NSW Health

Safe Staffing Levels Fact Sheet

Background

The implementation of safe staffing levels (SSL) in NSW public hospitals marks a significant step towards enhancing nursing and midwifery staffing. This initiative involves the introduction of minimum staffing levels, which will result in more nurses and midwives in NSW Health.

In May 2023, the Safe Staffing Levels Taskforce was established with key leaders from the NSW Nurses and Midwives' Association (NSWNMA), NSW Health, and Local Health Districts. The Taskforce have been working collaboratively to ensure the implementation of the Government's commitment of 2,480 full time equivalent staff towards the rollout of safe staffing levels over the coming years.

What is changing?

NSW Health is implementing significant enhancements to the nursing and midwifery workforce with the introduction of ratios and additional supplementary roles.

The changes allow flexibility in allocation of staffing according to clinical acuity and models of care in operation. Nursing and midwifery managers will continue to be empowered to make decisions regarding staffing based on local clinical considerations.

Where and when will the changes commence?

Implementation of the agreed safe staffing level areas will be scheduled in phases, with phase one to commence in level 5 and level 6 emergency departments from early 2024, before being progressively implemented across other hospitals and departments. Local health districts and Specialty Networks participating in the initial rollout will commence operational preparation over the coming months.

What has been agreed by the Taskforce?

Details of the agreed areas are as per the below:

Area	Policy Position
Emergency Departments	
Emergency Department Level 5 and 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 in charge/clinical NUM - 24/7 Triage – 24/7 plus one additional 8-hour shift in a calendar day.
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 in charge/clinical NUM – 24/7 if greater than 50 average daily presentations (18,000 presentations per year). Triage 24/7 if greater than 50 average daily presentations (18,000 presentations per year). Triage – 24/7 plus one additional 8-hour shift in a calendar day if greater than 110 average daily presentations (40,000 presentations per year).
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 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).
Emergency Department Level 2	Peer Group C Level 2 EDs only Level 2 EDs located in Peer Group D and MPS will be considered as part of the MPS Staffing model.
NHPPD and MAU Wards	
Medical/Surgical Assessment Units (MAU & SAU)	1:4 AM, 1:4 PM, 1:7 ND based on occupied beds In charge – 24/7
NHPPD – General Inpatient – Peer A	1:4 AM, 1:4 PM, 1:7 ND based on occupied beds In charge – 16 hours per day
NHPPD – General Inpatient – Peer B	1:4 AM, 1:4 PM, 1:7 ND based on occupied beds In charge – 8 hours per day (wards with 23 or less available/occupied beds) In charge – 16 hours per day (wards with 24 or more available/occupied beds)
NHPPD – General Inpatient – Peer C	
NHPPD – General Rehabilitation	1:5 AM, 1:5 PM, 1:7 ND based on occupied beds In charge – 16 hours per day **Note:** This ratio is aligned with current NHPPD requirements of 5.0
NHPPD – MH Adult Acute	1:4 AM, 1:4 PM, 1:7 ND based on occupied beds In charge – 16 hours per day
NHPPD – Palliative care	1:4 AM, 1:4 PM, 1:7 ND based on occupied beds

	In charge – 16 hours per day
Intensive Care, HDU, CCU and COU	
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 (eg does not apply to ward ready patients in ICU). In charge – 24/7 Other ACCCN Standards at the discretion of the department ACCESS type role 1:10–12 (Assumed Average POD size) Minimum unit size to require ACCESS role = 10 available/occupied beds Rounding for ACCESS role = 2 patients
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 (eg does not apply to ward ready patients in ICU). Other ACCCN Standards at the discretion of the department In charge – 16 hours per day Minimum unit size to require additional supernumerary in charge role = 10 available/occupied beds No requirement for ACCESS type role due to the types of patients these units admit and manage *provided that ENs who are engaged at the time of transition to the staffing levels will be counted as a RN for the purpose of the patient ratios outlined above.
High Dependency Units (Standalone units not part of an ICU)	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 (eg does not apply to ward ready patients in ICU). 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 at the time of transition to the staffing levels will be counted as a RN for the purpose of the patient ratios outlined above.
Coronary Care Units	1:3 – CCU Patients occupying beds (all shifts) In charge – 16 hours per day Minimum unit size to require additional supernumerary in charge role = 10 available/occupied beds
Close Observation Unit	1:2 Patients occupying beds (all shifts) In charge – 16 hours per day Minimum unit size to require additional supernumerary in charge role =

