Ratios

See updated STAFFING AND SKILL MIX PROTECTIONS on pages 3 & 5, as of 14 January 2024

RATIOS ROLLOUT: PHASE ONE

Safe Staffing Levels Taskforce Recommendations to implement ratios

JANUARY 2024

Safe Staffing Levels Taskforce timeline

After more than a decade of campaigning, the NSW Nurses and Midwives' Association (NSWNMA) secured an election commitment to reform the public health system workforce.

Following the 2023 state election, the Labor government agreed to implement a Safe Staffing Levels (SSL) policy to meet our Ratios Claim in five areas:

- Emergency Departments
- Intensive Care Units
- Maternity (a review of Birthrate Plus® and 1:3 in postnatal wards)
- Multi-purpose Services (MPSs), and
- the conversion of current Nursing Hour Per Patient Day wards and units to a shift by shift system

In April 2023, the SSL Taskforce was announced, consisting of NSWNMA and Ministry of Health (Ministry) representatives, with input from the NSW Minister for Health's office.

Since then, NSWNMA officials have participated in more than 20 taskforce meetings and a further 10 consultations with the Health Minister's office.

The Taskforce's role is ongoing, and its primary function is agree to, then monitor the phased implementation of SSL ratios across the public health system.

The NSWNMA is discussing variations to our 2023 Ratios Claim with public sector members and seeking endorsement by branches, prior to final agreement within the SSL Taskforce.

The following tables outline the recommendations of the Taskforce to implement the first phase of transparent, accountable and enforceable ratios in NSW.

Whilst there are variations to the 2023 Ratios Claim to consider, your NSWNMA Council agrees with these Taskforce recommendations and believes they deliver a strong foundation from which we will continue to build.

The NSWNMA Council is recommending public sector members vote 'Yes'.

SSL Taskforce process

The Ministry and the NSWNMA have each conceded ground throughout these robust discussions to achieve this outcome.

The NSWNMA Council has agreed it is time for public sector members to consider the SSL Taskforce recommendations to implement the first phase of ratios.

You are now asked to consider these recommendations and vote to adopt or reject them.

IF AGREED – these recommendations would be reflected in the *Public Health System Nurses' and Midwives' (State) Award* and the staffing enhancements would commence from March 2024.

IF REJECTED – we will need to commence significant campaigning in 2024 to convince the government further improvements are required. Nothing will be achieved with PHS members simply voting no.

The context of this consideration is:

- If we recommence further negotiations, the implementation of ratios will take even longer. We need workload relief now and the foundations of staffing reform to be embedded as soon as possible.
- Increased funding for more FTE, and ratios in other speciality areas, will be more likely if these reforms are proven to work, and importantly, the government will see a worthwhile ongoing investment.
- The related staffing enhancements in this first phase, should members accept the Taskforce recommendations, are significant and are able to deliver real change in many settings. The consideration is whether members agree this represents a strong foundation from which we can continue to build.

Staffing and skill mix protections

As confirmed on 14 January 2024, this clause will be inserted into the *Public Health System Nurses' and Midwives' (state) Award*, as part of the section outlining the Safe Staffing Levels:

> *If at the time of implementation of the staffing level outlined in this clause, there are wards/ units with staffing profile numbers higher than the specified staffing and skill mix, the existing staffing numbers and skill mix in those wards/units will either continue to apply or be subject to prior review and variation. A reduction in staffing profiles or numbers, or a reduction in skill mix, will not occur without a review that considers the clinical needs in the ward or unit taking place. If there is disagreement between the Employer and Association about the outcome of the review the provisions of clause 48, Disputes, will apply.*

This means that any current staffing profile number and/or skill mix in a ward/unit which is better than what the SSL recommendations call for will be maintained.

Under this clause on any ward or unit where SSL is implemented,

- Staffing numbers can't be reduced
- AINs can't be introduced into a staffing profile where they don't currently exist, and
- the percentage of RNs can't be reduced,

unless there is a review undertaken which considers clinical need. If the NSWNMA doesn't agree with the outcome of the review, the matter can be taken to a Dispute, including to the NSW Industrial Relations Commission if necessary.

