Independent Panel Process Recommendations with NZNO Analysis

Dear DHB members,

In providing this summary of the Independent Panel Process Recommendations it is important to clarify that these recommendations do not constitute a revised "MECA Offer". DHBs will provide NZNO with a revised offer on 28 May.

Below you will find the Panel's Recommendations in **bold** and then NZNO's analysis of the above recommendation in *italics*.

Please note that the Panel earlier clarified that in the instances where they have only used the term "nurses" this includes all of the roles covered by the NZNO/DHB MECA.

Summary of Recommendations

1. **The Parties report six monthly to Health Sector Relationship Agreement (HSRA) Group on compliance with the significant contractual commitments agreed within their MECA and that the HSRA pro-actively supports the Parties to correct issues of non-compliance.**

   The recommended role of the HSRA in compliance was not reflected in NZNO's submission, however, given the HSRA Group is set up as a tripartite forum consisting of representatives from district health boards, unions and senior Ministry of Health officials, we believe there is merit in this recommendation.

2. **The Parties use their best efforts to agree a three-year term to enable the implementation of the changes to workforce planning strategy and priorities recommended in the Report.**

   The Panel believes a 2 year term as advocated by NZNO does not provide sufficient time to progress the necessary shift in workforce planning strategy and priorities and risks a re-litigation of the issues in the next negotiations. The Panel acknowledges there remains a lack of agreement by the Parties on the Term of the Agreement.

The Panel proposes a 3 year term but have not specified the start and expiry dates.

NZNO proposed the term of the MECA expire no later than November 2019. The intention of this four month extension, along with an enhanced pay offer, was to allow time for the Pay Equity process to be completed given there has been a delay in commencing this.

The second DHB offer included a 2 year term.

3. **The Parties agree a national framework, to then be applied by each DHB Chief Executive, to review how the nursing perspective can, and does, influence clinical and business decisions within their DHB, initially focussing on nursing workloads, escalation pathways and incident reporting.**

NZNO submitted that:
The escalation pathway in the MECA requires diligence and contractual agreements around resourcing and timeframes to ensure that the necessary structure and procedural requirements for each step of this process are in place and functioning so that the new escalation process is effective and does deliver tangible relief for members while CCDM is being progressed.

NZNO advocates for the empowerment of the nursing and midwifery teams in decision making and this recommendation supports this goal.

4. **Each DHB CEO requires their local CCDM Council to oversee a review of the organisation's system and current practice for managing situations when the required staffing levels cannot be achieved, and requires their Director of Nursing to work with the CCDM Council to develop and implement, by 31 December 2018, an agreed plan to remedy any shortcomings identified by this review ensuring that the plan includes ongoing monitoring and evaluation of the escalation processes**.

This recommendation supports the NZNO approach taken in our submission

5. **The NZNO actively works with its members to achieve acceptance that robust, effective management of staff shortages and unmanageable workloads is dependent on staff willingness to work flexibly across clinical areas.**

NZNO indicated in our submission that there needs to be a culture shift in a number of DHBs to establish trust and confidence with our members

6. **The Minister of Health sets a clear expectation that DHBs must have sufficient nursing resources to ensure patient and nurse safety, through a Letter of Expectation to each DHB, to be sent as soon as practicable after ratification.**

This recommendation supports the NZNO approach taken in our submission

7. **The DHBs receive funding equal to 2% of the total national cost of the DHB employed nursing and midwifery workforce, immediately on ratification of the agreement to ensure DHBs have the nursing workforce capacity to deliver the required patient services. The increase in funding to be allocated to each DHB in accordance with the Population Based Funding Formula.**

The thrust of NZNO's submission was the need for adequate funds and resourcing for CCDM as well as addressing chronic staffing shortages urgently. This included:

- *factoring the right leave information to establish the right FTE*
- *All vacancies being filled in a timely manner*
- *Removing the "caps" on FTEs*
- *An appropriate and well orientated permanent pool to be available for immediate or short term gaps*
- *Maximising new graduates potential with permanent employment along with preceptor time allocated without the preceptors having to carry a normal patient load*

The Panels recommendation of a dedicated 2% of the nursing and midwifery budget to be allocated for safe staffing is significant and not seen previously for nursing and midwifery. Should DHBs be in the positon to offer this recommendation in a revised MECA offer then we expect that this will make a real tangible difference towards safe staffing. We would be vigilant in monitoring that this pool of money is used as intended.

8. **The DHBs, the NZNO and the other participating union, re-affirm their commitment to SSHW and CCDM.**

NZNO has committed to training its own staff and ensuring adequate resourcing to support its teams' contribution to the implementation of CCDM.

9. **The Ministry of Health include in the Operating Policy Framework the requirement that DHBs implement a validated patient acuity system and plan their DHB nursing workforce requirements in line with the CCDM programme methodology.**

This recommendation supports the NZNO approach taken in our submission.
It is essential that DHBs and NZNO have contractual agreements supported or mandated by the Ministry of Health that are put in place to ensure that CCDM process will be appropriately funded and resourced rather that being prioritised based on affordability as has been the case previously.

10. **The Ministry of Health gives urgent consideration to providing each DHB with funding equivalent to 2 FTEs per 600 FTE nursing staff, dedicated to supporting the ongoing implementation and development of the CCDM programme in line with the DHB's agreed timeline.**

NZNO advocated for adequate CCDM co-ordinator resource to be agreed and implemented in each DHB. This recommendation supports our submission

11. **The Ministry of Health support the SSHW governance group with its monitoring and compliance functions, including supporting remediation of non-compliance.**

This recommendation supports the NZNO approach taken in our submission.
See the comments above as per Recommendation 9

12. **The DHBs review the resourcing of the SSHW Unit to ensure that national support is available, as DHBs require, for the implementation of patient acuity reporting and the CCDM programme.**

NZNO advocated for the need to increase funds and resourcing for CCDM to be achieved. This

recommendation supports the need to increase the technical support that the SSHW provides to both DHBs and participating unions for the implementation of CCDM in all DHBs by 2020.

13. **The NZNO review their organisational response to CCDM and the resource available to promote and encourage their membership commitment to patient acuity reporting and the CCDM programme.**

NZNO has committed to training its own staff and ensuring adequate resourcing to support its teams' contribution to the implementation of CCDM. We will support the resourcing for training and education of members so that they are better able to fully participate in the programme.

14. **The NZNO and each DHB review the effectiveness of the local partnership and commitment to the union's formal participation in the programme governance and implementation at DHB level.**

It is important this does occur in order to progress a number of the recommendations.

15. **Lump Sum payment of $2000 to be paid on ratification to each nurse and midwife covered by the MECA. This payment is recognition of the recent workload difficulties experienced by nurses and midwives. This sum represents the equivalent of 3% of the RN5 Rate ($66,755) and the equivalent to 2.93% of the average rate of pay of those covered by the NZNO document increase.**
16. **3% increase on all MECA wage rates from 1 June 2018. The date of 1 June is recognition of the SSC policy against back pay.**
17. **3% increase on all MECA wage rates from 1 August 2018 in recognition of the cost of living;**
18. **3% increase on all MECA wage rates from 1 August 2019 in recognition of cost of living;**

NZNO strongly advocated for the first pay increase to apply from 1 August 2017 rather than a lump sum payment.
The State Services Commission (SSC) directive to State Sector employers not to provide for back dating of pay increases is referenced in the Panels report as the reason for not recommending back pay.
NZNO acknowledges that the Panels recommendations for pay increases, the lump sum and the term may not be acceptable to members.

19. **The Parties enter negotiations during the term of the Agreement to add two new steps in the Nurses Salary Scale.**
20. **Pay Equity negotiations be conducted during the term of the Agreement with a view to concluding the negotiations during the term.**

NZNO advocated for an extended scale for all occupational groups and as previously endorsed by members an agreed Pay Equity process. These recommendations do offer opportunities should there be an agreed term.

21. **The Parties appear to have reached agreement on the salary increase for Senior Nurses so the Panel makes no specific recommendation.**

NZNO members endorsed the need to address a relativity gap for senior nurses and midwives as an issue for the new MECA. This recommendation references this.

We have informed DHBs of our view in terms of the monetary items above and now need to wait until next week to find out what a revised proposed MECA will look like.

