Staff Side Counter Proposal to 'Shift Pattern Changes' to all in-patient areas and A&E in South Tees NHS Foundation Trust - March 23rd 2016

(written by Roaqah Shah – Chair of Staff Side and lead RCN rep)
NB The trust's director of nursing's comments are in **blue**;
staff side responses to them are in **red**

On 27th January 2016, the Staff Side Committee presented a response on the proposed 'Shift Pattern Changes' to the Change Management Steering Group. Within that response staff side highlighted several concerns that we felt posed a risk to the staff, organisation and patient care.

On 3rd February we received a response to those concerns from our Director of Nursing and an update of the work being done as part of this consultation process. We are happy that some of this work has commenced but are disappointed that the majority of this work was only instigated as a result of our opposition to the 'shift pattern change' proposal. We also feel that some of our concerns have not been satisfactorily addressed, those concerns are as follows.

1) Full time staff with child care costs will incur an additional charge for part of a day or could incur an additional full days cost. Part time workers will also find themselves with additional costs if they have to work an additional shift. This could be the same for staff who have caring responsibilities. Your response was that "***For some staff this may be the case, we will respond to staff requests to work specific days / shifts within the parameters of policy and service need."*** This does not negate the additional costs for the majority of our staff therefore the impact remains so staff will seek to reduce their current contractual hours.

2) We stated that staff currently working 25, twelve hour shifts in an 8 week period will incur additional travel cost if they are to now work 26, eleven and a half hour shifts in that same period. You responded by saying "***We acknowledge that for some staff***

this may be the case." This is the case for all staff who currently work 25, twelve hour shifts in an 8 week period and part time staff who now have an addition shift to work therefore the impact remains.

3) We stated that part time workers have chosen the number of hours they work as a direct link with the number of shifts they are available in a given period. Refusing to allow staff to reduce their hours, to reflect the number of previously worked shifts is changing their agreement. You responded by saying "***We will give full and fair consideration to staff requests, as clearly we want to reach a mutually agreeable position.***" Staff already had a mutually agreed position and that is to work the number of hours that directly link with the number of shifts they are available in a given period.

4) We highlighted that staff are effectively being asked to deliver the same amount of care in a reduced period of time with no additional support. If the shift changes are imposed, the nurse to patient contact time in a 24 hour period will be reduced by 1 hour. This will have a negative impact on pressure ulcer management, falls prevention and infection prevention and control etc. You responded by stating that ***"Staffing levels have been benchmarked nationally and are generally favourable; they are also reviewed in light of patient acuity and dependency on a regular basis. There is no justifiable reason why in our trust staff should be missing breaks on a regular basis."*** We feel that this response does not resolve or give a solution to delivering the same amount of care in a reduced period of time with no additional support therefore again, the impact remains.

5) Students Nurses will experience first hand the pressures placed on their Mentors during the imposed change which may have a negative impact on their chosen career pathway. Your response to this was "***The recruitment and retention of registered nurses is clearly of fundamental importance, we will be closely monitoring recruitment and retention rates as part of the overall Quality Impact Assessment (QIA). Student experience whilst on placement in the trust is closely monitored and reviewed formally in partnership with the University; this will enable us to monitor trends."*** We feel that this would be too late especially in light of the current recruitment problems experienced in the trust, therefore this remains a risk.

6) We alerted you to the fact that mentors will be unable to verify Student time sheets, as each 4 week period will accumulate a 0.5 hour shortage which are mandatory practice hours required to qualify. Your response was that "***University colleagues explain that student nurses throughout the region are required to work a variety of shift patterns to fit in with mentor / trust working patterns. Students are clear about the practice hours they are required to complete and it is their responsibility to ensure they are undertaken. They are not concerned that this proposal would cause any negative impact in relation to student placements."*** We agree that students are responsible for their own hours but they, like most staff, work 37.5 hours a week (150 hours in 4 weeks). If they are to mirror the shifts of their mentor and work 11.5 hour shifts (149.5 hours in 4 weeks), how do they make up the hour they will be short after an 8 week placement (common length of placement). Do students have to come in for a 1 hour shift on a different day? Should they be expected to stay behind once their mentors have gone home and complete the remaining hour? Should we split some of their shifts so they end up working even more days than their mentors?