Safe staffing ratios are a minimum, wards and units which have higher staffing numbers and/or better skill mix should keep them.

RECOMMENDATION FROM NSWNMA COUNCIL

The NSWNMA Council is recommending a Yes vote to public sector members, that we support the implementation of the SSL Taskforce recommendations to date.

Our fight for ratios has been about creating a better working life for members, and a better healthcare system for our communities. This fight has delivered almost $1billion additional recurrent funding, for an additional 2480 Registered Nurses/ Enrolled Nurses and midwives, and will see ratios firmly embedded into the PHS Award.

This will ensure the introduction of a shift by shift staffing system that is transparent, accountable, and enforceable for the first time in NSW, and will create a strong foundation as we campaign to have other specialties included.

The staffing increase in the state's public hospital emergency departments is modelled at an estimated 1,300 FTE.

Whilst the proposal to include Assistants in Nursing (AiNs) is a Ratios Claim variation, the manner of the introduction allows the number of AiNs per shift to be regulated, something that we have never had. This should prevent repeated shifts of poor skill mix being the status quo.

The Ministry has undertaken to work with us on reforming undergraduate AiN roles across the state, based on their course requirements, to ensure job-readiness is maximised.

Importantly, there is also agreement to work on increasing the EN workforce, the growing absence of which is driving the employment of AiNs.

This willingness to work with the NSWNMA on workforce design and pipelines is refreshing.

- A **YES** vote would see the Ministry commence roll out in the agreed areas from March 2024, commencing with Level 5 & 6 EDs.
- The areas where we are yet to agree will continue to be discussed within the SSL Taskforce meetings.

SSL Taskforce recommendations to date

Department	Proposed Implementation	Proposed skill mix variations	Our claim
Emergency Department			
Emergency Department (Level 5 & 6)	• 1:1 generally occupied Resus beds (all shifts) • 1:3 ED generally occupied treatment spaces (all shifts) • 1:3 ED SSU generally occupied beds (all shifts) • ED supernumerary in charge/clinical NUM – 24/7 • Triage – 34 hours per day. Eg. 1 AM, 2 PM, 1 ND (3x 8 hour shifts and 1x 10 hour shift)	ED Level 5 & 6: 85% RN, 15% EN. AiNs will not be counted in ratio numbers in levels 5 & 6 EDs	**AM:** 1:3 + supernumerary in charge + triage **PM:** 1:3 + supernumerary in charge + 2 triage **Night**: 1:3 + supernumerary in charge + triage Skill mix 90% RN, 10% EN – No AiNs in numbers
Emergency Department (Level 4)	• 1:1 generally occupied Resus beds (all shifts) • 1:3 ED generally occupied treatment spaces (all shifts) • 1:3 ED SSU generally occupied beds (all shifts) • ED supernumerary in charge/clinical NUM – 24/7 if greater than 50 average daily presentations (18,000 presentations per year). Averaging period still to be agreed • Triage – 24/7 if greater than 50 average daily presentations (18,000 presentations per year) • Triage – 34 hours per day. Eg. 1 AM, 2 PM, 1 ND (3x 8 hour shifts and 1x 10 hour shift), if greater than 110 average daily presentations (40,000 presentations per year)	ED Level 4: 85% RN, 15% EN/AINs With a maximum of one AiN per shift to be counted in the ratio numbers	
Emergency Department (Level 3)	• 1:1 generally occupied Resus beds (all shifts) • 1:3 ED generally occupied treatment spaces (all shifts) • 1:3 ED SSU generally occupied beds (all shifts) • ED supernumerary in charge/ clinical NUM – 24/7 if greater than 60 average daily presentations (22,000 presentations per year). • Triage – 24/7 if greater than 60 average daily presentations (22,000 presentations per year)	ED Level 3 & 4: 85% RN, 15% EN/AINs. With a maximum of one AiN per shift to be counted in the ratio numbers	**AM:** 1:3 + supernumerary in charge + triage **PM:** 1:3 + supernumerary in charge + triage **Night**: 1:3 + supernumerary in charge + triage Skill mix 90% RN, 10% EN – No AiNs in numbers

The following table outlines a guarantee that all patients requiring ICU and HDU care will be nursed by an RN, except in Level 4 ICUs where ENs **currently employed** will continue to be counted in the 1:1 or 1:2 ratio. AiNs will not count toward the safe staffing levels for ICUs. The **Staffing and skill mix protections** will also apply to all ICUs and HDUs, that is, existing superior staffing will be maintained.

