RMO Roster & Relief Review and Improvement Frameworks

Table of Contents

Overview

Background

A National Engagement Forum (SNEF) with the Speciality Trainees of New Zealand (STONZ) was formed as part of the RMO MECA settlement consisting of both DHB and STONZ representatives. The work plan for the SNEF was agreed and endorsed by the CE's in June 2019, with one of the items including a commitment to improving RMO rosters and the role of the reliever. The RMO Roster & Relief Review and Improvement Framework has been developed to support this work.

Phase 1

From July 2020 – March 2021 this framework was utilised to support the review and re-design of 53 rosters across 13 DHBs that included any of the four following roster components.

1. More than 72 hours rostered in a consecutive 7 day period
    a. In addition to the fatigue risk, the limits on hours Clause (17.1.2) in the STONZ MECA details "Individual RMOs should not be rostered to more than 72 hours in any 7 day period".
    b. This is also a pre-existing term within the NZRDA MECA which these rosters are non-compliant with.
2. Combined shifts of on-call and on-duty exceeding 16 hours
    a. Shifts in excess of 16 hours have the potential to be a high fatigue risk, especially where RMOs are unable to leave the hospital.
    b. Collated data also indicated there are some rosters nationally where there is no formalised recovery time following these shifts.
3. Insufficient recovery time following night shifts
4. More than 4 consecutive night shifts

The review of all 53 identified rosters is now completed and implementation of identified changes is also largely also complete.

Phase 2 – Psychiatry Registrars

A project was established in May 2020 to understand the specific and unique challenges that face Psychiatry trainees due to the nature and location of their work and identify potential mitigations that could be put in place.

Due to the positive outcomes from the first phase of roster reviews, it has been agreed that from 1 March 2022 – 31 July 2022, DHBs will complete a review of all Psychiatry Registrar rosters. Adjustments have been made to the roster review tool to ensure discussion on the key areas of concern identified during the data collation phase of the project including:

- Concern with roster fatigue and after hours' workload for some DHBs
- Challenges with access to safe parking and/or parking that is close by when required to travel between hospital and community sites with a lack of clarity on parking/mileage entitlements and access to taxi chits (or alternative)
- Challenges due to absences of other mental health clinicians and impact this has on RMO workload due to the nature of Psychiatry and the multi-disciplinary team
- Concern for Registrar safety when conducting home based assessments after hours
- Variation in quality of existing services available to support well-being and lack of clarity on the services that are available

Should any DHBs have concern regarding ability to complete roster reviews by the 31st July 2022 timeframe, this should be escalated to Bridget Laycock as project leave (contact details on page 7).

Phase 2 – Senior Registrar Leave

In addition, a project was established to further examine concerns relating to access to leave and leave cover for Senior Registrars. As an agreed recommendation from this piece of work, updates have been made to the Roster Review Tool and Relief Role Framework to incorporate outcomes from this project. It is

recommended that where issues with Senior Registrar leave are identified, the frameworks are utilised to support services and RMOs to jointly review models and consider possible improvements.

On-going Use

The RMO Roster & Relief Review and Improvement Frameworks have successfully supported DHBs and RMOs to work collaboratively to review rosters and identify solutions that can be implemented at a local level. Due to the positive outcomes seen with utilisation of this framework to date, service are strongly encouraged to continue use of the frameworks if concerns with rosters/relief models are raised or where change is considered.

Review of Rosters

Reviews are to be undertaken at a local level, jointly by the RMOs and the affected service.

The purpose of the review will be to identify whether a change or improvement to the roster and/or service is required to achieve the following,

- Minimise or mitigate fatigue
- Balance training requirements
- Ensure hospital service delivery and patient care

Throughout the review, DHBs and RMOs are encouraged to think innovatively and where ever possible, work smarter through efficiencies and supporting RMOs to work at the top of their scope of practice.

Resourcing

DHBs are to ensure they have a clear plan and appropriate support and resource in place to complete the review of Psychiatry rosters identified in phase 2 by 31 July 2022. Detail of individual DHB plans to review rosters will need to be submitted to SNEF for monitoring by early March 2022.

Where additional resource is expected as a result of the roster review outcome, DHBs are encouraged to start planning for potential growth in RMO FTE for the 2022/2023 financial year. An example methodology is included in Appendix 2 to support DHBs in estimating potential FTE impact.

The expectation is however, that not all roster reviews will result in additional RMO resource. DHBs and RMOs are encouraged to consider opportunities to work smarter through efficiencies and supporting RMOs to work at the top of their scope of practice. DHBs should also consider opportunities to utilise different workforces where appropriate to support the improvements. In particular, for the phase 2 Psychiatry Registrar roster reviews, the driver for the reviews relates not to roster compliance, but to the challenges presented due to the unique nature of the Psychiatry Registrar role. The review process therefore offers opportunity for development of innovative solutions which may or may not include roster changes.

It is recognised that while the review of phase 2 roster reviews is to be completed by 31 July 2022, implementation of agreed roster changes may take longer. The implementation of roster changes will be impacted by the ability to recruit FTE where it is required. DHBs should however, be committed to implementing roster changes as soon as possible which early planning will support.

Review and Improvement Process

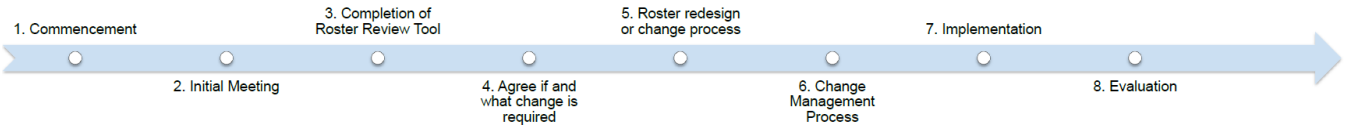
Three frameworks have been developed and agreed nationally between DHBs and STONZ to support the review and improvements of rosters and relief roles at a local level. These frameworks are,

1. Engagement and Roster Review
2. Roster Improvements and Fatigue Mitigations
3. Relief Roles

The purpose of these frameworks is to guide DHBs and RMOs through a local review of RMO rosters and relief roles to determine if and what improvements are required to minimise fatigue while balancing training requirements, hospital service delivery and patient care.

Recommended Approach

The recommended approach for the roster review and change process where a roster change is required is,



To note, steps 5 onwards are only necessary where it is agreed a change in roster or processes is required.

Each of the steps is outlined in more detail in the attached frameworks.

Project Contacts

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Framework 1: Engagement & Roster Review

The Engagement & Roster Review Framework provides guidelines and an approach for DHBs and their services and RMOs to engage locally to review RMO rosters and relief roles and determine whether a change in the roster or practices is needed to minimise or mitigate fatiguing roster patterns, improve RMO training, hospital service delivery and patient care.

Engagement Principles

The following overarching principles have been developed to support the engagement approach,

- A collaborative environment for RMOs and DHB services to provide constructive feedback and develop a shared understanding of current rostering practices
- Innovative thinking outside the box to drive what might work in the future
- Transparent and results-driven with a commitment to positive change

Step 1: Roster Review Commencement

The purpose of the roster review is for RMOs and DHB services to jointly consider and discuss the multiple aspects of a roster and the impacts these have on RMO's, training accessibility, hospital service delivery and patient care.

To support this, a roster review tool including a series of questions has been developed with a patient-centred focus. For each of the identified rosters, the following 5 key areas are to be reviewed using the tool to guide the process and ensure national consistency:

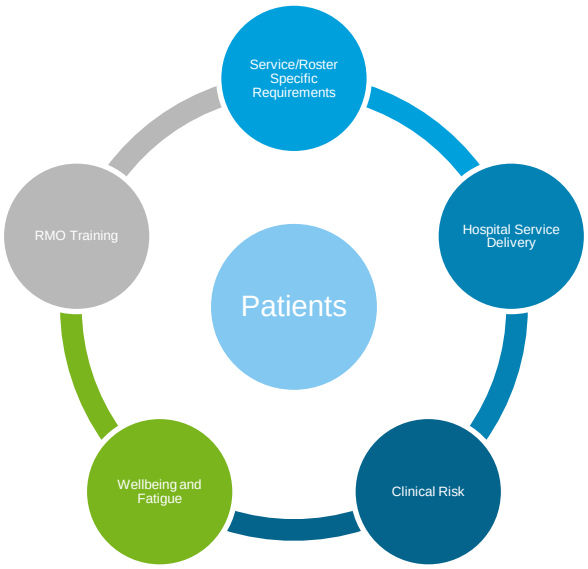
1. Service/roster specific requirements
2. Hospital service delivery
3. Clinical risk
4. Wellbeing and Fatigue
5. RMO training

The tool will aid in determining the outcome of the review which is to be jointly agreed between the DHBs and RMOs and will establish if and what changes are necessary. To note, the review may determine either no change is required to the current roster model or it may indicate improvements are needed.

Where improvements are needed these could be significant such as changing a roster model to more effectively align with workload or they could be small such as amending an internal process to improve the management of calls directed to the overnight Registrar. The Roster Improvements and Fatigue Mitigation and the Relief Model frameworks also available are to assist thinking on the different changes or adjustments that can be made to improve DHB processes, rosters and/or relief.

