HEALTH AND AMBULANCE SERVICES COMMITTEE

Members present:

Ms L Linard MP (Chair)
Ms RM Bates MP
Mr SL Dickson MP
Mr AD Harper MP
Mr JP Kelly MP
Dr CAC Rowan MP

Staff present:

Ms D Jeffrey (Research Director)
Ms E Booth (Principal Research Officer)

PUBLIC BRIEFING—INQUIRY INTO THE HOSPITAL AND HEALTH BOARDS (SAFE NURSE-TO-PATIENT AND MIDWIFE-TO-PATIENT RATIOS) AMENDMENT BILL 2015

TRANSCRIPT OF PROCEEDINGS

WEDNESDAY, 17 FEBRUARY 2016

Brisbane

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Committee met at 9.16 am

FLEMING, Dr Lesley OAM, Acting Chief Nursing and Midwifery Officer, Clinical Excellence Division, Department of Health

HARMER, Mr David, Director, Legislative Policy Unit, Strategic Policy and Legislation Branch, Strategy, Policy and Planning Division, Department of Health

WAKEFIELD, Dr John, Deputy Director-General, Clinical Excellence Division, Department of Health

CHAIR: Good morning, ladies and gentlemen. Before we start, I request that mobile phones be turned off or switched to silent mode. I now declare this public departmental briefing of the Health and Ambulance Services Committee's inquiry into the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015 open. I would like to acknowledge the traditional owners of the land on which we meet and pay my respect to elders past and present.

I am Leanne Linard, the chair of the committee and member for Nudgee. The other members of the committee are: Ms Ros Bates, deputy chair and member for Mudgeeraba; Mr Steve Dickson, member for Buderim; Mr Aaron Harper, member for Thuringowa; Mr Joe Kelly; member for Greenslopes; and Dr Christian Rowan, member for Moggill.

Thank you for your attendance here today. The committee appreciates your assistance. The purpose of this briefing is to receive information from the department about the bill which was referred to the committee on 2 December 2015.

The committee is a statutory committee of the Queensland parliament and as such represents the parliament. It is an all-party committee which takes a nonpartisan approach to inquiries. This briefing is a formal proceeding of the parliament and is subject to the Legislative Assembly's standing rules and orders. You have previously been provided with a copy of the instructions for witnesses, so we will take those as read. Hansard will record the proceedings and you will be provided with the transcript. This briefing will also be broadcast.

I remind all those in attendance at the briefing today that these proceedings are similar to parliament to the extent that the public cannot participate in the proceedings. In this regard I remind members of the public that under the standing orders the public may be admitted to or excluded from the hearing at the discretion of the committee.

I remind committee members that officers are here to provide factual or technical information. They are not here to give opinions about the merits or otherwise of the policy behind the bill or alternative approaches. Any questions about the government or opposition policy that the bill seeks to implement should be directed to the responsible minister or shadow minister or left to debate on the floor of the House. I now invite officers from the Department of Health to make an opening statement.

Dr Wakefield: Madam Chair and members of the committee, thank you for the opportunity to brief you regarding the Hospital and Health Boards (Safe Nurse-to-Patient and Midwife-to-Patient Ratios) Amendment Bill 2015. As you have noted, this bill implements the government's 2015 election commitment to legislate workload provisions and nurse-to-patient ratios with the goal of ensuring patient safety and quality health care.

Minimum staffing ratios have been established in other jurisdictions across the world in response to growing concerns amongst nurses about their ability to continue to provide high-quality care in an environment where patients in hospitals are sicker and older and have more complex care needs than ever before. Nurses want to work in an environment where they are able to provide high-quality care for patients.

The research shows that patients are worse off when there are lower numbers of nursing staff. International research over the last two decades has demonstrated that when there are more nurses available to care for patients there is a positive impact on patient outcomes, as well as nurses' job satisfaction, retention and overall system performance. This pattern has been consistent across many developed countries where this research has been undertaken, including the United States and the United Kingdom.

There is also evidence from Australia of the problems associated with lower numbers of nursing staff and relevant patient outcomes. A study conducted by Dr Diane Twigg published last year showed that over a four-year period in three teaching hospitals in Western Australia there were higher rates of adverse events—that is, patient harm—including respiratory failure rate; sepsis, which is infection; and pressure injuries when there were fewer nurses caring for patients.

