Her evidence will be that an NP will understand, in absolute clinical terms, why they are doing something. They alone, amongst their colleagues in nursing, will be able to determine why a person is unwell, what can be done to treat that person, and exactly how the treatment should be enacted.[164]

185. Denise Lyons also provides evidence about the key differences between the scope of practice of an NP *vis a vis* an RN. The differences she identified include NPs:

(1) exercising significantly greater autonomy;

(2) carrying higher responsibility and accountability;

(3) undertaking expanded and higher-risk clinical functions;

(4) carrying greater personal accountability and legal risk;

(5) having higher qualification, continuing professional development and regulatory requirements.[165]

186. Denise Lyons identifies that even at senior levels, the role of an RN is not authorised for independent diagnosis, prescribing, or autonomous medical decision-making.[166]

187. Dr Kiprillis identifies the role of the NP as being equivalent to that of a senior registrar in the medical hierarchy.[167] However, in addition to the high level of technical clinical skill and associated responsibility, Dr Kiprillis identifies that an NP also provides a high level of nursing care in a way that is holistic and differs from the type of care provided by medical practitioners.[168]

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161 Statement of Noelleen Kiprillis, 17.03.26, [96].
162 Statement of Noelleen Kiprillis, 17.03.26, [102].
163 Statement of Noelleen Kiprillis, 17.03.26, [104].
164 Statement of Noelleen Kiprillis, 17.03.26, [104].
165 Statement of Denise Lyons, 17.03.26, [54].
166 Statement of Denise Lyons, 17.03.26, [65].
167 Statement of Noelleen Kiprillis, 17.03.26, [105].
168 Statement of Noelleen Kiprillis, 17.03.26, [106].

188. Denise Lyons identifies that doctors and NPs both practice independently but come from different educational and professional frameworks and bring different clinical perspectives. In particular, NPs bring a nursing perspective and philosophy to their role which is combined with advanced clinical authority, enhancing team function and ensuring care is coordinated and patient centred.[169]

(ii) Evidence from workers

189. The ANMF will rely on a body of evidence from NP workers in order to demonstrate the nature of the work of an NP, the level of skill and responsibility involved in doing the work, and the conditions under which the work is done. A number of common examples and pertinent themes emerge from the lay witness statements:

(1) The NP's work represents the pinnacle of advanced practice as a nurse.[170] The skill level exhibited, and the nature of the NP's work, is altogether different from the work performed by RNs.[171] The lay witness statements of Nikki Johnston (NP), Stephen Voogt (NP) and Jason Moloney (NP) provide examples of their examination, treatment and management of patients from which the extent of the NP's clinical skill and the scope of their advanced practice is readily apparent.[172]

(2) NPs use "*the same modalities of treatment as a medical practitioner*";[173] NPs assess patients, order scans and pathology and formulate an appropriate diagnosis and treatment.[174] In treating patients, NPs prescribe medications.[175] The role necessitates an advanced knowledge of pharmacology and different treatment regimes.[176]

(3) The NP's work is defined by autonomous clinical decision-making. In their delivery of safe patient-centred care, the NP collaborates with medical

169 Statement of Denise Lyons, 17.03.26, [66] and [70].
170 Statement of Jason Moloney, 18.03.26, [33]; Statement of Samantha Beattie, 19.03.26, [32].
171 Statement of Nikki Johnston, 17.03.26, [30]; Statement of Jason Moloney, 18.03.26, [30]-[31]; Statement of Kerrie Duggan, 18.03.26, [29]-[36]; Statement of Rose McCrohan, 18.03.26, [29] and [38]; Statement of Noelleen Kiprillis, 17.03.26, [98]-[104]; Statement of Samantha Beattie, 19.03.26, [35], [37].
172 Statement of Stephen Voogt, 18.03.26, [21]-[22]; Statement of Nikki Johnston, 17.03.26, [32], [33], [40] and [53]; Statement of Jason Moloney, 18.03.26, [44].
173 Statement of Stephen Voogt, 18.03.26, [18].
174 Statement of Stephen Voogt, 18.03.26, [18]; Statement of Lesley Salem, 18.03.26, [20]; Statement of Jason Moloney, 18.03.26, [32] and [35]; Statement of Rose McCrohan, 18.03.26, [30]; Statement of Samantha Beattie, 19.03.26, [33].
175 Statement of Stephen Voogt, 18.03.26, [18]; Statement of Rose McCrohan, 18.03.26, [31]-[34]; Statement of Samantha Beattie, 19.03.26, [38]-[40], [59]-[60] and [61(c)-(f)].
176 Statement of Samantha Beattie, 19.03.26, [33].