Key Review Areas

The diagram below demonstrates the 5 identified key roster areas have equal importance while maintaining patients and patient care at the centre of all discussions and decision making.



Roster Review Attendees

The review of the roster is to be completed locally by service leads and RMOs with representatives from the following encouraged to also participate in the roster review meetings. DHB decision-makers should attend or be easily accessible to ensure a timely progression of the roster review and outcome,

- Service Leadership including Operations/Business/Service Manager and Clinical Director/Lead or similar
- Other clinical leads associated with RMO training
- RMOs
- RMO Support
- Roster writer (if this is different to the RMO Support)
- Human Resources
- Union Delegate

Timeframe

DHBs will be asked to provide a plan outlining timeframes for completing the roster review/s to SNEF.

Engagement with RMOs on identified rosters should, therefore, commence as soon as possible and in line with the plan and timeframes agreed.

Meeting Times and Location

Meetings should be held at a time that maximises attendance and in a location with a collaborative space. For example, meet directly after handover or at the end of the day to target the availability of the desired attendees.

Step 2: Initial Roster Review Meeting

To commence and progress the review of the roster, hold an initial meeting to,

1. Establish an SMO and RMO lead for the review
2. Understand the benefits and challenges of the current roster model
3. Jointly agree on priorities for the roster
4. Familiarise yourself with the roster review tool and identify which questions will require collation of additional information to inform and complete the review

RMO & SMO Lead

Establish an RMO and SMO lead for the roster review process with the expectation that the review is clinically led.

Where appropriate and agreed, the identified RMO lead can be utilised to collate and feed back to the group on the collective RMO view.

Current Roster Model Benefits & Challenges

Develop a joint understanding of the current roster model and the benefits and challenges (e.g. service delivery, RMO training, etc.). The purpose of this is to identify potential improvement opportunities within the model for both DHBs and RMOs.

Jointly Agree Priorities

Jointly agree priorities the roster model needs to deliver on as an outcome of the roster review. To note, the roster model may not be delivering on all of the agreed priorities currently.

Priorities should support a patient-centred model of care and as an example may include some of the following,

- Continuity of care
- Receiving and delivery of training
- Mitigating or minimising fatigue
- Cost-effectiveness
- Work-life balance
- Leave availability/relief capacity

- Workforce pipeline
- Model sustainability
- Level of cover

An example of agreed priorities is included in Appendix 3.

Example Initial Meeting Agenda

To assist with the initial meeting and ensure key actions are completed, an example meeting agenda is provided below.

Item No	Agenda Item	Discussion Leader	Paper/ Page #
1	**Commencement** • Apologies • Minutes		
2	**Purpose of Roster Review Meeting** • Overview		
3	**Clinical Leads** • Identify the RMO and SMO lead for the roster review		
4	**Review & Discuss Roster Review Tool** • Review tool and identify actions to ensure all information is gathered to complete review		
5	**Jointly Agree Priorities** • Jointly agree on key priorities for the roster		
6	**Timelines** • Agree the next steps and roster review timeframes		

Step 3: Roster Review Meeting

The completion of the Roster Review Tool should occur once all parties have had an opportunity to collate any additional information required to progress through the review.

Timeframe

The review meeting is to occur within 6 weeks following the initial meeting. Where this isn't possible or there are challenges with collating information to inform and complete the review, ensure delays are communicated in a timely manner to all parties.

Roster Review Documentation

Minutes are to be recorded for the review in particular for the questions that require discussion. This is to ensure there is documentation if an outcome to the review cannot be agreed and escalation is required.

Example Roster Review Meeting Agenda

An agenda template has been included to assist with the roster review meeting and ensure key topics are covered.

Item No	Agenda Item	Discussion Leader	Paper/ Page #
1	**Commencement** • Apologies • Minutes		
2	**Purpose of Roster Review Meeting** • Overview • RMO & SMO Lead to provide an update • Jointly agreed priorities		
3	**Review Roster Tool** • Review roster against the tool		
4	**Outcome** • Jointly agree on the outcome of the review		
5	**Timelines** • Agree on the next steps and timeframes		

Roster Review Tool

The roster review tool will take you through a series of questions on the 5 key areas. These questions are to develop a joint understanding of the current model's benefits and challenges. It will also prompt conversation and discussion on why the current roster model is in place and where there may be flexibility while ensuring agreed priorities are maintained and the roster model mitigates fatigue while balancing training, hospital service delivery and patient care.

It is important as part of these discussions to also include the role of the reliever/s and how leave is currently covered within the roster.

Completion of the Tool

To simplify and support timely completion of the Roster Review Tool, where possible questions have been developed with a "yes" or "no" answer. There are however some questions within the tool which will require discussion to ensure a joint understanding of the roster.

Where the answer to a question requires no further action, progress to the next question. For example:
Question:

Does the current roster deliver on the agreed roster priorities? If no, please provide detail on the deficiencies.

Answer:

Where the answer is "yes", progress to the next question.

If an outcome to a question cannot be jointly agreed, the default is to accept the answer that requests further discussion or information. For example:

Question:

Does the current roster deliver on the agreed roster priorities? If no, please provide detail on the deficiencies.

Answer:

Where the answer cannot be agreed, "no" is the default.

Roster Review Tool

Service/Roster Specific Requirements *Specific requirements to ensure patient care, hospital service delivery and RMO training across the roster model. This could include as an example, RMO workload, team structure, model of care or budget requirements.*	**Complete**
Does the current roster deliver on the agreed priorities? If no, please provide detail on the deficiencies.	
Has there been a change in workload for RMOs since the roster was implemented? If yes, how was the change in workload measured and what resourcing changes have occurred to align with this? Resourcing changes could include, • SMO and RMO FTE • Nurse Practitioner • Allied Health technical • Technology, including software, networks and hardware • Review of work flow, e.g. reducing duplication, ensuring staff work at the top of their scope If no change to resourcing has occurred, how is the change in workload managed?	
Has the role of the RMOs changed since this roster was implemented? For example, • Model of care • Clinical workload e.g. patient volume/acuity • Ease of access to RMO Training If yes, please provide detail on the changes.	
Is there an alternative roster model that could deliver on the agreed priorities? If no, what alternative rosters have been considered in the past and what were the foreseen challenges with implementing the alternative?	
Are there any challenges to changing the roster? If yes, please provide further information on what these challenges are. Challenges may include, ○ Cost ○ RMO, SMO or other workforce pipelines ○ Previous engagement with RMOs and SMOs	
Does the experience (including, service, training, and roster) of a relieving RMO mostly align with that of an RMO within a team position? If no, what improvements could be made?	
If generic relief cover is unavailable, what is the relief model used to cover leave (including in hours and after hours shifts)? Where after hours are re-allocated, Is this manageable within the current roster? If no, what improvements could be made?	

Hospital Service Delivery *The delivery of specialist medical and surgical services to the population the DHB serves.*	**Complete**
Does the roster support collaborative and appropriate service delivery overnight? If no, what improvements could be made?	
Are there opportunities where flexibility would improve the management of clinical demand? If yes, what are these? For example, • Shift start and finish times • Sharing or pooling urgent referrals with other services	
Is the current roster pattern appropriate to manage the clinical workload (e.g. peaks in workload)? If no, what improvements could be made?	
Are the expectations for weekend ward rounds clear? What improvements could be made?	

Travel between community and hospital sites	
Are RMOs required to work across more than one hospital and/or community setting as part of their role? If yes, do RMOs: 1. Have and know how to access a taxi chit and/or fleet car? 2. Have parking available if using a fleet car or personal vehicle?	
Are there any changes that could be made to reduce travel between sites and streamline work?	
Home Based Assessments	
Are RMOs required to undertake home based assessments after hours? If yes, • Are there appropriate escalation processes in place if an RMO does not feel safe to complete a home based assessment? • Are RMOs aware of the escalation process? • Are RMOs aware of and know how to access policies/procedures surrounding home based assessments for the service?	
Are there any challenges with the home based assessment model and are there any improvements that could be made while maintaining the benefits of home based assessments for patient care	
Managing absence of Clinicians across the service	
Are there any on-going challenges with absences of staff across the wider medical team that has a significant impact on RMO workload and are there any improvements that could be made to reduce these impacts?	
Is there an escalation plan in place where there are absences across the wider medical team?	

Clinical Risk	**Complete**
Does the current roster safely deliver on patient care? For example, ○ Continuity of care ○ Alignment between RMO and SMO roster ○ Appropriately frequent and effective handovers If no, what is preventing this?	
Are there any identified clinical risks within the roster? If yes, please provide detail on these.	
When is clinical risk greatest within the current roster model and what mitigations are in place?	

Wellbeing and Fatigue	**Complete**
Have there been identified areas of increased fatigue within the current roster pattern? If yes, please provide detail on these.	
What fatigue mitigations are currently in place?	
Do RMOs have an opportunity for a break while on night shifts (either onsite or offsite)? If no, what factors impact the ability for this and how could these be managed given the expectation RMOs should have a break overnight?	
Does the roster provide the minimum recovery days following night shifts as detailed in the STONZ MECA? If no, are there any other fatigue mitigations in place following night shifts?	
Is there a mechanism in place to ensure RMOs are not working beyond the limits of hours' provisions in the STONZ MECA of more than 140 hours in a 14-day period? If no, what could be implemented to manage this?	
When an RMO raises fatigue concerns, what are the current processes and mitigations to manage this?	