Studies to date have analysed very large data sets as well, including thousands of patients across hundreds of hospitals using quite sophisticated analytical techniques. These results do show a statistically significant relationship between more nurses, improved safety outcomes and better job satisfaction for nurses. The quality of this research I think is evident from the many studies that have been published in leading medical journals—for example, the *Lancet*, the *British Medical Journal* and the *Journal of the American Medical Association*, or JAMA as it is commonly known. In fact, a study on nursing ratios by Dr Linda Aiken and her colleagues published in the *Lancet* in 2014 won the global project of the year award from the Consortium of Universities for Global Health as a measure of its impact. Another study by Linda Aiken and her colleagues published in JAMA in 2002 won the article of the year from this leading health services research organisation in the USA.

Nursing workforce modelling shows a projected shortfall of nurses by 2023 across the health sector in Queensland. It is really important that we sustain our largest clinical workforce, which is the backbone of the health system and particularly at the front line enables us to meet the growing needs of our patients. This proposed bill seeks to facilitate this. The introduction of minimum nurse-patient staffing ratios is intended to ensure nurses are able to provide the quality of care that patients deserve and want, whilst also improving nursing job satisfaction and retention.

It will be important to assess the impact of the introduction of ratios across Queensland, and we very much recognise this. To this end, the department is working to finalise arrangements to allow world-class research to be conducted into the implementation and impact of nurse ratios in Queensland. This research will actually ensure that the department has independent findings evaluating this policy and that will allow us to determine the effect of this new legislation on the patients that we serve, on the nurses that deliver care and on the system level outcomes.

The bill proposes a legislative framework comprised of workload provisions, minimum nurse-to-patient ratios and reporting requirements. Queensland's hospital and health services will be required to comply with workload provisions to ensure prescribed wards are staffed with the appropriate skill mix and number of staff to meet service demands. To achieve this, the bill enables the chief executive of the Department of Health to make a nursing and midwifery workload management standard.

The management standard, developed based on the existing business planning framework, or BPF, will guide the hospital and health services when, for example, calculating the nursing and midwifery staffing requirements, developing and implementing strategies to manage staff supply and demand, and evaluating nursing and midwifery staff performance. This sophisticated planning required by the standard will allow hospital and health services to determine optimum staffing to meet service demand for each prescribed hospital ward.

The proposed nurse-patient ratios will actually underpin this planning by setting mandatory minimum staffing levels or a floor, if you like. Requirements relating to minimum nurse-patient ratios will be prescribed by regulation to allow their phased implementation. The government has endorsed minimum ratios of one nurse or midwife to every four patients for morning and afternoon shifts and one nurse or midwife to every seven patients for a night shift. Ratios will initially be implemented in the acute medical wards in 28 hospitals, acute surgical wards in 24 hospitals and acute mental health wards in two hospitals.

The bill enables the Minister for Health to temporarily exempt a hospital and health service from ratio requirements. A temporary exemption maybe granted for up to three months with an option to extend this exemption for up to a further three months. The minister may also place conditions on this exemption. The power to grant exemptions gives government the flexibility to respond quickly to extenuating circumstances that temporarily impact on an HHS's ability to comply with the legislation—for example, where an HHS is experiencing some difficulty recruiting sufficient nursing staff.

Finally, the bill enables the chief executive of the Department of Health to require those HHSs to provide information relating to their nursing and midwifery workload management. It also enables the chief executive to publish that information. So under this provision the chief executive will be able to request this information regarding compliance with ratios and the standard in respect of those facilities and wards to which those ratios apply and also their compliance with the BPF, or business planning framework, in respect of other facilities and wards.

The legislation was subject to broad consultation during its development, with almost 50 key stakeholder groups. Exposure drafts of the bill, the regulation and management standard were provided to, as I said, many stakeholders including the hospital and health services, nursing and midwifery professional colleges, Queensland University schools of nursing and midwifery, the Queensland Nurses' Union, the Australian Workers' Union and Together union, the Australian Medical Association Queensland and private sector organisations.

On behalf of my colleagues, I thank you for the opportunity to provide these opening remarks. We would be delighted to take any questions from the committee on this bill.

CHAIR: Dr Wakefield, thank you very much for your opening comments and overview of the bill. You mentioned that ratios have been mandated in other jurisdictions domestically and internationally. For the benefit of the committee, could you outline how the ratios used in some of those jurisdictions compare to the ones proposed here and how they were chosen as the right ones?

Dr Wakefield: In terms of the jurisdictions that have implemented nurse-patient ratios in Australia, Victoria has been the lead. I think they have had NPRs since the early 2000s, with legislation introduced last year. California in the United States has also mandated nurse-patient ratios, again since the early 2000s. I understand that in the last two or three years 13 of the state jurisdictions in the US have also introduced or are in the process of introducing nurse-patient ratios.

