

**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.<sup>1</sup>

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.

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<sup>1</sup> 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,<sup>2</sup> 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.***

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<sup>2</sup> 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.<sup>3</sup> 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

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<sup>3</sup> 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,<sup>4</sup> 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

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<sup>4</sup> 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.***