How could the RMO workforce capacity be utilised to mitigate fatigue? For example, • Report for Duty (RFD) relievers to assist busy teams or provide rest • Rosters with embedded relief	
What resources are available to RMOs to support their wellbeing and are RMOs aware of the resources that are available to them?	
Are there any improvements that could be made to support RMO wellbeing?	

RMO Training *The receiving and delivering of training in the hospital setting and the ability to attend external courses and conferences for RMOs, including relievers.*	**Complete**
Does the current roster ensure an appropriate level of training and education are accessed by RMOs (including relievers) within the roster? If no, please provide further detail as to why not.	
Is RMO attendance at teaching sessions recorded by the service? If no, how does the service ensure teaching is attended by RMOs?	
Are there barriers for RMOs' to attend teaching? If yes, please provide detail.	
Does the current roster ensure college requirements and accreditation standards are met? If no, please provide further detail as to why not.	
Is there adequate capacity available to ensure appropriate cover for Medical Education Leave and Conference leave requirements? If no, what improvements could be made?	
Is supervision, training and teaching attendance ensured for RMOs in relief roles? If no, what improvements could be made to ensure this?	

Step 4: Roster Review Outcome

Following collaboration and joint completion of the tool, participating parties need to agree whether the current roster model reasonably and practically delivers on the following,

1. Jointly agreed priorities
2. Monitors and responds to workload
3. Mitigates fatigue
4. Ensures training requirements, hospital service delivery and patient care

Where it is agreed that the current model does not deliver on these, improvements to the roster model or DHB processes is required. DHBs and RMOs will then jointly work through a process to improve rosters and/or processes locally.

To note, this is also an opportunity to discuss and agree other improvements, although not necessarily required as an outcome of the review.

Escalation Pathway

If an outcome of the roster review cannot be jointly agreed, the DHB Chief Medical Officer (CMO) or delegate and STONZ representative will meet to discuss the completed review and current roster to work through discrepancies and agree next steps.

Step 5: Roster Re-design Process

Where the improvement of a roster or DHB process is agreed as part of the roster review, the following approach is recommended when making changes,

- Ensure a balanced perspective and consider wider impacts, e.g. trade-offs
- RMO representation in the development of changes, for large or complex rosters this may include establishing a working group with RMO and DHB participation
- If possible, develop innovative roster solutions which may have not been considered before
- Understand and mitigate barriers for changing the roster, e.g.
    - Cost
    - Availability of appropriate RMOs, e.g. level, training pathway, etc.
    - Training impact
- Consider the impact of changes on the wider multidisciplinary team (MDT)

Step 6: Change Management Process

A change management process will be required to implement any run description and/or roster changes as an outcome of the review. This will need to be completed using the standard DHB and RMO MECA change processes with consideration given to the contractual requirements of the STONZ and NZRDA agreements.

A template change and consultation document is included in Appendix 4.

Step 7: Implementation

DHBs and RMOs should work to implement the agreed roster and/or run description changes as soon as feasible.

Step 8: Evaluation

It is recommended a meeting is held to jointly evaluate the implemented changes to ensure the roster has been reasonably and practically improved.

DHBs may want to identify measures and use the Roster Review tool as a guideline.

Where issues are identified during the evaluation, actions and timeframes will need to be established to address these.

Where it is agreed that the implemented solution has reasonably and practically improved the roster, this concludes the roster review process.

Timeframe

It is recommended the evaluation occurs 2 – 6 months' post-implementation to allow sufficient time to see the impact of these changes.

Evaluation Attendance

Attendance at the Evaluation meeting should include all the participants who were involved in the completion of the Roster Review tool.

Additional RMOs may need to attend if there has been a run rotation to ensure the impact of the changes is captured in the evaluation.

Example Evaluation Meeting Agenda

To assist with the Evaluation meeting and ensure key steps are completed, an example meeting agenda is provided below. Included in the agenda are three questions to answer which will support with evaluating the implemented changes.

Item No	Agenda Item	Discussion Leader	Paper/ Page #
7	**Commencement** • Apologies		
8	**Purpose of Evaluation Meeting** • Overview		
9	• Review and Discuss Implemented Solution • Are there any on-going barriers to implementing the agreed outcomes of the review? • Have the implemented changes reasonably and practically improved the roster and/or service and delivered on the agreed priorities? • Were there any unintended consequences and how were these addressed?		
10	**Timelines** • Agree outcome • (If required) Agree the next steps and timeframes		
11	**Next Meeting (if required)** • Meeting date		

Framework 2: Roster Improvements and Fatigue Mitigation

The Roster Improvement and Fatigue Mitigation Framework provides example rosters or improvements for consideration by DHBs and RMOs in services where improvements have been agreed as required to achieve one or more of the following,

- Minimise or mitigate fatigue
- Balance training requirements
- Ensure hospital service delivery and patient care

In considering fatigue, this needs to be done in a context that fatigue is a physiological state of reduced physical and mental performance capability caused by four main factors:

1. Sleep loss
2. Extended time awake
3. Working and sleeping at suboptimal times in the circadian body clock cycle
4. Workload (mental and physical)

Workplace fatigue is inevitable for workers who cover 24/7 rosters. It cannot be eliminated and must be managed through periods of unrestricted sleep to repay sleep debt. During a roster cycle fatigue is variable and can accumulate. The process and roster improvement examples within this framework consider the four main factors of fatigue and encourage periods of rest.

Roster and Service Improvements

The roster examples provided are to aid thinking, and DHBs and RMOs are encouraged to think openly and innovatively to find local solutions.

The examples included in this framework may not be fit for purpose for all services and through the review process, other improvements may be identified and agreed.

A number of service improvement examples are also outlined and should be considered as a first step or interim solution before progressing to roster changes. An evaluation is required to ensure the changes successfully address the concerns identified as part of the roster review.

Resourcing

Some of the examples detailed in the framework as options for roster improvements may require additional RMO resource and/or FTE (fulltime equivalent) to implement with FTE estimates based on 0.2 FTE per each additional day of cover required.

Roster Examples

To keep the roster examples within this framework concise, rosters read downwards. For example, RMO 1's second week on the roster is RMO 2's roster line. RMO 8's second week is RMO 1's.

Roster examples do not include relief cover for night duties, sleep days and leave cover unless stated. The expectation is that leave for these examples is approved in line with the ratios detailed in Appendix 2 of the STONZ MECA.

More than 72 hours rostered in a consecutive 7 days

Roster solutions and mitigation examples are provided for rosters with more than 72 hours rostered in a consecutive 7 days.

Example - Current Roster

This roster example has 8 RMOs and models a roster which includes a roster breach where an RMO exceeds 72 hours rostered in a consecutive 7 days in a single week as per RMO 5's roster line.

The roster provides 24/7 cover and includes handovers at the start and end of the shifts. It also has 34 Monday to Friday shifts where RMOs are onsite across the 8-week roster cycle.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1					**N**	**N**	**N**
RMO 2	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 3			**L**			X	X
RMO 4	**L**			**L**		X	X
RMO 5						**L**	**L**
RMO 6						X	X
RMO 7					**L**	X	X
RMO 8		**L**				X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1600	8.5 hours	**L**	0730 – 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Service Improvements

The following change to the model could be made to reduce the number of hours in a consecutive 7-day period. Internal processes to support such a change would need to be considered across the service and ensure such a change is sustainable within the current RMO resource;

- Provide a flexible half-day off either side of the weekend within the 7-day period, reducing the hours of work to less than 72.

Roster Improvements

Three potential roster examples are provided below which reduce the hours in a consecutive 7-day period to be less than 72.

Example 1 – Lengthen night shifts and shorten long days

This roster example shortens the length of the long days from 15 hours to 13 and lengthens the night shifts from 10 hours to 12. In comparison to the *current roster example,* this reduction in length of long days reduces the maximum hours in a consecutive 7-day period from 72.5 to 68.5.

The number of Monday – Friday shifts also reduces with this model from 34 days to 32 across the 8-week roster cycle and to maintain the same level of cover an increase of 0.4 FTE is required.

With this example, there is no ability to increase the length of the night shifts to 12 hours without reducing the number of consecutive night shifts to a maximum of 4 consecutive nights as the total hours for 7 consecutive night shifts would exceed 72.

To note, the limits on hours' provisions in the NZRDA MECA prohibit no more than 2, 12-hour night shifts in a consecutive 7-day period. For rosters which also have RMOs covered by the NZRDA MECA, an interim solution could be considered such as implementing a 12-hour night shift for Saturday and Sunday nights only as per the second roster option below.