Department	Proposed Implementation	Skill mix	Our claim
Intensive Care Services UPDATED as of 14 January 2024**			
Intensive Care Unit (Level 6) **Intensive Care Unit (Level 5)**	• 1 RN : 1 ICU patients occupying beds (all shifts) • 1 RN : 2 HDU patients occupying beds (all shifts) provided that the above ratio applies to those ICU patients required to be nursed as such (e.g. does not apply to 'ward ready' ICU patients). • Supernumerary in charge – 24/7 • Other ACCCN Standards at the discretion of the department • ACCESS role of 1:10-12 pod of beds (assumed average pod size) • Minimum unit size to require ACCESS role = 10 available/occupied beds • Rounding[1] for ACCESS role = 2 patients	**Note:** Currently, some ICUs employ a limited number of ENs, these positions should be replaced by RNs through natural attrition as the incumbents resign from the unit	In addition to the below ratios, the claim sought the application of the ACCCN Workforce Standards **AM:** 1:1 + supernumerary in charge + Access Nurse **PM:** 1:1 + supernumerary in charge + Access Nurse **Night:** 1:1 + supernumerary in charge + Access Nurse Access nurses at 1:4 to 1:8 AiNs are only to be used in addition to ratio numbers
Intensive Care Unit (Level 4)	• 1 RN* : 1 ICU patients occupying beds (all shifts) • 1 RN* : 2 HDU patients occupying beds (all shifts) provided that the above ratio applies to those ICU patients required to be nursed as such (e.g. does not apply to ward ready patients in ICU). • Other ACCCN Standards at the discretion of the department • Supernumerary in charge – 16 hours per day • Additional 10 hours of supernumerary in charge, if the unit is at least 10 beds • ACCESS role not applicable		
High Dependency Units	• 1 RN* : 2 HDU patients occupying beds (all shifts) • Supernumerary in charge – 16 hours per day • Minimum unit size to require additional supernumerary in charge role = 10 available/occupied beds		**AM:** 1:2 + supernumerary in charge **PM:** 1:2 + supernumerary in charge **Night:** 1:2 + supernumerary in charge AiNs are only to be used in addition to ratio numbers
Coronary Care Units	• 1:3 – CCU Patients occupying beds (all shifts) • Supernumerary in charge 16 hours per day • Minimum unit size to require third supernumerary in charge role = 10 available/occupied beds		
Close Observation Unit	• 1:2 – COU patients occupying beds (all shifts) • Supernumerary in charge – 16 hours per day • Minimum unit size to require additional supernumerary in charge role = 10 available/occupied beds		

* Provided that ENs who are engaged in Level 4 ICUs or HDU at the time of transition to safe staffing levels will be counted in the 1:1 or 1:2 ratio

1 See further background information on Rounding

<table>
<tr><th>Department</th><th>Proposed Implementation</th><th>Skill mix</th><th>Our claim</th></tr>
<tr><th colspan="4">NHPPD wards and MAU</th></tr>
<tr><td>Medical/Surgical Assessment Units (MAU & SAU)</td><td>• 1:4 AM
• 1:4 PM
• 1:7 ND
• Supernumerary in charge – 24/7</td><td rowspan="6">Peer Group A, B and C1 NHPPD and MAU – 80% RN, 20% EN & AiNs

Rehabilitation wards (sub-acute) – 70% RN, 30% EN & AiN

Proposes maximum of 1 AiN per shift in Peer Group A, B and C1 NHPPD wards</td><td>AM: 1:3 + supernumerary in charge