There are similarities and differences between those, particularly in the context of, for example, the specific ratios that are used in terms of the specific shifts, but there is also a lot of similarity—for example, one to seven or one to eight as a ratio for the night shift. The breadth of application across different wards and services can differ. In terms of the specific technical aspects of that question, I would like to see whether my colleague Lesley Fleming has any additional comment on that.

Dr Fleming: Thank you, John. I really do not have any additions, other than to say that the ratios staffing is based on the research that consistently demonstrates a significant difference in association between ratios and increased nursing numbers with patient outcomes, with reduced mortality and reduced failure to rescue. There are other significant outcomes that are associated with increased nursing, but they are the major ones that really constantly over the last decade or two have demonstrated that an increase in nursing hours will give you improvement with your patient's mortality and failure to rescue.

Dr Wakefield: We would be quite happy to provide information to the committee on some of the details of the other jurisdictions if you so wish.

CHAIR: Thank you. We are proposing to talk to Victoria, but it would be interesting if you could. Information from particularly some of those overseas jurisdictions would be very interesting. You gave a statistic, I think it was 2025, about potential projected shortages. Has Queensland Health done some modelling about the overall impact of mandated ratios on the staff required in the short, medium and long term?

Dr Fleming: The workforce data modelling related to the introduction of ratios was commenced in the early part of 2015. Data modelling, as you know, is not a perfect science and is based on a number of assumptions. At that time there was an identification that around 250 nurses would be required to implement ratios within Queensland. Since that time consultation has occurred and there has been some clarification that ratios will apply to acute medical and surgical wards. As part of the ongoing work that we need to do, further data modelling is being undertaken in consultation and collaboration with all of our colleagues within the HHS. We are refining the data modelling. We will have a clear picture of the number of nursing staff required to implement it by 31 March.

CHAIR: You mentioned an additional 250. Say we just use that number. Obviously there is an expectation that this would result in additional.

Dr Fleming: Yes. The preliminary data modelling identified 250. As I said, in the refinement that occurs with data modelling we have made sure the assumptions are that ratios apply to the acute medical and surgical. Certainly there is a deduction made from the preliminary data modelling that there will be a need for an increase in staffing levels, yes.

CHAIR: In terms of a time horizon, when would the 250 be required by?

Dr Fleming: They will be required when the bill becomes an act and starts on 1 July.

Ms BATES: Dr Fleming, I have a number of questions on the data modelling. You said initially that 250 nurses would be needed to implement the ratio but that you are going to have to do further data modelling. So the truth is that you do not yet actually know how many new nurses you need.

Dr Fleming: Nurse staffing levels are a very complex issue, as you would know and as everyone knows. There are a variety of variables that need to be considered. It is very hard at any point in time to say that for a hospital, a facility, you will need this number of nurses on this day. In terms of saying, 'Do we have a final number that will absolutely say that every scenario will be covered?,' I take your point. It is a complex issue that we do need to refine and understand in the data modelling to give you a range of options and scenarios. It will be unlikely in any data modelling scenario that we come up and say, 'The answer is X.' It will depend a lot the scenarios: the occupancy of hospitals, the acuity of hospitals, those sorts of things.

Ms BATES: So we do not have a cost of implementation of this policy?

Dr Fleming: I think the preliminary data modelling identified 250 nurses so that gave, I think, the costing of around $25.9 million. As I said, once we do further data modelling or refinement of the data modelling that costing will also be refined.

Ms BATES: This one you might have to actually take on notice. My understanding is that the modelling was based on average length of patient stay, post-operative mortality rates, hospital acquired inflection rates and hospital readmission rates within 28 days of surgical and medical wards. Would you be able to take that on notice and get back to us about whether that was used in the modelling for determining the numbers of nursing staff that would be required.

Dr Fleming: I believe that we could answer that they were not the assumptions used in the data modelling.

Ms BATES: What were the assumptions?

Dr Fleming: The assumptions were based on the wards that were identified as acute medical and surgical wards. They were based on the legislation that identifies which wards would be included; they were based on occupancy of the acute hospital surgery and medical wards.

Ms BATES: Dr Wakefield, you mentioned in your submission to us today that there was broad consultation for an exposure draft and that many stakeholders were consulted. I think I have asked in the past, and I notice in a submission that you made earlier as well, but I would like to see where the draft is, what it was based on, what the submissions were. You alluded briefly to nursing unit managers and HHS boards et cetera. I would like to know what the NUMs positions were on that. I have been a NUM in the past and I, like most NUMs, like to determine our staffing numbers on patient acuity and on the skill mix of your staff. I would really like to know what the on-the-ground nurses thought about nurse-patient ratios. I can give you an example. In the respiratory unit at Gold Coast University Hospital on night duty, if it is a one-to-seven nurse-patient ratio, how do you then factor in that, on average, routinely they have to have four nurses specialling four patients just in that one ward on night duty.