	10 available/occupied beds

Note: The ratios are flexible and can apply across a ward/unit, including for all nursing staff and patients. For example, in an ED with a 1:3 ratio, where there are 30 designated treatment spaces with 10 nursing staff – the nursing staff may be allocated across the unit as required by clinical need.

Skill Mix

The safe staffing levels implementation provides a new minimum percentage of registered nurses (where ratios apply), which are outlined in the table below. The minimum skill mix proportions in the table must be met within the staffing profiles of the ward/unit. Once a ward/unit has met this minimum skill mix (subject to the shift-by-shift limitation on AINs outlined below) and the applicable ratio, additional ENs and AINs can be engaged as required but won't count towards the ratio.

The safe staffing levels rollout includes limitations on the proportion of non-RNs that can count towards the ratio as follows:

Clinical area	RN Skill mix %
Emergency Departments Level 5 – 6	Minimum 85% RN
Emergency Departments Level 3 – 4	Minimum 85% RN
NHPPD: Medical Assessment Units, NHPPD (Peer Group A, B, and C1 General inpatient), Palliative Care, Adult Acute Mental Health	Minimum 80% RN
NHPPD: Identified General Inpatient, i.e. lower acuity– Peer C2 and Rehabilitation.	Minimum 70% RN

Policy framework for AIN shift limitations

Assistants in Nursing (AIN) continue to be a valuable part of the NSW Health nursing and midwifery workforce.

NSW Health will create a policy/framework (that will be subject to ongoing review by the Safe Staffing Levels Taskforce) that will provide for a shift limit of 1 AIN per shift (counting towards the staffing ratio) – with the exception of level 5 and 6 emergency departments and intensive care units where AINs will not count towards the minimum ratio.

In rehabilitation wards and C2 wards that are lower acuity (wards to be determined), up to 2 AINs may count.

The Taskforce will continue to review the AIN shift limitations, the policy framework, its impact and rollout.

Implementation principle

If at the time of implementation 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/unit 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 NSW Health and the Association about the outcome of the review the award dispute provisions will apply.

The intent of SSL is to enhance the nursing and midwifery workforce (RN/EN). In the lead up to the SSL rollout, should there be normal business reviews that propose reductions in staffing orskill mix, then the above principles will also have application.

Transitional Provisions

NSW Health is committed to implementing all necessary measures to meet the safe staffing levels requirements. A transition period will allow wards/units to achieve these staffing changes as quickly and as safely as possible.

The parties will continue to work through transitional arrangements and hold discussions, including:

- on how to best enhance support where safe staffing levels will not be met within the transition periods;
- to provide for more than one AIN per shift (counting towards the skill mix ratio) in limited circumstances such as where there are workforce supply concerns in meeting the shift limitation, as well as make provision for existing AINs where needed; and
- to provide alternative staffing models where NSW Health and NSWNMA agree

Which areas of safe staffing are the Taskforce still deliberating?

The Taskforce is continuing discussions on implementing safe staffing levels in the following areas:

MPS and Peer Group D facilities with an ED
The Taskforce is currently engaging with LHDs that run MPS and Peer Group D facilities with an ED to better understand the variations in staffing requirements that exist based on the size and scope of services provided; location, including the needs of the community; and other local factors.

Maternity services
A Birthrate Plus® Review Working Group has been established under the Safe Staffing Levels Taskforce to progress the implementation of the Government's commitment to introducing safe staffing levels for postnatal wards in maternity services and a review of the Birthrate Plus® methodology. The Taskforce continues to discuss a ratio staffing model for dedicated postnatal wards, which is consistent with the NSWNMA 2023 claim.

What is next?

The Taskforce continue to meet regularly to determine an agreed position on the outstanding areas above that will enable the broadest possible implementation of safe staffing levels across NSW Health.