practitioners and other nurses.[177] But it is the NP alone that bears responsibility and accountability for "*the complete episode of care*".[178] The NP carries appropriate levels of professional indemnity insurance in recognition of this and the risks inherent to the work.[179]

(4) The nature of the NP's work in multiple settings is not dissimilar to the work performed by doctors – by way of example, the NP's skills and responsibilities are on par with those exercised by a senior medical officer in a public hospital or a general practitioner in a primary care clinic or a residential aged care facility.[180] The only tangible differences between the NP and the doctor in these settings are a reflection of particular limitations in statute (for example, an NP cannot sign off on the removal of a person's driver's licence), restrictions under the MBS (for example, benefits payable in respect of certain scans and tests) and, on occasion, the employer's own policy (for instance, in a public hospital where the NP is employed in a rapid assessment and treatment unit and their practice is limited to common patient presentations; fractures, laceration, superficial foreign bodies and minor illnesses).[181]

(5) The NP's work encompasses four distinct pillars of NP practice: clinical, education, research, and leadership.[182] It is the multi-dimensional aspect of the NP's work, as a professional making a positive contribution to society and the profession, that speaks to the NP's value and the responsibility inherent to the role. Despite contributing in multiple domains, NPs are required to keep up their clinical work in order to maintain their NP endorsement.[183]

(6) Increasingly, and particularly in primary care settings, the NP works to their full scope of practice and is committed to expanding their scope to better serve the needs of the communities they serve.[184] NPs typically go beyond the 30 hours

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177 Statement of Nikki Johnston, 17.03.26, [40]; Statement of Rose McCrohan, 18.03.26, [24] and [40]-[42].

178 Statement of Jason Moloney, 18.03.26, [26]-[27]; Statement of Samantha Beattie, 19.03.26, [33], [38] and [61(i)].

179 Statement of Nikki Johnston, 17.03.26, [31]; Statement of Jason Moloney, 18.03.26, [37].

180 Statement of Noelleen Kiprillis, 17.03.26, [105]-[106; Statement of Jason Moloney, 18.03.26, [28]-[29]; Statement of Stephen Voogt, 18.03.26, [18]-[20].

181 Statement of Stephen Voogt, 18.03.26, [31]; Statement of Jason Moloney, 18.03.26, [36] and [41]-[42]; Statement of Samantha Beattie, 19.03.26, [52].

182 Statement of Nikki Johnston, 17.03.26, [37]-[52]; Statement of Jason Moloney, 18.03.26, [43] and [45]; Statement of Mary Fenech, 18.03.26, [29]-[34].

183 Statement of Nikki Johnston, 17.03.26, [43].

184 Statement of Lesley Salem, 18.03.26, [26]-[29]; Statement of Jason Moloney, 18.03.26, [63]-[64]; Statement of Kerrie Duggan, 18.03.26, [37]-[38]; Statement of Samantha Beattie, 19.03.26, [42]-[43].

of continuing professional development required of them to maintain their NP endorsement.[185] NPs are professionally accountable for ensuring they practise safely and competently within their scope.[186]

(7) The NP, with their extensive career in nursing, prioritises the practice of holistic person-centred care.[187] Lesley Salem (NP) practises with "*a foot in medicine and a foot in nursing*".[188] As Nikki Johnston (NP) observes,[189]

> "As a NP, I provide the whole unit of care in a different person-centred manner. I adopt a whole person approach in formulating a treatment plan that takes into account how the person fits into the world (have they got money, support etc). This time and consideration is one of the biggest gifts I can give."