It is likely given our response to the recommendations that DHBs will need to approach government for funding to go beyond the Panel's recommendations.

A bulletin summary of the proposed MECA offer from the DHBs will be available on Thursday 31 May.

Nga mihi,

Lesley Harry & Chris Wilson on behalf of the negotiation team

NEW ZEALAND NURSES ORGANISATION | TŌPŪTANGA TAPUHI KAITIAKI O AOTEAROA

NZNO Submission to the Independent Panel Process

26 April 2018

Authored by Lesley Harry & Chris Wilson

Part 1 - Safe Staffing

Introduction

Achieving safe staffing is critical as our members continue to work under-staffed and under pressure and endeavour to provide a quality health service. It is no longer sustainable, it is a crisis that must be urgently solved.

Patient acuity is higher than ever before. Patients no longer present with single medical problems- many have complex medical issues.

Members are working significantly longer working hours, not getting meal or toilet breaks, working unpaid overtime and extended shifts and then expected to do and update Trendcare. These working conditions are unhealthy and potentially expose members to health and safety factors. For example fatigue which may impact on clinical decisions and result in possible errors in practice.

In the 2017 NZNO Employment survey fewer than half of all nurses working in a clinical area felt there were usually enough nurses to provide safe care.

Quotes that sum up what our members often report they are experiencing:

> *"The overloading we experience every day is draining and dangerous for the nurses and the patients. We are short one or more RN daily. Trendcare shows I have a workload of 11.45 hours to accomplish in 8 hours. No one and nothing happens to help me and my patients. Is it any wonder I am beside myself and crying as I try to write my notes? Another day another ward. One of us has 15 hours work, one 12 one 10.5 according to Trendcare. But we have only 8 hours to do it in. No one and nothing happens to help us and our patients. The floor manager says it is what it is. I find myself crying as I write this. "*

> *"Adequate staffing is a major issue in terms of patient safety. I am unable to provide the quality of care patients deserve. This also takes a toll on my own wellbeing as I constantly feel like I cannot catch up at work. I feel like I am failing my patients. At my own workplace, I have seen nurses leaving NZ in large numbers for better pay and working conditions. This increases our staffing problems. Unfortunately staffing and pay goes hand in hand."*

> *"It is disheartening not being able to do my job for my patients, their families and my own standards. I start and end each shift filled with anxiety, start worried what the day may bring, finish worrying I forgot something or made a mistake in my rush."*

> *"When you're constantly working at capacity and barely have time to get the tasks done, how is it possible to provide care and compassion to your patients, let alone spend meaningful time with them. When every shift means every nurse has a full workload, how is it possible to fit in ongoing education and practice improvements or allow nurses to consult with each other and think critically."*

NZNO recently surveyed members on solutions to address safe staffing and working conditions. Their overwhelming feedback clearly advocates that more staff are needed in all DHBs to alleviate the safe staffing crisis right now.

Care Capacity Demand Management

The Safe Staffing/Healthy Workplaces Committee of Inquiry (SSHWCI) was set up in 2005 as a result of the first national DHB/NZNO DHB MECA. In June 2006 the Safe Staffing/Healthy Workplaces Committee of Inquiry defined the essential elements of safe staffing and healthy workplaces based on evidence cited in the literature reviewed and in national forums. The Committee made recommendations including the setting up of a Safe Staffing/Healthy Workplace Unit.

The Committee Report identified the elements that are necessary to achieve safe nursing and midwifery staffing for an effective healthcare environment. They saw the elements as interdependent. These elements were:

- The requirement for nursing and midwifery care
- The cultural environment
- Creating and sustaining quality and safety
- Authority and leadership in nursing and midwifery
- Acquiring and using knowledge and skills
- The wider team
- The physical environment, technology, equipment and work design

The key aspects of these elements were detailed in the Report.

In the 2006 report the aspect our members most resonated with was:

"Identifying and delivering the appropriate staffing levels requires an effective nursing and midwifery system – one that is able to deliver the right number of nurses or midwives with the right competencies to provide the right care in the right place at the right time to every patient admitted to the service."

This is yet to be achieved in 2018, twelve years on from the report.

The (SSHWCI) Report recommendations were included in the NZNO/DHB MECA 2007-2010 including a plan of work for the next 3 years including the setting up of a Safe Staffing/Healthy Workplace Unit.

Lack of progress on safe staffing was obvious in 2010 and our membership were very frustrated.

Accordingly the 7 Elements and a commitment to implementing them were then included in the NZNO/DHB MECA 2010-2011.

Again in 2011/12 there was a very clear lack of progress and safe staffing was the number one issue for our members in these negotiations.

Very clear assurances were again given that there would be the implementation of the following

"The ***parties*** agree to work together to establish a national framework for a whole of system approach to care capacity management which:

- provides efficient, effective, user friendly processes and structures

- provides centralized, multi stakeholder governance

- is used constantly and effectively at all levels to manage and monitor care capacity

- includes a core data set by which the health of the system is monitored and is used to inform forecasting, demand planning and budgeting

- includes consistent, credible, required responses to variance in care capacity

- recognises the need for local solutions consistent with the principles of healthy workplaces

Despite clear commitments expressed in the DHB MECAs to match patient need to staffing for over 10 years we still have DHBs who have not yet even implemented a validated acuity tool. This tool is essential is gathering information which informs staffing required to match patient need.

> *"CCDM needs to be implemented ASAP when a problem is flagged - not left until the ward is at breaking point."*
>
> *"There are simply just not enough nurses and yet we cannot fill vacancies due to financial constraints."*
>
> *"Variance Response Management works well when adhered to, but when short staffed often just told "there is no help" or "well I haven't had a break either". When we are short staffed and forced to care ration, I feel stressed, overwhelmed and guilty that I can't compare care to the standards patients deserve. Each time I have a shift like that, I seriously consider a change in job, or a change in career all together. I often come home from work and browse the job adverts. If I could go back in time, I wouldn't do nursing again – it is too stressful."*

CCDM is currently not a fix for these areas outside of Trendcare; theatres, midwifery, ED, outpatients, community teams (eg District, Public Health Nurses, Mental Health).

For the 2017 DHB MECA negotiations our members indicated that the lack of progress on CCDM or a validated acuity tool in the 20 DHBs is appalling, disrespectful and unsafe staffing is at its most significant.

The cynicism and lack of trust is evident. They are demoralised, indicated waiting 10 years is totally unacceptable, saw previous agreements as lip service and their patience has run out.

> *"Regularly I feel like I'm being pulled left and right while trying to provide care for all my patients"*
>
> *"One of my patients only got to see me twice all shift…thank the Lord he was stable and didn't need me between my 2 brief visits. My other 4 patients according to Trendcare required at least 3 hours of nursing each. This was a pretty average shift. I've had enough. A job I love dearly. But it's just not worth it."*

The amended wording in the proposed 2017 DHB MECA sets out the DHBs new obligations to deliver on agreed milestones within specified timeframes. The new reporting processes will require DHBs to now deliver with momentum.

The transparency requirements mean that we are better able to identify which DHBs are lagging behind and hold them to account given these agreements would now be specified in the DHB MECA and are consequently enforceable.

Notwithstanding there remains a very significant lack of trust and faith in the process from NZNO members given the length of time any CCDM implementation has taken thus far with limited results.

Specific concerns from members include:

Will stalling occur again no matter what the DHB MECA says?

Will DHBs employ enough staff time to resource CCDM as per the agreed process?

Will delegates and members on the committees in reality be freed up to appropriately participate?

It is essential that DHBs and NZNO have contractual agreements supported or mandated by the Ministry of Health that are put in place to ensure the CCDM process will be appropriately funded and resourced rather than being prioritised based on affordability as has been the case previously. NZNO having to take a legal pathway to see the DHB MECA agreements implemented is clearly not an appropriate or satisfactory remedy for any party.

Adequate CCDM Co-ordinator resource needs to be agreed and implemented in each DHB.

Further the data enacted by CCDM specifically the outcome of the staffing methodology and fulltime equivalent (FTE) calculations needs to be immediately implemented in each DHB.

With persistent underfunding and the failure to implement CCDM 10 years on we have a critical issue in our hospitals that has brought our members to the place of needing immediate remedies.

