Doncaster and Bassetlaw Hospitals NHS
NHS Foundation Trust

Please Note: This policy is currently under review and is still fit for purpose.

Roster Policy
Nursing & Midwifery

This procedural document supersedes: CORP/EMP 35 v.1 (amended) – Nursing and Midwifery Rostering Policy.

Did you print this document yourself?
The Trust discourages the retention of hard copies of policies and can only guarantee that the policy on the Trust website is the most up-to-date version. **If, for exceptional reasons, you need to print a policy off, it is only valid for 24 hours.**

Author)	Jason Mullarkey – P & OD Project Manager
Date revised	November 2014
Approved by:	Policy Approval and Compliance Group
Date of approval:	26 November 2014
Date issued:	8 January 2015
Next review date:	October 2017 – **Extended to November 2018**
Target audience:	Nursing and Midwifery

Amendment Form

Please record brief details of the changes made alongside the next version number. If the procedural document has been reviewed **without change**, this information will still need to be recorded although the version number will remain the same.

Version	Date Issued	Brief Summary of Changes	Author
Version 2	8 January 2015	• Major review and changes as a result, therefore PLEASE READ IN FULL • Document transferred to new format • Updated in line with Roster Improvement Programme outputs • Introduction of consistency, standardisation, accountability and controls	Jason Mullarkey
Version 1 (minor amendment)	November 2011	Reference regarding the security policy included at the bottom of page 4 and in item 5.2	Val Colquhoun
Version 1	February 2011	• This is a new procedural document, please read in full.	Val Colquhoun

Nursing & Midwifery Rostering Policy

CONTENTS

1. INTRODUCTION

Doncaster & Bassetlaw Hospitals NHS Foundation Trust recognises the value of its workforce and is committed to supporting staff to provide high quality patient care. Whilst acknowledging the need to balance the effective allocation of the nursing workforce with supporting staff to achieve an appropriate work life balance, it is recognised that the Trust needs to be able to respond to changing service requirements. A flexible, efficient and robust rostering system is the key to achieving this objective.

This policy is for use by all Nursing and Midwifery areas across Doncaster & Bassetlaw Hospitals NHS Foundation Trust.

2. PURPOSE

The workforce is the most important and critical resource of the Trust and principles need to be established to ensure a clear understanding and consistency in the approach to the effective and efficient utilisation of the workforce to ensure safe rostering is in place.

This document is designed to provide details of the roster policy, background and explanation as to why having a policy is so important and how it should be adhered to in conjunction with the use of e-Roster. It also explains the procedures and processes involved from inception of a team through to the creation and management of a roster, along with guidance on the best practice approach to managing workforce planning. For ease of use the distinction between policy and best practice has been highlight through this document.

The purpose of the **policy** is to ensure that duty rosters are produced and managed to an agreed standard, which is consistent across the Trust.

This policy is intended to support the effective and efficient management of The Trusts workforce, to deliver safe care, the desired patient experience and treatment of their people.

The purpose of the **best practice** is to provide guidance and support in how to practically achieve the objective of managing a workforce which delivers high quality, safe patient care in an efficient and effect manner.

3. DUTIES AND RESPONSIBILITIES

Director of Nursing, Midwifery and Quality (DNMQ)

- Accountable for ensuring Trust wide compliance with the policy to ensure that the wards are able to deliver high quality and safe patient care with appropriately skilled staff.

- The Director of Nursing, Midwifery and Quality is joint accountable with the Director of Finance and Infrastructure for recommending to the Board of Directors the resource levels for each ward/department.

- The Director of Nursing, Midwifery and Quality will hold formal reviews of the policy so that it remains current and supports safe staffing levels.

Heads of Nursing/Midwifery (HoN/HoM) are responsible for:

- Ensuring compliance with the Policy within their respective Care Group.

- Agreeing and signing off temporary change to resource for each ward/department with the Matron/Management Accountant, as per the change control process.

- Conduct Key Performance Indicator (KPI's) reviews with the Matron and Management Accountant to ensure that the nursing resource is managed efficiently.

- Monitoring and reporting against KPI's in conjunction with the Management Accountant and Human Resources Business Partners and for reporting through the Care Group performance mechanisms to the Director of Nursing and the Chief Operating Officers Care Group monthly accountability meetings.

- Reviewing and approving ward/department rosters which require escalation as a result of them failing to achieve the KPI measure for 2 or more periods in a row

Matrons are responsible for:

- Ensuring policy implementation and compliance within each Care Group

- Monitoring, approving and escalating to their HoN the ward/department duty roster on completion (level 2 approval) using Roster Analyser as per the roster calendar. Arrangements between Matrons must be made to cover leave in order to ensure rosters are approved as per the calendar ready for publication on the wards.

- Producing analysis reports on staffing, expenditure and quality in their area of responsibility using Roster Central reporting system.

- Approving all shifts where temporary staff are requested as per the change control process

- Approve all additional hours and duties.

- Providing guidance and support to the Ward/Department Manager or designated other in the creation of duty rosters, using the KPI's as a reference.

- Notifying the HoN and Care Group accountant of any additional hours agreed above the approved staffing resource templates.

- The implementation of an early intervention and recovery plan for wards/departments failing to meet KPI's.

- Reviewing KPI audits (these measures would be balanced providing evidence of safe, efficient and high quality care) and ensuring the development and implementation of appropriate action plans to ensure patient safety and quality of care at all times.