(8) The NP often works in remote settings with marginalised populations for whom access to health care is limited.[190] The NP often goes "*where no one else wants to go*", practising holistic care and expanding the provision of effective preventative healthcare and chronic disease management to more and more people.[191]

(9) NPs have shown themselves to be adaptable, moving into new settings and expanding the service offering, whilst taking the necessary steps to upskill and expand their scope of practice. Many of the NP's clinical skills are transferrable to different settings.[192] There is considerable demand for NPs to fill locum positions and backfill medical practitioners on leave.[193]

(10) The demand for NPs has grown considerably, particularly in primary health and residential aged care settings, as awareness of the NP's skill has grown and regulatory barries (for example, collaborative arrangements) have been

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185 Statement of Nikki Johnston, 17.03.26, [61]; Statement of Jason Moloney, 18.03.26, [66].
186 Statement of Samantha Beattie, 19.03.26, [42] and [44].
187 Statement of Jason Moloney, 18.03.26, [34]; Statement of Kerrie Duggan, 18.03.26, [42]; Statement of Samantha Beattie, 19.03.26, [33]-[34], [53] and [56].
188 Statement of Lesley Salem, 18.03.26, [19] and [21].
189 Statement of Nikki Johnston, 17.03.26, [35]-[36] and [70]-[74].
190 Statement of Lesley Salem, 18.03.26, [22]; Statement of Mary Fenech, 18.03.26, [17].
191 Statement of Lesley Salem, 18.03.26, [30]-[37]; Statement of Jason Moloney, 18.03.26, [38]-[40]; Statement of Mary Fenech, 18.03.26, [17]-[25].
192 Statement of Stephen Voogt, 18.03.26, [25]-[30]; Statement of Lesley Salem, 18.03.26, [44]; Statement of Jason Moloney, 18.03.26,[62]; Statement of Mary Fenech, 18.03.26, [19]-[20] and [45]; Statement of Samantha Beattie, 19.03.26, [46]-[51] and [61(h)].
193 Statement of Lesley Salem, 18.03.26, [46]; Statement of Jason Moloney, 18.03.26, [61]; Statement of Kerrie Duggan, 18.03.26, [47] and [52]-[58]; Statement of Rose McCrohan, 18.03.26, [43]-[46].

removed. NPs are filling the gaps in systems of care incapable of being adequately resourced by general practitioners.[194]

(11) The NPs working in urgent care and specific emergency settings for at-risk groups play a critical role in alleviating pressures on the healthcare system, limiting paramedic attendance and preventing unnecessary hospital admissions.[195]

(12) Many NPs have led the way in the provision of best practice healthcare. Nikki Johnston (NP) contributed as a palliative care specialist to the Royal Commission into Aged Care Quality and Safety as "*an expert solution focused witness*", and has pioneered the provision of NP led voluntary assisted dying in the ACT.[196] Stephen Voogt (NP) was instrumental in assisting previously failing residential aged care facilities respond to COVID-19 and meeting aged care standards.[197]

190. Additionally, the evidence of the ANMF's lay witnesses will establish that the NPs work has changed considerably over time. These changes, some welcome, have nonetheless increased the difficulty of the nature of the NP's work and the level of skill and responsibility involved in doing the work.

191. In respect of the latter, the lay witnesses identify the following changes:

(1) Higher acuity and complexity of patient care.[198]

(a) Stephen Voogt (NP) describes how residents are entering residential aged care later in life and the increasing pressure on aged care facilities to provide acute care, rather than transferring residents to hospitals. This makes the NP's job harder, because of the potential for different prescriptions to interact negatively with each other.[199] Additionally, these complexities speak to the high skill level of NPs in aged care in circumstances where "*the spectrum of practice is very broad: you have*

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194 Statement of Stephen Voogt, 18.03.26, [19], [23]-[24] and [32]; Statement of Lesley Salem, 18.03.26, [39] and [45]; Statement of Samantha Beattie, 19.03.26, [61(a)-(b)].

195 Statement of Jason Moloney, 18.03.26, [49]-[51]; Statement of Kerrie Duggan, 18.03.26, [45]-[46]; Statement of Samantha Beattie, 19.03.26, [47] and [49].

196 Statement of Nikki Johnston, 17.03.26, [10], [29], [45], [47] and [60].

197 Statement of Stephen Voogt, 18.03.26, [11(e),(h) and (i)].

198 Statement of Kerrie Duggan, 18.03.26, [48]-[51]; Statement of Mary Fenech, 18.03.26, [35]-[38]; Statement of Samantha Beattie, 19.03.26, [54].