7) We highlighted that the new proposed 13 eleven and a half hour shifts in a 4 week period leaves a short fall of 0.5hrs per WTE per 4 week period which totals 6.5 hours per year per WTE not worked. You responded by saying "***This shortfall will relate to staff who are contracted to work 37.5 hours only so does not apply to all affected staff. Those full time staff will be expected to undertake core 7 mandatory training within this time frame. This is a positive move which we envisage will increase mandatory training compliance and support staff to undertake training in paid work time. Completion will be monitored at appraisal and recorded on the E-roster system."*** It still remains unclear when or how these hours should be utilised. Does the member of staff wait until they have accumulated the 6.5 hours at the end of a given year, then come in for an additional 6.5 hour shift? Are they expected from time to time to stay behind after a shift and complete the particular core training due? Are they supposed to tell their managers when they have done this hour by hour? We still feel that this will be difficult for managers to monitor without it being rostered and therefore believe it will result in a loss of man hours and paid wages.

8) The sickness absence ready reckoner calculates sickness in hours when calculating the number of hours you are off before triggering the 3.6%. The hours a member a staff is off on sick leave before triggering does not change but the number of days practice they can be off before triggering will increase. For example a full time worker has to be off sick 61.5 hours before triggering which currently equates to 5 whole shifts (long days) and 1.5 hours. With the new change to shift patterns imposed, that same full time worker has to be off sick the same 61.5 hours but it now equates to 5 whole shifts and 4 hour before triggering any monitoring. Your response was that ***"The 3.6% trigger in the Sickness Absence Policy is calculated on the number of cumulative working hours lost over the 12 month rolling period, therefore, regardless of the numbers of hours scheduled to work, hours lost due to sickness are counted/recorded. All sickness is recorded in calendar days for payroll purposes but does not influence the trigger for long-term or short-term absence management."*** The point we were trying to make was that a 'staff member' can be off for longer in days as a direct result of the shift pattern change before triggering because the 3.6% trigger is calculated in hours. This may mean nothing to the individual people off sick but for every 4.5 staff members off sick at a given time, the organisation would be paying for a 'days' extra agency or overtime cover yet none of these staff will have yet triggered, therefore not be monitored. If 9 staff were off sick, 2 extra days agency or overtime paid, 13.5 staff = 3 days, 18 staff = 4 days, 22.5 staff = 5 days and so on. We were under the impression that stepping in and monitoring sickness at the earliest opportunity would help reduce overall sickness absence and support staff back to work as soon as possible which in turn reduces the overall sickness absence bill.

9) Study time allocated to full time staff will be impossible to coordinate as the shifts proposed are 11.5 hours and most booked mandatory training is 6 hours for example ILS, CMAT etc. This leaves 5.5 hours to roster which is a shift that does not exist. However it has been suggested that a 6 hour shift can be rostered to make up these hours, an early or late shift. The concern here is we now have 2 staff working 2 x 6 hour shifts in order to cover the long day which this equates to 12 hours instead of the 11.5 hours required when 1 member of staff works a long day in the proposed change. A waste of 0.5 hours every time this occurs. You responded with ***"We would propose that if a staff member has undertaken a period of study for 6 hours that they***

would be rostered to work a further 6 hour shift patterns (this would include a 30 minute break).” This would be reasonable but another member of staff would have to mirror them and also be on a 6 hour shift with a 30 minute break which would effectively leave the total shift 30 minutes short as a normal working day is 12.5 hours.