Acute Staffing Shortage Escalation Pathway

We have escalation provisions under the current 'Hours of Work' clause in the DHB MECA however they were not deemed effective.

As part of these DHB MECA negotiations it was proposed that the Acute Staffing Shortage Escalation provisions were significantly strengthened and further given the nature of same that these provisions are more appropriately placed in the Healthy Workplaces Agreement, Appendix 1(b) of any new ratified DHB MECA. The following section is included in the proposed wording:

Escalation Pathway

In the event that an acute staffing shortage cannot be alleviated, patient cares, and the volume and range of services may be reduced in accordance with direction by the appropriate manager and employer policies. To support safe staffing and the escalation pathway DHBs agree to the following:

- *Timely recruitment processes to avoid unwarranted delays*
- *The role of health and safety legislation and PCBUs*
- *Patients and staff safety and wellbeing are paramount objectives of the escalation process*
- *Response times shall ensure effective remedial action to address unsafe staffing and will be agreed by the parties for each part of the process*
- *Managers shall be trained on the escalation pathway*

- *NZNO shall train own staff*
- *Clarification provided on who has authority to address each stage of the process at each DHB*
- *Incident reporting is critical to the escalation process*
- *Consideration to be given to appropriate skill mix*
- *Availability of casuals/ new graduates/ resource nurse*

It will however require diligence and contractual agreements around resourcing and timeframes to ensure that the necessary structure and procedural requirements for each step of this process are in place and functioning so that the new escalation process is effective and does deliver tangible relief for members while CCDM is being progressed.

Immediate Staffing Issues/Solutions and Workload Issues/Solutions

"One of the biggest issues with staffing is very often when an RN or HCA has called in sick there is nobody available to cover them so the team is expected to work with less people for the same amount of patients"

"We can no longer "Do more, for less, with less". Not replacing staff who leave doesn't spread the load fairly or safely. An aging nursing population who are all going to retire soon need to be replaced by experienced staff. There should be no new grads looking for jobs."

"Didn't have a lunch break today as was too busy. Ate a scone and had a coffee while doing notes….starving at end of shift."

"Immediate employment of casual staff to cover sickness/annual leave. Immediate approval to provide cover for long term sick leave and long term annual leave. (We have staff off for months yet DHB will not provide cover - we are expected to work up and fill the gaps.)"

"A member reported in a recent survey that last year 3 new grads were employed for a 1 year contract to one ward. All 3 were not employed permanently. A few months later these positions were re-advertised resulting in the ward needing to orientate new nurses when a more positive outcome would have been to employ the new grads."

Resolution options for consideration – noting they must have funding attached to them to succeed:

- ***Escalation Process implemented as above with resourcing to enact same, national consistency of process and training for DHB managers, NZNO staff and members. Agreed timeframes are needed to provide any confidence in the process for our members***

- ***Agreement that DHBs are factoring in the appropriate leave calculations in the DHB MECA to establish the right FTEs***

- ***Agreement that ACC parental or long term sick leave are still counted in terms of hours to be replaced***

- ***All vacancies are filled in each DHB and in a timely manner, with the clear agreement that as soon as a resignation is received this is the trigger to activate the recruitment process***

- ***Remove the "caps" on FTEs and offer more flexible rostering arrangements to retain and attract staff.***

- ***An appropriate permanent pool available in each DHB including some availability on each shift so there is an ability to deal with the "immediate" and "short term" gaps. These pool staff to be well orientated to units so the relief is effective.***

- ***Maximising new graduate potential with these members having permanent employment thereafter along with appropriate preceptor time allocated rather than these preceptors carrying a normal patient load as is often the case.***

- ***Amend the DHB MECA to ensure that 2 full consecutive days off work are the normal rather than the exception. Despite this being essential to safe staffing DHBs are refusing to acknowledge this.***

Part 2 – Pay

Introduction

The Fair Pay settlement in the 2004 DHB MECA bargaining round resulted in significant pay increases across the whole pay scale for 25,000 members directly employed at that time in DHBs.

The bench mark occupational groups for that negotiation included Police, Teachers and MRTs.

Although the settlement was significant it failed to address remuneration recognition for post graduate qualifications. Over half of NZNO members surveyed in 2017 have at least one post graduate qualification and many have several and the lack of recognition for qualifications is a source of frustration for our members as reflected in these member comments:

> *"I don't tell my patients that I've got a masters degree in nursing. I like to think it is reflected in the care I give to my patients and their families. It's definitely not reflected in my pay."*

> *"I just finished my masters. [N]on nurses and even nurses ask me [whether I] get a pay rise, when I go no, they ask why on earth I'd do it…[and] I say to be the best nurse I can be."*

Post graduate qualifications in nursing have in some cases improved access to better models of care, and improved interventions and outcomes for people with long-term conditions. For example diabetes, mental health, nurse prescribing, nurse practitioners.

The care and support settlement has disrupted pay rate relativities between the unregulated caring workforce and the regulated workforce. Addressing the historical undervaluing of nursing and midwifery relative to male dominated occupational groups is an important step in any settlement.

New Zealand nurses and midwives perceive themselves still at considerable disadvantage in comparison to many other sectors relative to the education, effort, risk and responsibility that working as a nurse or midwife entails.

The Nursing Council Berl report 2012 confirmed that NZ will continue to be reliant on retaining the nurses it trains and attracting experienced internationally qualified nurses until 2035 and beyond.

The 2017 NZNO employment survey results showed a disturbing proportion of members who intend to leave the profession to work abroad or retire early.

In terms of nursing and midwifery workforce planning, attracting nursing and midwifery students, and retaining both younger and older nurses and midwives will be crucial, for converging demographic changes.

We are experiencing a chronic shortage of midwives wanting to work in the public system, and must avoid a similar crisis in nursing, which is inevitable if the workforce issues are not addressed before the exodus of baby boomers from the sector.

We see pay as vital to the retention and recruitment of the nursing and midwifery workforce.

Pay Scales

Pay for registered nurses and midwives vary depending on experience, duties and responsibilities. New graduates earn $49,449 and after four years experience can earn $66,755 and they stay there unless they are appointed as a senior nurse, senior midwife, or nurse practitioner.

The designated senior nurse and midwifery scale ranges from Grade 1 $70,871 through to Grade 8 $114,967.

What the bald salaries do not show however, is the lack of career progression, the flat structure and the minimum increases to pay that comes with increased managerial and professional responsibility that is required of a middle level nurse or midwife and through to the designated senior nurse and midwifery roles.

The 2005 settlement clearly failed to address the relativities at the higher end of each of the scales. Over 70% of nurses and midwives are employed on step 5 of the RN/RM scale and there are very few roles at the higher salaries for very senior nurse and midwifery managers, or nurse consultant/ nurse practitioners, for example.

With the exception of the community nurse and midwife scale all other occupational groups covered by the MECA have between three to five annual service steps. The flat pay structure relative to other professional groups in the DHB sector as well as teaching and police, does not adequately recognise the acquisition of skills and expertise that comes with experience.

Experienced nurses and midwives are required to mentor new graduate nurses and midwives and less experienced nurses and midwives and co-ordinate shifts on top of their current workload and without financial recognition. These members may or may not receive a PDRP/ QLP allowance.

The lack of pay progression beyond year five and the requirement to move into appointed senior nursing or midwifery positions or management roles is a significant problem for the many nurses and midwives who derive greater job satisfaction from their clinical work at the bedside.

The professional development recognition programme and quality leadership programme provide for allowances. However, the majority of nurses or midwives either opt not to participate or have been discouraged to do so by unsuccessful attempts to achieve the required standards and perceptions that the process is not a supportive one.

Bargaining parameters

The bargaining parameters imposed by Government are designed to keep wages low in the health sector relative to the rest of the public service including local government and the private sector.

This coupled with the uncertainty caused by the global financial crisis has tempered wage expectations for nearly a decade.

As the economy improves and the cost of housing soared, member expectations of pay increases that retain the value of their income and recognise their skills and qualifications is inevitable.

The bargaining parameters (0.7% in 2015 and 1.7% in 2017) and the financial pressure on DHBs to reduce their financial deficits and deliver financial surpluses has hindered our ability to address the most serious and pressing issues for nurses and midwives.