199 Statement of Samantha Beattie, 19.03.26, [54(c)].

to be on top of physical assessment, physical treatment and death and dying".[200]

(b) Nikki Johnston (NP) describes the high volume of multimorbidity presentations leading her to conclude that "*[p]eople are living longer not living better*". This makes the job more difficult as, "*nothing is 'simple' anymore, everything is complex*".[201]

(c) Jason Moloney (NP) describes system pressures that see ever increasing numbers of patients re-directed from acute settings to primary care settings, increasing the complexity of care managed by the NP.[202]

(d) Samantha Beattie (NP) describes how, faced with such complexity, "*fragmentation of care within the health system*", where patients see multiple providers across general practice, hospital services, allied health and specialist clinics, impacts the flow of information as between services and effective treatment.[203]

(e) Additionally, Samantha Beattie (NP) speaks to the added complexity of managing multiple complex physical health conditions in the context of mental illness, necessitating additional time, trust-building and coordination of care.[204]

(2) To a much greater level, the aged care sector is now governed by aged care standards. As the FWC observed in the Aged Care Proceeding, expectations for all aged care workers in caring for patients with dementia and associated behavioural issues have increased substantially.[205] This has had a profound effect on NPs, who once regularly resorted to sedative prescriptions. These days, NPs spend considerably more time examining the underlying causes of behaviours, and liaising with families in respect of proposed treatment.[206]

(3) Population changes have increased the complexity of the NP's work: increasing numbers of trauma survivors and people experiencing homelessness, language

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200 Statement of Stephen Voogt, 18.03.26, [34]-[37].
201 Statement of Nikki Johnston, 17.03.26, [62]-[66].
202 Statement of Jason Moloney, 18.03.26, [52]-[54].
203 Statement of Samantha Beattie, 19.03.26, [54(d)].
204 Statement of Samantha Beattie, 19.03.26, [54(e)].
205 See for example, *Stage 1 Decision* at [602] – [612].
206 Statement of Stephen Voogt, 18.03.26, [38]-[42].

barriers, cultural differences and expanding cities and towns where people live further away from established heath care services.[207] Samantha Beattie (NP) details the impact these factors have on the complexity of the NP's work in "*managing not only a medical diagnosis but a network of interacting clinical, social and behavioural issue*s" together with the NP's increasing role in putting in place appropriate "*bridging care*".[208]

(4) People's greater access to information about health (commonly referred to as the "*the Dr Google effect"*) has required NPs to play a greater educative role.[209]

(5) The expectations of people accessing health care have also increased.[210] The risk of occupational violence remains and, in some settings, incidents have increased.[211]

(6) A greater role for telehealth, particularly in residential aged care and in primary health clinics in remote settings. This has necessitated the development of new skills by NPs in effectively using this technology and adapting their communication with patients, often under significant constraints (for example, a lack of internet connection in remote communities necessitating that consultations are delivered by telephone).[212]

192. Finally, the NP, like all workers, progresses in their skills with time in the role. Starting out as a NP, having attained one's Masters' qualification and having achieved endorsement by the NMBA, is "*its own steep learning curve*".[213]

193. As Samantha Beattie (NP) observes, "*the NP's role is a continuation of the skills developed as a specialist RN, but still amounts to a complete gear shift*."[214]

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207 Statement of Nikki Johnston, 17.03.26, [75]-[78]; Statement of Kerrie Duggan, 18.03.26, [59]; Statement of Mary Fenech, 18.03.26, [41], [44] and [45]; Statement of Samantha Beattie, 19.03.26, [54(a), (h) and (i)].

208 Statement of Samantha Beattie, 19.03.26, [55]-[56].

209 Statement of Nikki Johnston, 17.03.26, [79]-[81]; Statement of Kerrie Duggan, 18.03.26, [60]-[62]; Statement of Samantha Beattie, 19.03.26, [54(f)] and [57]-[58].

210 Statement of Jason Moloney, 18.03.26, [55]-[57]; Statement of Mary Fenech, 18.03.26, [39]-[40].

211 Statement of Rose McCrohan, 18.03.26, [49]-[50]; Statement of Jason Moloney, 18.03.26, [58]-[60]; Statement of Samantha Beattie, 19.03.26, [62]-[64].

212 Statement of Lesley Salem, 18.03.26, [40]-[43].

213 Statement of Jason Moloney, 18.03.26, [46]; Statement of Kerrie Duggan, 18.03.26, [43].

214 Statement of Samantha Beattie, 19.03.26, [35].

194. With time in the role, the NP cements their practice and solidifies their skills.[215] Per Jason Moloney (NP):[216]

> "New NPs need to learn how, in assessing patients, not to make assumptions and jump to conclusions. You learn how to think outside the box, rather than 'anchoring' a diagnosis. By this I mean you have to remain open to alternative diagnoses, take note of all aspects of the patient's presentation and reported history and weigh up the potential that you might be dealing with the worst-case scenario. Developing this skill as a NP takes vocational training and time in the role."