Option 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**NW**	**NW**	**NW**	**NW**	**Z**	**Z**	**Z**
RMO 2			**LW**			X	X
RMO 3						**LW**	**LW**
RMO 4						X	X
RMO 5		**LW**			**LW**	X	X
RMO 6					**NW**	**NW**	**NW**
RMO 7	**Z**	**Z**				X	X
RMO 8	**LW**			**LW**		X	X

Option 2 – Interim Solution

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 2			**L**			X	X
RMO 3						**LW**	**LW**
RMO 4						X	X
RMO 5		**L**			**L**	X	X
RMO 6					**N**	**NW**	**NW**
RMO 7	**Z**	**Z**				X	X
RMO 8	**L**			**L**		X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1600	8.5 hours	**L**	0730 – 2230	15 hours
LW	0730 - 2030	13 hours	**N**	2200 – 0800	10 hours
NW	2000 – 0800	12 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Example 2 – Shorter Shifts

Two roster examples are provided to demonstrate options for reducing rostered hours over a weekend period, resulting in less than 72 hours rostered in a consecutive 7-day period.

Option 1

This roster example splits the weekend long day shift into two 8 hour shifts, reducing the maximum hours in a consecutive 7-day period from more than 72 to 65.

While this example does not impact the number of Monday – Friday day shifts RMOs are onsite for, it does increase the weekend frequency from a 1:3.5 to a 1:2.3. To maintain a weekend frequency of at least 1:3, an increase of 1 FTE is required for this example.

This model does however, have other benefits such as the overlapping of shift start and finish times to provide additional capacity. For example, by extending the weekend evening shift to finish at 2330, this increases the number of RMOs on duty between 2230 – 2330 by 1 in comparison to the *current roster model,* the additional capacity can then be utilised to manage a potential back log in ED and support the RMO coming on to the night shift.

Option 1 – Roster Example

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**N**
RMO 2	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 3				**L**		X	X
RMO 4			**L**			**D**	**E**
RMO 5						X	X
RMO 6		**L**				**E**	**D**
RMO 7						X	X
RMO 8					**L**	X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1600	8.5 hours	**L**	0730 – 2230	15 hours
D	0730 - 1530	8 hours	**E**	1500 – 2330	8.5 hours
N	2200 - 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Option 2

This roster example changes the weekend shifts from two consecutive long days to 1 long day of 15 hours and 1 shorter day of 8 hours, reducing the maximum rostered hours in a consecutive 7-day period to 65.5.

In line with Option 1, this example does not impact the number of Monday – Friday day shifts RMOs are onsite for. However, it does increase the weekend frequency from a 1:3.5 to 1:2.3. To maintain a weekend frequency of at least 1:3, an increase of 1 FTE is required.

The benefits of this model include an increase in cover from 0730 – 1530 of 1 FTE for Saturday and Sunday. As an example, this additional capacity could be utilised to roster or formalise unrostered weekend ward rounds that are occurring in practice in some services across DHBs nationally.

Option 2 – Roster Example

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**N**
RMO 2	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 3			**L**		**L**	X	X
RMO 4						**LW**	**S**
RMO 5						X	X
RMO 6						**S**	**LW**
RMO 7						X	X
RMO 8		**L**		**L**		X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1600	8.5 hours	**L**	0730 – 2230	15 hours
LW	0730 - 2230	15 hours	**S**	0730 - 1530	8 hours
N	2200 - 0800	10 hours	**X**	Rostered Off	-
Z	Rostered Off	-			

Example 3 – Hybrid Shift Roster

The following roster example is a hybrid of an ordinary roster and a shift roster and reduces the hours in a consecutive 7-day period to a maximum of 58.5. It utilises some of the shift roster principles to reduce the hours per shift to a maximum of 10 hours.

This roster model can work well for services where there isn't a need for a strong team structure and SMO informal teaching and supervision is provided onsite up until at least 10 pm.

This model does reduce the onsite Monday – Friday shifts for RMOs from 34 to 23. However, if supervision can be provided onsite for the evening shifts in addition to the day shifts, RMOs would have appropriate supervision for 28 shifts.

Due to the design of this example, it is recommended the following are considered when adopting this approach,

- Nature of work and service delivery model
- Contact time of RMOs with SMOs
- Accessibility to informal and formal teaching opportunities
- Attendance at clinics and other service provisions

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	E	E	X	X	D	D	D
RMO 2	D	D	D	D	D	X	X
RMO 3	N	N	N	N	Z	Z	Z
RMO 4	D	D	D	D	D	E	E
RMO 5	X	X	D	D	D	X	X
RMO 6	D	D	E	E	E	X	X
RMO 7	D	D	D	D	N	N	N
RMO 8	X	X	D	D	D	X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
D	0730 - 1630	8.5 hours	E	1600 – 2400	8 hours
N	2200 - 0800	10 hours	X	Rostered Off	-

Combined shifts of on-call and on-duty exceeding 16 hours

Roster solutions and mitigation examples are provided for rosters with combined shifts of on-call and on-duty exceeding 16 hours.

Example - Current Roster Model

This roster example has 4 RMOs and provides cover for evening, weekend and night shifts through combined shifts of on-call and on-duty exceeding 16 hours with no formalised recovery time following the combined on-call and on-duty shift.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**			**L**		X	X
RMO 2			**L**			**L**	**L**
RMO 3						X	X
RMO 4		**L**			**L**	X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0800 - 1600	8 hours	**X**	Rostered Off	-
L	0800 – 1600 onsite / 1600 – 0800 on-call, offsite				

Service Improvements

Feedback received as part of the data collection phase indicated there are common challenges that can occur as part of the on-call and on-duty combined shifts, and which if addressed would enable more effective management of the workload, outside of changing the roster. These include;

- Communication with overnight Registrar
  - Reduce the number of roles phoning the overnight Registrar to 1 or 2 to ensure calls are at an appropriate level for the Registrar and provide an opportunity for calls to be regulated.
  - Increase nurse leadership and seniority overnight to triage calls to the on-call Registrar

- Increased understanding
  - Increase staff understanding within services which have a Registrar on-call, offsite overnight on the appropriateness of calls and call-backs into the hospital for the Registrar.
  - Clarify with staff the Registrar's hours of work and when they are available on and offsite each day.

- Delegated Authority
  - If appropriate, provide delegated authority to the Emergency Department to admit patients directly into a service. This avoids delays and the need to call the Registrar back into the hospital to admit a patient. To note, this may not be appropriate for some services and is dependent on other DHB processes and policies.

- Recovery days
  - Jointly agree a reasonable threshold and process to generate a recovery day following the combined on-call and on-duty shift. The threshold could include the number of phone calls received, call-backs into the hospital and opportunities for breaks overnight.

Roster Improvements

Example 1 – Formalise Recovery Time

The following example continues with combined shifts of on-call and on-duty exceeding 16 hours. However, the example demonstrates the ability to provide formalised recovery time following the shift where the jointly agreed threshold has been met to generate the recovery day.

For example, the agreed threshold may be a minimum of 1 call-back into the hospital and where this minimum occurs the recovery time following the shift applies.

To note, for some services, this may already occur in practice.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**	8/Z				L	X
RMO 2			**L**	8/Z	**L**	X	X
RMO 3		**L**	8/Z			X	L
RMO 4	8/Z			**L**	8/Z	X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0800 – 1600	8 hours	**X**	Rostered Off	-
L	0800 – 1600 onsite / 1600 – 0800 on-call, offsite				
8/Z	0800 – 1600 unless called in overnight, then sleep day applies				

Example 2 – Pool night cover with other services

To reduce the length of the on-call and call-back shift to be 16 hours or less, this roster example pools together three smaller services to provide onsite overnight cover while evening and weekend cover remains in the individual services.

In this example, RMOs will work a set of night shifts at a frequency of 1:9 weeks (Night Reliever position is included in these ratios) with combined shifts of on-call and on-duty not exceeding 16 hours, noting this example is based on RMOs working 7 consecutive nights and where they have regular opportunities for rest and/or sleep overnight.

This model could be utilised for when there are several smaller services within one department/directorate and collectively have the workload overnight for an onsite RMO.

When adopting this model, the following should be considered,

- The workload of individual services who are to be pooled to ensure this is manageable overnight
- The expertise required for each service and the ability for RMOs from other services to provide appropriate cover
- Clear escalation pathways for RMOs working outside of their usual service

Service 1

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1		**L**			**L**	**X**	**X**
RMO 2			**L**			**L**	**L**
RMO 3						**X**	**X**
RMO 4	**L**			**L**		**X**	**X**

Service 2

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				L	L	L
RMO 2			**L**			X	X
RMO 3		**L**		**L**		X	X

Service 3

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**N**
RMO 2	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 3		**L**			**L**	**X**	**X**
RMO 4			**L**			**L**	**L**
RMO 5						**X**	**X**

Night Reliever

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	Service 3	Service 3	Service 3	**Service 3/L**	Service 3	X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0080 - 1600	8 hours	**N**	2200 – 0800	10 hours
Z	Rostered Off	-	**X**	Rostered Off	-
L	0800 – 1600 onsite / 1600 – 2200 on-call, offsite				

Insufficient Recovery Time Following Night Shifts

Roster solutions and mitigation examples are provided for rosters with insufficient recovery time following night shifts. Insufficient recovery time is where the recovery days following night shifts are less than those detailed in the STONZ MECA. As per clause 17.4.6 of the STONZ MECA, the recovery time following nights should be 3 sleep days following 4 or more night shifts and 2 sleep days following 3 or less night shifts.

