SESH 2015

Public Services International

Safe and Effective Staffing for Health

Report of a Working Group meeting

Background

A group of PSI affiliates met with invited experts on Safe and Effective Staffing issues[1] to develop policy and campaign options for PSI and health and social service unions. The Working Group reviewed union involvement in staffing campaigns and assessed current evidence supporting the relationship between staffing and patient outcomes, staff working conditions, and economic dimensions and effects.

[1] The Background brief and Programme are annexed to this Report.

Conclusions of the Working Group

Based on current evidence from several countries, the Working Group concluded that with few exceptions, current approaches to staffing in health are failing, that patients are paying a high price due to sub-optimal outcomes and incurring harm, including patient mortality, and that health workers are suffering job-related harm. The Working Group concluded that safe nurse-to-patient ratios were essential.

Overall conclusion: Minimum-level nurse-to-patient ratios are a non-negotiable safety net that save lives and prevent harm.

Supporting arguments:

Health is a high-risk, high-hazard industry within which minimum industry standards are justified and must be applied - such standards include staffing levels
The safety net provided by minimal nurse-to-patient ratios should be a non-negotiable feature in an industry where safety is critical and intrinsic to its overall purpose
Enforceability is required, which in turn necessitates a standard that can be systematically measured and monitored for accountability

Health systems entrenched in the status quo that have tolerated substantial deterioration cannot self-correct without clear objectives that are provided by the imposition of legally mandated and enforced minimum ratios

Many, if not most of the current systems for establishing staffing in health represent a form of uncontrolled experimentation that is not evidence-based, but driven by tradition, practice, the preferences of management and, above all, cost containment. There is little evidence of efficacy or impact and few or no attempts to measure and justify scientifically the benefits of the models used.

The lack of scientifically defensible approaches and the particular absence of minimum staffing floors is unconscionable in a high-risk, high-hazard industry such as health. A lack of such basic protections is not tolerated in other high hazard industries, e.g. air travel.

The argument that minimum nurse-to-patient ratios are blunt and restrictive should be set aside, given that a ratio can be applied with sufficient flexibility to deal with fluctuations in demand, once the mechanism is instituted. All staffing systems represent some form of ratio as a ratio merely describes a numerical relationship between one factor and another, in this case between the number of nursing hours provided and the number of patients requiring care. Any configuration of nurse staffing in relation to patients can be expressed as a ratio.

Certainly if a single ratio is applied indifferently in diverse settings, it will take away value from ratios and reduce their meaning. Nevertheless, the least effective option without doubt is the absence of any floor. Consequently, a single ratio once applied and enforced was agreed to be preferable to the current absence of a mandated minimum in the majority of countries and health settings; without such a safety net, patients are exposed to risk and their lives are endangered.

Establishing staffing floors does not excuse an organization from building on these to ensure quality of care and raising the level of optimal outcomes for patients; floors are designed to prevent deterioration of services from minimally safe to unsafe. Floors are not a proxy for effective staffing levels. Their purpose is to prevent degradation, but they are a prerequisite and the point of departure for effective staffing.

The Working Group reviewed six essential aspects of union involvement in the health staffing agenda:

1. A need to clearly articulate the staffing agenda that unions are advocating
2. The strength of the evidence that unions can use to validate and support action
3. The current methods being used or advocated to plan and deliver staffing
4. Options for unions that need to leverage system change
5. Ways for unions to influence staffing improvements and to maintain defensible staffing systems in the face of ongoing pressure
6. The need to establish standards that emerges now, at a critical junction when the new Post-2015 agenda and its focus on substantially increasing "*health financing and the recruitment, development, training and retention of the health workforce in developing countries*" will provide both an opportunity and a challenge to health workers' demands for improved employment and working conditions.

Securing minimum staffing levels for health workers should become a priority for health services unions. Mandated minimum nurse-to-patient ratios are unlikely to be secured and sustained without union mobilization and advocacy.

Outcomes

The major outcomes included a consensus statement (see below): "Nurse-to-patient ratios save lives!" and agreement on a 12-month roadmap of commitments.

Outcome statement
(http://www.world-psi.org/en/nurse-patient-ratios-save-lives)

Nurse-to-patient ratios save lives!

A PSI working group on Safe and Effective Staffing for Health (SESH), that met on 11-12 May at UNISON in London, declares nurse-to-patient ratios saves lives.

15 May 2015 UNISON - SESH

Health unions gathered in London raise alarms for all people in the UK and for health and social services unions around the world.

Universal access to quality health and social care services should be among the central priorities of all governments, as these services underpin human rights and quality of life. Current trends of austerity budgets, privatisation and outsourcing as well as renewed structural adjustment policies are making the attainment of universal access to health and social care services more difficult.