Dr Wakefield: As I understand, what you are asking for is who was consulted and what was their—

Ms BATES: I know you have given us a list. The QNU, obviously, and the Together union and the College of Nursing et cetera, but what did the people on the ground actually put in their submissions to the exposure draft? I do note that during estimates the shadow minister asked Mr Walsh, the DG, about who was consulted, how were they consulted and where all the working documents were. I do not want to misquote *Hansard*, but—I am pretty sure this is an accurate representation—the DG said that the Office of the Chief Nursing and Midwifery Officer undertakes a range of policy development issues, including nursing staff-patient ratios, and in undertaking that policy they would be ensuring they were documenting consultation with all stakeholders in order to formulate the policy. My question is: where is it?

Dr Wakefield: In respect of what I see as two questions here—one is about the consultation and the feedback and the documentation there—I have certainly been privy and advised about that consultation and have read a document which summarises all the feedback and the consequences of that feedback in terms of changes. I will seek advice from my colleague about the status of that document.

The second question I hear you asking is concern from NUMs—nurse unit managers, that is—about how the ratio impacts on the need for greater nursing provision of care when the acuity of patients is high. By way of seeking to advise you about the intent of this policy, it really covers two components. One is the nurse-patient ratio which is a base, a floor, a minimum below which the

prescribed services cannot go, but as part of the legislation there is enshrined in there the notion of the standard which actually allows for the BPF—the business planning framework—to prescribe the specific skill mix of nurses based on the acuity of patients. In other words, the ratios are actually a floor and, in fact, the legislation requires the health services to make sure they manage the needs of nursing in any particular ward based on the acuity, which may see those ratios being much higher, or lower depending on which you way interpret it—many more nurses to include, for example, a nursing special, which are such that the actual number of nurses on that ward at that particular time is much higher. I think that concern from nurse unit managers is about the ratio required, the actual number of nurses that would be on the ward. The short answer is no; that is the minimum.

Ms BATES: So NUMs have the flexibility to put on more staff if they need to? What if they do not need more staff? What if the ward is quiet and you do not need to have one nurse for every four patients if the acuity of the patients is such that they are ambulatory and six days post-operative and you do not need to have that many staff?

Dr Fleming: I do think I understand the question, and you raise the very significant point of acuity. I would say that I think it is because of the standard that has the workload management within it that makes the NUMs and the nurses 'on floor', as we say, much more confident about ensuring they do have the right number. I refer to your point about 'If the acuity is not there, what then will occur?' To be honest, as John is saying, there will be a one to four, so if you have 24 patients you will have six nurses. That will stand. It is the higher acuity that certainly will be addressed by BPF or the workload management standard.

Ms BATES: I still think NUMs need to have the ability to not put staff on. I come from the private sector. There is no way I would be having that many nurses if I did not require it. Is this policy eventually going to cover the private sector as well? Is that anticipated in the future?

Mr KELLY: Chair, I think that is a question for the minister.

Ms BATES: Was there any work done, then, to look at the impact on the private sector? You have actually had submissions from the Private Hospitals Association of Queensland and Anglicare, Mater and Uniting Health, Pindarra et cetera. They must have had a view about whether it would roll out into their sector as well.

CHAIR: That is outside the terms of the bill before the committee. You do not have to answer it.

Ms BATES: Did they have concerns I guess is my question, without asking you to make a policy direction on behalf of the minister, which you cannot?

Dr Fleming: I think we can answer that due to the fact of the work and the policy and the bill, that certainly no data modelling—as you would know, Madam Deputy Chair, we would not have access to that private information like we would within the public healthcare system, so no data modelling was done on that.

Dr Wakefield: Going back to the original question about who was consulted and what was the feedback from that consultation, which would include the private organisations, could I take that question on notice? In terms of provision of a document, I would need to seek the director-general's approval to release such a document. Could I do that?

CHAIR: Thank you, Dr Wakefield. I was going to suggest that you might take that on notice.

Mr KELLY: Thank you all, particularly Dr Fleming. Thank you for your leadership of our profession for many years and particularly for your work when I was in your team at the royal Brisbane hospital and for the opportunities I received to build my skills in the area of understanding research, which would not have been possible without your leadership.

I have a number of questions, and I will probably touch on some of the things the member for Mudgeeraba is raising as well. I am interested in the ratios, how they impact on nursing models of care and whether they will allow, in your opinion, the capacity for management teams in various areas to adopt various models of care—primary care, team nursing, case management approaches. What are your thoughts on that?