Example - Current Roster Model

This roster example has 8 RMOs and models a roster with insufficient recovery time following night shifts as there is only 1 recovery day following 2 consecutive night shifts, not 2 as per clause 17.4.6 of the STONZ MECA. This is demonstrated in the first two weeks of RMO 1's roster.

The roster provides 24/7 cover and includes handovers at the start and end of the shifts. It also has 34 Monday to Friday shifts where RMOs are onsite across the 8-week roster cycle.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**Z**
RMO 2						**X**	**X**
RMO 3		**L**			**L**	**X**	**X**
RMO 4						**L**	**L**
RMO 5						**X**	**X**
RMO 6			**L**			**X**	**N**
RMO 7	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 8				**L**		**X**	**X**

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 – 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Service Improvements

By agreement, the following improvements could be considered for implementation to mitigate fatigue following night shifts without increasing recovery time directly following nights,

- A rostered half-day off or full day off later in the week not directly following the night shifts.
- A clear process for RMOs to raise concerns if they are feeling fatigued following their night shifts and the ability for the service to provide a half-day or full-day off to rest.
- Where it is agreed the night shifts on a roster are not particularly fatiguing, less recovery time following nights can be agreed.

Roster Improvements

Example 1 – Increase sleep days

To ensure the roster meets the minimum recovery time following night shifts of 2 sleep days following 2 nights, this roster model increases the number of sleep days following the 2 consecutive night shifts from 1 sleep day to 2.

With the increase in sleep days, the Monday – Friday day shifts where RMOs are onsite reduced from 34 to 33 days across the 8-week roster cycle. To maintain the same level of cover as the *Current Roster Model* an increase of 0.2 FTE is required.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**Z**
RMO 2	**Z**		**L**			**X**	**X**
RMO 3					**L**	**X**	**X**
RMO 4						**L**	**L**
RMO 5						**X**	**X**
RMO 6				**L**		**X**	**N**
RMO 7	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 8		**L**				**X**	**X**

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 - 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Example 2 – Change Night Shift Split and Increase Sleep Days

This roster example changes the split of night shifts from 5 and 2 consecutive night shifts to 4 and 3 consecutive nights and provides 3 sleep days following 4 consecutive night shifts and 2 sleep days following 3 consecutive nights.

With the change in the split of night shifts and an increase in sleep days, the Monday – Friday day shifts where RMOs are onsite reduces from 34 to 32 days across the 8-week roster cycle. To maintain the same level of cover as the *Current Roster Model* an increase of 0.4 FTE is required.

The benefit of this model is it reduces the number of weekends impacted by night shifts from 2 weekends to 1, reducing the weekend frequency from a 1:2.7 to a 1:4 across the 8-week roster cycle. This model also reduces the number of consecutive night shifts from 5 to 4 nights.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**N**
RMO 2	**Z**	**Z**		**L**		**X**	**X**
RMO 3					**L**	**X**	**X**
RMO 4						**L**	**L**
RMO 5						**X**	**X**
RMO 6			**L**			**X**	**X**
RMO 7	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 8		**L**				**X**	**X**

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 - 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

More than 4 Consecutive Night Shifts

Roster solutions and mitigation examples are provided for rosters with night shifts patterns of more than 4 consecutive night shifts.

To note, more than 4 consecutive night shifts can be rostered where it is agreed there are regular opportunities for rest and/or sleep during nights as per clause 17.3.3 of the STONZ MECA. However, the outcome of the roster review may indicate the need for a reduction in consecutive night shifts to a maximum of 4 nights if the workload does not allow regular opportunities for rest and/or sleep overnight.

Service Improvements

The following process or resource changes may be considered for implementation to support appropriate rest overnight for rosters with night shift patterns of more than 4 consecutive night shifts,

- Improve processes and escalation pathways for RMOs on night shifts to ensure regular rest and/or sleep opportunities are provided
- Increase the wider multidisciplinary team (MDT) resource overnight to support redistribution of work from the RMO where appropriate

Roster Improvements

Example - Current Roster Model

This roster example is of a basic roster with 8 RMOs and provides 24/7 cover with handovers incorporated into the start and finish times and does not include any additional service provisions such as weekend ward rounds.

However, with 7 consecutive night shifts rostered, this exceeds the limit of a maximum of 4 consecutive nights as per clause 17.3.2 of the STONZ MECA and will need to be addressed unless it is agreed that regular opportunities for rest and/or sleep are provided.

This model provides 34 Monday - Friday day shifts where RMOs are onsite across the 8-week roster cycle.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1					**N**	**N**	**N**
RMO 2	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 3			**L**			X	X
RMO 4	**L**			**L**		X	X
RMO 5						**L**	**L**
RMO 6						X	X
RMO 7					**L**	X	X
RMO 8		**L**				X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 - 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Example 1 – 3 and 4 Consecutive Night split

This roster example splits the night shifts into 4 and 3 consecutive shifts and provides 3 sleep days following 4 consecutive nights and 2 sleep days following 3 nights to reduce the number of consecutive nights to no more than 4.

With splitting night shifts and providing additional sleep days, the Monday – Friday day shifts where RMOs are onsite reduced from 34 to 32 days across the 8-week roster cycle. To maintain the same level of cover as the *Current Roster Model* an increase of 0.4 FTE is required.

The benefit of this model is there is no impact on the weekend frequency of 1:4.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**N**
RMO 2	**Z**	**Z**		**L**		**X**	**X**
RMO 3					**L**	**X**	**X**
RMO 4						**L**	**L**
RMO 5						**X**	**X**
RMO 6			**L**			**X**	**X**
RMO 7	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 8		**L**				**X**	**X**

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 - 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Example 2 – 2 and 5 Consecutive Night Split

Where it is agreed as part of the roster review that the opportunities for rest and/or sleep overnight is suitable for up to 5 consecutive nights shifts this roster example could be utilised.

This example splits the night shifts into 5 and 2 consecutive shifts and provides 3 sleep days following 5 consecutive nights and 2 sleep days following 2 nights to reduce the number of consecutive nights to less than 7.

With the splitting night shifts and providing additional sleep days, the Monday – Friday day shifts where RMOs are onsite reduced from 34 to 33 days across the 8-week roster cycle. To maintain the same level of cover as the *Current Roster Model* an increase of 0.2 FTE is required.

The benefit of this model is there is a lesser impact on the onsite Monday – Friday day shifts.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**L**				**N**	**N**	**Z**
RMO 2	**Z**		**L**			**X**	**X**
RMO 3					**L**	**X**	**X**
RMO 4						**L**	**L**
RMO 5						**X**	**X**
RMO 6				**L**		**X**	**N**
RMO 7	**N**	**N**	**N**	**N**	**Z**	**Z**	**Z**
RMO 8		**L**				**X**	**X**

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 - 2230	15 hours
N	2200 – 0800	10 hours	**Z**	Rostered Off	-
X	Rostered Off	-			

Framework 3: Relief Roles

The purpose of the Relief Framework is to assist DHB's and RMO's thinking on models which could be implemented to improve the relief experience for RMOs in relief roles and to support the leave process in services where there are no designated relief roles (for example senior registrar rosters).The framework provides examples of 8 relief models currently implemented in DHBs nationally. Detailed within each of the models are some potential benefits and challenges and an example of where each model could be utilised.

RMO Relief Roles - Overarching Challenges

Through engagement with RMOs in both a focus group and discussion within the working group, common themes have been identified regarding the overarching challenges with relief roles

- Limited continuity of care and ability to participate fully in the patient journey
- Difficulty establishing SMO mentors and regular contact with supervisors
- When covering across multiple services, regular attendance at RMO teaching sessions can be difficult to achieve, as teaching can occur on different days of the week for each service
- In general Colleges do not accredit RMO's time in a relief role for training
- Ability to plan life outside of work is impacted due to the notification timeframes of duties
- Relief position numbers have increased and as a result in RMOs are spending more time in relief impacting college accreditation and training time

RMO Relief Roles - Best Practice Guidelines

To offset the challenges and improve the RMO relief experience, the following best practice guidelines have been developed:

1. Establish service and team preferences that align with individual RMO vocational training pathways and assign duties accordingly throughout the run
2. Assign relievers to a single team or at a minimum, a service for at least a consecutive 2-week period resulting in,
    - Opportunity for continuity of care
    - SMO mentoring and contact time
    - Teaching attendance
3. Communicate relief duties to RMOs with as much notice as possible. Noting duties can change within the time frames detailed in the STONZ MECA
4. Relievers cover a limited number of services with assigned SMO supervision and the ability to attend RMO teaching enabling conversations with colleges regarding the accreditation of training time
5. Where appropriate, implement Embedded Relief (Relief Model: 5) or Rotating Relief (Relief Model: 4) to minimise the number of relief positions overall
6. At the commencement of the relief run, relievers are provided with an orientation which may include,
    - An introduction into what relief entails
    - Clarification on roles and responsibilities
    - Identifying key contacts, including designated supervisors
    - Details on service teaching sessions to enable regular attendance
    - Key service specific information
    - RMO units and services are encouraged to invite RMOs to apply for leave prior to roster publication allowing maximal time for notice and deployment of relief RMOs. RMOs are also encouraged to plan their leave ahead of time and ensure they have a spread of leave to enable periods of rest and recuperation through the year.
7. RMO units and services are encouraged to invite RMOs to apply for leave prior to roster publication allowing maximal time for notice and deployment of relief RMOs. RMOs are also encouraged to plan their leave ahead of time and ensure they have a spread of leave to enable periods of rest and recuperation through the year

Rosters without designated relief roles (i.e. Senior Registrar Rosters) - Overarching Challenges

A survey was undertaken of trainees working in rosters where Registrars are unable to be covered by a planned leave reliever (i.e. SET Surgical Registrar rosters). These rosters are commonly small rosters with 2-10 trainees, rosters that do not have readily available access to a locum pool and where the roster is commonly split between Junior and Senior trainees. These rosters may be rosters that are written by a chief resident or similar role.