E-3 Argument as to why the ANMF position should be preferred

195. As observed in the *Nurses Decision* at [61], under the current structure of the Award, a NP has a very high relativity (54 per cent in the first year and 58.5 per cent in the second year) compared to an RN Level 1 pay point 1, and a first year NP has a rate of pay about the same as an RN Level 5 grade 1, who exercises management and leadership responsibilities. Based on the above evidence, the Expert Panel would be satisfied that this relativity is justified by work value reasons and necessary to achieve the modern awards objective.[217]

196. The skill and responsibility of an NP, both in terms of their clinical practice and the prevalence and level of invisible skills exercised, is substantially greater than that of an RN. The nature of the NP's work and the conditions under which their work is done also reflect a higher level of work value.

197. A reduction in relativity as between RNs and NPs would also fail to recognise the material increases to NP work value in recent years, and regulatory changes in recent years that have expanded the NP's responsibilities and embraced the NP working to their full scope of practice.

198. The retention of existing progression points, whereby the NP progresses in their second year, would also reflect the increased work value of an NP after an initial period in the role.

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215 Statement of Nikki Johnston, 17.03.26.03.26, [56]-[58]; Statement of Jason Moloney, 18.03.26, [46] and [47]; Statement of Rose McCrohan, 18.03.26, [47]-[48]; Statement of Samantha Beattie, 19.03.26, [35]-[36].

216 Statement of Jason Moloney, 18.03.26, [46].

217 Cf the insufficiency of evidence identified by the Expert Panel in the Aged Care Proceeding, see *Nurses Decision* at [61].

E-4 Conclusion

199. For the reasons identified above, the amendments to the NP rates of pay identified in the ANMF position document are justified by work value reasons and necessary to achieve the modern awards objective and minimum wages objective.

PART F PROGRESSION

F-1 The parties' positions

(i) The ANMF position

200. The ANMF seek the deletion of cl 15.2 of the Award "*Progression through pay points—other than aged care employees*".[218]

(ii) The other parties' positions

201. The deletion of 15.2 is not opposed by CHA[219] (or ABI).[220]

202. Healthscope opposes the deletion of cl 15.2 of the Award and contends that cl 15.2 should be modified to retain the part time or casual employee equivalent of 1,786 hours experience per annum for the time based progression.[221]

203. APHA also oppose the deletion of cl 15.2 of the Award.[222] APHA's position is that a single year for the purposes of time-based incremental progression for part-time and casual employees should be based on attainment of 1,786 hours (as currently provided at Award cl 15.2(a)(ii)).[223]

F-2 Evidence as to progression

(i) Registration and Accreditation Scheme

204. It is a requirement for ongoing registration that all ENs, RNs (including NPs) and Midwives comply with the Registration Standard: Continuing Professional Development.[224] Under that CPD Registration Standard, "*continuing professional development*" is defined to be the means by which members of the profession maintain, improve and broaden their knowledge, expertise and competence and develop the personal and professional qualities required throughout their professional lives.[225]

205. That standard applies equally whether the applicable nurse works full-time or part-time in paid or unpaid practice.[226] In order to meet that standard, all nurses must complete a minimum of 20 hours of CPD each 12 month registration period. NPs must complete

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218 ANMF position document at [23].
219 CHA position document at [3(b)].
220 ABI position document at [1].
221 Healthscope position document at [3].
222 APHA position document at [11].
223 APHA position document at [12].
224 CPD Registration Standard.
225 CPD Registration Standard, p 4.
226 CPD Registration Standard, p 2.

an additional 10 hours each registration period. So too must and RNs and Midwives with scheduled medicines endorsement.[227]

(ii) Evidence from workers

206. As is common in the sector, the ANMF's evidence will establish that lay witnesses held multiple roles at variable Full Time Equivalent (FTE) hours. Many nurses and midwives work multiple roles, or have their full-time hours with the one employer split amongst multiple wards/units.

207. These workers progress in their skill development with time in the role and upon completion of CPD.

F-3 Argument as to why the ANMF position should be preferred

208. Nurses in classifications covered by the Award will broaden their knowledge, expertise and competence via mandatory CPD requirements where such requirements are not based on the number of hours that they work.