Dr Fleming: Thank you very much, Mr Kelly. You would know as well as I do that within Queensland we have had the absolute benefit of a business planning framework. Part of that business planning framework over the last decade—in fact, over the last 15 years—is about developing a service profile. Part of the service profile is very much where you identify what models of care you need to put in place to meet the needs of the group of patients who are in the area, or in the ward on this occasion. There is no thought and I have no evidence—quite the reverse—that ratios would in any way impede that ability to set up models of care that were best suited to patient needs.

Mr KELLY: The member for Mudgeeraba is asking a lot of questions about what nurses on the ground think. I guess I am the one sitting on the panel who has most recently been a nurse on the ground, in both public and private sector settings. I have not worked in a public hospital for just on 12 months now. I am assuming things have not changed, but the last time I was in a medical ward, which was just over 12 months ago, the acuity in medical wards was very high. The focus on patients who became medically stable was very much on discharging them either to a subacute unit or into the community with appropriate supports. Has that changed in the last 12 months?

Dr Fleming: I do not believe it has. I think we are aware that certainly in Queensland, and, as we know, with all of the international literature in the developed economies, we are seeing the changing nature of health. As John identified, we are seeing patients come in who have high acuity. We have ageing populations. The acuity is not diminishing. As we know, there is a correlation, certainly, within nursing that we should have between the acuity level of patients, because their needs are different, and the nursing numbers. It has not changed. There certainly is some evidence within the international research that the ratios or higher levels of nurses will, in fact, have association with a reduced length of stay because of the intensity of their needs being able to be met when required.

Mr KELLY: I will get to the research in a minute.

Dr Fleming: Okay.

Mr KELLY: With the concept of the ward being quiet—

Dr Fleming: I see what you are saying.

Mr KELLY:—the reality is that if you have 24 patients you are going to be busy and you are going to need your six nurses. We do not keep patients in hospital who do not need to be there. I will state publicly that I am married to a private sector NUM and I have worked in private hospitals quite recently. My understanding is that the funding arrangements for public and private hospitals are very different. Private hospitals get funded quite differently to public hospitals, do they not? To put it crudely, public hospitals get funded to get people back into the community; private hospitals, to put it crudely, are about bums in beds. What are your thoughts on that?

Dr Fleming: As you know, my experience previously was at Metro North. I take your point, Mr Kelly. In that large health service—and I believe it would be the case in many if not all of the health services—the acuity of patients is increasing and, therefore, there are not slow days where we do not have patient needs that are quite extensive. I think public, as we know, is where we have our emergency departments that take the high-acuity patients from accidents. A whole range of people who have high-acuity needs come through our emergency departments. Those are the cohort of patients that we admit and they are, indeed, needy patients who need the high-intensity nursing that the public healthcare system can provide.

Mr KELLY: I am absolutely staggered at the amount of research that has been done on these questions, in terms of both the costs and the benefits. There is an overall summary, which is quite good, that looks at basically a systematic review that says that the evidence is incredibly strong. Other studies put real figures on decreased nursing ratios—real figures on things such as hospital acquired infections, increases in pressure areas, increases in patient falls, increases in people missing delirium episodes, increases in people missing deteriorating patients. I was really pleased to see that you gave us a figure for the cost of this program. In fact, I have never seen the member for Buderim or the member for Moggill pick up their pens so quickly to write down a number. I want to ask you about the benefits of this program. What does it cost the system, roughly, for one single pressure area to develop and be missed by a nurse? Can you put a figure on that?

Dr Wakefield: I can put a figure on that. Obviously there are different grades of pressure injury, but health economics research was done that suggested that the increase in the average length of stay is about three to four days for a patient who gets a pressure injury. Obviously you can compute that into the cost of a bed per day. Even leaving aside the patient distress, family distress and the pain of having a pressure injury, the additional cost on the system is three to four days of staff to bed.

Mr KELLY: Having an understanding of health economics, we should never rule out the costs to the family. They are not costs in a dollar sense but they are costs nonetheless.

Dr Fleming: Yes, emotional.

Mr KELLY: The research is quite clear: there are significant benefits in terms of reducing all of those instances that I have just outlined; is that correct?

Dr Fleming: That is correct.