10) Managers will not be able to monitor and ensure hours owed are worked when it is some months before a member of staff will have accumulated a whole shift? For example:

12 hours a week = 23 weeks before 1 x 11.5 hour shift is owed which equates to over 5 months

15 hours a week = 19 weeks before 1 x 11.5 hour shift is owed which equates to over 4.5 months

18 hours a week = 16 weeks before 1 x 11.5 hour shift is owed which equates to almost 4 months (0.5 hours still remains owed to the roster)

24 hours a week = 12 weeks before 1 x 11.5 hour shift is owed which equates to almost 3 months

27 hours a week = 10.5 weeks before 1 x 11.5 hour shift is owed which equates to over 2.5 months

30 hours a week = 10 weeks before 1 x 11.5 hour shift is owed which equates to almost 2.5 months

33 hours a week = 9 weeks before 1 x 11.5 hour shift is owed which equates to 2 months (0.5 hours still remains owed to the roster)

36 hours a week = 8 weeks before 1 x 11.5 hour shift is owed which equates to almost 2 months (0.5 hours still remains owed to the roster)

You said that “***Effective management of e-roster is essential regardless of the shift pattern used. Accountability in the new centre structure is very clear, monthly KPI meetings are currently held with Heads of Nursing and this will continue.”*** We understand were the accountability is but are still concerned that for some part time workers, it is months before they owe a shift. It could also be some time before a member of staff owes half a shift and then the manager will have to rely on another member of staff owing half a shift in that same roster which we feel remains problematic. It should never be the case that staff are expected to do their extra half or full shift before a complete half/full shift worth of hours has accumulated.

11) Currently car parking on most days is unmanageable. On a daily basis we are seeing more and more cars parked along the pavement, blocking entrances, obstructing the flow of traffic as well as posing a risk to pedestrians. You state "***We do acknowledge that car parking can be challenging, we don't however anticipate that this proposal will have a significant impact in this regard; we are not proposing to increase staffing templates and would expect any increases to be offset to an extent by a reduction in those staff undertaking overtime shifts and temporary workers."*** We are not convinced that parking won't be a problem because it has always been a problem and increasing the number of days that staff have to attend work can only exacerbate this.

12) This proposal is likely to increase the number of staff wishing to reduce their hours in order to reduce the number of days worked to mirror what they currently work. This will effectively reduce the number of registered and unregistered nursing establishment further. You said ***"We are currently gathering that information and will then have a better understanding."*** It has become apparent in several (many) of the one to ones completed to date, that this will be the case.

13) Sickness absence percentages will increase as more and more staff will struggle to cope. You stated that ***"There is currently no evidence to support this. Absence rates will be monitored as part of the overall QIA and we will manage sickness in line with policy. We believe that not having adequate breaks on a long day is likely to have a detrimental impact in terms of staff health and well-being."*** We agree that there is currently no evidence to support this (as it has not been rolled out yet) but there is evidence to support the fact that staff are worried, stressed and anxious about this change and the impact it will have on them. In addition to this there is evidence to support that stress and anxiety are commons causes of sickness absence at present in our trust. However there is no evidence to support "***not having adequate breaks on a long day is likely to have a detrimental impact in terms of staff health and well-being"*** because we have no definition for an adequate break other than that which is stated in the EWTD which we as a trust are currently complying with.

The Staff Side Committee feel that the other concerns raised in our response on the 27th January have not been addressed in the paper presented to us on the 3rd February but are still important to our ***staff, the organisation and patient care*** as a whole. Concerns such as:

- Historically, staff have not taken breaks to deliver essential patient care, as a 'good will gesture' they have NEVER claimed this. Also, they have not claimed for the hours that they work beyond their finish time. Increasing breaks essentially increases the time staff are not paid for delivering essential patient care. Staff will withdraw their 'good will' and claim this as time owing, or, what is more likely, overtime, as clearly afforded in AFC.

- On night shifts there are several areas that only have 2 members of staff working which prevents them getting a true break, away from the area and uninterrupted. They accept this in order to ensure the safety of their patients and provide support to their colleagues. This proposal will only increase the period of time that they won't get a true uninterrupted break, away from the work area. Another 'good will gesture' staff will withdraw.

