Hamilton

CITY OF HAMILTON

PUBLIC HEALTH SERVICES
Family Health Division

TO: Mayor and Members Board of Health	**WARD(S) AFFECTED:** CITY WIDE
COMMITTEE DATE: December 3, 2012	
SUBJECT/REPORT NO: Public Health Nurse Staffing (BOH12033) (City Wide)	
SUBMITTED BY: Elizabeth Richardson, MD, MHSc, FRCPC Medical Officer of Health Public Health Services Department **SIGNATURE:**	**PREPARED BY:** Dorothy Barr-Elliott (905) 546-2424, Ext. 4888

RECOMMENDATION

That the Board of Health authorize and direct the Medical Officer of Health to increase the complement of permanent Public Health Nurses by up to 6.0 FTE to be funded within the existing budget.

EXECUTIVE SUMMARY

Public Health Services (PHS) has found it challenging to manage Public Health Nurse (PHN) turnover for several years. While it is uncommon for PHNs to leave employment with PHS, there is a high level of mobility due to frequent maternity leaves and transfers of PHNs between assignments. Each PHN move contributes to reduced service available to clients while the position is posted and filled, and then the new PHN oriented to and trained for the work. In some cases it can take up to a full year for a PHN to be fully trained for their new position.

Attempts to mitigate PHN understaffing by adding temporary positions have not been successful. PHNs in temporary positions express concern about job security and demonstrate a strong preference for permanent positions, especially in today's challenging financial times. It is anticipated that PHN moves and associated understaffing could be reduced if additional permanent PHN positions above approved complement were established to reduce movement of staff seeking permanent positions. PHNs in these positions would be assigned to meet operational needs, and service levels could be more effectively maintained.

Alternatives for Consideration – See Page 5

FINANCIAL / STAFFING / LEGAL IMPLICATIONS (for Recommendation(s) only)

Financial: While the total PHN complement, including permanent and temporary positions, would be greater than that supported by the budget, the budget would be carefully managed to ensure that Public Health Services remains within budget.

Staffing: It is anticipated that increasing the number of permanent positions would reduce PHN movement between work assignments. Individuals in these positions would be assigned to meet operational needs. A memorandum of understanding with the Ontario Nurses' Association (ONA) would be required. If staffing trends significantly change, it is possible that layoffs would be required to contain spending within approved budgets. However based on several years data and experience, this is unlikely to occur.

Legal: No legal implications

HISTORICAL BACKGROUND (Chronology of events)

The PHN staffing model in PHS involves one job description encompassing the work of all approximately 170 PHNs. Within this one job description, PHNs hold highly varied assignments, ranging from clinic services to home visiting to policy development. With PHS PHNs being primarily female, maternity leaves are frequent.

Historically, PHN understaffing was avoided through the use of a centralized staffing approach. PHNs were hired by Assistant Directors of Nursing who oversaw the entire PHN complement, rather than by the Managers to whom they would report. When PHNs left for maternity leave, they were generally replaced by PHNs without the assignments being defined as temporary. When PHNs returned from maternity leave they were commonly assigned to a different program than the one they had left. Although this staffing approach was largely successful in maintaining staffing levels, it was not ideal for both clients and the PHNs. With increasing specialization, it became

more important for PHNs to return to their pre-maternity leave assignments in order to take advantage of training and experience. In some cases PHNs were asked to practice in areas other than their area of interest. Also, it was challenging for Managers to be accountable for staff and team performance when they did not make hiring decisions.

Currently, each Manager fills PHN vacancies as they arise. When PHNs take maternity leave, they are generally replaced by temporary PHNs, and return to their previous assignments after their leave has finished. This approach supports Manager accountability and allows PHNs to return to work in areas where they have both interest and expertise. PHN moves and understaffing, however, have proven to be an ongoing challenge.

POLICY IMPLICATIONS

The recommended approach is not specifically referenced in the Budget Complement Control Policy. It does, however, align well with the principles of that policy, including principle #3: “Program managers are provided adequate flexibility to manage their complement to ensure efficient and effective delivery of programs/services”.

RELEVANT CONSULTATION

Helen Klumpp, Manager of Finance and Administration, reviewed the report to ensure accuracy of financial information.

Gord Muise, Senior Labour Relations Officer, reviewed the report to ensure that an appropriate labour relations approach was included, and has agreed to assist in the development of a memorandum of understanding with ONA.

Debbie Paddock, Staffing/Workforce Planning Specialist, reviewed the report to ensure alignment with Human Resources policies and procedures.

*Susan Hall, ONA Bargaining Unit President, and Robert McGregor, ONA Labour Relations Office*r, reviewed the report to ensure that the interests of ONA members were addressed. General support for the recommended approach was provided at an ONA Labour Management Committee meeting.

All feedback received from those listed above was incorporated into the report.

ANALYSIS / RATIONALE FOR RECOMMENDATION

(include Performance Measurement/Benchmarking Data, if applicable)

Temporary PHN positions contribute to PHN movement:

PHS has extensive experience with PHNs in temporary positions and has been very successful in providing ongoing employment for these individuals. Despite this, PHNs in temporary positions express concern about job security and demonstrate a strong preference for permanent positions, especially in challenging financial times. PHNs generally move from temporary to permanent positions whenever possible, even if that involves leaving preferred areas of work. Subsequently, PHNs often move to assignments within their areas of interest. In turn, can leave a vacancy that has a significant effect on providing service, but is too short to allow for a new temporary PHN to be hired and trained. These moves are made under the provisions of the ONA 50 (Public Health) collective agreement.