Due to the determination of our members we have been able to push beyond the parameters set by Government. The stretch beyond the bargaining parameter has been slight and insufficient to address the fundamental issues facing the nursing and midwifery workforce.

Nationally, midwifery and mental health and addiction services are in deep crisis and the solutions are now so complex that we can see no visible end in sight.

The environment has seen an exodus of midwives who are no longer being prepared to work in the public system. Nearly a quarter of all nurses and midwifes are planning retirement within the next few years.

We must act now to stem the flow of nurses and midwives leaving to work in Australia and opting for early retirement or leaving the profession if we want to prevent a crisis as the baby boomers leave the workforce.

Care and Support Settlement

We cannot avoid highlighting the impact of the settlement on the value of nursing and midwifery despite the legislative constraints in respect of setting a precedent for other Pay Equity settlements. The settlement benefits over 55,000 caregivers. The impact of the settlement on relativities and the morale of our DHB workforce should not be understated.

As a result of the settlement a level 4 caregiver as at 1 July 2019 can earn $53,193 p.a. In 2021 a level 4 caregiver annual salary will increase to $56,322. A DHB HCA currently can earn $42,650 on step 4.

An Enrolled Nurse on step 3 currently can earn $50,685. An RN/RM on step 1 can earn $49,449 p.a and $53,528 on step 2.

Unless these relativities are addressed the value of the nursing and midwifery qualifications will be significantly diminished.

> "*If I go back to caregiving [I] will likely get more than being an EN, in fact at my last job I would be paid $4 more (an hour) as a caregiver."*

It is important to note that the NZQA training programme for caregivers is provided in house by the employer and comes at no cost to the employee. Training is mostly done during work hours and requires very part time additional study.

Unlike the police who are paid while undergoing their basic (non degree) training, student nurses and midwives sacrifice income whilst studying and accumulate around $30,000 dollars in student debt, which requires around $2,500 to service for the first 10 years of a nurses employment.

Pay Parity

Medical Radiation Technologists with a 3 year degree have extended pay scales in comparison to nurses and midwives. MRTs start on $51,902 and can earn $70,778 after five years service.

An MRT can earn up to $91,196 dependent on criteria including job content, skill shortage, and responsibility of the position and level of performance. Charge, and clinical tutors can earn up to $100,366.

Secondary School Teachers progress to $73,650 after seven years and to $78,000 with a post graduate qualification. Primary School teachers progress to $73,000 after 7 seven years and to $75,949 with a post graduate qualification.

Australian pay rates

NZNO research shows a significant number of members intend to move to Australia for higher incomes and to save for their retirement. Australian wage rates are attracting our finest to its shores and the attraction is across all classes of nurses and midwives.

Pay rates for nurses in Australia start and range from approximately $60,431 to $65,697, approximately $11000 to $17000 more than NZ nurses and midwives. The top service steps range between $76,700 and $83,600, approximately $9,948 to $19,700 more than NZ nurses and midwives.

One member recently told us that *"In only the last year, five nurses from my department, have left for Australia."*

The NZNO negotiating team is a microcosm in terms of what is happening. One member has moved with his family to Australia and another has taken leave to experience work in Australia. We hope she returns.

Pay Equity – recognising the uniqueness of Nursing and Midwifery

In the June 2015 quarter, median hourly pay for males was $24.07 and for females it was $21.23. The gender pay gap was 11.8 percent. That means a typical male earns about 12 percent more for an hours work. As a female dominated profession, nurses and midwives are particularly affected by the gender pay gap.

Only a small hand full of nurses and midwives working in DHBs earn more than $100,000 and those will mostly be Nurse Practitioners who are also constrained by only 4 service steps relative to the resident doctors' scale with equivalent qualifications, Residence doctors were one of our bench mark comparison for that group.

The unique nature of nursing and midwifery is all too often disregarded in discussions relating to pay parity and pay relativities. The true nature of caring 24/7 to the sick and dying is unique to nursing.

The holistic nature of nursing and midwifery is unlike any other health professional group and extends to all aspects of patient care.

> *" As nurses, we are the backbone of the healthcare system – without us the medical staff would not gain an accurate view of a patients progress, families would not have a reference person to advocate for them and the patient, treatments would not be carried out – the list goes on. As a nurse I do not just look after the physicalities of my patient but the psychological, emotional wellbeing of the patient, family and whanau."*
>
> *"As a nurse I can look after a ventilated patient, a baby who needs bubble cpap, a patient who needs dialysis, a cardiac patient with obscure cardiac rhythms, a patient with delirium, a patient who is dying and needs palliative care. I can make a heart beat again…"*

Although we have clear evidence that supports the need for significant pay increases, members are increasingly calling for pay that recognises the real value of the skills and attributes required of their roles in an increasingly acute and stressful environment.

Few nurses and midwives can avoid the effects of working across all shifts. The well documented dangers of nursing and midwifery (especially night shift work) include increased risks of breast cancer, obesity, heart disease and long term sleep disturbance.

Additional dangers due to working night shift include social and family disruption, occupationally acquired infection, back injury and increasingly direct violence from patients and the public.

Although nurses and midwives receive penal rates and shift allowances, the calculation of 'compensation' payments based on a proportion of their pay which we submit are low, will not adequately recognise the significant risks associated with shift work.

We are not here advocating an increase to the penal rates but wish to illustrate the need to recognise the nature of nursing, and the wider effects of low pay.

Recommendations

The evidence that exists now outside of a proper pay equity investigation demonstrates that there needs to be a significant shift in the current NZNO DHB MECA pay scales.

Attached is a table of current state of pay rates as presented in our submission.

It is our view that the appropriate range for a HCA should sit between $44,500 and $56,300, the appropriate range for an enrolled nurse should sit between $57,500 and $61,500. The appropriate range for a registered nurse or a midwife should sit between $64,300 and $80,000.

These rates are based on service and do not include additional qualifications.

Due to the amounts presented it is implied that movement through the range above will require additional steps in scale structure.

Entry level adjustments and progress through the scales will be required to recognise post grad qualifications.

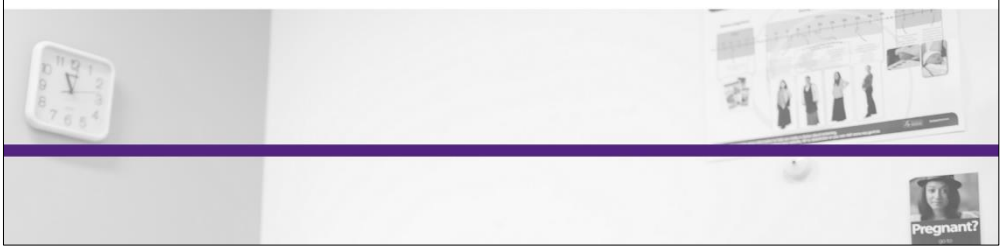
Community and senior nurse and midwifery scales will need to be adjusted relative to the classifications above.

I will now leave you with our members' voices.

	Caregivers Settlement	Current NZNO N&M DHB MECA	Queensld Nurses*	Victoria Nurses*	West Australia Nurses*	Secondary Teachers NZ 3 yr degree	Primary Teachers NZ 3 yr degree	MRTs/ 3 yr degree
Health Care Assist								
1 1 July 2019 1 July 2021	$42,763 $44,849	$36,955						
2		$39,269						
3		$41,894						
4 1 July 2019 1 July 2021	$53,193 $56,322	$42,650						
Enrolled Nurse								
1		$44,505	$57,929	$53,651	$55,665			
2		$46,977						
3		$50,690						
4								
5			$61,482	$60,139				
6					$62,137			
Registered Nurse/Midwives								
1		$49,449	$64,292	$60,431	$65,697	$47,000	$47,980	$51,902
2		$53,528				$49,000	$49,588	
3		$56,864				$51,200	$51,508	
4		$60,081				$53,200	$54,330	
5		$66,752		$67,064		$56,550	$59,621	
6			$83,144		$86,452	$60,500	$69,099	$70,778
7						$64,800	$70,481	
8						$69,400	$71,891	
9						$73,650	$73,000 (PG)	
10				$76,702		$78,000 (PG)	$75,949 (PG)	

*Australian wages are in Australian dollars.

"When you're constantly working at capacity and barely have time to get the tasks done, how is it possible to provide care and compassion to your patients, let alone spend meaningful time with them?"