On International Nurses' Day 2015, the global trade union federation Public Services International – PSI, representing 20 million workers in 160 countries, warns of threats to patient and family care from increasing privatisation, outsourcing and funding cuts in health and social services. Under these conditions, our members, and especially nursing professionals, are unable to deliver safe and reliable health services. Patients deserve better than this. Health workers deserve better.

PSI's working group of health unions and invited experts met at UNISON headquarters on 11 and 12 May. After reviewing the research from many countries, the group concluded that most current approaches to staffing in health are failing and there is compelling evidence that patients are paying a high price in terms of harm and sub-optimal outcomes. PSI calls on governments, the UN system and health and social service operators to implement safe staffing policies to ensure that patients get the care they deserve.
Safe staffing through nurse-patient ratios is a proven method to ensure that the necessary staff are available when needed. There is ample evidence that patients are exposed to unnecessary health and vital risks when nurse-to-patient ratios fall below safe levels. Mandated minimum staff-to-patient ratios save lives, by setting standards below which care must not fall.

PSI supports the UK affiliates' criticisms of health sector policies, especially the systemic risks posed by privatisation in health and social services, known as the Private Finance Initiative model. In an effort to conceal state borrowing, the government uses the Private Finance Initiative model to attract much more expensive private financing. The real impact of the Private Finance Initiative model is felt only after a few years, when hospital trusts are forced to cut heavily into operating and staff costs or face bankruptcy. Unions insist that government not sell off our future for short-term accounting tricks.

PSI is putting governments and health and social service operators on notice. Safe staffing and the achievement of nurse-to-patient ratios will be central to all of our activities, whether in rich, middle-income or disadvantaged countries. Unions will pressure and negotiate for measures to protect patient care.

PSI SESH SAFE AND EFFECTIVE STAFFING FOR HEALTH UNISON

Commitments to action

The Working Group members underwrote five commitments that addressed the areas identified in the discussions and agreed on a 12-month roadmap to move the agenda forward.

1. **Issue a statement** to announce the conclusion of the Working Group
2. **Produce a summary record** of the workshop as a platform for the next steps
3. **Establish a hub** for affiliates for communication, information and evidence, to include:
   - 3a. Infographic summary of the situation in as many countries as possible
   - 3b. Map that affiliates can use to direct enquiries and to facilitate networking, enabling affiliates to offer - or seek - advice and guidance on safe staffing campaigns
   - 3c. Documentation on what unions can do and what they have done
4. **Undertake a membership survey** with a questionnaire focusing on key questions
5. **Hold an international day of action** to highlight the safe and effective staffing agenda

Action	Purpose	Steps	By whom	By when
Issue a statement	Inform PSI affiliates and broadcast to healthcare workers the SESH Working Group conclusion	Draft Agree Publish	PSI	15 May 2015
Produce a summary record	Capture proceedings & build a platform for future action	Draft Consult Sign off	PSI	27 May 2015
Establish a hub	Provide a portal for communication, information and research	• set up hub on PSI website • infographic summary • map actions • document what unions can do and have done • contribute material	PSI PSI EPSU EPSU All affiliates All affiliates	From 27 May 2015 to 27 May 2016
Undertake a membership survey	Build the empirical trade union evidence base and provide a baseline from which to measure change over time	• draft the questions • circulate to group for comment • use web translator • administer survey • collate results • publish on hub	Gail Adams (UNISON) Kelly Trautner (AFT)	30 November 2015
Hold an international day of action	Highlight generality, extent and urgency of the issue of safe and effective staffing • Awareness • Solidarity • Build alliances for action The day can become an annual event, supported by the unions that have successfully effected change		Judith Kiejda (NSW ANMF)	Day to be selected based on existing "special" days and overall objective

The strength of the evidence

The invited experts who shared their evidence on the range of safe staffing issues included Professor Peter Griffiths, Southampton University; Jane Ball, Principal Research Fellow, Southampton University; Professor Anne-Marie Rafferty, King's College, London University; and Professor Alison Leary, London Southbank University.

There is evidence supporting a relationship between staffing and the impact on patients, on staff and on productivity :

- **Impact on patients:** There is irrefutable evidence that staffing deficits are detrimental and harmful, but the multitude of influencing factors has made it difficult to pinpoint 'ideal' staffing numbers, skill-mix and distribution. Unions need to be involved in the generation of evidence to strengthen this area. New metrics are emerging, particularly around care rationing (triage by the staff themselves of the work meant to occur at the point of service delivery).
- **Impact on staff:** There is evidence demonstrating a relationship between staffing, staff well-being and the stability of the workforce.
- **Impact of staffing on productivity:** There is limited evidence that demonstrates the economic impact of various staffing configurations. The modelling often examines either the crude bottom line accounting costs of staff, or the impact of staffing on a single factor, for example the prevention of patient falls. Neither approach addresses the returns on investing in staff. This area remains problematic.