The survey identified the following challenges:

- Relief positions are often not fit for purpose to provide cover for Senior Registrars. As a result, Senior Registrars have historically often been required to swap their on call/afterhours shifts in order to take leave.
- There can be a lack of transparency and variation in the leave approval process including:
    - How leave decisions are made and by who
    - How/when leave applications are escalated and to who
    - How much leave should be taken per run
    - What is incorporated in the salary where relief cover is provided within the salary and what is payable in addition to the run category
    - Varied levels of communication regarding the process and timeframes
- Periods of reduced staffing have a significant negative impact on ability to take leave for those remaining on the roster.
- Leave required to be applied for a long time in advance with limited flexibility for leave after the roster is published.

Rosters without designated relief roles (i.e. Senior Registrar Rosters) - Best Practice Guidelines

1. Encourage RMOs to apply for leave prior to roster publication allowing maximal time to ensure they have a spread of leave to enable periods of rest and recuperation through the year
2. Provide RMOs entering the service with clear and transparent information on leave processes, for example:
    - Leave approval process and key contact for leave applications where not a standardised process
    - Service specific parameters and requirements for leave
    - Escalation process for leave applications
3. Ensure clear and transparent information on the salary within the run description including:
    - Confirmation of what allowances are included within run category and salary
    - What hours/penalty payments may be claimed in exceptional circumstances
4. For rosters written by a chief resident or other Registrar ensure the Registrar has access to the roster writing and leave management guide to support the roster writing and leave approval process.
5. Ensure there is consideration to relief models 7 (embedded relief/re-allocation) and/or model 8 (service changes) to enable leave access.

Relief Models

To support DHBs in reviewing their current relief models or considering future models and improvements a number of models have been provided below as examples.

Each of the models is currently implemented in a DHB nationally, with the potential benefits, challenges and an example of where each model could be utilised provided.

In reviewing each of the models, consideration should also be given to the best practice guidelines and how these would be applied to minimise or offset any of the challenges identified for each model. DHBs may also want to consider using multiple models in tandem, for example utilising Embedded Relief (Relief Model: 5) to reduce the overall relief position numbers and Pooled Relief (Relief Model: 4) to ensure appropriate leave cover.

Relief Model and Roster Examples

Note for each example rosters read downwards to keep the examples concise. For example, RMO 1's second week on the roster is RMO 2's roster line. RMO 8's second week is RMO 1's.

For the examples provided within the framework, relief duties include cover for planned and unplanned leave, night relief and rostered days off (RDO).

Relief Model 1: Designated Service Relief

Relieving RMOs are employed into a designated service and only provide relief cover for that specific service roster. As an example, the designated General Surgery relievers only provide relief cover for duties within the General Surgery roster.

Benefits

The benefits of the designated service relief model may include:

- Supports regular attendance at service teaching sessions as these are a standard scheduled expectation within the service
- May support prerequisite requirements for vocational training – option to accredit should be discussed with the relevant College.
- Consistent supervision from within one service and opportunities for regular contact with supervisor
- RMOs can establish a clear understanding of service specific processes
- Increased opportunities for continuity of care and end-to-end patient journey

Challenges

The challenges with the designated relief model may include:

- Reduction in flexibility with available relief capacity limited to use in one service and not across services where there may be a need.
- Where the relief capacity has been fully utilised, any additional cover required is internal or by a locum. For smaller services, this may result in difficulty sourcing cover

Example

This model is suited to smaller or specialised services where a low number of relief positions with a specific skill set or experience are required. A common example is O&G.

It is also suited to instances where the provision of relief in a dedicated service and the experience in the run can be tailored to meet prerequisite requirements for a specific vocational pathway, for example, a General Surgery Registrar applying to the Surgical Training program.

Relief Model 2: Pooled Relief

Pooled relief is where relieving RMOs are in one large pool and relief cover is provided from within this pool for multiple services. Rosters for the relief RMOs can include duties from all services covered by the relief pool. For example, a Surgical House Officer relief pool would provide relief cover for all Surgical Specialities (e.g. General Surgery, Orthopaedics, Plastic Surgery, etc.).

Benefits

The benefits of pooled relief may include:

- Flexible rostering as duties can be shared across several RMOs to ensure an effective and compliant roster with after-hours duties spread across the pool of RMOs.
- Where multiple services require partial FTE to align with the relief ratios detailed in the STONZ MECA, these can be combined resulting in fewer relief positions overall
- Greater flexibility than service-specific reliever roles increasing the ability to approve and cover leave
- Provides a broader experience for RMOs to 'try' out different specialities. To maximise this benefit, RMO Units are encouraged to identify with their RMOs in advance of the run, areas of interest and align relief rosters to this where possible

Challenges

The challenges with pooled relief may include:

- Continuity of care as relieving RMOs may cover across multiple services within a 1 -2-week period
- Inconsistent supervision for RMOs if they regularly relieve across multiple services
- Attendance at teaching sessions if this falls on different days for the different services covered by the pool
- Difficulty determining the length of time an RMO covers a specific service throughout a run, potentially impacting prerequisite requirements for college training programs
- Where services require relieving RMOs to have previous experience, it can be difficult to ensure RMOs with the appropriate experience are available and allocated a relief role

Example

The Pooled Relief model can be utilised to provide relief cover for House Officer rosters and depending on the size of the rosters this could also be divided into Surgical and Medical pools.

The model can also be used for Medicine Registrar basic trainees as it provides opportunities for Registrars to experience a variety of medical sub-specialties. Noting, RACP relief requirements.

Relief Model 3: Aligned Pooled Relief

Aligned pooled relief is where relieving RMOs are in one large relief pool which provides cover for multiple services, however within this each RMO is aligned with 1-2 primary services.

Rosters for the relief RMOs can include duties from all the services covered by the relief pool, however, preference is always given to the aligned 1-2 services. For example, the Surgical House Officer relief pool provides relief cover for all Surgical Specialities (e.g. General Surgery, Orthopaedics, Plastic Surgery, etc.) a Surgical Reliever aligned to Orthopaedics and Plastic Surgery will be rostered to cover those services where possible before capacity is utilised to cover General Surgery.

When aligning services, consideration should also be given to attendance at weekly teaching sessions and where possible align services with teaching which falls on the same day.

Benefits

The benefits of aligned pooled relief may include:

- RMO vocational pathway and preferences can be considered when allocating the aligned services
- Continuity and an opportunity for RMOs to learn service-specific processes
- Increased and consistency of supervision with the ability to identify a named supervisor for an RMO within the core services with which they are aligned
- Retains flexibility for duties to be shared across several RMOs to ensure roster compliance and maximise cover for leave across services.
- Where multiple services require partial FTE to align with the ratios detailed in the STONZ MECA, these can be combined resulting in fewer relief positions overall
- A broader experience for RMOs to ‘try’ out different specialities
- Ease of implementation where there is pooled relief even if the alignment of services is informal

Challenges

The challenges with aligned pooled relief include:

- Service demands may mean RMOs are needed outside of their aligned services
- Requires service buy-in to ensure RMOs are aligned with their designated services as much as possible
- Ensuring an understanding of the effective use of the model

Example

The Aligned Pooled Relief model can be utilised to provide cover for House Officers rosters and depending on the size of the roster/s this could be divided into speciality pools, for example Surgical and Medical Relief pools resulting in further service alignment.

The model can also be used for Medicine Registrar basic trainees (noting, RACP relief requirements) as it provides opportunities for Registrars to experience a variety of Medical sub specialities while providing an

aligned experience with 1-2 services. For example, a Medicine Reliever is allocated to a large relief pool and aligned with their preferred services of Haematology and Oncology. Where ever possible the RMO Unit would roster this reliever to cover shifts within the Haematology and Oncology services.

Relief Model 4: Rotating Relief

Rotating Relief is where throughout the run, RMOs rotate from a team position into a period of relief and a relieving RMO rotates into a designated team position. The purpose of this model is to ensure adequate relief cover while reducing the period individual RMOs are in a relief role.

The length of time an RMO is in relief may be as short as 1 – 2 weeks or more than 6 weeks depending on the roster model and length of the run.