- Wards/departments operating within their budgetary constraints

Ward/Department Manager are responsible for:

- Ensuring policy implementation and compliance within each ward.
- Updating of establishments and the safe staffing of each ward/department lies with individual Ward/Department Managers.
- Approving the roster (1st Line approval), in line with the roster calendar, which will include confirming it meets defined parameters of e Rostering.
- Ensuring the roster is an accurate, current and maintained record of what has been worked.
- Timely maintenance of the roster to ensure it is always current and accurate. This is to avoid sizeable administration burden building towards the end of the period.
- Ensuring that the roster is 100% updated, accurate and finalised at point of lock down at the time details are forwarded to payroll. No change can be made after this time.
- Undertaking the Level 1 validation and approval, checking the roster analysis information. The Ward/Unit Manager approves the roster and informs the Matron that it is ready for their review identifying any areas of concern.
- Ensuring that their expenditure does not exceed the allocated budget in all wards, units and departments (hereafter referred to as departments).
- The safe staffing of the department even if they do not directly undertake the task of producing the duty roster.
- Nominating a Roster Creator and deputy and ensuring that they are appropriately trained.
- Ensuring that there are enough nurses in the right place at the right time, based on the agreed and funded skill mix, with the required competencies, to deliver safe care or escalate in accordance with Safe Staffing Escalation for Inpatient Areas Policy (Nursing and Midwifery) PAT/PS 18.
- The fair and equitable allocation of annual leave and study leave.
- Approving and managing requests for leave in accordance with the Trusts, policies such as the Carers leave Policy and Leave for domestic emergencies etc.
- Considering all roster requests from staff, ensuring fairness and equity in working patterns

- Monitoring the quality of care provided through clinical governance mechanisms e.g. audits as part of the ward assurance tool assessment, to ensure the resource profile and hence rostered shifts are fit for purpose.

- Investigating any reports of short-staffing and take steps to prevent recurrence.

- Monitoring those factors which impact on staffing levels, e.g. sickness, occupancy rates and respond to these appropriately.

- Ensuring that before appointing to a vacancy, the Ward Manager must consider the best way in which to meet the current service delivery need.

- Requesting the use of additional duties and hours from the Matron.

- Identifying training needs in relation to the roster software for themselves and their team members, and raising this requirement with the e-Support team

Roster Creators are responsible for:

- The creation of all rosters. In their absence the designated deputy is responsible for roster creation.

- Bringing any areas of concern to the attention of the Ward Manager.

e-Support Team are responsible for:

- The production of the Trust wide Roster Calendar.

- Ensuring the Healthroster system remains appropriately configured and governs any requests in line with the change control process.

- Providing support and on-going training to the Healthroster users.

- Liaising with the suppliers Healthroster Support Team to resolve system issues as required.

Management Information

- Responsible for the production and distribution of e-Roster KPI reports.

Staff are responsible for:

- Attending work as per their duty roster.

- Adhering to the requirements set out by the roster policy.

- Being reasonable and flexible with their roster requests and being considerate to their colleagues within the rules set out by the Trust.

- Notifying the ward/unit manager of changes to a planned or worked shift as per policy (ie keep ward manager/line manager updated).

- Notifying the ward/unit manager of changes to personal details, e.g. address, telephone number, etc.

- Requesting shifts and annual leave using Employee on-line.

- Ensuring that personal details are kept up to date on Employee on Line (maintaining own details on Employee Online).

Management Accounts

- Responsible for the provision of budgetary information and supporting the management teams on the financial aspects of delivering high quality and safe care to our patients.

4. TRAINING

Training needs must be identified and raised by the Ward Manager for themselves and their team members. Where the requirement cannot be fulfilled locally (by the Ward Manager/roster co-ordinator) they must be shared with the e-Support team who are responsible for designing and delivery end user training.

5. PROCEDURE

The DNMQ and The Director of Finance and Infrastructure hold joint accountability in determining the required resource for each ward/department.

The Head of Nursing and Care Group Management Accountant are responsible for creating the proposed structures and workforce requirements for approval.

Once established these resources are then the responsibility of the Care Group Matron and Ward/Department Manager who must ensure these requirements are met. This is achieved by creating the individual roster which must then be approved for each period of use.

5.1 Establishment & Budget

Working with colleagues in management accounts the operational managers decide upon the resource requirements and hence set the establishment and budget for each team. The approved shift patterns and hands per shift plans are then designed to be used as a template for the creation of each roster.

Any deviation from this template must be in accordance with the change control process in order to protect the safety of patients and avoid unnecessary cost.

Templates should be reviewed at least annually, and always as a result of a change to the ward baseline (eg number of beds, workforce review using safer nursing care tool etc.).

5.2 Roster creation

It is the responsibility of the Ward/Department manager to allocate their team members into the available shifts as per the agreed template of shift patterns and hands per shift.

In order to achieve this, their team members should have minimum restrictions to their working patterns, and the ward/department should have the least number of local rules in place.

The person creating the roster will take into account any approved requests and create the roster which will allocate resources for a period of 28 days. The roster should be created, approved by the Matron/HON and available to view in its final state 6 weeks in advance of it taking effect.

5.3 Electronic Rostering (e-Roster)

Also, refer to your local operational framework

This is a computerised system specifically designed to support ward/dept managers, matrons and senior managers in efficient and effective workforce planning. This is a management aid, and hence the objective of its introduction is to enhance and improve the management of the teams by being a user friendly method of handling all aspects of workforce planning.

In the first instance, this tool is being implemented within nursing and midwifery services across the organisation.