"We've insufficient resources to maintain safe, meaningful, and purposeful care as we are skimming the surfaces and rationing care."

"I'm tired of working with skeleton staff and constantly apologising to patients for delay in cares.

We are begging for new staff to be employed to help us, we seem to survive on the bare bones.

There is not enough fat in the system to work in a healthy environment."

"I am exhausted. I am burnt out. I am so tired. I hate the stress of coming to work and having absolutely no idea what the staffing will be. Its exhausting."

"Nurses leave the ward each shift feeling guilty, inadequate and dissatisfied. We need safe staffing."

"We simply need more staff."

"We need the implementation of an effective acuity tool to make our work load safe."

"Ultimately it's the patients who are affected when we can't do our jobs well."

"We already had staffing and workload issues, but even more so now. We are losing our best and our experienced for better pay."

"I constantly teach new staff to then wave goodbye to them as they leave for Australia."

"We are the glue that holds the patients health journey together."

"We bring the holistic dimension to health, patient care and the community at large - we do not just deal in a single aspect but with it all."

> I can look after a ventilated patient, a baby who needs bubble CPAP, a patient who needs dialysis, a cardiac patient with obscure cardiac rhythms, a patient with delirium, a patient who is dying and needs palliative care, I can recognise signs of deterioration, and I can respond to cardiac arrests.
>
> I can make a heart beat again.

> Highly skilled and compassionate nurses (of which I am one) are the backbone of a safe and efficient public heath system.

> We are the backbone of healthcare, we are carers, educators, go betweens, advocates and are vital for any community.

We are undervalued.

We are the people who make the hospital tick.

We are the eyes and ears of the team.

We make sure medications are accurate and appropriate, and know how to give increasingly delicate, complicated or sometimes toxic medications in a safe way.

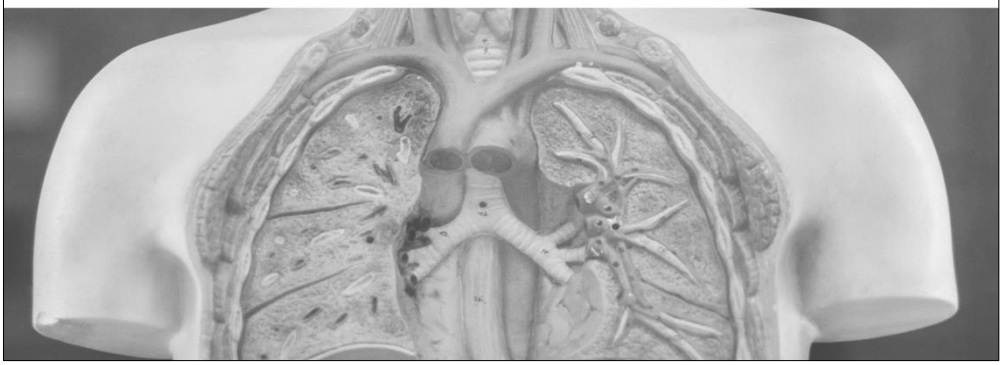
We educate, encourage and explain to our patients so they actually understand the medical jargon and have hope of improving their health.

We are the people who are there walking beside you from birth to death and for everything in between.

We are the ones who give the health service its most noticeable aspect of compassion.

We are experts in caring and giving healthcare in an accessible way that makes a difference.

"We are the heart of the health system, help that heart to keep beating."



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Mission statement
NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

Independent Panel Process
22 May 2018

Final Report and Recommendations on bargaining between the New Zealand Nurses Organisation and the District Health Boards

Independent Panel Process

Final Report and Recommendations
22 May 2018

Summary
The Multi-Employer Collective Agreement (MECA) between New Zealand Nurses' Organisation and 20 District Health Boards (NZNO/DHB) has been under negotiation since June 2017. The Parties have proposed two settlements, but both failed to be ratified by the NZNO members.[1]

The Independent Panel Process was established on 16 April 2018 to help the Parties reach an agreement. The task of the Panel has been to hear submissions from the Parties, consider the issues presented and make recommendations to help the Parties reach an agreement.

The Panel finds that while changes in remuneration are required, fundamental workforce issues cannot be addressed through remuneration alone.

The Panel has identified that nurses have lost faith that DHBs will address workload issues, which underlies their reluctance to ratify the proposed new MECA. Both parties agree that an agreed workforce strategy would help mitigate these issues. However, there appears to be a lack of implementation due to lack of resources, leadership and non-compliance with past agreements.

The Panel's recommendations are themed around:

- A longer-term agreement with an effective mechanism for dealing with non-compliance is needed;
- Improved escalation systems, a more supportive environment, and immediate funding for additional nurses to meet current workload needs;
- Leadership, commitment and additional resources to develop and implement the Care Capacity Demand Management (CCDM) programme;
- An increase to pay rates to address higher costs of living and recruitment issues.

The Panel's recommendations represent a way for the Parties to address the underlying issues that have led to the current situation. If agreed and ratified, the Panel's recommendations will have significant fiscal costs. However, the Panel believes a significant investment in the nursing workforce is needed not only to increase trust and morale, but to improve patient safety and outcomes.

[1] In this Report, the members covered by the Agreement are referred to as nurses but the Panel recognises that the Agreement covers registered nurses including senior nurses, enrolled nurses, midwives and NZNO members working in a variety of unregulated positions alongside nurses and midwives.

The panel has followed the process set out in the terms of reference

The terms of reference asked the Panel to consider the following issues:

1. Proposed pay increases;
2. Any lump sum Payment;
3. Other non-financial provisions including implementation of Care Capacity Demand Management (CCDM) and training on the Escalation Pathway;
4. Immediate Staffing issues/solutions;
5. The term of the Agreement;
6. Workload issues/solutions;
7. Pay Equity issues/solutions.

It was agreed in the terms of reference that the Panel's recommendations do not necessarily have to reflect the positions of either Party. The Panel has proceeded however on a 'no surprises' basis in formulating its recommendations.

The Panel met with the Parties' representatives on Thursday 26 April, and after the meeting delivered an Interim Report on Monday 7 May. The Parties met the Panel again on Monday 14 May to discuss the Panel's Interim Recommendations. Based on this discussion, the Panel amended the Report and Recommendations. The Final Report was delivered to the Parties on Monday 21 May 2018.

All Parties have fully cooperated with the Panel. The Parties helped the Panel to understand both the specific issues preventing an agreement and the context within which the issues have arisen. The Ministry of Health has provided assistance in the information gathering process, and has made available an independent secretariat that has very ably assisted the Panel.

An agreed workforce strategy is needed

The Panel's approach to its task has been to first understand the issues that had prevented the Parties from reaching an agreement that could be ratified by the membership of the NZNO. This required the Panel to understand the context within which the negotiations were taking place to identify what issues were preventing a successful negotiation.

From the comments made by nurses and their representatives, it is clear that the workload of nurses and how it is managed was a fundamental issue that needed to be addressed. It was also apparent from the DHB representatives that they were aware of the need to address the issue. However, resource constraints meant that measuring nurse workloads was not a priority for many DHBs.

Both Parties appear to agree that a workforce planning strategy is needed to ensure the safety of nurses and patients. The Panel noted that the current MECA supports a partnership approach to addressing workforce issues, and that both the NZNO Strategy for Nursing 2018-

2023 and the DHB Workforce Strategy and the DHB Nursing Workforce Strategy 2018 in principle agree with the fundamental importance of an agreed workforce planning strategy to ensure the efficient and effective running of the health service.

However, what appears to be lacking is the implementation of any strategy in a timely way. The Panel accepts this is due to a combination of a lack of resources, leadership and an effective mechanism to ensure compliance with what has been agreed by the Parties.

It appears that staffing and workload issues have not been a high priority due to resource constraints. This is even though the instruments and mechanism to accurately assess patient acuity and staffing required has been available to DHBs through a validated patient acuity tool and the Care Capacity Demand Management (CCDM) programme for many years.

The Panel believes that DHBs need to fundamentally shift their strategic priorities to address workforce issues. While all Parties are united in providing professional, high value care to patients, current workloads have led to unsustainable staff exhaustion and burn-out. The nursing workforce has experienced considerable stress when striving to maintain professional standards of patient care.