Benefits

The benefits of rotating relief may include:

- Improves and provides continuity of supervision for RMOs and more regular access to SMOs and teaching
- Supports RMOs new to the DHB or country to be appropriately orientated to the service and/or hospital without the need to allocate to a team position for a full rotation
- Promotes teamwork as all RMOs will have a period of relief within their roster
- A reduction in the length of time RMOs are allocated to relief
- Provides greater continuity and consistency for the RMO, services, and patients as RMOs can remain in a team position for up to 20 weeks of a 26-week rotation (dependent on the roster model).

Challenges

The challenges with rotating relief may include:

- At Registrar level, advanced trainees for most training programs, are unable to participate in relief rotations due to the impact on training requirements potentially increasing relief vacancies or the duration of the relief period for other Registrars on the roster.
- Colleges may no longer accredit time in relief towards training where Registrars are working across multiple services and RMOs rotate into pooled relief
- Increased administrative requirements and complexity to manage the processing of relief payments to RMOs when on relief rotation, particularly in short rotations such as a 1- 2-week cycle

Example

This relief model can be utilised for services with large teams or ward-based models of care where an RMO from each ward or team rotates into a period of relief.

This model can also be used in an Emergency Department roster where a week of relief rotates through the roster cycle; for example, RMO's may do 4 – 5 weeks of relief throughout a 6 month run. This may be presented in a roster as follows,

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1	**D**	**D**	**D**	x	x	**E**	**E**
RMO 2	**E**	**E**	**x**	x	**N**	**N**	**N**
RMO 3	x	x	x	**D**	**D**	**D**	**D**
RMO 4	x	x	**E**	**E**	**E**	x	x
RMO 5	**N**	**N**	**N**	**N**	x	x	x
RMO 6	**Relief Week**						

Roster Key

Key	Hours	Duration	Key	Hours	Duration
D	0800 - 1800	10 hours	**E**	1600 - 0100	9 hours
N	2230- 0830	10 hours	**X**	Rostered Off	-

Relief Model 5: Embedded Relief

Embedded relief is where RMOs work a complete roster (no additional support required to staff the baseline roster) and cover RDOs, sleep days and day duties of RMOs on nights within the team without the need for a reliever. Where relief has been embedded as part of the roster, the full roster is published with shifts evenly shared across the RMOs contributing to that roster.

Benefits

The benefits of embedded relief may include:

- Roster certainty as this is published, inclusive of all shifts, before the commencement of the run.
- Provides continuity and consistency for RMOs, services and patients as relief cover is only required for planned and unplanned leave.
- Where there is additional ordinary hours capacity such as on a Wednesday, this can be utilised to cover leave for ordinary hours reducing the reliance on relievers.
- As these are not designated relief positions:
    - Positions can be accredited towards training or college's prerequisite requirements
    - As there is no defined relief role all positions are remunerated as a team position
    - Creates positions that are valuable for both the service and RMO's

Challenges

The challenges with embedded relief may include:

- Reduced flexibility as rosters are published before the commencement of the run, impacting cover for planned leave as this model can only cover leave for ordinary hours where there is capacity within the roster. To offset this, DHBs may want to consider using this model in combination with other relief models.
- Additional cover for planned leave is required for all evening, weekend and night duties and for periods of leave requiring day time cover

Example

This model is suited to small services with no formalised team structure or large services with a ward-based model of care to cover planned roster vacancies such as RDOs, day duties due to nights and sleep days.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
RMO 1						X	X
RMO 2	**N**	**N**	**N**	**N**	Z	Z	Z
RMO 3						**L**	**L**
RMO 4						X	X
RMO 5					**N**	**N**	**N**
RMO 6	Z	Z	Z			X	X

Roster Key

Key	Hours	Duration	Key	Hours	Duration
Blank Cell	0730 - 1530	8 hours	**L**	0730 – 2230	15 hours
N	2200 - 0800	10 hours	**X**	Rostered Off	-
Z	Rostered Off	-			

Relief Model 6: After-Hours (Rostered Additional) Relief

The After-Hours Relief model is where RMOs are assigned to a team position Monday – Friday as per their allocation and their relief duties only consist of hours over the ordinary hours such as evenings, weekends and nights. This is suited to services where the number of RMOs required during the day time is more than the after-hours requirement.

Benefits

The benefit of After-Hours Relief may include:

- Provides continuity and consistency for Monday – Friday ordinary hours for RMOs, services and patients
- Positions can be accredited towards training or college's prerequisite requirements
- Creates positions that are valuable for both the service and RMO's
- Supports regular attendance at service teaching sessions as these are a scheduled expectation within the service

Challenges

The challenges with after-hours relief may include:

- RMO's are assigned to a specific team so cannot be deployed as a report for duty reliever if there is a vacancy without additional cost
- These positions cannot be utilised to provide additional cover within ordinary hours
- Difficult to implement as most services require complete relief cover rather than just evening, weekend and night cover

Example

This relief model is suited to small services with 1-2 positions which participate in a collective after-hours roster with other services. Vacancies within ordinary hours are also covered internally and only after-hours shifts require relief cover. For example, a mostly clinic based service such as Mental Health; Registrars contribute to a collective acute after hours' roster and work within their clinic setting during ordinary hours.

This model could also be utilised to cover leave for senior or advanced trainees where relievers have insufficient experience to provide cover during ordinary hours. However, can provide cover for the evening, weekend and night roster.

Relief Model 7: Embedded Relief/Re-allocation

This model includes development of a roster template that allows for a set number of RMOs to be away at any given time, with afterhours shared across those remaining within the service. This is done either by writing the roster to accommodate and minimise the impact of pre- approved leave or by RMOs swapping shifts to accommodate leave booked after roster publication. In this model, the roster is written (and remunerated) based on the number of Registrars required at work on any given day instead of the number of RMOs allocated to the service.

Where this model is implemented, this must be documented in the run description including information regarding relief capacity and the ratio according to which the roster is written.

Where this model is incorporated into existing rosters without an increase in FTE, there may be an impact on weekly average hours and run category. This model is likely to function most effectively where, in some instances, the roster is written to incorporate cover for leave.

Benefits

- As there are no designated relief positions:
    - Positions can be accredited towards training
    - As there is no defined relief role all positions are remunerated as a team position
    - Creates positions that are valuable for both the service and RMO's

Challenges

- Does not provide cover for ordinary hours
- Reduced flexibility due to reliance on leave being planned in advance or for RMOs to swap shifts for any leave approved after the roster is published. This can result in RMOs working high hours where shift swaps occur Periods of reduced staffing (unfilled position/maternity leave/extended leave/etc.) may impact on ability to take leave for those remaining on the roster

Example

This model is well suited to services with senior trainees where leave cannot be covered by a junior reliever and where relief at a senior level is not accredited for training i.e. SET surgical Registrar rosters. This model can be used in combination with other models i.e. the junior surgical pool relief may be able to cover SET trainee's ordinary hours, however embedded relief/re-allocation required for cover of SET after hour's duties.

Relief Model 8: Service Changes

In certain positions, senior registrars may provide services in the hospital that cannot be adequately covered by a reliever/junior registrar during their absence. In addition, relief roles cannot be implemented at a Senior Registrar level due to college restrictions. It is important that Registrars in these roles continue to have access to leave due to the importance for rest and recuperation. The following possible solutions may be appropriate to provide cover for senior registrar leave in specific roles by exception and where no other model can be accommodated:

- Where reasonable, SMO cover may be provided for shifts that cannot be covered by a relief RMO due to type of work required i.e. after hour's acute operating lists. Or;
- Service changes when senior registrar leave cannot be covered. i.e. evening acute operating list not offered by the service. Or;
- Changes to the service after-hours on call structure, i.e. junior registrar to escalate to the SMO where required rather than escalation to a senior registrar

Benefits

- As these are not designated relief positions can be accredited towards training or college's prerequisite requirements

Challenges

- SMO cover not a suitable option for all services (dependant on service model)
- Reduced service capacity where service changes are required
- Periods of reduced staffing (unfilled position/maternity leave/extended leave/etc.) may impact on ability to take leave for those remaining on the roster

Appendix 2: Methodology for Estimating RMO FTE

To support DHBs with the planning of potential costs, the following method is provided to estimate FTE requirements.

Assumptions

1 FTE = Monday to Friday 5 days of cover therefore 1 FTE divided by 5 days = 0.2 FTE.

Therefore, for roster solutions that may require additional FTE to maintain the current level of cover Monday – Friday, an additional 0.2 FTE is required per day of cover.

Example

At the outcome of a review, it is agreed locally that a roster with seven consecutive night shifts is too fatiguing and nights shifts need to be split into two sets of three and four consecutive nights.

To ensure the current level of cover is maintained, additional FTE is required to cover the sleep days now falling on a Monday and Tuesday following the set of 3 consecutive night shifts (Friday, Saturday and Sunday night).

Calculation

To calculate the FTE requirements, multiply the 2 additional days of cover by 0.2 FTE, totalling an FTE requirement of 0.4.

The formula for this example is, 2 x 0.2 = 0.4

Head Count

As it can be challenging to recruit RMOs to positions that are less than 1 FTE and weekday days off will often fall simultaneously on the same days and not run consecutively across the week, estimating based on headcount may be more reflective and accurate for budgeting and planning purposes. On this basis, as per the example 0.4 FTE would then equate to 1 headcount FTE.