It rosters staff to an agreed duty requirement, manages staff availability and contracts which allows clear visibility of the workforce.

It will also track and produce reports for absence, leave, additional duties, overtime and bank/agency use.

The Trust has a planned calendar that ensures that all e rosters will be produced on the same day. A copy is on the e-Systems page of the intranet.

The aim of this policy is to ensure that duty rotas are produced to an agreed standard, which is consistent Trust wide for all areas utilising the e-Roster system.

E Roster aims to:

- Ensure safe/appropriate staffing for all departments using fair and consistent rotas.
- Minimise clinical risk associated with the level and skill mix of staffing levels.

- Improve monitoring of sickness and absence by department/ward and/or individual, generating comparisons, whilst identifying trends and priorities for action.
- Improve planning of clinical and non-clinical non-effective working days e.g. annual leave, sickness and study leave.
- Ensure that the required number of inpatient beds is safely staffed to meet elective and emergency demand.
- Provide effective management of clinical establishments.
- Encompass self-rostering where it is currently used effectively.
- Allocate shifts on a fair, consistent and transparent basis
- Enable creation of meaningful reports and data for analysis, decision making and audit

5.4 Key principles, inputs, steps and variables to take into account when creating the roster

The purpose of this section is to give detail and clarity on the key aspects of managing and maintaining an effective roster, to provide consistency, fairness and efficiency. These key aspects are:

- Shift Allocation
- Requests
- Staffing levels
- Vacant shifts
- Temporary staffing
- Staff redeployment
- Shift duration
- Roster production
- Headroom & unavailability
- Managing Annual leave
- Managing special leave
- Flexible working
- Monitoring & Compliance

5.4.1 Shift Allocation

Policy:
All staff are expected to cover a locally agreed number of weekend/night/on call during a set period unless flexible working entitlement has been granted for which these shifts are exempt.

Unsociable hours/weekend shifts should be evenly distributed and fair in accordance with agreed contractual restrictions.

All staff should have an annual (as a minimum) formal review of existing shift patterns with their ward/department manager (this must be quarterly where there is a flexible working agreement due to health reasons), which may be incorporated into appraisal any agreements must be documented in the personal file.

Staff will be able to change a shift from a completed roster only if another appropriately skilled/competent member of staff is available to work the shift- and only with authorisation from the ward / department manager/shift leader/ coordinator. This avoids unforeseen problems with changes in skill mix and continuity of cover.

Sickness/carers leave cover – where absence had occurred due to sickness, or in accordance with the Carers leave Policy or Leave for domestic emergencies, the shift leader/coordinator takes responsibility that any shortages in staffing are adequately covered or escalated using the process outlined in the Safe Staffing Escalation for Inpatient Areas Policy (Nursing and Midwifery) PAT/PS18

Best Practice:
In areas where the workload is known to vary according to the time of the day or day of the week staff numbers and skill mix should reflect this within the roster.

Senior staff with the same skill sets should work opposite shifts. They should work in a way that provides optimum use of their skills over the working week.

Ward/Department Managers will have an agreed procedure with their staff in the event of changes needing to be made to a roster when available to view.

Shift changes should be kept to a minimum and authorised by the Ward/Department Manager or designated deputy.

Staff are responsible for shift changes and approved only by the Ward/Department Manager or designated deputy.

The roster template must, within budget, provide a roster which when reviewed on a day to day basis meets the demand for nursing staff, which is dependent upon patient need and acuity rates (ie the roster should have the ability to flex within budget to meet the fluctuating need of the ward on a daily basis)

5.4.2 Requests

Policy:
To provide a consistent workforce, requests cannot always be guaranteed. The granting of requests will remain at the discretion of the Ward/ Department Manager.

All wards will implement consistent approach to managing requests from team members. Requests permitted will be categorised as priority and non-priority requests. The number of priority requests per individual will be based upon the contractual hours worked, and these priority requests will always have precedence when trying to accommodate everyone's requests when creating the roster. Additional requests are permitted, however these will only be considered after the whole team's allotted priority requests have been accommodated.

The priority requests per person are on a pro rata basis as follows:

0 – 30 hours	=	2 requests
Over 30 hours	=	4 requests

Two months of forward planning rosters will be visible at any one time for staff to make requests to allow for fair accessibility for all staff. Rosters will close to requests 6 weeks prior to the start date of the roster.

Late requests may be considered by the Ward/Department Manager under special circumstances.

Any issues relating to requests for personal patterns on a regular basis should only be considered on an exception basis and must be justifiable and where possible kept to a minimum. Any agreement made/in place must be reviewed formally on a quarterly basis to ensure they remain appropriate, and those deemed no longer appropriate must cease. Personal patterns are not considered as requests (see flexible working 4.4.12).

Best practice:
It cannot be assumed by staff that the roster will be written to accommodate them. **Requests may be denied**, as the needs of the service must take priority. Staff must be considerate of their colleagues, and the requirement that they are fulfilling their share of unsociable hours.

League tables of shift approval history within the eRoster system will be used to facilitate the decision making process when approving or denying requests.