The Panel recognises that implementing this shift in priorities will take time. The Panel also recognises the DHBs will need additional resources to achieve this. As a sign of good faith, what is required is an initial injection of resources and demonstrable commitment to implementation of existing commitments already agreed in the MECA.

The Panel is conscious that its task is not an inquiry into workforce strategies, but it has concluded that unless a number of workforce related issues are addressed immediately, it will be difficult to reach agreement between the Parties. The Panel's recommendations are therefore designed to assist the Parties to immediately alleviate the stress placed on both the DHBs and Nurses through the current workloads and also to assist the Parties to give priority to implementing a longer-term solution through a validated patient acuity system and CCDM.

Related to the workload issue is the sense that there is not sufficient recognition of the impact on the nursing function, within hospital settings, caused by the significant increases to patient acuity that have occurred over the last decade. These changes to the nursing function are principally due to both the aging population and the numbers of patients with multiple co-morbidities. This has increased the complexity of nursing care in hospitals and related settings, requiring a more skilled, knowledgeable and experienced workforce. It seems these changes have not been recognised. There is no evidence of any form of job evaluation having been undertaken of the nursing function (excepting the workforce analysis included in the CCDM programme) for many years. This lack of recognition has led to a sense of grievance that underlies both workloads and remuneration. The recommendations recognise while changes in remuneration are required, the fundamental workload issues cannot be addressed through remuneration alone.

A longer-term agreement with a mechanism for dealing with non-compliance is needed

The Panel has noted the lack of an effective mechanism to ensure commitments made under the MECA are implemented, particularly related to the implementation of the CCDM programme. This has contributed to the reluctance to ratify the current agreement. There is an understandable reluctance to resort to legal action for non-compliance. However, if there is no confidence in the agreed provisions being implemented then other forms of compliance and accountability need to be explored by the sector. If this is not undertaken then these issues will re-emerge in the next round of negotiations.

The Panel recommends that a high-level commitment needs to be made to improving the nurse workforce planning strategy, and to ensuring compliance with commitments agreed in the MECA. It is for the Parties to agree to the effectiveness of the existing compliance and accountability procedures.

The Panel considers the long established, tripartite,[2] Health Sector Relationship Agreement (HSRA) Group could be useful for this process. The Panel envisages DHBs and the Union reporting to the HSRA Group on compliance against significant contractual commitments. This would enable early identification of non-compliance and allow the tripartite group to help achieve compliance within the relevant DHBs. The HSRA framework could also encourage the use of engagement, co-design and change management methodologies currently used in some DHBs, including the High Performance High Engagement programme (HPHE).

Finally, the Panel recommends a longer Agreement term. This will help ensure the necessary changes are sufficiently progressed within the term of the Agreement. A two-year term is insufficient time to progress the necessary shift in workforce planning strategy and priorities, and risks a re-litigation of the issues in the next negotiations. The Panel acknowledges there remains a lack of agreement by the Parties on the term of the agreement, with the NZNO preferring two years and the DHBs three years.

The Panel therefore recommends that:

1. ***The Parties report six monthly to the Health Sector Relationship Agreement (HSRA) Group on compliance with the significant contractual commitments agreed within their MECA and that the HSRA pro-actively supports the Parties to correct issues of non-compliance.***

2. ***The Parties use their best efforts to agree a three-year term to enable the implementation of the changes to workforce planning strategy and priorities recommended in the Report.***

[2] Parties to the HSRA are the health sector unions affiliated to the Council of Trade Unions, the 20 DHBs and the Ministry of Health.

Management of the Nursing Workforce, Leadership and Influence

The Panel were made aware of examples where DHBs have well established systems, processes and structures which ensure the nursing perspective influences organisational priorities and decision-making.[3] However the Panel accepts that currently the perception of DHB nurses is that they do not have "a voice" within their workplace and that their contribution is not valued. This factor has contributed to low morale and discontent across this section of the DHB workforce.

Having reviewed the DHBs' Nursing and Midwifery Workforce Strategy, the Panel can see that all DHBs do recognise the value of nursing and midwifery practice in decision making.

The Panel believes the mismatch between DHBs stated strategy and nurse perceptions is likely due to the organisational structures, and in particular the delegation and decision-making systems within the individual DHBs. It appears to the panel that many of these structures and systems directly conflict with the DHBs' stated strategy for their nursing workforce.

The panel has assumed that the senior nurses within DHBs want to influence clinical and business decision making, and that CEOs are right to expect this influence will enhance service provision, support workforce development, protect staff health and safety and contribute to DHBs being high performing organisations.

***The panel therefore recommends that**:*

3. ***The Parties agree a national framework, to then be applied by each DHB Chief Executive, to review how the nursing perspective can, and does, influence clinical and business decisions within their DHB, initially focussing on nursing workloads, escalation pathways and incident reporting.***

Improved escalation systems and a more supportive environment are needed to meet current workload needs

The Panel has identified that a fundamental barrier to reaching an agreement is the loss of faith among nurses that DHBs will address workload issues they face. This loss of faith is despite the 2006 Safe Staffing Healthy Workplaces Committee of Inquiry (SSHW), and the CCDM programme that arose from the inquiry. The purpose of CCDM was to address workload issues in an evidence-based way through the participation of both the nursing staff and management. Little progress has been made by most DHBs in implementing the CCDM programme, despite commitments made on several occasions since 2007.

However, even in the absence of CCDM, all DHBs are contractually committed to endeavouring "to ensure safe staffing levels and appropriate skill mix in work areas" and should this not occur an escalation process is provided for in the current Agreement (Clause

[3] The Panel consulted the Ministry of Health's former Chief Nurse. She recommended that Auckland and Whanganui DHBs could be seen as exemplars of where the nursing perspective is effectively influencing organisational decision-making.

6). This clause also provides for the DHB incident management process to be activated to enable the reporting and review of significant inadequate staffing levels.

The Panel acknowledges the need for this process since, even with the best intentions and processes (including the CCDM programme), DHBs will experience times when they simply cannot adequately staff all clinical areas.

However, the Panel was disturbed at the frequency of reported significant staffing shortages. It appears the base number of nurses rostered is very often inadequate for the expected workload. The nurses also reported that the process of adding more nursing resource to the clinical area to meet higher workloads is inadequate and/or ineffective, leaving both patient and staff safety at risk.

Further, most of these DHBs do not acknowledge, let alone encourage, the use of the escalation and incident management processes agreed in the current MECA (Clause 6). The Panel has concluded this is due to these processes being dependent on a supportive environment.

The Panel would see a supportive environment as one which works to avoid un-manageable difference between the required and the available staffing. When unacceptable staffing levels occasionally do occur, staff are supported to cope. Such support could include staff receiving training in time management, effective decision-making, de-escalation methods, workplace resilience or prioritisation when "care rationing" is required. A supportive environment is also one in which all staff are willing to apply their general skills in other clinical areas when demand workloads shift.

The unsupportive environment and the ineffectiveness of the agreed escalation process is seen by the Panel as a significant contributor to the level of discontent and frustration felt by nurses. Work is urgently needed by both parties to remedy this unsatisfactory situation. Clinical staff need to be able to confidently use the escalation process. Executives need to empower operational leadership, particularly duty nurse managers, to take whatever action is necessary to prevent the safety of patients or staff being compromised.

Most nurses, midwives and patients have seen little or no tangible benefit from CCDM, leading to significant frustration. While the Panel acknowledges the tremendous good will displayed since the SSHW unit was established and that there is a deep wellspring of good faith that persists in the sector, nurses have lost patience that improvements will come to their ward, unit or clinic any time soon. Now that loss of patience has become a loss of trust in DHB management and in NZNO, and this is a major impediment to ratification.

The Panel recognises how hard it is to rebuild trust, especially in the context of more than a decade of staffing agreements reached, commitments made and repeated failures to deliver. It seems that for a decade or more, nurses and midwives in many DHBs have coped with persistent staffing and workload issues with only the promise of a properly equipped and supported future to sustain them.

The Panel has of necessity had to rely on anecdotal evidence relating to staffing levels. Based on this, the Panel accepts that there is frequently a mismatch between the nursing hours needed for patient care and the nursing resource available. Further the Panel accepts that this situation occurs across DHBs and across clinical areas, albeit to varying degrees.

