POLICY REMIT 1:
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Policy Remit – Review of NZNO strategies for Safe Staffing

Policy Remit – Recommendation:

That NZNO shall, during the 2021/22 year:

1) Conduct an independent evaluation of its current Safe Staffing strategies, including CCDM, and publish any results showing significant outcomes for nursing workloads and patient safety at the national level; and
2) Present options to campaign for additional Safe Staffing mechanisms, including legislated minimum nurse/patient ratios, for consideration and endorsement by NZNO members.

Introductory note:

On 7 August 2018, NZNO members voted to ratify a Multi-Employer Collective Agreement between NZNO and the 20 DHBs. The MECA states that both parties commit to full implementation of CCDM in all DHBs by 30 June 2021. Nothing about this Policy Remit alters that commitment. Members are encouraged to read the entire Policy Remit before voting on the two recommendations above.

Background:

The origin of NZNO's Safe Staffing strategies can be traced to the collective employment agreement negotiations with District Health Boards in 2001. As Manchester and O'Connor (2001) reported, concerns of NZNO members had reached a tipping point.

"There are variations on a theme, but essentially the story remains the same around the country:

- *not enough nurses;*
- *nurses regularly doing extended and double shifts to plug the gaps;*
- *nurses who are doing a lot of overtime and extra shifts having to take sick leave, compounding the problem;*
- *nurses feeling under intense pressure as they struggle to provide safe care;*
- *inexperienced staff taking on too much responsibility;*
- *problems with skill mix;*
- *hospital budgets being blown on internal and external agency staff;*
- *agencies unable to provide the staff requested;*
- *nurses' increasing frustration and anger at the situation;*
- *beds being closed for months;*
- *delegates not being able to attend NZNO meetings because they are ill or can't be released from the wards."*

In response to these member concerns, a campaign was launched for minimum nurse/patient ratios to be included in NZNO/DHB collective agreements, based on the ratios introduced in the Australian state of Victoria the preceding year. NZNO members voted to endorse this strategy at Regional Conventions in 2002.

The ratios campaign was refreshed ahead of negotiations for the first national DHB MECA. Under the banner of "Nursing the System Back to Health" (NZNO, 2003), the updated strategy sought:

- *Nurse to patient ratios*
- *The establishment of associate charge nurse positions*
- *Dedicated time for professional education and development*
- *The evaluation of patient outcomes*

Colleges and Sections were consulted on what the ratios should be in their specialty areas. The strategy ruled out any trade-off between Safe Staffing and pay rises in the MECA negotiations (Safe staffing 'bombshell', 2003). Campaign goals also included staffing standards in Private Hospitals and regulations which stipulated minimum nurse staffing levels in Aged Care.

Led by President Jane O'Malley and working in partnership with Ministry of Health Chief Nursing Advisor Frances Hughes, NZNO secured initial agreement in 2002 to pilot minimum nurse/patient ratios in three DHBs. However, the Health Minister later withdrew support and the pilot did not proceed (O'Malley, 2005).

During the 2004-5 DHB MECA negotiations, both NZNO and the DHBs came to agree that nurse/patient ratios alone would not address all of the issues involved in Safe Staffing. An agreement was therefore reached to set up a Committee of Inquiry to investigate the workload issues of nurses and midwives, and to develop sustainable solutions (COI, 2006).

Recommendations of the Committee of Inquiry included the establishment of a Safe Staffing/Healthy Workplaces Unit (SSHWU), under the direction of DHB and NZNO representatives (later expanded to include Ministry of Health representation and union reps from the PSA, E Tū and MERAS). In 2009 the programme which came to be known as Care Capacity Demand Management (CCDM) was launched by the SSHWU in the first three demonstration sites (Waitematā, West Coast and Bay of Plenty DHBs).

NZNO's Safe Staffing Strategy in the DHB Sector since 2009 has focused on achieving implementation of CCDM nationally. The current NZNO/DHB MECA 2018-2020 states:

"The DHBs and NZNO commit to the following:

1) Full implementation of CCDM in all DHBs by 30 June 2021"

Outside of the DHB Sector, NZNO has taken different approaches. In 2008, NZNO launched a petition for the voluntary staffing guidelines in Aged Care facilities to be replaced with mandatory minimum staffing levels. This goal has remained largely consistent through subsequent Safe Staffing campaigns in the Aged Care Sector, up until the current "In Safe Hands" campaign.

In Private Hospitals and in the Primary Health Care Sector, NZNO's strategy led to the Healthy Workplace Project, involving NZNO/employer forums to discuss ways of implementing the elements of Safe Staffing identified by the 2006 Committee of Inquiry (Sectors introduced, 2011). These NZNO strategies taken together represent a small selection of the possible evidence-based safe nurse staffing models (ICN, 2009).

Rationale:

More than a decade after the launch of CCDM, opinion within Nursing and Health remains divided over its benefits. With the agreed date for full implementation of CCDM of 30 June 2021 now approaching, it is timely to review the outcomes of the programme for patients and for the members of nursing teams.

