MERAS update – partnership in action

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MERAS Co-Leader (Midwifery)

Midwives are very familiar with the concept of 'partnership' as the principle underpinning the model of midwifery care in New Zealand. What may be less well understood by MERAS members is that the DHB MERAS MECA (Multi Employer Collective Agreement) and the collective agreements that MERAS has with non-DHB maternity units are also partnership agreements between MERAS and the DHB or maternity facility employer.

Clause 1.2 of the MERAS MECA says:

"MERAS and the DHBs share a strong interest in getting health workforce development right by building a midwifery workforce and work contexts that are flexible, productive, sustainable and able to deliver on health goals. The parties recognise the value of working cooperatively and constructively together to achieve the over-arching goal of maintaining and advancing a midwifery workforce that takes shared responsibility for providing high quality healthcare on a sustainable basis. To this end the parties may agree to establish forums to progress the ongoing interest and issues of the parties outside of bargaining."

Over the last two years an increasing number of maternity services have established maternity or midwifery forums providing an opportunity for MERAS workplace representatives, midwife managers, midwifery leaders, the MERAS Co-Leader (Midwifery) and other midwives to meet together to discuss issues affecting midwifery and maternity.

The focus has been on midwifery workforce issues and ensuring that at a time of workforce pressures midwives are able to focus on providing midwifery care instead of doing things that can be undertaken by others. It is interesting how often, after-hours, even in large maternity units midwives have been expected to do administration tasks, clean and make beds and restock rooms. Providing access to sufficient administration support and non-clinical support (HCAs) enables midwives to focus on providing midwifery care.

Enhancing clinical midwifery leadership

As well as the focus on midwifery staffing MERAS has also been working with midwifery managers and midwifery leaders to enhance midwifery clinical Leadership. As an outcome of the DHB MERAS MECA the following statement was included in the Terms of Settlement:

"It was widely discussed at bargaining about the union's desire to have a designated senior midwife on each shift at secondary and tertiary maternity units. While a number of DHBs do already have a designated Senior Midwife on each shift some DHBs, especially the smaller DHBs, do not. This will be an important area for CCDM [Care Capacity Demand Management] to review and discuss as it looks at staffing requirements. In the meantime, we encourage all DHBs to review their practices now and where practicable to include a designated senior midwife on each shift."

MERAS believes that having a designated senior midwife (clinical midwife coordinator or clinical charge midwife) is vital to supporting midwives on each shift. The senior midwifery role ensures there is an experienced midwife on duty to support new graduate midwives, registered nurses and new LMC practitioners as well as liaising with medical staff and providing advice to midwives working in primary maternity units or assessing women at

Kelly McConville stepped down as chair of the MERAS National Representative Council (NRC) at the union's recent annual general meeting and was awarded life membership. Victoria Christian, stepped down as deputy chair. The new chair of the NRC is Karen Ferraccioli and the new deputy is Michelle Archer. From left, Jill Ovens, Victoria Christian, Caroline Conroy, Kelly McConville, Karen Ferraccioli and Michelle Archer.

home. Many midwifery leaders are working hard to make this happen in their maternity services and currently five out of six tertiary maternity units have a senior midwifery role on duty 24/7 and many secondary maternity units either have or are working hard to achieve this. Some such as Palmerston North do have 24/7 coverage whilst others have senior midwifery roles on AM and PM shifts and are working hard to achieve this for the night shift as well. Depending on the configuration of the birthing suite and maternity ward some larger maternity services really need a senior midwifery role on both the birthing suite and the maternity ward given the acuity and staffing challenges in both areas.