PHN movement contributes to reduced productivity:

Each PHN move contributes to understaffing because of the time required to post, interview and allow wrap-up for the assignment being vacated. When this happens, Managers offer increased hours to any part time PHNs who are interested. This is helpful but insufficient to cover the service gap.

In addition, each PHN move requires orientation, training and mentoring over a six to twelve month period to gain full competence in the new assignment. Specific required training may be delayed pending availability of that training where it requires either the time of other staff, or paid outside trainers. Orientation and mentoring requires a significant commitment from Managers and other PHNs on the team. With a flat organizational structure having no Supervisors, Managers are responsible for both direct staff supervision as well as essential program components such as assessing evidence, collaborating with community partners, program development, program monitoring and evaluation and supporting a high standard of professional practice. High levels of PHN movement further increase Manager workloads, and make it very challenging for Managers to successfully address all of their required duties. PHN movement and understaffing detract from the ability of a program to provide the best possible service to the community.

Family Health Division mitigation efforts have not been successful:

As the PHS division with the highest number of PHNs, the Family Health Division experiences the challenges related to PHN movement most acutely. Within the division, there are on average 4.0 FTE PHNs in temporary positions at any point in time, with the majority of such individuals filling maternity leaves. (At the time of writing this report, there were 8.0 FTE PHNs in the Family Health Division in temporary positions.) In an attempt to increase staffing levels, since 2010 Family Health Managers have hired additional temporary PHNs at a level that trends predict is necessary to maintain

staffing. This level has been difficult to maintain given staff movement. Increasing the number of temporary PHNs has increased the likelihood of PHNs moving to secure a permanent position, and so contributed to an increase in the number of PHN moves. The approved complement of PHNs in the Family Health Division is 52.3 FTE. In 2012, there have been 31 PHN moves so far in the Family Health Division, representing a 53% rate of turnover by FTE. The majority of these moves involve significant training requirements. This high level of internal movement is problematic.

Family Health Division PHN Staffing					
	PHN Moves				
Year	Maternity and Illness Leaves	Temporary to Permanent	Permanent to Permanent	Other*	Total
2009	9	3	5	2	19
2010	4	4	3	4	11
2011	5	5	7	7	24
2012**	13	6	9	3	31

*Retired, resigned, permanent to temporary
**As of August 31st, 2012

While PHN understaffing is partially offset by increasing the hours of other staff, generally gapping and staff turnover combine to negatively impact service delivery. Although the Family Health Division complies with the Family Health Program standards within the Ontario Public Health Standards (OPHS), there is great potential to do more work to help each child in Hamilton have the best possible start in life, which is a priority in Hamilton. A more stable staffing model would allow the Family Health Division to minimize wait times for home visiting (currently five to six weeks), develop evidence-based curricula for child safety, increase positive parenting material on the website, provide comprehensive orientation and mentoring for new staff, and reach OPHS Foundational Standard targets related to population health assessment, surveillance, and program evaluation, which are currently not met. The newly Healthy Babies Healthy Children protocol, scheduled for implementation in 2013, is anticipated to create new workload demands, making it more important than ever to minimize avoidable staff movement.

Permanent PHN positions above complement are expected to reduce PHN movement:

PHS requires a more stable PHN staffing model to maximize productivity and best serve the community. It is anticipated that PHN movement could be reduced if additional permanent PHN positions were established. These positions would replace some of the temporary positions currently in place. It is difficult to accurately forecast the impact of such a staffing approach, but it is estimated that PHN moves within the Family Health Division could be reduced by 25-30%. Individuals would be assigned to meet operational needs, in accordance with a memorandum of understanding to be developed with ONA. Spending would be contained within approved budgets. If

approved, additional permanent PHN positions would be first introduced in the Family Health Division, and if successful in reducing PHN movement, then possibly utilized in other areas of PHS as well.

ALTERNATIVES FOR CONSIDERATION

(include Financial, Staffing, Legal and Policy Implications and pros and cons for each alternative)

The Board of Health could direct the Medical Officer of Health to seek language in the ONA 50 (Public Health) collective agreement to limit the ability of PHNs in temporary positions to move to other positions until their temporary positions have ended.

Financial:

Pro: The risk of overspending would be reduced.

Con: Generally, changes to a collective agreement are negotiated in exchange for other considerations. For example, an employer could seek greater flexibility in staffing approaches in exchange for salary increases. It is not anticipated that it would be possible to offer salary increases in exchange for increased staffing flexibility at the next round of negotiations with ONA, so this alternative could be difficult to implement.

Staffing:

Pro: The possible need to layoff PHNs would be avoided.

Con: PHNs would likely view additional restrictions as contrary to a supportive working environment. This approach would not address turnover related to maternity and illness leaves.

Legal: No legal implications

Given these considerations, this alternative is not recommended.

CORPORATE STRATEGIC PLAN (Linkage to Desired End Results)

Focus Areas: 1. Skilled, Innovative and Respectful Organization, 2. Financial Sustainability, 3. Intergovernmental Relationships, 4. Growing Our Economy, 5. Social Development, 6. Environmental Stewardship, 7. Healthy Community

Skilled, Innovative & Respectful Organization

- A skilled, adaptive and diverse workforce, i.e. more flexible staff

Financial Sustainability

- Delivery of municipal services and management capital assets/liabilities in a sustainable, innovative and cost effective manner

Growing Our Economy

- A skilled and creative labour pool that supports new employers

APPENDICES / SCHEDULES

No Appendices / Schedules attached.