Appendix 3: Example Agreed Priorities

Surgical Non-SET Registrar Roster Example:

The Surgical Non-SET Registrar roster example below consists of 9 Registrars and 4 surgical teams with 2 Registrars allocated to each team and a night relief position to cover the daily duties of the RMO on night shifts. Cover for planned and unplanned leave is provided in addition to the roster below.

Where possible, long days and weekends are rostered to align with the team on-call days.

The example is based on a repeating 9 week cycle throughout the run.

		Week 1							Week 2							Week 3						
		Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Team		AB	CD	EF	GH	AB	EF	EF	AB	CD	EF	GH	CD	GH	GH	AB	CD	EF	GH	EF	AB	AB
AB	RMO 1					L	X	X	L					X	X						LW	LW
	RMO 2	L					X	X					N	N	N	N	N	N	N	Z	Z	Z
CD	RMO 3						X	X		L				X	X		L				X	X
	RMO 4		L				X	X					L	X	X					N	N	N
EF	RMO 5						LW	LW						X	X			L			X	X
	RMO 6			L			X	X			L			X	X					L	X	X
GH	RMO 7				L		X	X						LW	LW						X	X
	RMO 8					N	N	N	N	N	N	N	Z	Z	Z				L		X	X
NIGHT RELIEF	RMO 9	N	N	N	N	Z	Z	Z				L		X	X	L					X	X

		Week 4							Week 5							Week 6						
		Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Team		AB	CD	EF	GH	GH	CD	CD	AB	CD	EF	GH	AB	EF	EF	AB	CD	EF	GH	CD	GH	GH
AB	RMO 1						X	X					L	X	X					N	N	N
	RMO 2	L					X	X	L					X	X	L					X	X
CD	RMO 3						LW	LW						X	X					L	X	X
	RMO 4	N	N	N	N	Z	Z	Z		L				X	X		L				X	X
EF	RMO 5			L			X	X			L			X	X				L		X	X
	RMO 6					N	N	N	N	N	N	N	Z	Z	Z			L			X	X
GH	RMO 7				L		X	X					N	N	N	N	N	N	N	Z	Z	Z
	RMO 8					L	X	X				L		X	X						LW	LW
NIGHT RELIEF	RMO 9		L				X	X						LW	LW						X	X

		Week 7							Week 8							Week 9						
		Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Team		AB	CD	EF	GH	EF	AB	AB	AB	CD	EF	GH	GH	CD	CD	AB	CD	EF	GH	AB	EF	EF
AB	RMO 1	N	N	N	N	Z	Z	Z	L					X	X					L	X	X
	RMO 2						LW	LW						X	X	L					X	X
CD	RMO 3					N	N	N	N	N	N	N	Z	Z	Z		L				X	X
	RMO 4		L				X	X						LW	LW						X	X
EF	RMO 5					L	X	X					N	N	N	N	N	N	N	Z	Z	Z
	RMO 6			L			X	X			L			X	X						LW	LW
GH	RMO 7				L		X	X					L	X	X				L		X	X
	RMO 8						X	X				L		X	X			L			X	X
NIGHT RELIEF	RMO 9	L					X	X		L				X	X					N	N	N

KEY		
	Normal Day	0800-1600
L	Long Day	0800-2230
N	Night Duty	2200-0800
LW	Weekend long day	0800-2230
Z	Sleep day following nights	-
X	Off duty	-

Example Agreed Priorities

For the Surgical Non-SET Registrar roster above, as an example agreed priorities could include while not limited to:

- Excellent patient care
- Effective distribution of workload for maximised productivity
- At a minimum, maintain the current level of hospital service delivery
- Alignment of RMO and SMO rosters, including team structure and continuity of care
- Roster clarity and formalised expectations for Saturday ward rounds
- Mitigates fatigue and supports a work-life balance, including,
    - weekend frequency to be no more than 1:3
    - Relief availability to provide adequate cover and opportunities for leave
- Appropriate training and supervision, including,
    - SMO contact time
    - Theatre time
    - Progression on a surgical pathway
- Staffing capacity to align with patient demand

Please note this is an example only. Actual priorities will need to be agreed between DHB services and RMOs and will be dependent on individual service need.

Appendix 4: Example Change Consultation Document

<<DHB Logo>>

RMO Run Change Consultation

<<Run Name>>

<<Date>>

Introduction

The purpose of this document is:

- To present to you the proposed <<implementation/changes>> of a <<run name>> run at <<xx District Health Board>> from the <<date>>.
- To explain the rationale behind the changes, and
- To give you an opportunity to provide feedback before any final decisions are made.

It is important that you carefully consider and understand the information contained in this document and supporting material as it explains how the changes we are proposing affect you, your current position, your team and <<XX>>DHB going forward.

We want to hear from you about all aspects of the proposal. We will keep an open mind and consider all of your feedback before a decision is made about the final run description and roster. The NZRDA and STONZ will be included in this consultation regarding the proposed roster and run descriptions and we respect that you may wish to discuss this with them.

Reasons for Change

<<XX>>DHB would like to propose the implementation of a <<run name>> position at <<Hospital>> from the <<date>>.

Detail reasons for the change or implementation including background information about the current situation and strategic drivers.

The proposed rosters and run descriptions for the <<xx>>DHB <<run name>> are attached in appendices 1 & 2 for your review.

Potential Impact of Change

Potential Impacts of Change on RMO Training Opportunities:

-

Potential Impacts of Change on RMO Career Progression:

-

Supervision:

-

Potential Impact on RMO's Work Life Balance Opportunities, Including the Roster:

-

General Considerations:

-

Expected Impact on Run Category:

The run categories for <<xx>>DHB <<run name>> are detailed in the table below. A run review will, however, be completed following the implementation of the new <<positions/roster>> to confirm the hours of work.

Run	Current Run Category *(if applicable)*	New Run Category (STONZ)	New Run Category (NZRDA)
<<XX>>DHB <<Run name>>	X	X	X

STONZ Hours Breakdown:

Average Working Hours - STONZ	
Basic hours (Mon-Fri)	X
Rostered additional hours (inc. nights, weekends & long days)	X
All other unrostered hours *To be confirmed by a run review*	X
Total hours per week	X
Category	X

NZRDA Hours Breakdown:

Average Working Hours - NZRDA	
Basic hours (Mon-Fri)	X
Rostered additional hours (inc. nights, weekends & long days)	X
All other unrostered hours To be confirmed by a run review	TBC
Total hours per week *Falls <<above/below>> mid of salary band therefore remunerate at a category <<x>> until confirmed by a run review <<delete if not require>>*	X
Category	X

Consultation & Feedback

Principles

The change will be progressed in a manner consistent with the over-arching principles set out in Clause 14.2 of the STONZ MECA and <<Clause 10.12 or Schedule 9b>> of the NZRDA MECA.

Consultation

From today we will engage with you in this process and you are also encouraged to provide feedback about the proposal. When providing feedback please remember to be constructive in your comments, suggestions and alternatives. While there is no way to guarantee that all points of view will be agreed with, everything will be carefully considered.

It is important that you understand the rationale for the proposed changes. You can request a meeting with your union delegate, the DHB <<service>> team or your HR Advisor to ask questions at any stage during the consultation period.

Ballot Process

Following consideration of feedback, a ballot will be undertaken to seek your agreement to the change. The aim of the consultation will be to achieve 2/3rds agreement and no more than 1/3rd disagreement to the proposed <<run description/s and/or roster>>.

The ballot process will be administered by the <<RMO Unit/HR/Service>> team on behalf of the service and will be sent to you as a survey link from <<Name>>, <<Role>>. Once the consultation period has ended we will review the ballots and confirm the final outcome.

Timeline

The timeline below sets out the key steps in this change process.

Please note: This timeline is indicative only; changes may occur as a result of your feedback with further phases of consultation required.

Date	Action
<<Date>>	Consultation period begins with proposal sent to STONZ and NZRDA unions
<<Date>>	Final proposal document to be sent to RMOs
<<Date>>	Opportunity for group consultation meeting and review of feedback. To note, If consensus is achieved ballot to be conducted during the meeting.

Contacts

We recognise that change affects people in many different ways. While some people may be positive about the prospect of change, others may be feeling anxious, concerned, or experience any number of similar responses. If you have any concerns either for yourself or for members of your team we encourage you to speak to your manager in the first instance. Additionally, information on the support available for you is outlined below.

Name and Title	Contact Number	Email Address
STONZ Union	022 493 1609	Support@stonz.co.nz
NZRDA Union	(09) 526 0280	ask@nzrda.org.nz

You have the right to independent representation and advice throughout this process. That representation and advice can be from a union delegate or other support person or representative of your choice, as long as we ensure that all support is provided within the allocated timeframes.

<<Provider Name>> confidential counselling services are available to you for personal support. You can contact them by phone <<provider phone number>> or via their website <<provider website>>.

Approval

Approved	<<Clinical Director Full Name>> <<Clinical Director Position Title>>	Date: <<date>>

Approved	<<Manager Full Name>> <<Manager Position Title>>	Date: <<date>>

Appendix 1: Proposed Run Description

<<Proposed run description>>

Appendix 2: Proposed Roster

<<Proposed roster>>