5.4.3 Staffing levels/Skill Mix

(Refer to individual ward operational framework)

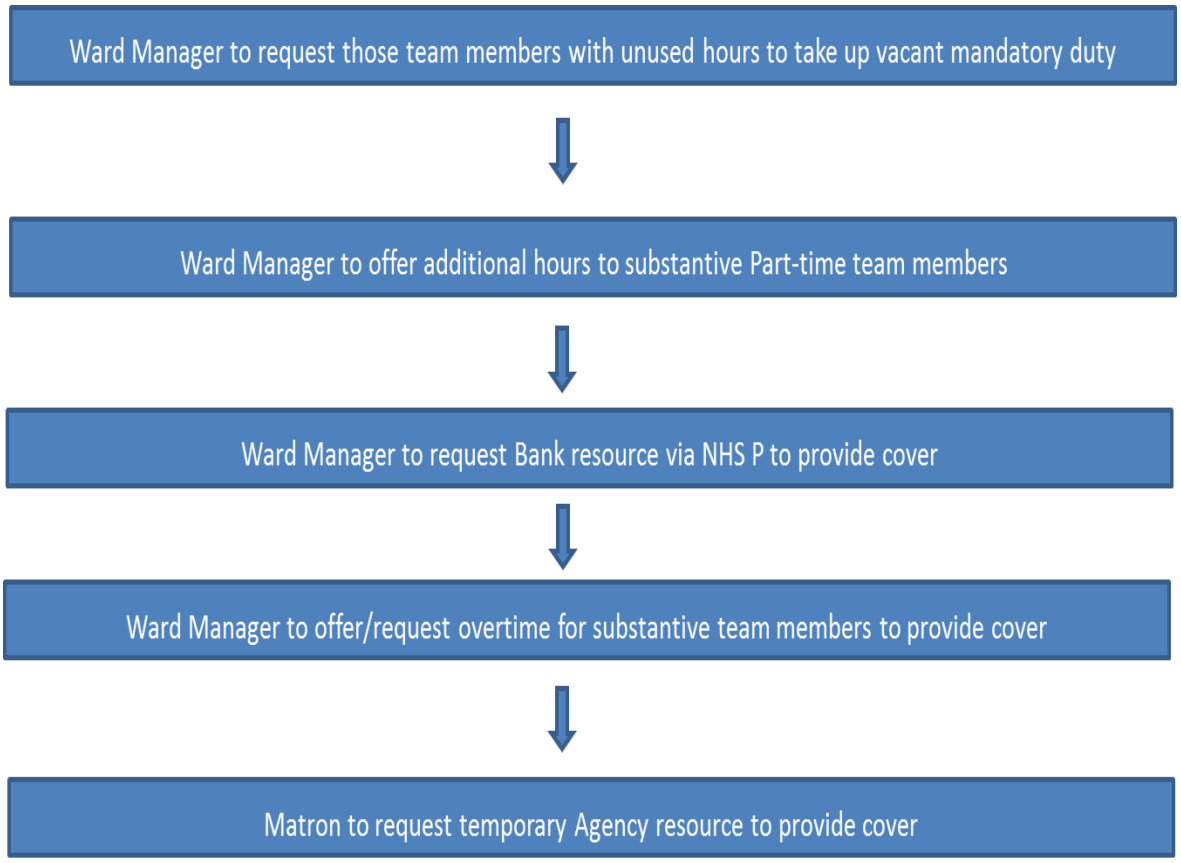
Policy:

All staff planned to take charge of the ward/department will be able to demonstrate their ability to coordinate or take charge of the ward / department. This competency will be assessed annually as part of their appraisal.

The General Ward Escalation process (Safe Staffing Escalation for Inpatient Areas Policy) is to be initiated if the safety or quality of patient care is compromised due to the increased activity, patient dependency or acuity.

5.4.4 Vacant Shifts

Policy:
There are clearly defined steps to follow in order to fill vacant shifts, and these should always be followed in order. **Only vacant mandatory shifts (shifts which exist in the roster template and are signed off by the matron and management accountant) can be filled. Non mandatory shifts must be approved in accordance with the change control process.** The steps are:



Note: Overtime must be authorised by Matron before it is offered.

5.4.5 Temporary Staffing

Policy:
Bank/agency staff will be booked according to the above process steps which is in line with the escalation process in the Safe Staffing Escalation for Inpatient Areas Policy (Nursing and Midwifery).

Temporary staff will not be used to cover for annual leave, or be included in the establishment numbers for calculating allowances such as annual leave, study etc.

Escalation (Refer to Trust/local Escalation Policies)
Escalation will be undertaken when, either a Care Group or NHS P draws attention to a major problem with staffing, including:

5.4.6 Staff Redeployment

Best practice:
Staff may be required to work in other areas in the Trust to provide a safe and efficient service as stated in employee contract.

The competence and skills of an individual will be assessed to ensure they are appropriately matched to the requirements of the ward/department they are being moved to.

The department Bleep Holder, Matron and Clinical site manager will review staffing levels and move staff appropriately to maintain safe staffing levels across all departments

5.4.7 Shift Duration

Policy:
The Trust has a responsibility to ensure the health and wellbeing of workers, and to comply with working time regulations, Agenda for Change (A4C) terms and conditions of employment. These principles must, as far as practicable, be implemented to protect all employees at work.

This policy refers to the term 'handover' and for the purpose of this policy is the time between 2 shifts that includes the patient report. Further clarification can be found in the handover policy.

For the purpose of clarity, a break will be defined as a rest period.

Any alterations to shift times, rest periods and handovers must be completed through the change control process (see appendix 2).

In line with the Agenda for Change terms and conditions of employment (A4C) and the European Working Time Directive (EWTD), all shifts in excess of 6 hours must include a minimum of 20 minutes unpaid break. It is recommended that any shifts of 12 hours or more have a minimum of 40 minutes unpaid break.