A number of reviews of individual CCDM components have so far been undertaken, and some small-scale outcome studies have also been reported. These include the following.

The Health Services Research Centre (2013) sought to establish if shifts on six wards at two DHBs which had the staffing design determined by the CCDM methodology performed better in terms of staff and patient outcomes. The study found that staff perceptions were significantly better, although patient perceptions were less clear. A stated limitation on the research was that none of the wards had adopted all of the recommended FTE calculations.

Lawless (2014) summarised research up to that point, including an evaluation of CCDM in one ward at Northland DHB which showed measurable gain in all three target areas: quality patient care, a quality work environment for nurses, and making best use of health resources.

Hunn (2015) analysed the methodology used to calculate the number of FTE required to staff a shift, and recommended some small adjustments to the way "specialling" and "shift coordination" were treated.

Hendry, Aileone & Kyle (2015) evaluated CCDM implementation in selected locations between 2009/10 and 2011/12. They found positive outcomes across some measures. However, findings also included an unexpected overall drop in Nursing Hours Per Patient Day (ie. worse understaffing) in the group of seven DHBs which had partially implemented CCDM (p.61). There were no changes in Patient Safety and Satisfaction or in Staff Health and Wellbeing which could be specifically attributed to CCDM.

Despite these local and/or partial reviews, however, to date there has been no comprehensive, nationwide evaluation of CCDM showing its effect on nursing workloads and patient safety. The most recent research (McKelvie, 2019; p.215) has reported, on the basis of the limited available evidence, that "with few exceptions, the majority of NZ's frontline nurses are still waiting for the promises and tangible outcomes to materialise". The perceived lack of action on past promises to implement CCDM and employ additional staff, and a resulting lack of trust among nurses and midwives have been formally acknowledged by Government (Clark, 2018).

Nor has a formal evaluation been published of NZNO's Safe Staffing strategies in Private Hospitals or in the Primary Health Care Sector. In Aged Care, campaigns for mandatory minimum staffing levels are yet to achieve this goal.

This policy remit therefore calls for NZNO to conduct such an evaluation and publish any results showing significant outcomes for nursing workloads and patient safety at the national level, during the 2021/22 year.

The decade since the launch of CCDM has also seen new developments in Safe Staffing mechanisms internationally. NZNO's international engagements, particularly through the International Council of Nurses (ICN) and Global Nurses United (GNU), have increased our knowledge of these overseas developments.

In 2015, the mandatory nurse/patient ratios in Victoria which had served as the model for NZNO's original Safe Staffing strategy were enshrined in law. With the passage of The Safe Patient Care (Nurse to Patient and Midwife to Patient Ratios) Act 2015, the State of Victoria became the second place in the world (after California) to remove the matter of Safe Staffing from collective bargaining by legislating minimum nurse and midwife-to-patient ratios. Elsewhere in Australia, Queensland began implementing legislated ratios in 2016.

Outcomes to date for patients and for members of the California Nurses Association/National Nurses United and the Queensland Nurses and Midwives Union were presented at the last GNU Annual Meeting (Brookes, 2019).

Also in 2016, Wales became the first jurisdiction in the European Union to pass legislation creating a legal duty for Local Health Boards and NHS Trusts to regard the importance of ensuring appropriate levels of nurse staffing in all settings. Under the law, nurse staffing levels are not specified according to ratios, but are calculated based on patient acuity, professional judgement and quality indicators. At the 2019 ICN Congress, reflections on this approach were offered by the Welsh Government's Nursing Officer. Also at the ICN Congress, leading researchers Aiken and McHugh (2019) summarised the current state of knowledge around outcomes of Safe Staffing mechanisms in California, Ireland, Queensland and Chile.

Before concluding, the Board of Directors would like to offer an observation about the relationship between the two main types of Safe Staffing mechanism in use today – mandated ratios and acuity-based systems. In the past, these have sometimes been seen as mutually exclusive alternatives. More recent thinking, as reported for example in Willis and Gasquoine (2019), is that the two can work together by factoring in acuity after baseline staffing is established according to minimum staffing ratios. This Policy Remit does not imply withdrawal of NZNO support for any existing Safe Staffing mechanism.

The Board of Directors would also like to acknowledge a stated limitation of the Committee of Inquiry which established the current DHB Safe Staffing framework – namely, insufficient priority given to the concerns of Māori nurses regarding culturally safe practice and exposure to discrimination in the workplace (COI, 2006; p17). Current Safe Staffing mechanisms do not fully address Te Tiriti o Waitangi commitments to staff and health consumers.

The proposals contained in this Policy Remit have been submitted by the Board of Directors to an all-member vote because they relate to long-established NZNO strategies which are core to NZNO's Mission. The Board believes that consideration and possible endorsement of any additional Safe Staffing mechanisms, including legislated minimum nurse/patient ratios, should only be embarked upon if there is a clear democratic mandate from the NZNO membership.

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