Safe staffing

With the midwifery staffing shortages that many maternity services are currently experiencing there are times when there are not the expected number of midwives rostered on duty or sick calls have reduced the number of expected staff. If the workload within the maternity service exceeds the midwives available to provide care action needs to occur to ensure women and babies continue to receive quality care and safe staffing is maintained. The DHB MERAS MECA and the non-DHB Collective Agreement outline what should happen in these cases:

Clause 8.1 *"In the event that an acute staffing shortage cannot be alleviated, patient cares and the volume and range of services may be reduced in accordance with direction by the appropriate manager and employer policies."*

The clause then continues to outline the actions that should be taken:

- *the midwifery manager or duty manager will be immediately informed of the situation by the midwife*
- *the midwife will not be required to take additional workload until strategies have been implemented to address the immediate workload issues, not withstanding any immediate duty-of-care requirements*

The clause then continues explaining that the senior midwife in the DHB, at the time of the event (this may be a core midwife shift coordinator after hours), will report the event to the most senior manager in the DHB (usually the duty manager). Most maternity units have an escalation plan and that will usually outline a similar process. It's also useful if the senior midwife on duty completes an 'incident form' when these staffing situations occur and notes the staffing shortage on Trendcare. It may mean that you are completing incident forms for several shifts in a row.

If additional staffing support cannot be provided the senior midwife on duty can have discussions with the duty manager and obstetric staff to delay commencing inductions or elective caesarean sections and other ways (as outlined in the escalation plan) to manage the workload until staffing improves. The senior midwife on duty may also be able to have discussions with LMCs about discharging some women and babies home.

If you are working beyond the end of the shift to assist your colleagues on the next shift make sure you claim for those hours but also look after yourself and ensure you are 'fit to work' and not doing excessive extra hours or 'on-call'.

Completing incident forms, notifying the duty manager, doing your best to complete Trendcare and claiming for the hours that you are working all help your midwife manager to demonstrate to senior managers the acuity and workplace pressures within the maternity service. This assists in gaining additional funding for more midwives and support staff as improvements to admin support and access to health care assistants for non-clinical support after-hours can be helpful.

Please email or phone me if staffing shortages are occurring frequently on your ward or unit as I am working closely with several of the midwifery leaders to ensure that the executive leadership level of the DHB understand the pressures within the maternity service and the support that is needed to improve the situation.

Please email or phone caroline.conroy@meras.co.nz or phone 027 6888 372

MERAS
Midwifery Employee Representation & Advisory Services

For MERAS Membership e-mail merasmembership@meras.co.nz or call 03 372 9738

Pay equity update

MERAS members are excited that interviews for the pay equity process for DHB-employed midwives will be underway from September.

MERAS co-leader (industrial) Jill Ovens says eight DHBs were selected as interview locations, including Northland, Waitemata, Auckland, Counties-Manukau, Tairawhiti, Capital and Coast, Nelson-Marlborough and Canterbury.

"The choice of interview locations was a joint process with the DHBs aiming to include a mix of small, medium and large DHBs, rural as well as urban, those with large Māori and Pasifika populations, and those with socio-economic deprivation," Jill says.

A sample of DHB-employed community midwives, core midwives, Māori and Pasifika core midwives, associate charge midwives/midwife co-ordinators, and charge midwives/charge midwife managers will be interviewed.

MERAS interviewers include Helenmary Walker (Counties Manukau DHB), Sabine Weil (Waikato DHB), Victoria Christian (Auckland DHB), Kath Boyle (Capital and Coast DHB) and MERAS co-leader Caroline Conroy (CMDHB) all of whom attended a two-day training session on the pay equity process, tools and techniques that will be used.

The interview process is not a statistical exercise requiring a specified percentage of interviews. Thus, it may look as if the number is small (around 60 altogether) but if more information is needed, Jill says more interviews can be conducted. Other information such as research can also be used.

A panel that included a MERAS nominee in each of the participating DHBs selected interviewees from expressions of interest received from midwives who met the agreed criteria in the above roles.

Through the one-and-a-half hour interviews, information will be gathered that is representative of the work done by midwives and will be compared with information from interviews held with the appropriate comparator groups using the same tools and techniques.

The idea is to compare midwifery with similar male-dominated occupations to establish pay differentials attributable to gender inequity. Jill says most similar occupations within DHBs are predominantly women. However, comparator groups may have been historically male-dominated with a majority of women today.

Interviews will also be held with employees from the agreed comparator groups and any differential could result in a variation to pay rates in the MERAS DHBs MECA which would be backdated to 31 December 2019.