209. By the Determination of 20 December 2024 made further to the *Nurses Decision*,[228] the Expert Panel deleted clause 15.3 of the Award that provided for progression through pay points by 1786 hours of experience for part-time or casual employees in aged care, notwithstanding a submission by 360 Health + Community to the contrary.[229] That is despite the Expert Panel adopting a classification structure for aged care employees that involved progression based on years of service.[230]

210. The approach sought by the ANMF is consistent with the determination made by the Expert Panel in the Aged Care Proceeding.

F-4 Conclusion

211. For the reasons identified above, deletion of cl 15.2 of the Award "*Progression through pay points—other than aged care employees*" is necessary to achieve the modern awards objective and (to the extent that this involves the variation of modern award minimum wages) is justified by work value reasons and necessary to achieve the minimum wages objective.

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227 CPD Registration Standard, p 2.
228 MA000034 PR782723.
229 *Submission of 360 Health + Community*, 6 December 2024.
230 See *e.g.*, Award clause 15.3(b) – Minimum rates for "Registered nurses-aged care employees".

PART G PHASING

G-1 The parties' positions

(i) The ANMF position

212. The ANMF seeks the following phasing in arrangements:

(1) A first operative date of 30 June 2026;

(2) Five annual increments starting on 30 June 2026, with further increases on 30 June 2027, 2028, 2029 and 2030; and

(3) Increases weighted equally in 20 per cent instalments across the 5 increments.[231]

213. In the event that no final determination has been made varying the Award by 30 June 2026, the ANMF seeks an interim order for the following variations to the Award ("**interim order**"):

(1) Variations to the AIN, Student EN, RN / Midwife and OHN classification structures as identified in the "*Classification structure showing differences on rates and classifications*" on page 4 above ("**agreed new rates**");

(2) Increases of 20 per cent of the difference between the agreed new rates for AINs, Student ENs, RNs / Midwifes and OHNs and the current weekly rates for equivalent classifications under the Award;

(3) Increases of 20 per cent of the difference between the rates determined for NPs in the Nurses Decision and the current weekly rates under the Award; and

(4) Increases of 20 per cent of the difference between the agreed new rate for an introductory ENs (being $1,419.40), and the current weekly rates for ENs other than aged care under the Award.[232]

(ii) The other parties' positions

214. CHA (supported by ABI)[233] agrees to the ANMF's operative date and phasing-in proposal.[234] It says that the first instalment (together with consequential changes to the Award) should occur no less than 6 months after publication of a determination.[235]

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231 ANMF position document at [24].
232 ANMF position document at [25].
233 ABI position document at [1].
234 CHA position document at [3(c)] and [18].
235 CHA position document at [19].

215. CHA (supported by ABI)[236] support the interim position with respect to AINs, RNs, Midwives and OHNs.[237] Accordingly, the only point of disagreement appears to be whether an interim order would be made with respect to student ENs.[238]

216. Healthscope's position that the annual incremental increases should be applied on 1 July, not 30 June.[239] The Healthscope position document does not address the interim order and so it is understood it agrees with that proposal (in which it has an interest), save for the proposed operative date.[240]

217. APHA's position is that the operative date should be 1 July 2026, with further instalments on 1 July of each of the next four years.[241] APHA does not oppose the interim order, subject to the anterior oppositions articulated in its Position Paper (including as to the operative date).

218. ACCPA has not expressed a view as to phasing.[242]

G-2 Argument as to why the ANMF position should be preferred

219. The following propositions as to the proper approach to the commencement and phasing-in of minimum wage increases can be readily gleaned from the *Stage 1 decision*[243] at [976]-[990], the *Stage 2 decision*[244] at [405]-[409], the applicable provisions of the FW Act and the approach of the FWC in other cases:

(1) The default rule or presumption is that a determination varying modern award minimum wages comes into operation from 1 July in the next financial year after it is made (or on the day it is made if made on 1 July), *unless* the Commission is satisfied that it is appropriate to specify another day. As has been recognised by the Commission, this is not a difficult presumption to displace.[245] In the ordinary case, the specified day must not be earlier than the day on which the determination is made (s 166(1)–(3)).[246]

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236 ABI position document at [1].
237 CHA position document at [29] – [30].
238 CHA position document at [5].
239 Healthscope position document at [4].
240 Healthscope position document at [5].
241 APHA position document at [14].
242 ACCPA and ABI joint position document.
243 *Stage 1 Decision* [2022] FWCFB 2000 (4 November 2022).
244 *Stage 2 Decision* [2023] FWCFB 93 (18 May 2023)
245 *Australian Workers' Union* [2022] FWCFB 4 at [153].
246 Section 166, *FW Act; Stage 1 Decision* [2022] FWCFB 2000 (4 November 2022), [982].