Discussion

The cost of turnover associated with poor staffing as well as the unquantified value of the discretionary efforts made by staff to compensate for understaffing t can be measured in the form of activities performed outside of the job description and extra time invested in work from missed breaks and unpaid overtime. There are particular costs in relation to agency and permanent staffing.

There is empirical evidence of the impact of mandated ratios on the return of nurses to the workforce and on retention of nurses in the workforce.

Unions themselves need to participate in data collection and research, and to lead in the development of new forms of evidence. They could study the impact of workload stress; how health and human life is valued; the impact of allowing discretion in staffing (through the presence of soft regulations or the absence of enforcement of regulations) and the frequency of resulting deficits in staffing; and the outcomes for patients and staff when the deficits either are - or are not - compensated by extra staff efforts. New research metrics of care rationing and work effort are specific avenues to explore.

In addition to generating new evidence, there is a need to amalgamate current evidence and not to treat the various forms of evidence in a hierarchy where 'pure' research is the gold standard, but rather to consider all available forms of evidence, including empirical observation when well summarized and construct an analysis on this basis. A 'twin-track' approach would enable research and longitudinal studies to sit alongside less rigorous but faster methods for generating knowledge. There is a need for new research instruments and approaches as current approaches are not adding much that is new to the body of knowledge. Interestingly, the research frontiers in staffing issues call for new forms of collaboration between trade union and university-based researchers.

In conclusion, the evidence is patchy on some issues and very focussed on inpatient hospital settings. There is nonetheless sufficient evidence to support minimum floor ratios as a life-saving intervention. There is also growing evidence to support the establishment of levels that deliver quality as well as prevent harm.

Staffing methodologies

The case studies demonstrated a wide range of methodological approaches to staffing. It was clear that the most durable were based on mandated nurse-to-patient ratios. Whereas there is no 'one-size fits all' methodology, unions must be able to critique prospective or existing methodologies to establish that they are fit-for-purpose.

Local differences in workforce models, care models and funding models mean that local staffing solutions are required. Regardless of local variance, however, the staffing methodology must perform its basic purpose which is to match the health worker resource provided to patient demand.

In conclusion, a ratios-based approach is the best option, recognizing that the ratio must take account of numbers, skill mix and workforce distribution, be developed to be as sensitive as possible in application, and vary to reflect local differences. Whatever system is arrived at, it must be simple in application, mandated, and protected. The impact of the system on patients, staff and productivity should be observable and observed. Accountability based on monitoring for enforcement is paramount.

Levers to effect system change

Unions need the grass-roots support from their membership to deliver change. It is important to mobilize and educate members around the need for and urgency of change and this includes building a sense of hope and possibility: staff may have become used to a lower bar and can benefit from exposure to the testimony of members of unions where change has been achieved. Preparing to leverage the change takes time. Unions must also consider other terms and conditions of decent work for their members.

The staffing agenda that unions are advocating must be clearly articulated not only to the union members, but also to the community and the employers. Unions are the vehicle to effect change but they cannot deliver change on their own: securing community support is vital.

Union leverage is critical to achieving system change on staffing that is beneficial for patients and for staff. The range of leverage options available to unions include:

- Targeting the system at multiple levels (legislative, policy, regulations, local system, technical etc.) is important
- Legitimizing the experience, attitudes and views of nurses as valid empirical evidence
- Messaging in tune with community interests that is clear and consistent
- Promoting respected voices from inside and outside the union to champion staffing
- Validating action by using the best available evidence from all sources
- Addressing local issues squarely that include the local public – private mix, health and delivery models, training and education, and preparedness
- Building on other unions' experiences and gains
- Being vigilant to seize opportunity when political conditions are ripe for advocacy and action, e.g. enacting legislation. Preparing to act during brief 'political moments'
- Planning for life after the change before the change to ensure sustained enforcement.

Getting there is the start – the constant battle

Unions having achieved mandated staffing systems emphasized that achievement of a system that includes minimum base levels is only the beginning. The system requires constant attention for compliance and defence against attempts to erode the integrity of the new system. This is of high value to unions. Staffing is of primary concern to members and intrinsic to their working conditions.

Mandating and enforcing safe staffing is an organizing tool

A successful focus on staffing has value as a union organizing tool. There is empirical evidence of increased membership and union commitment with a strong and mandated staffing methodology. Nurses return to and stay in healthcare settings that have newly mandated safe staffing standards.

Defending the reasonable workload agenda and broadening coverage

In the most successful cases, unions are integrally involved in policy, in ensuring compliance with the staffing system, and in all activity related to system revision and change. Staffing is a permanent feature of the landscape for health unions. After a stable initial system is achieved, the next goal is to broaden coverage, by achieving coverage of parts of the health sector not yet covered.