For example:

Shift start time	Shift finish time	Rest allocation	Actual hours paid (worked)	Actual hours on site
07.00	15.00	30 minutes	7hrs 30 minutes	8 hours

Shift start time	Shift finish time	Rest allocation	Actual hours paid (worked)	Actual hours on site
07.00	20.00	1 hour	12 hours	13 hours

All shifts across all wards/departments should be standardised to ease redeployment and temporary staffing. Any wards/departments not adhering to the standardised shift times must be on an exception basis and approved by the Head of Nursing.

Standard early and late shifts should be a minimum of 5 hours and a maximum of 8 hours duration each (excluding rest allocation), start and finish times can be individualised to each area.

Any changes to shift patterns must be in accordance with the change control process. Temporary change must be discussed with and approved by your matron/Head of Nursing in accordance with the change control process and finally approved by your accountant. Once approved it must then be communicated within your Care Group. Permanent changes must also be in accordance with the change control process and hence approved by both Director of Nursing and Midwifery, and Management Accounts

The ward/dept manager, individual 'in charge' is responsible for facilitating breaks.

No periods of duty should exceed 13 hours (inclusive of unpaid rest period).

Best practice:
The number of consecutive standard shifts recommended for staff to work is 8.

The number of consecutive long shifts recommended for staff to work is 2. Staff may work more than this (to a maximum of 3) if they specifically request in writing to the Ward Manager.

Night duty should not exceed a maximum of 4 consecutive shifts

Rest periods must be planned, and taken, within working time. Both A4C and EWTD stipulate that rest breaks should not be taken at the start or end of a shift.

If, in exceptional circumstances, the needs of the service do not permit you to take a rest break during working time, the unused entitlement should be taken at another point, in agreement with your Line Manager.

Any additional or under worked hours from regular shift patterns must be managed by the ward/department manager on a monthly basis. These hours may be either worked/taken back in lieu to meet service demands or the manager will agree to pay such hours. It is expected that this time shall be used during the following period of off duty. In exceptional circumstances hours may be carried over but in all instances must be used within 3 months. The maximum time to be carried over to the next period must not exceed +/- 1 shift.

Handover periods must be 30 minutes in length and any exception to this must be approved by the Head of Nursing. They must allow adequate and safe handover of clinical and managerial ward/department functions.

Attention must be given to the length of the overlap time. This must be agreed with the Matron and the Head of Nursing.

Staff should be allocated a minimum of one weekend off per roster however this may be at the discretion of the ward manager based on service requirements. The Ward Manager will document in their local policy the number of weekends and nights each member of staff is required to do in a 4 week roster. This should be a guide only, may be subject to change to meet the needs of the service, and managed by the Ward Manager.

5.4.8 Roster Production/Responsibilities

Policy:
The Ward/Department Manager is accountable for either completing the roster or appointing a responsible individual to create the ward/department roster within the constraints of the Rostering Policy. Responsibility for rosters lies with the ward/department manager. Any issues relating to over/under rostering need to be raised with Matron before final authorisation.

Publication of rosters will be scheduled across all wards in the Trust to be available for requests, authorisation and publication at the same time. This will apply in due course when e-Rostering has been implemented. All rosters will commence on a Monday.

Rosters should not be published before final authorisation by the Matron /identified deputy

Best practice:
Rosters must be completed at least 4 weeks in advance of the start date, using eRoster. This will enable staff to better manage their personal arrangements and to afford the Staff Bank office sufficient time to fill vacant shifts. However staff are expected to be reasonable in terms of changes to shifts in order to meet changes in circumstances. In these cases 48 hours' notice of a change would be expected.

All rosters should be composed to adequately cover 24 hours (or agreed set hours) utilising permanent staff proportionally across all shifts. Nights, weekends, bank holidays and specific shifts given a high priority on e-Rostering must be filled first.

Non clinical time for roles such as Ward/Department Administration, Clerical staff and Housekeepers should be entered appropriately.

The Ward/Department Manager has a responsibility to give staff accessibility to view the authorised roster.

All student nurses/midwives shifts should be included with the name of their allocated mentor identified. They must be identified as supernumerary.

With agreement between the University and Ward Manager student nurses/midwives in their first year of training can work long shifts /nights.

If any of the staff are working non–standard shifts such as late starts, this should be entered to avoid misinterpretation.

The roster must be maintained regularly to ensure its accuracy, and once locked for payroll there must be no further changes made.

5.4.9 Headroom & unavailability limits

Policy:
The headroom figure is an adjustment to the establishment to account for staff unavailability and non-productive time. Unavailability is broken down in to the following categories. The total percentage of these should equate to the 24% (approx.) headroom that is built into each establishment.

Annual leave

Annual leave threshold should be set at 15%, and this will be based on current people in team and not budget (ie vacancies and temporary cover not to be included). Calculation of 15% to be based on actual shifts worked over a week (ie No. shifts worked x 15% = weekly A/L allowed). Wards are to aim to have 15% workforce on A/L for each roster period throughout year to effectively manage resource evenly, and exceptions to this must be approved by Matron (Ward Manager must calculate annual leave allowance of team to ensure that this is achievable. In teams where there is high % of long service staff with

higher A/L allowance, exceptions may be required). The allowance can be used flexibly between RGN's and HCA's if skill mix allows.