- Staff will suffer 'burn out' as a result of working more shifts over a given period posing a risk to patient safety and quality of care.

- Many times staff are told when leaving a shift late that it is down to their 'time management' even though they are clearly delivering essential patient care. This is going to increase, as there is less time to deliver the same amount of care, but no additional staff. This will add to the pressure on an already highly pressurised nursing workforce.

- The reputation of the organisation being 'a good place to work' will be damaged at a time when we are scouting for the best and the brightest.

The position of the Staff Side Committee remains. We still feel that there is a more efficient way to bridge the gap in the nursing/midwifery establishment without causing any disruption to:

- Patient care
- The staff members work life balance
- Child care payments
- Current travel costs
- Income
- Management time to do rosters
- Staff morale
- Parking

More efficient ways such as stated in our first paper and as follows;

Sickness Absence Management – We first believe that a more robust monitoring of sickness absence will aid in supporting our staff back to work. A project we hope is already underway. We also feel that the organisation could utilise redeployment more effectively when staff are unable to deliver all the care required for their substantive roles when they suffer an ailment but have other skills and competencies to deliver other necessary work required in the organisation as a whole.

Better Recruitment and Retention Processes – We need a recruitment and retention process fit for purpose. We have lost many of our skilled knowledgeable qualified nurses/midwifes to the private sector and have seen a longer than necessary delay in our recruitment processes.

Internal Bank of Nursing Staff – Currently an increasing number of posts are generated that do not require the post holder to be clinical. Yet many of them are registered nurses/midwifes and have expressed an interest in remaining registered. This is not the first organisational restructure, so it makes sense that these staff protect their skills and ensure they preserve their career options. An internal bank of nursing/midwifery

staff should be generated to support those who wish to remain registered and to support the organisation with their fill rates.

The Staff Side Committee believe that all Ward Manager/Senior Sisters, Matrons, Lead Nurses and any other clinical nurse/midwife related role should be permanently rostered for 1 x 6 hour clinical shift in their substantive centres every week.

We believe that this would benefit many of the targets we have set for our future and enable us to achieve our goals. Goals such as:

- Better infection control – by being present at the heart of care delivery, those with up to date information on key messages, target challenges, knowledge of resources and changes to practice can update staff by facilitating learning and sharing best practice on a regular basis.

- Frontline leadership at the heart of care delivery – this will enable our nurse/midwife leaders to reinforce the trusts' core values. Additionally, this will create a working environment which is supportive and respectful, a vision we expected from the introduction of the supervisory ward manager. This will contribute to high quality, safe and efficient healthcare.

- Support for staff – staff need support and access to support from their managers/leaders regularly. Our Matrons, Managers and Leaders will be able to see for themselves how staff work individually, as a team, with other professions and organisations at the heart of care delivery. They can quickly identify problems, good practise and give feedback, praise or constructive criticism at the time, when it is most effective.

- Assurance to Patients – seeing Matrons, Managers, Lead Nurses etc, working regularly in the clinical areas, supporting and facilitating the learning of staff while delivering essential frontline care on a regular basis, can only result in positive feedback and reassurance. We have already developed the use of the 'nurse in charge badge' to reassure patients and highlight leadership. This will

only improve as patients will regularly have sight and access to those who lead nursing in the organisation.

- Ensuring up to date clinical skills for all nursing/midwifery staff – recently we were faced with those in supervisory positions being required to work in clinical areas. We need to be certain at all times that all our nursing/midwifery staff have the competence to perform essential skills that are required on a daily basis such as blood transfusion, intravenous therapy, parental nutrition, complex discharges, medical device use and so on.

- Support revalidation of all Nursing/Midwifery staff – working clinically, regularly can only support the requirements of revalidation. It will instil confidence in the confirmer and aid in the collection of evidence required for all nursing/midwifery staff.

- Bridging the gap in the nursing establishment – all the above will effectively bridge the gap in the nursing establishment and increase our fill rates.