Mr DICKSON: I welcome you all here this morning. I am interested in dollars and I am interested in patient care and health, as we all are in Queensland. I think we all realise that the budget for Queensland Health is greater than 25 per cent of the Queensland budget, which is a huge amount of money. We do want people looked after in the best possible way. What is the natural growth per annum over the past five years—and you can come back to the committee with this answer if you do not mind—in nurses in these particular fields? Will it outweigh the extra 250 nurses that you are looking to procure and bring into the industry? Possibly they may be needed; I do not know. We will hear that information, I imagine, when you come back to us. Can you give any numbers off the top of your head as to natural growth at the moment?

Dr Fleming: The simple answer is no, but we have access to that. Growth in our graduates, growth in the different levels: we would be able to give that information to you. We could give you an overall percentage of the growth in nursing numbers, if that is what you are seeking. I do not have that.

Mr DICKSON: If you could refine it into the areas we are looking to implement these 250 nurses, I think that would be a good criteria, just over the past five years. That would give us a very true picture of where we need to go.

Dr Fleming: Yes.

Mr DICKSON: I make the point very clearly that, yes, we want to see the health system as good as we can humanly get it, but somebody has to pay for it and that is the Queensland taxpayer. Thank you so much for coming along today. I could ask you numerous questions and drill into a lot of detail, but I am happy to look at the bill and I am happy to see the answers that you can give us when you bring back those numbers.

Dr Wakefield: Madam Chair, I would like to take that on notice in terms of providing some specific detail about the areas that you are talking about, the prescribed areas. There are some general statistics that I think bear this out. There are two particular ways of looking at it. There is a growth in demand for services through population growth and so on. The impact, whether it is in nursing or medicine or any one of our clinical professions, is that that responds to growth in demand for services. That is traditionally between three and five per cent a year in terms of growth of activity in the hospital system. I will clarify the exact figure for Queensland. That has an impact on more nurses and more doctors every year.

On top of that, I suppose, this legislation is providing that ceiling. For whatever the activity, there will be a floor for the nursing staff. That is the bit that, as I have said, we estimate at this point in time equates to 250 nurses FTE and a cost of $25.9 million. Obviously that changes at every point in time when you measure it, because in the past 12 months we have had the three or four per cent growth in activity. It requires both measures to be meaningful. That is what we will come back with, because 250 nurses might equate to 270 nurses in a year's time, if that makes sense, because the activity has grown.

Mr DICKSON: Dr Wakefield, basically I am looking for a GAF chart—and you can put both of those principles in place, if you like—over the past five years with the numbers that are actually in natural growth for those areas, and also the projected figures with this 250 nurses built into it. It is pretty simple. It is like any business principle: that GAF chart will give us those numbers very openly and clearly. I am not looking for anything that we should not be looking for. It is very straightforward: numbers on the seats in those wards. It is a pretty clear question.

Dr Wakefield: Yes, Mr Dickson. That will be fine.

Mr HARPER: As we have heard, the non-government members have some issues around the cost of implementation of this nurse-patient ratio safety bill. Let us be really clear: this is about patient safety. This is about managing adverse effects. In terms of those adverse effects, if you look back at the past three or four years and, with your modelling, look forward with the extra nurses, would you anticipate there would be a reduction in those adverse effects? I do not like to use the term 'adverse effects', because that means a patient suffers, whether it is respiratory failure on a ward or similar.

With the modelling that you have done—and there is a whole heap of complex things that you have looked at in terms of population, ageing population, population growth rates et cetera—you will have an idea now of your fixed beds on wards and how many people you can put in the acute settings of medical, surgical and mental health, that is, the ones that you mentioned. You have the modelling quite close in terms of what historically, retrospectively, has come through in the last few years and where we are going. Would you agree it is reasonably close to accurate with that figure of 250? Could you provide the number of adverse effects you have seen in the past three to four years? Can you

even equate that—I know it is a bit complex—to the nursing numbers that are on the wards? At the end of the day, I think the bill certainly has merit in terms of making the patient journey as safe as possible. I ask you to elaborate on that.

Dr Wakefield: I will start answering that and then ask my nursing colleague to answer the rest of it. There are many studies, all of them with findings that we have drawn on for this. Modelling out, if you like, the return on investment or the health economic benefit in terms of patient harm, for example, is something that could be done. I am not aware that we have done that, but I will check with Lesley. We know the evidence that is there. This policy clearly needs to deliver a benefit and, recognising that, we have sought to undertake that high-level research so that we actually can identify exactly in the Queensland context what benefits are delivered as a result of this policy. We will be able to report out with rigorous research on what those impacts are, including in terms of the benefits that accrue by reduction of patient safety events for example, and the economics that go behind that as part of this policy. In terms of the specifics of whether we have used any of that previous research to model the potential impact of this legislation, Lesley, can you comment on that?