It is essential that nurses, midwives, and patients gain tangible relief from these staffing and workload issues. Tangible relief requires more nurses and midwives now. Recognising that it takes time to recruit and deploy more staff, the commitment of additional funds to initiate increased recruitment requires immediate action. Until the CCDM programme can be delivered in all practice areas, and throughout all DHBs, an increase in the DHB employed nursing workforce is required.

In the absence of a system such as CCDM, to objectively match patient need with nursing resource, each DHB's management will need to support the professional judgement of their senior nurses, led by their Director of Nursing, as to the extent of additional nursing required to ensure all their clinical areas are safe, healthy workplaces.

Therefore, to relieve the immediate workload issues the Panel recommends that:

4. ***Each DHB CEO requires their local CCDM Council to oversee a review of the organisation's system and current practice for managing situations when the required staffing levels cannot be achieved, and requires their Director of Nursing to work with the CCDM Council to develop and implement, by 31 December 2018, an agreed plan to remedy any shortcomings identified by this review ensuring that the plan includes ongoing monitoring and evaluation of the escalation processes***.

5. ***The NZNO actively works with its members to achieve acceptance that robust, effective management of staff shortages and unmanageable workloads is dependent on staff willingness to work flexibly across clinical areas.***

Additional funding for more nurses is needed

The Panel heard evidence that investing in a larger nursing workforce also has the potential to increase workforce productivity, improve health system performance, and ultimately achieve better outcomes for patients.

However, simply making the workforce larger will not ensure these intended gains are achieved. Additional investment in the nursing workforce must be rigorously focussed on building the capacity to respond immediately to short-notice staffing shortfalls. Once this capacity is developed, additional nursing resources should focus on developing and implementing the CCDM programme and the SSHW action plan.

The panel recommends the Minister of Health set a clear expectation that DHBs must have sufficient nursing resources available to meet short-notice staffing shortfalls. DHBs must ensure that nurse managers are able to immediately resolve the staffing shortfalls, as per the

escalation provision in Clause 6 of the current MECA. DHBs must have a sufficient number of experienced nurses available, and these resources must be available to cover any clinical area.

The Panel recognises that meeting these expectations may not be possible based on current funding and believes additional funding should be made available. The Panel estimates the funding needed is 2% of the existing national spend on all DHB nursing and midwifery services. This funding should be allocated to DHBs on the basis of the Population Based Funding Formula.

The Panel recognises that some DHBs are already committing the necessary resources to immediately resolve staffing shortfalls. These DHBs would be free to deploy the additional funding to other activities, as they have already prioritised the investment in nursing resources needed to ensure patient and staff safety.

The Panel believes this approach will incentivise DHBs to hasten the development of the CCDM in order to "iron out" any over staffing resulting from the Panel's blunt, but necessary recommendation.

The Panel would see these funds being used according to the recommendations of Directors of Nursing and Midwifery working in conjunction with the SSHW Unit (see also recommendation 3). Expenditure and performance should be monitored by the SSHW Governance Group and reported to the Tripartite, HSRA Steering Group.

The Panel recognises this will have a significant fiscal cost. However, the Panel believes this investment is necessary to ensure there are enough nurses and midwives to deliver safe and effective care to all patients, at all times. This investment also has the potential to increase workforce productivity and improve patient outcomes.

The Panel also recognises the risk that more DHB nurses could result in recruitment issues in other parts of the health and disability sector, such as aged care and primary care. However, the Panel is convinced this crisis must be addressed by DHBs. The Panel believes this risk can be mitigated by DHBs, Health Workforce NZ, nursing education providers and the nursing regulator working together to address nursing workforce issues. For example, DHBs and Health Workforce NZ could explore making funding available to employ and develop suitable new nursing graduates, supporting the ongoing stability of the DHB nursing workforce.

Therefore, to relieve the immediate workload issues the Panel recommends that:

6. ***The Minister of Health sets a clear expectation that DHBs must have sufficient nursing resources to ensure patient and nurse safety, through a Letter of Expectation to each DHB, to be sent as soon as practicable after ratification.***

7. ***The DHBs receive funding equal to 2% of the total national cost of the DHB employed nursing and midwifery workforce, immediately on ratification of the agreement to ensure DHBs have the nursing workforce capacity to deliver the required patient services. The increase in funding to be allocated to each DHB in accordance with the Population Based Funding Formula.***

Leadership, commitment and additional resources are needed to implement the CCDM programme

The Panel recognises that whilst there is a high degree of frustration relating to the DHBs' lack of progress in implementing CCDM, substantial progress has been made by NZNO and DHBs engaged together in the work of the SSHW Unit and its development of the sophisticated CCDM programme.

The Panel recognises there are a number of DHBs which have made significant investments to implement the CCDM programme. The commitment of these DHBs has been crucial to the ongoing development of the programme, which has been ably led by the staff of SSHW unit. The NZNO and DHBs have engaged in the work of the SSHW Unit, supporting the programme's development. Evaluations have shown, albeit subjectively, the programme has benefited staff, patients and in some cases reduced fiscal costs.

However, there are DHBs where little or no progress has been made. The Panel believes one of the major obstacles is DHBs being unwilling or unable to adequately resource implementation. To successfully implement the programme, investment is needed in programme management (for training, co-ordination, monitoring and evaluation of the CCDM programme), and in a validated patient acuity tool,[4] to measure the care needed by different patients.

This lack of resourcing and slow progress has resulted in much frustration among nurses. In addition, many nurses believe certain calculations are being manipulated. As a result, many nurses see patient acuity reporting as "just another administrative burden" rather than an investment in the future. This attitude degrades the quality of the patient acuity data, which undermines the integrity and accuracy of the CCDM programme.

The Panel believes the NZNO should more actively support DHBs to develop the understanding of, and commitment to, the programme by the nurses across the clinical areas. This programme requires a partnership between DHBs and nurses to be effective.

The panel recognises many DHBs cannot fund the nursing resource required for the day to day patient needs, let alone the resource required to successfully manage patient acuity reporting and other components of the programme. It seems that until nurses feel they are adequately resourced to meet the needs of patients, many will not contribute positively to the programme.

The Panel recognises the increased commitment to CCDM that all the DHBs have made during this round of negotiations, including changes to the governance mandate and improved reporting and accountability frameworks. However, the Panel believes the timelines currently proposed will need regular review.

The Panel considers successful implementation will require a minimum of around 1.0 FTE for the patient acuity system and 1.0 FTE for CCDM programme management, per 600 FTE

[4] Trendcare is currently the only acuity tool which meets the CCDM programme standards/specifications.

nurses. This view is based on information provided by DHB leadership, the union leaders, the operational nurse managers and the nursing staff.

The Panel acknowledges the unique attributes of the CCDM programme and congratulates the nursing profession developing this programme within the tripartite arrangement. This programme has the potential to provide great benefits to the health system, well beyond nursing. It is the understanding of the Panel that CCDM is the only valid and reliable resource utilisation and planning tool available within the NZ health sector. The value of the programme is also demonstrated by the considerable international interest that it is attracting. The Panel believes this interest is not misplaced and that the Ministry of Health should also have a strong interest in seeing the potential benefits of the programme realised.

To further the development and implementation of CCDM the panel recommends that:

8. ***The DHBs, the NZNO and the other participating union, re-affirm their commitment to SSHW and CCDM.***

9. ***The Ministry of Health include in the Operating Policy Framework the requirement that DHBs implement a validated patient acuity system and plan their DHB nursing workforce requirements in line with the CCDM programme methodology.***

10. ***The Ministry of Health gives urgent consideration to providing each DHB with funding equivalent to 2 FTEs per 600 FTE nursing staff, dedicated to supporting the ongoing implementation and development of the CCDM programme in line with the DHB's agreed timeline.***

11. ***The Ministry of Health support the SSHW governance group with its monitoring and compliance functions, including supporting remediation of non-compliance.***

12. ***The DHBs review the resourcing of the SSHW Unit to ensure that national support is available, as DHBs require, for the implementation of patient acuity reporting and the CCDM programme.***

13. ***The NZNO review their organisational response to CCDM and the resource available to promote and encourage their membership commitment to patient acuity reporting and the CCDM programme.***

14. ***The NZNO and each DHB review the effectiveness of the local partnership and commitment to the union's formal participation in the programme governance and implementation at DHB level.***

Nurse pay rates need to increase to address higher costs of living and recruitment issues

The Panel has heard arguments from both Parties relating to the level of remuneration that they consider to be fair and which adequately recognises the level of skill and professionalism of nursing staff at all levels. The Panel has also heard arguments relating to relativities both within and outside the health sector.