As we stated at the start of this paper we appreciate some of the work has been done but we are not convinced that it is enough to satisfy our members.

As far as annual leave is concerned we agree, as your response states that there is no change to holiday entitlement but there is still concern with regard to allocation of that entitlement. The Staff Side Committee raised several concerns regarding annual leave allocation. We believe that before applying any proposed shift pattern changes, some staff already have difficulty getting their holiday entitlement sanctioned. The Trust does not permit annual leave carry over into the next year for those that were unable to get leave sanctioned and staff often lose the couple of hours left over that don’t make up a complete shift and are therefore unable to be requested. That is without mentioning the difficulty they already have getting their fair share of the popular dates.

If the shift pattern changes are imposed, staff will in fact have more ‘days’ annual leave to request if they request a week’s holiday that is reflective of the week’s work that they are expected to do. For full timers this will be 34.5 hours, therefore the % of staff on annual leave at any one time will need to be increased. If staff do what is suggested in appendix 2 of your response and take 46 hours annual leave a week so that they only have to work a further 9 long shifts for the remaining 3 weeks, this effectively reduces a full timer’s annual leave entitlement by more than 2 weeks a year. Instead of having 8.91 weeks annual leave a year it would equate to 6.68 weeks a year. Staff are already exhausted so we should not be encouraging them to reduce the number of week’s annual leave they are entitled to in a year, on top of expecting them to work an additional shift a month.

We appreciate that some work is being done as part of the break escalation process but believe it to be too late and not fit for purpose. If the organisation truly believed that staff needed longer, uninterrupted breaks away from the work station, then we would have thought as a minimum some work would have gone into finding out how the current break systems first work, from ward to ward. The Staff Side Committee have, in several of the Change Management Steering Group Meetings, highlighted the fact that the ‘Break Time Escalation Proforma’ is too long, too complicated and not fit for purpose. If staff have the time to complete this form, they have the time to take a break. Not only this, the suggestion that managers need to display a time table to indicate what time a break should be taken has only alienated staff. They are fully aware of what time breakfast, lunch, tea and supper should be because part of the duty of care to their patients is to ensure their patients nutritional needs are met and met at appropriate times of the day.

We reiterate that staff don’t always get their breaks or get their breaks on time because they are delivering essential patient care. They do this as a ‘good will gesture’ and they have NEVER claimed this in the past. On night shift there are several areas that only have 2 members of staff working which prevents them getting a true or uninterrupted break away from the work area. They accept this in order to ensure the safety of their patients and provide support to their colleagues. This proposal will only

increase the period of time that they won't get a true uninterrupted break, away from the work area. Increasing breaks essentially increases the time staff are not paid for delivering essential patient care. If forced to, staff will withdraw their 'good will' and claim this as time owing, or what is more likely, overtime as clearly afforded in AFC. Staff also at present; do not claim for the hours that they work beyond their finish time. They also come in early to relieve their colleagues of their duty and to get a head start on the day, none of which is ever claimed for. It would be naïve for the trust to ignore the fact that care is often delivered on the 'good will' of its staff, as it would also be naïve to ignore the fact that the NHS does not deliver essential patient care on 'good will'.

We would also like to point out that the organisation will in fact have to 'pay protect' all 1642 staff members as this proposal cannot guarantee that the half hour they lose from an unsocial shift (new 11.5hr shift worked nights and weekends as opposed to 12hr shift) will be backfilled with an unsocial shift.

Our ***counter proposal*** is this, increase the current working day by 20 to 30 minutes to allow for the provision of breaks that equal an hour. If the trust is truly concerned about the wellbeing of its staff and how that impacts on patient safety, it will implement only this change to the current shift patterns and work with the staff to come up with practical solutions to ensure they get adequate uninterrupted breaks.

Increasing the length of the current working day by 20 to 30 minutes will make very little difference to the staff members work load. It will however instil confidence in the staff that the trust does in fact care about their rest periods during a long shift, is concerned about the morale of staff and the effects this period of consultation has had on their attitude towards working for this organisation.