Dr Fleming: I believe John is correct. Your question absolutely pointed to the right direction of why we are doing the research: to in fact get some comparison. It is also going to be a comparison study between a state that does not have ratios and Queensland. We will look at that and it will relate to the outcomes. With regard to the retrospective calculations or modelling that you have mentioned, that work has not been done. We may be able to get some ideas from the research to do some retrospective, but the research will demonstrate the patient outcomes.

Mr HARPER: Thank you very much for that. Would it be fair to say that some investment upstream economically may mean there will be some savings downstream in terms of managing those adverse effects? In my mind that is the way I see it: it is a good investment in getting the balance right. I will just ask one other question. I note that maternity wards are not included. Is there a reason for that and is there a plan going forward in terms of the nurse-patient ratio?

Dr Wakefield: I think this demonstrates the outcome of the consultation process and goes to, I think, Mr Kelly's question and comment. That is, as a consequence of the feedback about the different models of care used in maternity there was a decision made that at this point in time it would not be sensible to apply the ratios to maternity because it would potentially impact adversely on some of those more innovative and community based models. Lesley, is that correct?

Dr Fleming: I believe that is correct. As Mr Kelly was talking about, the Holy Grail that we all seek is to get the best model of care for the best patient outcomes, and maternity and midwifery have certainly been strong advocates for different models that give better outcomes. At this stage, once we have gained further information, should there be some areas that need to be included, the legislation will allow for that.

Mr HARPER: I just make the comment that after 25 years in Ambulance I have a lot of friends in the nursing profession, and they are telling me that this is the right course to chart. They are saying that getting our patient-nurse ratios right is the way forward, so well done and thank you very much for your comments.

Dr ROWAN: Thank you to the Department of Health today for your submission and also to you, Dr Wakefield, for all of the great work that you have done in patient safety over many years as a former executive director of the Patient Safety Centre.

Dr Wakefield: Thank you.

Dr ROWAN: I want to come to you first, Dr Fleming, in relation to whether nurse-to-patient ratios should be mandated for the private sector.

Dr Fleming: My opinion about that is that—

CHAIR: Sorry, but you do not have to give an opinion. It is outside the terms of the committee.

Dr Fleming: I am sorry, Dr Rowan, but I think the minister will have to answer that one.

Dr ROWAN: Sure. Dr Fleming, just in relation to the 250 nurses, I think the figure was $25.9 million. Has there been any work done on the projected costs of management of this additional workforce by the Department of Health?

Dr Fleming: Just a clarification: the extra 250 nurses or—

Dr ROWAN: I think the figure was 250 nurses and approximately $25.9 million. Whether it is those 250 nurses or beyond—we do not really know exactly what the figure is—has the department done some modelling around an increase in management costs of actually managing that additional workforce?

Dr Fleming: That specific question has not been answered, no. As you would know, our hospitals—and that is what we are talking about, because it is the acute surgical and medical wards—currently have a nursing structure that would allow the management of further nursing staff, so I do not think we require a new management structure for the extra 250. It would be that the 250 are spread throughout the state and then it would be if they can be absorbed within the current nursing management structure. I do not know that there would be further management other than that.

Dr ROWAN: Okay, so no additional management costs. Dr Wakefield, are some new data measurement mechanisms going to be implemented in order to measure a change in clinical outcomes or reduction in adverse incidents? Following on from that, who will monitor this and will it be publicly reported?

Dr Wakefield: Thank you, Dr Rowan, for your question. My understanding, obviously having been in this role for a few weeks and getting to grips with this policy and the underpinning assumptions—and it is similar to the member for Thuringowa's question—is that there is modelling that could be done which has not yet been done based on what we would expect to see in terms of a reduction of, for example, the mortality and infection rates and the pressure injuries and so on that have been found in the studies that we have looked at.

What will be done is a reasonably significant investment in independent research. That will explore those questions prospectively, so it is not based on modelled outcomes from someone else's research. You can actually say, 'As a consequence of this policy'—for example, in a year's time or two years time or as the research occurs from baseline—'there has or has not been a reduction in, for example, pressure injuries and the other types of very much nurse-sensitive patient safety outcomes where we know there is a level of harm or a level of burden now.' We will be able to provide that information and it will be published at a system level. The research will identify that and it will be published in peer reviewed literature and we will be able to say with confidence whether and what the impact has been. There will always be questions about attribution and whether this change has led to that consequence. There are always methodological questions, but the short answer is yes.

Dr ROWAN: Specifically who will be doing that and how will it be independently validated before it is put in the public domain?