Working day i.e. management day/non clinical day

Less than 1%

Study day

Less than 2% to be reviewed

Maternity leave/special leave

No additional time allocated

Loss of contracted hours

Contracted hours not used over a 4 week roster period should be less than 1%

Best practice:
Sickness

Should be at or below 3.6%

Total staff unavailability to be less than or equal to **24**% (exceptions will include Midwifery due to increased clinical supervision).

5.4.10 Managing annual leave

Policy:
Annual leave should be allocated according to Employment and Work Life Balance Procedures. The weekly annual leave granted should be 15% to be based on actual shifts worked over a week (ie No. shifts worked x 15% = weekly A/L allowed). Wards are to aim to have 15% workforce on A/L for each roster period throughout year to effectively manage resource evenly, and exceptions to this must be approved by Matron. The allowance can be used flexibly between RGN's and HCA's if skill mix allows.

Annual leave should be allocated in hours for each member of staff.

The Ward/Departmental Manager or designated deputy will approve all annual leave before it is taken.

Best practice:
Each Ward/Department should calculate how many staff should be taking annual leave in any one week. An agreed proportion of the total hours need to be set. Staff should be made aware of the need to maintain this number constantly throughout the year.

Ward/Departmental Managers reserve the right to allocate unbooked leave.

Staff should take approximately 40% of their annual entitlement by 31st August each year.

Fair, personal and equal allocation of annual leave requests should be available to all staff in high sought after periods such as school holidays and summer months, and public holidays such as Easter and Christmas.

The allocation of leave during the school holidays should not be increased. Annual leave requests for school holidays will be shared equally amongst those requesting.

Quarterly reviews of outstanding annual leave for each member of staff should be made by the ward manager/department manager to avoid accumulation of untaken leave.

Any leave of longer than 2 weeks in duration must be formally requested in writing to the Ward Manager and a copy kept in the personal file.

Individuals are expected to manage their own annual leave and the full year allowance should be used by 31st March each year. Any annual leave not used by 31st March each year will be forfeited except in exceptional circumstances and where authorised by the Ward/Departmental Manager. The rolled over annual leave should be taken within the first quarter of the annual leave year. The Ward/Departmental Manager is responsible for ensuring leave accrued during maternity leave or long-term sickness is allocated accordingly, in line with terms and conditions of employment.

Managers must be aware that leave taken by staff on term time contracts will be included in the total amount of the annual leave allocation for the ward. Adjustments to allow for staff to take their entitlement during school holidays must be factored into the percentage that can be allocated each roster period. Term time contracts should be reviewed annually per the flexible working policy.

5.4.11 Special leave/Study leave

Policy:
Special leave should be allocated in conjunction with the Employment and Work-Life Balance Policy.

Ward/Department Managers must ensure all staff are allocated annual mandatory study days. This training is equally as important as delivering clinical care and must be protected. The responsibility for identifying and receiving the training lies with individual staff in conjunction with their Line Manager.

Study Leave should be for a maximum duration of 7.5 hours per day (excluding unpaid rest period).

Best practice:
Other study leave should be allocated equally and in accordance with the available workforce headroom in each individual area.

Fair and equal allocation of study leave should be available to all staff and requested following Trust procedure.

Link Nursing Roles – The Trust recognises link roles are an important commitment that each ward has to factor into work patterns.

5.4.12 Flexible working

Policy:
The Flexible Working Policy should be used as a process by any staff unable to work 'normal' working hours/ shift patterns to apply in writing to the ward / department manager for a suitable variation to these that will continue to provide cover to meet the service need. A formal response must be provided by the ward manager to any application. Applications may not always be granted, and re deployment may need to be considered.

Flexible working/personal pattern arrangements must be reviewed after 3 months and annually thereafter to ensure fairness and equality in rostering is maintained.

Best practice:
The Trust recognises that there may be occasions throughout their employment when staff are unable to work the 'normal' shift pattern used in their workplace.

In line with the Trust's Flexible Working, employees who wish to change their hours of work should first discuss this with their Manager.

- Any flexible working arrangements should be openly acknowledged and published, i.e. the number of part time posts a ward can permit, the number of fixed days (personal patterns) that staff work, which can be safely accommodated per unit.
  Flexible working arrangements will usually be agreed for a set period and subject to review.

6. MONITORING AND COMPLIANCE WITH THIS POLICY

Policy:
Key performance indicators and parameters will be set and monitored, using analysis reports in the e-Roster system. Each monthly roster will provide evidence of efficient and effective workforce planning.

Ward/Department Managers and Matron/Head of Department must review/audit their rosters and shift patterns quarterly (see audit tool, Appendix 1), to monitor the effectiveness of the roster to meet service need and maintain fairness and equality to all staff.

Best practice:
Additional audits will also take place and be conducted by independent parties, the results of which will be presented to the executive board for review.

7. EQUALITY IMPACT ASSESSMENT

An Equality Impact Assessment (EIA) has been conducted on this procedural document in line with the principles of the Equality Analysis Policy (CORP/EMP 27) and the Fair Treatment For All Policy (CORP/EMP 4).

The purpose of the EIA is to minimise and if possible remove any disproportionate impact on employees on the grounds of race, sex, disability, age, sexual orientation or religious belief. No detriment was identified. See Appendix 3.