PM: 1:3 + supernumerary in charge

Night: 1:4</td></tr>
<tr><td>NHPPD – General Inpatient – Peer Group A</td><td>• 1:4 AM based on occupied beds
• 1:4 PM based on occupied beds
• 1:7 ND based on occupied beds
• Supernumerary in charge – 16 hours per day</td><td rowspan="3">AM: 1:4 + supernumerary in charge

PM: 1:4 + supernumerary in charge

Night: 1:7

85% RNs

AINs are only to be used in addition to the ratios numbers</td></tr>
<tr><td>NHPPD – General Inpatient – Peer Group B</td><td>• 1:4 AM based on occupied beds
• 1:4 PM based on occupied beds
• 1:7 ND based on occupied beds
• Supernumerary in charge – 8 hours per day (wards with 23 or less patients)
• Supernumerary in charge – 16 hours per day (wards with 24 or more patients)</td></tr>
<tr><td>NHPPD – General Inpatient – Peer Group C1</td><td>• 1:4 AM based on occupied beds
• 1:4 PM based on occupied beds
• 1:7 ND based on occupied beds
• Supernumerary in charge – 8 hours per day (wards with 23 or less patients)
• Supernumerary in charge – 16 hours per day (wards with 24 or more patients)</td></tr>
<tr><td>NHPPD – MH Adult Acute</td><td>• 1:4 AM
• 1:4 PM
• 1:7 ND
• Supernumerary in charge – 16 hours per day</td><td>AM: 1:3 + supernumerary in charge

PM: 1:3 + supernumerary in charge

Night: 1:5

85% RNs

AiNs only to be used in addition to the ratios</td></tr>
<tr><td>NHPPD – Palliative care</td><td>• 1:4 AM
• 1:4 PM
• 1:7 ND
• Supernumerary in charge – 16 hours per day</td><td>AM: 1:4 + supernumerary in charge

PM: 1:4 + supernumerary in charge

Night: 1:7

85% RNs

AiNs are only to be used in addition to the ratios numbers</td></tr>
</table>

Department	Proposed Implementation	Skill mix	Our claim
NHPPD – General Inpatient – Peer Group C2	• 1:4 AM based on occupied beds • 1:4 PM based on occupied beds • 1:7 ND based on occupied beds • Supernumerary in charge – 8 hours per day (wards with 23 or less patients) • Supernumerary in charge – 16 hours per day (wards with 24 or more patients)	C2 hospital wards, on a case-by-case basis, to be agreed between the LHD and NSWNMA will have either – 70% RN, 30% EN & AIN or 80% RN,20% EN & AIN. In C2 wards with a 70% RN & 30% EN & AiN skill mix, the maximum number of AiNs per shift would be two.	**AM:** 1:4 + supernumerary in charge **PM:** 1:4 + supernumerary in charge **Night:** 1:7 85% RNs AINs are only to be used in addition to the ratios numbers
NHPPD – General Rehabilitation	• 1:5 AM • 1:5 PM • 1:7 ND based on occupied beds • Supernumerary in charge – 16 hours per day Note: this ratio is aligned with current NHPPD requirements of 5	70% RN, 30% EN & AIN For rehabiltiation wards, a maximum of two AiNs to be counted per shift	**AM:** 1:4 + in charge **PM:** 1:4 + in charge **Night:** 1:7 Includes AiNs 85% RNs with a maximum of one EN and one AiN per shift

Background on key Taskforce negotiations

How enforcement/compliance will occur

- An escalation process that requires a positive obligation by the employer to comply (must be able to demonstrate attempts at recruitment, extra-hours, overtime, agency etc).
- Non-compliance, once flagged, must be addressed within 24 to 48 hours, whether that is at the level of ward staff and NUM/MUM, NSWNMA representatives, and facility DoN&M, or LHD/Ministry throughout the escalation process.
- Escalates from local solutions (following shift will be compliant), through to the Ministry intervening to alter patient flow, including reducing services and surge beds, or by agreement with the NSWNMA.
- Does not involve the Reasonable Workload Committee processes.