The NZNO have stated in their initial submissions that the flat pay structure through the current salary scales, and the previous offer of 2 + 2% increases over two years, has been unacceptable to members. The NZNO also found the remuneration increases in the Panel's Interim Report unacceptable. These were: a 3% increase from 1 June 2018; 3% increase from 1 August 2018; 3% increase from 1 August 2019; and a lump sum of $1500 for all staff covered by the MECA.

The NZNO found the Interim Report's recommended 3-year term of the MECA unacceptable (from 1 August 2017 to 1 August 2020). The NZNO expressed concern that there was a 10-month gap between the start of the MECA term (1 August 2017) and the first pay increase on 1 June 2018. The NZNO repeated concern about the date for completion of the pay equity negotiations and repeated their claim for completion by the end of 2019.

DHBs noted they were under pressure to reduce their financial deficits and deliver surpluses. DHB noted their previous offer to the NZNO were at the limits of affordability. They are also constrained by SSC policy that prevents back pay, making paying increase before 1 June 2018 infeasible. DHBs were also conscious that funding for pay increases would be in addition to the recommendation to increase the nursing and midwife workforce by 2% at each DHB.

The Panel's task has been to recommend a remuneration package that compensates for increases in the cost of living, helps reduce recruitment difficulties and ensures staff are rewarded for their qualifications and experience.

The Panel believes the remuneration package recommended below appropriately balances the need to compensate nurses for increases in the cost of living, and the financial constraints faced by DHBs. It is equivalent to a substantial pay increase over the term of the agreement, plus a commitment to pay equity negotiations within the term of the agreement. When calculating the total value of the recommendations, the cost of the 2% increase in nursing and midwife staff should also be included.

The Panel accepted that the flat pay structure was a barrier to accepting previous offers. After further submissions from the Parties, the Panel recommends the Parties review the salary scales and negotiate two new steps in the scale during the term of the Agreement.

The Panel accepted that too few nurses and midwives were being recruited, due to a lack of resources. These recruitment difficulties are addressed above by Recommendation 7, which provides 2% of the total national cost of nursing and midwifery workforce for increased staffing. This additional resource is to be rigorously targeted at reducing workload issues, and to help implement the CCDM programme.

After considering the contribution of both Parties to the Interim Recommendations the Panel recommends the following remuneration:

15. ***Lump Sum payment of $2000 to be paid on ratification to each nurse and midwife covered by the MECA. This payment is recognition of the recent workload difficulties experienced by nurses and midwives. This sum represents the equivalent of 3% of the RN5 Rate ($66.755) and the equivalent to 2.93% of the average rate of pay of those covered by the NZNO document increase.***

16. ***3% increase on all MECA wage rates from 1 June 2018. The date of 1 June is recognition of the SSC policy against back pay.***

17. ***3% increase on all MECA wage rates from 1 August 2018 in recognition of the cost of living.***

18. ***3% increase on all MECA wage rates from 1 August 2019 in recognition of cost of living.***

19. ***The Parties enter negotiations during the term of the Agreement to add two new steps in the Nurses Salary Scale.***

20. ***Pay Equity negotiations be conducted during the term of the Agreement with a view to concluding the negotiations during the term.***

21. ***The Parties appear to have reached agreement on the salary increase for Senior Nurses so the Panel makes no specific recommendation.***

The above represents substantial salary increases and a commitment to pay equity negotiations within the term of the agreement and the negotiation of two new salary steps.

When calculating the total value of the recommendations, the cost of the 2% increase in nursing and midwife staff also should be included.

Conclusion

The Panel's recommendations represent a way for the Parties to address the underlying issues that have led to the current situation. If agreed and ratified, the Panel's recommendations will have significant fiscal costs. However, the Panel believes a significant investment in the nursing workforce is needed not only to increase trust and morale, but to improve patient safety and outcomes.

The Panel understands that in any negotiation there must be respect for all arguments and compromises are often necessary to accommodate the interests of all the Parties. The Panel's recommendations have balanced the interest of both Parties and provide a platform for a renewed partnership on which the MECA can be agreed.

Panel Members

Margaret Wilson, Chair
Julie Patterson, Member
Geoff Annals, Member

Summary of Recommendations

1. ***The Parties report six monthly to Health Sector Relationship Agreement (HSRA) Group on compliance with the significant contractual commitments agreed within their MECA and that the HSRA pro-actively supports the Parties to correct issues of non-compliance.***

2. ***The Parties use their best efforts to agree a three-year term to enable the implementation of the changes to workforce planning strategy and priorities recommended in the Report.***

3. ***The Parties agree a national framework, to then be applied by each DHB Chief Executive, to review how the nursing perspective can, and does, influence clinical and business decisions within their DHB, initially focussing on nursing workloads, escalation pathways and incident reporting.***

4. ***Each DHB CEO requires their local CCDM Council to oversee a review of the organisation's system and current practice for managing situations when the required staffing levels cannot be achieved, and requires their Director of Nursing to work with the CCDM Council to develop and implement, by 31 December 2018, an agreed plan to remedy any shortcomings identified by this review ensuring that the plan includes ongoing monitoring and evaluation of the escalation processes***.

5. ***The NZNO actively works with its members to achieve acceptance that robust, effective management of staff shortages and unmanageable workloads is dependent on staff willingness to work flexibly across clinical areas.***

6. ***The Minister of Health sets a clear expectation that DHBs must have sufficient nursing resources to ensure patient and nurse safety, through a Letter of Expectation to each DHB, to be sent as soon as practicable after ratification.***

7. ***The DHBs receive funding equal to 2% of the total national cost of the DHB employed nursing and midwifery workforce, immediately on ratification of the agreement to ensure DHBs have the nursing workforce capacity to deliver the required patient services. The increase in funding to be allocated to each DHB in accordance with the Population Based Funding Formula.***

8. ***The DHBs, the NZNO and the other participating union, re-affirm their commitment to SSHW and CCDM.***

9. ***The Ministry of Health include in the Operating Policy Framework the requirement that DHBs implement a validated patient acuity system and plan their DHB nursing workforce requirements in line with the CCDM programme methodology.***

10. ***The Ministry of Health gives urgent consideration to providing each DHB with funding equivalent to 2 FTEs per 600 FTE nursing staff, dedicated to supporting the ongoing implementation and development of the CCDM programme in line with the DHB's agreed timeline.***

11. ***The Ministry of Health support the SSHW governance group with its monitoring and compliance functions, including supporting remediation of non-compliance.***

12. ***The DHBs review the resourcing of the SSHW Unit to ensure that national support is available, as DHBs require, for the implementation of patient acuity reporting and the CCDM programme.***

13. ***The NZNO review their organisational response to CCDM and the resource available to promote and encourage their membership commitment to patient acuity reporting and the CCDM programme.***

14. ***The NZNO and each DHB review the effectiveness of the local partnership and commitment to the union's formal participation in the programme governance and implementation at DHB level.***

15. ***Lump Sum payment of $2000 to be paid on ratification to each nurse and midwife covered by the MECA. This payment is recognition of the recent workload difficulties experienced by nurses and midwives. This sum represents the equivalent of 3% of the RN5 Rate ($66.755) and the equivalent to 2.93% of the average rate of pay of those covered by the NZNO document increase.***

16. ***3% increase on all MECA wage rates from 1 June 2018. The date of 1 June is recognition of the SSC policy against back pay.***

17. ***3% increase on all MECA wage rates from 1 August 2018 in recognition of the cost of living;***

18. ***3% increase on all MECA wage rates from 1 August 2019 in recognition of cost of living;***

19. ***The Parties enter negotiations during the term of the Agreement to add two new steps in the Nurses Salary Scale.***

20. ***Pay Equity negotiations be conducted during the term of the Agreement with a view to concluding the negotiations during the term.***

21. The Parties appear to have reached agreement on the salary increase for Senior Nurses so the Panel makes no specific recommendation.