Dr Wakefield: The Department of Health have tendered internationally for researchers with a track record in undertaking this type of research so that we can be sure that we are getting the best possible researchers. In terms of the status of that at this point in time, Lesley, is that something that has been finalised?

Dr Fleming: I think it is about to be finalised. I think the finalisation of that is very close. I have not received information back that it has been signed off, but it is only a week or so away I think.

Dr Wakefield: Because there is a procurement process to this and I would not like to breach my obligations, could we seek to take that on notice and if that contract has been signed and can be made available to the committee then we would do so?

Dr ROWAN: I have one final quick question. With regard to the Department of Health in terms of the extra 250 nurses, can you guarantee they will be paid on time?

CHAIR: Thank you. That comment is out of order.

Ms BATES: Dr Wakefield, this policy—this bill—is a seven-page document and at this stage we do not know how many nurses we are going to need and we do not really know how much it is going to cost us. I think there is one glaring example that is missing out of this, and you might be able to let me know because it is not in the minister's speech and it is certainly not in this document. Again, for an exposure draft of a cast of thousands it is a pretty slim bill to be presenting without knowing exactly how much it is going to cost the Queensland taxpayers. What seems to be missing is the 1,400 assistants in nursing who are not covered under this. Does that mean they are no longer going to be necessary and they will not be employed, because that is 1,400 staff who are currently included in the nursing workforce who are not even looked at in this bill? What is going to happen to them?

Dr Wakefield: I will deal with that in two components. The first one is about the cost and the impact. I would like to reiterate that, based on the modelling work that has been done, we estimate, with some assumptions, that the cost will be $25.9 million recurrent and it will pertain to a modelled gap of 250 FTE nurses, so I think it is not true to say that we do not know how much it is going to cost. The actual cost and the actual impact are subject obviously to particularly the regulation and the inclusion or exclusion of certain facilities, wards and so on. In terms of that modelling, as Lesley just said, by the end of March we will have a further refined model of cost and FTEs, so I think we do know the impact. The impact will be dependent upon some of the detail in the regulation.

Ms BATES: This is based on the hospitals that you have identified like Atherton, Bundaberg, Caboolture et cetera.

Dr Wakefield: Correct.

Ms BATES: If you have to expand that, then it is going to cost more.

Dr Wakefield: That is correct. It is the regulation that prescribes it and, depending on how that lands, that is going to make the difference. You asked us specific questions about assistants in nursing, and it is true to say that the assistants in nursing are not included in the calculation of the ratios in the bill. You have also asked what will happen to those assistants in nursing as a consequence of this bill. Again, I defer to Dr Fleming as the nursing expert to comment on that.

Dr Fleming: Yes, they are not included in the ratios calculation. There is research that would suggest that the skill mix also has some impact on patient outcomes. I think, however, we are all well aware of the very vital role that AINs can play within our healthcare system and it is not my understanding that these people will not be employed but they will not be counted in the ratios.

Ms BATES: So it was not an oversight or an omission, a deliberate omission?

Mr Harmer: It was not an oversight. As Dr Wakefield has explained, the nursing ratios set a minimum. The workforce planning actually occurs through the application of the standard. When the standard is applied and the skill mix is determined, it is likely that AINs would be employed through the application of that process rather than through the application of the ratios.

Mr KELLY: What is the ratio in intensive care for ventilated patients?

Dr Fleming: One to one.

Mr KELLY: That has been the case for a very long time?

Dr Fleming: It has.

Mr KELLY: What drives that ratio?

Dr Fleming: Certainly patient outcomes, but then I think the profession has had a very strong voice through their colleges of identifying and working with patient outcomes of the best staffing ratios they should have with intensive care patients, who have really high acuity, as you know.

Mr KELLY: It is based on research?

Dr Fleming: Yes, in our areas of intensive care. There has been some research that we have referred to, but we have not introduced that. That has been done in ICU but the ratios as we are talking about in this bill do not apply to ICU because they do have the one to one and they even have further infrastructure to support that one to one.

Mr KELLY: It is widely accepted across the profession. It is managed currently and has been for as long as I have been nursing—close to 30 years—and it saves lives. Thank you.

CHAIR: Thank you. The time for our hearing has now expired. You have taken four matters on notice, and I thank you for that. I ask you to provide your responses by Monday, 22 February and our secretariat will be in contact to confirm the questions asked and those time lines. On behalf of the committee, I thank you sincerely for coming along today for providing your expertise to this committee. I can certainly comment that my office is receiving much contact in support of these measures and I look forward to hearing much more as we hear further submissions in the future. Thank you.

Dr Wakefield: Thank you, Madam Chair, and thank you, committee members.

Committee adjourned at 10.16 am