Maximum number of AiNs per shift

- The SSL Taskforce recommendation is that an agreed skill mix applies to a ward/unit profile, for example of 80% RN, 20% EN/AiN (80/20), and there will be a limit to how many AiNs count within the agreed ratio numbers; any beyond that would represent non-compliance.
- The number of AiNs currently employed in the public health system is estimated at 1800, and the size of the staffing enhancement envelope that has been allocated is 2480 FTE.
- Using part of the additional 2480 FTE to replace AiNs needs to be limited if we are to see the first implementation phase go as wide as possible.
- There is no separate funding for AiNs to be supernumerary at this stage. If AiNs are not included in ratios, there is a potential risk these positions wouldn't be maintained in the workforce profile. Paid positions for undergraduates to embed learning would be at risk, which would be an overall loss to our nursing and midwifery professions.
- AiNs play an important role as part of the nursing team in the appropriate setting; employing undergraduates as AiNs supports their job-readiness.
- Skill mix has been an issue plaguing members under the current staffing system. These ratios reforms address many of the widespread skill mix issues by preventing early career nurses from being in charge of a ward with multiple AiNs.
- This reform presents us with the opportunity to regulate the number of AiNs and the wards on which they can be employed, rather than allowing the current approach of increased growth in this classification through stealth.

Rounding

- The Ministry has agreed with the NSWNMA that rounding will not occur (with the exception of rounding for ICU ACCESS role). An additional patient above the ratio must be staffed, and not doing so constitutes a breach to be escalated by the compliance procedures outlined above. For example, a ward with 28 patients on a morning shift would have 7 nursing staff plus an in charge. If a 29th patient is admitted to the ward, the employer must take immediate steps to allocate an additional nursing staff member to that ward.

Agreements to local ratio variations

- There will be a clause in the Award, as there is in the Victorian ratios legislation, that allows for agreed local variations to the Award where significant and ongoing recruitment issues can be demonstrated. An example might be a remote site in a town that struggles to attract a workforce and where extensive recruitment attempts have failed.
- This would require consultation and agreement between the LHD and NSWNMA, and will be for a limited time, requiring a clear pathway for resolution and ongoing monitoring.
- The LHD will need to use this time to address the systemic issues to ensure compliance by the end of the agreed timeframe.
- This will assist in the rebuilding of the workforce whilst ensuring that we do not normalise non-compliance.

Transitional arrangements

- The schedule for implementation is still being developed by the Ministry, meaning the exact implementation timing for each hospital and specialty has not yet been finalised. Once a particular facility or service commences under the implementation schedule, there will be a transition period before enforcement is possible, allowing for services to recruit the additional staff required to achieve the ratios.
- The length of this period is yet to be finalised by the Taskforce, but NSWNMA representatives are pushing for enforceability to be available as soon as possible after implementation.

HOW DO WE COMPARE

For details about different ratio arrangements across Australia, take a look at the **State by State comparison**.

Victoria's ratios system was introduced back in 2000 however, the system in place today is different to when it was first implemented.

If the Taskforce recommendations are accepted, within three years NSW will have a ratios system that is comparable to Victoria's, which has taken more than 20 years to evolve.

In Queensland, specialty areas including ED, ICU and maternity do not yet have ratios.

In Victoria, resus staffing in ED on a morning shift is 1:3 (this will be 1:1 in NSW) and there are no legislated ICU ratios.

Maternity, Multi-Purpose Services, and Level 2 EDs

Maternity, MPSs and Level 2 EDs remain part of the government's commitment to implement Safe Staffing Levels. The NSWNMA and Ministry representatives on the Taskforce are continuing to work on implementation arrangements, and remain committed to resolving these. Arrangements for these areas are not yet included in Taskforce recommendations, and therefore not part of this vote.

A thorough review of Birthrate Plus® has commenced. It is widely acknowledged there are significant midwifery shortages statewide. Taskforce recommendations for Maternity skill mix ratios will be made after the Birthrate Plus® review is complete.

Taskforce discussions continue regarding our MPS claim for three nurses on each shift, two of which must be RNs.

If the Taskforce recommends variations from our ratios claim for Maternity, MPSs or Level 2 EDs, these will be brought to members prior to any final decision being made. The NSWNMA remains committed to ensuring strong foundations are built and will enable more specialties to be phased in.