APPENDIX 1 – AUDIT TEMPLATE

Rostering Audit Template

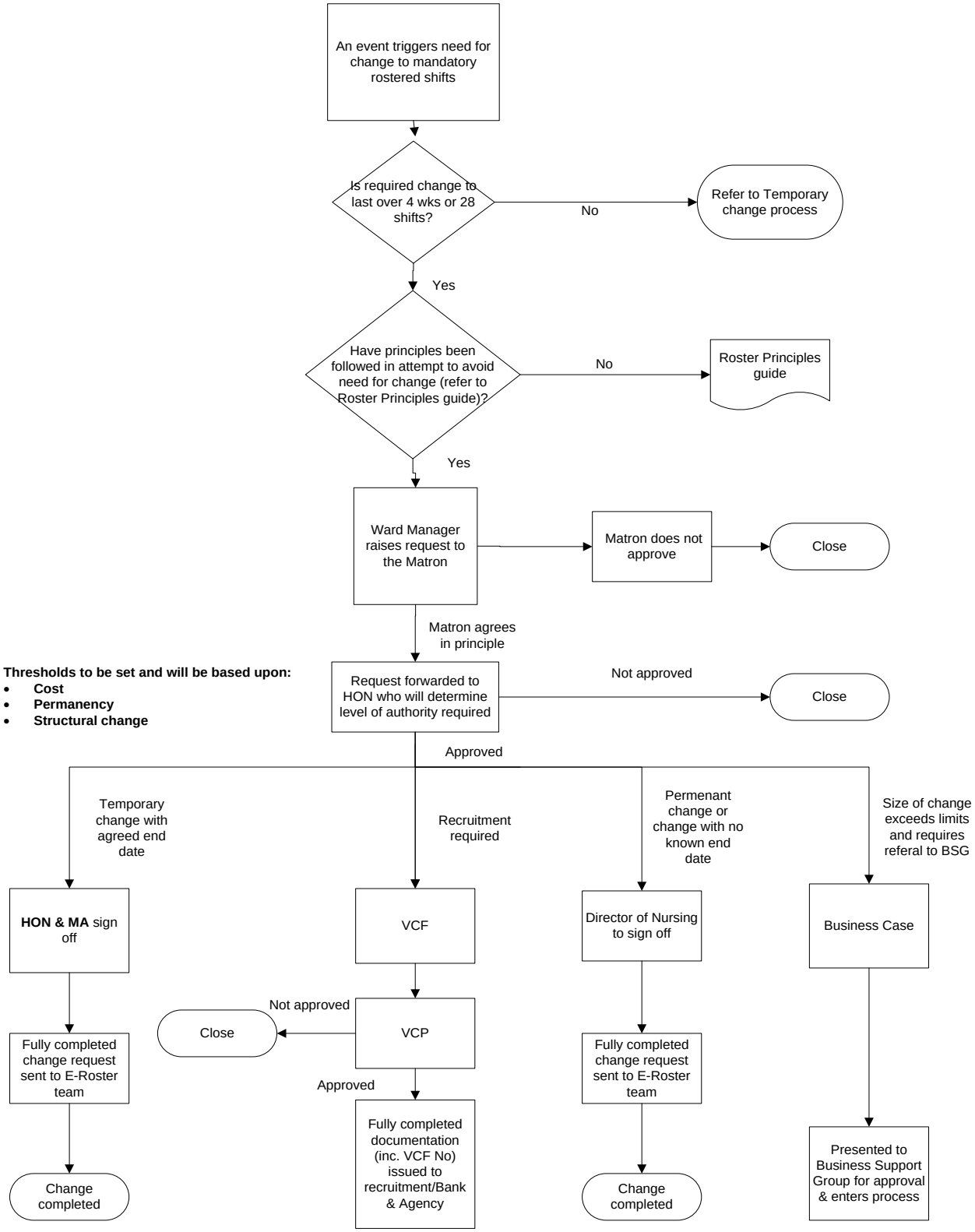
Ward / Department:
Audit completed by: **Date:**

	Yes/No	Comments	Actions
1) Are all staff aware of the policy?			
2) Do the shift and break times conform to European Working Time Directives as set out in the policy?			
3) Are the approved minimum numbers of staff rostered for each shift?			
4) Is the agreed department Skill mix maintained?			
5) Have any staff been moved within the Trust to cover vacant shifts?			
6) Is Annual Leave allocated as per policy?			
7) Is study leave allocated fairly as per policy?			