(2) The Commission may also specify that changes take effect in stages if it is satisfied that it is appropriate to do so (s166(4)). Such an approach is commonly referred to as *"phasing in*". As the Full Bench stated in the *Stage 2 decision* at [414]:

> "While we acknowledge that phasing-in may be a valid approach to increases in particular circumstances, there is no decision rule that this is the approach to be utilised in all cases. Whether phasing-in is appropriate is a matter to be determined based on the particular circumstances before the Commission."

(3) The Commission has the power to make appropriate transitional arrangements to mitigate hardship where there is a need to do so. As the Full Bench observed in the *Penalty Rates – Transitional Arrangements decision*[247] at [142]:

> "the determination of appropriate transitional arrangements is a matter that calls for the exercise of broad judgement, rather than a formulaic or mechanistic approach involving the qualification of the weight accorded to each particular consideration."

(4) In exercising its power, the Commission will do that which is "*fair and just*" (s 577(a)). The Commission must take into account the objects of the FW Act and "*equity, good conscience and the merits of the matter*" (s 578). Fairness in this context is to be assessed from the perspective of both the employer and the employee.[248] The Commission will determine what, "*in all the circumstances*" is "*fair and reasonable*"[249]. Fairness is plainly a relevant consideration, as encapsulated in both the modern awards objective (s 134) and the minimum wages objective (s 284).

(5) Sections 134(ab), 284(1)(aa), together with the s 3(a) object of the FW Act to provide workplace relations laws that "*promote [..] gender equality*" now established a clear imperative to eliminate identified gender-based undervaluation. Such an effort is integral to the ability to achieve gender equality in the workplace relations systems. These matters must now also inform the exercise of the

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247 *Penalty Rates – Transitional Arrangements decision* [2017] FWCFB 3001 (5 June 2017).
248 *Stage 1 Decision* [2022] FWCFB 2000 (4 November 2022), [983]-[984].
249 *Stage 2 Decision* [2023] FWCFB 93 (18 May 2023), [420].

power and discretion of the Expert Panel when determining the commencement and phasing-in of minimum wage increases.

220. Having regard to such matters,[250] the Full Bench in the *Stage 2 Decision,* at [420], the Full Bench determined that:

> "In all of the circumstances, we consider that it is fair and reasonable that the interim increase should come into effect on 30 June 2023. This date will ensure no confusion in relation to increases from the Annual Wage Review, which will, in all likelihood, take effect from 1 July 2023. We are also satisfied that it is appropriate that the interim increase not apply until 30 June 2023. While it is correct that, should we consider it reasonable to do so, we could apply the interim increase from an earlier date, we consider it prudent to ensure fair notice to employers of the date of effect of the increase to enable employers to make the necessary arrangements for the payment of the increase."

221. For the reasons identified in the *Stage 2 Decision*, increases to minimum rates under the Award should be phased in by increases on 30 June 2026. That this should occur by five annual increments is uncontroversial and appropriate based on the particular circumstances before the Expert Panel.

222. In the event that no final determination has been made varying the Award by 30 June 2026, the Expert Panel would make the interim order to enable increases agreed by the parties to commence and to prevent the process of eliminating identified gender-based undervaluation from being delayed.

G-3 Conclusion

223. For the reasons identified above, the Expert Panel would implement the following phasing in arrangements:

(1) A first operative date of 30 June 2026;

(2) Five annual increments starting on 30 June 2026, with further increases on 30 June 2027, 2028, 2029 and 2030; and

(3) Increases weighted equally in 20 per cent instalments across the 5 increments.

224. In the event that no final determination has been made varying the Award by 30 June 2026, the Expert Panel would make the interim order as set out above.

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250 Save for those identified at [2191(5)] where the relevant provisions had not yet been enacted.

PART H CONCLUSION

225. For the reasons given above, the Expert Panel would vary the Award in the way sought by the ANMF as identified in the ANMF position document.

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20 March 2026

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