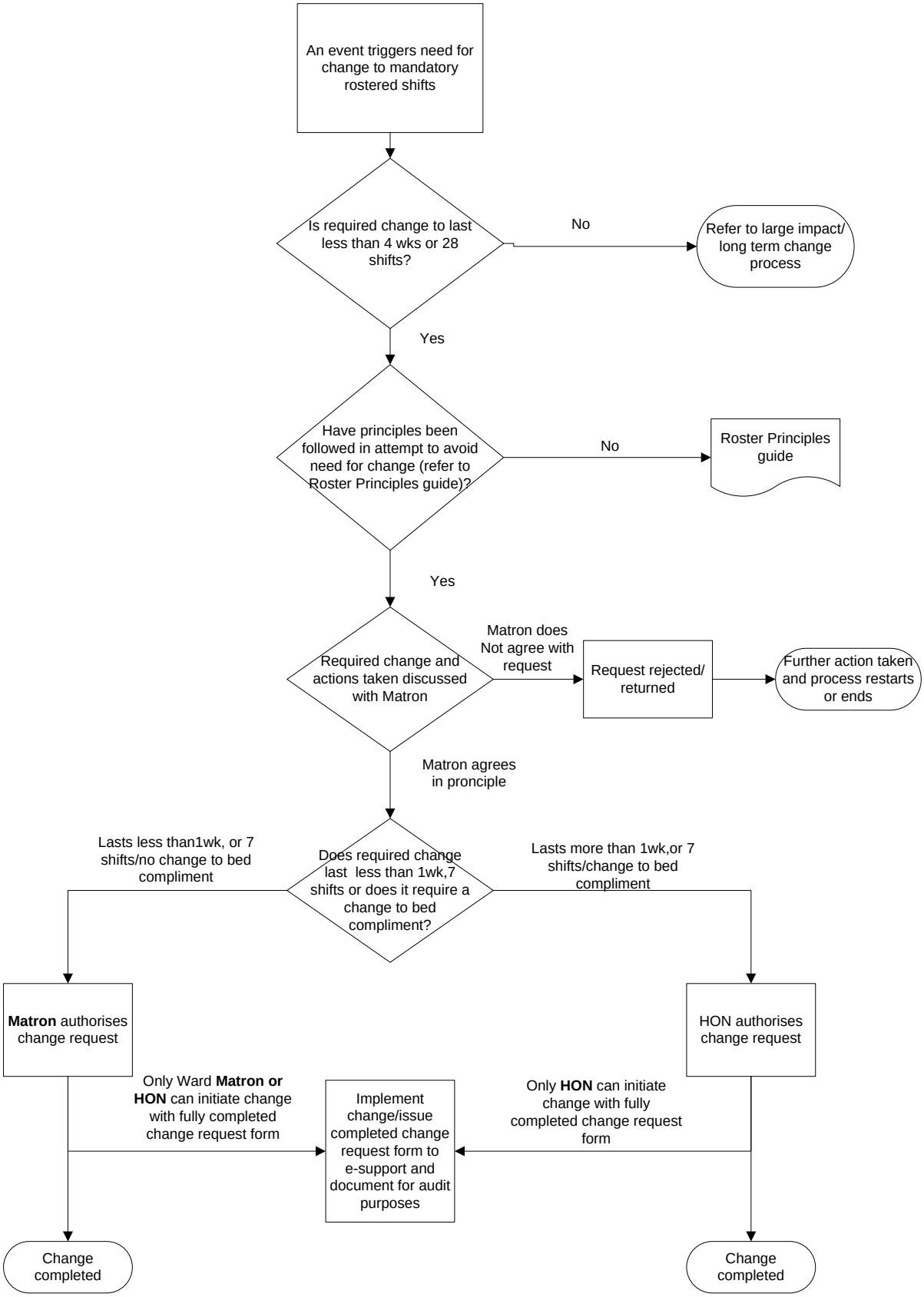
	Yes/No	Comments	Actions
8) Are any of the Work-Life Balance Procedures in use for any person in the ward/department?			
9) Are there 4 weeks of completed roster available for the staff to view?			
10) Does the ward have appropriate handover time?			
11) Are break time guidelines being followed?			
12) Is there evidence of quarterly/annual review of existing flexible work patterns?			
13) Are 3/12 of rosters available for requests?			
14) Does Matron/Head of Department approve roster?			
15) Is annual leave 15% (or by exception at agreed level to ensure all can have their entitlement)?			
16) Is there evidence of quarterly review of existing shift/work patterns?			

APPENDIX 2 – CHANGE CONTROL PROCESSES

Long Term/High cost/Permanent change request process



Roster temporary Change request process



APPENDIX 3 - EQUALITY IMPACT ASSESSMENT PART 1 INITIAL SCREENING

Service/Function/Policy/ Project/Strategy	CSU/Executive Directorate and Department	Assessor (s)	New or Existing Service or Policy?	Date of Assessment
CORP/EMP 35 v.2	People & Organisational Development	Jason Mullarkey	Update to existing policy	30/10/2014

1) Who is responsible for this policy? Name of CSU/Directorate **People and Organisational Development**

2) Describe the purpose of the service / function / policy / project/ strategy? To deliver efficient, effective and safe care, whilst also providing clarity and consistency for all nursing and midwifery teams.

3) Are there any associated objectives? Enables accurate reporting of staffing models

4) What factors contribute or detract from achieving intended outcomes? – Joint staff side agreement, teams acceptance and adherence to the policy

5) Does the policy have an impact in terms of age, race, disability, gender, gender reassignment, sexual orientation, marriage/civil partnership, maternity/pregnancy and religion/belief? Details: [see Equality Impact Assessment Guidance] - **No**

- **If yes, please describe current or planned activities to address the impact** [e.g. Monitoring, consultation] –

6) Is there any scope for new measures which would promote equality? [any actions to be taken] **One of the specific outcomes of the policy is to deliver consistency of approach and hence equality to the methods of managing work patterns**

7) Are any of the following groups adversely affected by the policy?

Protected Characteristics	Affected?	Impact
a) Age	**No**	
b) Disability	**No**	
c) Gender	**No**	
d) Gender Reassignment	**No**	
e) Marriage/Civil Partnership	**No**	
f) Maternity/Pregnancy	**No**	
g) Race	**No**	
h) Religion/Belief	**No**	
i) Sexual Orientation	**No**	

8) Provide the Equality Rating of the service / function /policy / project / strategy – tick outcome box

Outcome 1 √	Outcome 2	Outcome 3	Outcome 4

If you have rated the policy as having an outcome of 2, 3 or 4, it is necessary to carry out a detailed assessment and complete a* **Detailed Equality Analysis form in Appendix 4

Date for next review: October 2017

Checked by: Jason Mullarkey Date: October 2014