# All District Health Boards

6 July 2021

Jill Ovens and Caroline Conroy
MERAS

Dear Jill and Caroline

**Re: Offer for Settlement of the DHBs/MERAS MECA**

This letter constitutes a formal offer of settlement for the MERAS MECA.

This offer includes agreement to the following key elements:

- A term from 1 February 2021 to 12 February 2023.
- A flat rate salary increase of $1,200 on each step of the Registered Midwives Salary Scale and Designated Senior Midwives Salary Scale grades 2 through to 4, effective from 1 August 2021.
- A flat rate salary increase of $1,200 per step for all employees (other than case load Midwives) effective from 1 August 2022.
- For Caseload Midwives, a flat rate salary increase of $1,200 effective from 1 August 2021 and effective from 1 August 2022 the introduction of a new step of $101,199 (effectively a $1,200 increase) from 1 August 2022.
- The introduction of Maternity Care Assistant under coverage of the MECA that are remunerated on a scale that mirrors the Health Care Assistants in the NZNO MECA.
- Delete step 1 of the Community Midwives salary scale.
- Effective from 1 July 2021 the introduction of a CPD pool at each DHB for all Midwives who are MERAS members, equivalent to $1,000 per midwife.
- The introduction of an ACC Top-up for employees injured as a result of a work place assault.
- The introduction of a Bargaining Fee.
- The introduction of a Midwifery Career Pathway and a gender-neutral job sizing tool, once pay equity has been completed.
- A new Public Health Emergency clause
- Agree that a national policy is to be developed by the Midwifery Leaders Group that clarifies it is the receiving DHBs responsibility to provide accommodation and food for flight midwives.
- Agreement that MERAS will work with Midwifery Leaders on "new ways of working" for midwives, including working from home arrangements where appropriate and that this work will inform the next round of bargaining.
- Encourage DHBs via the MECA Implementation Plan to have a designated senior midwife on all shifts and wards in secondary and tertiary units.

- Include advice in the Implementation Plan in reference to Clause 8.5 that Designated Senior Midwives should be paid for time worked (over and above contracted hours) when responding to orange or red VRM after hours.

Other issues:

- It was agreed that access to safe, free parking and public transport for staff, especially for those starting or finishing later shifts (11pm), was better dealt with at the relevant DHB.
- It was agreed that the MERAS claim for uniforms used by midwives, including scrubs, to clearly identify the wearer as a midwife, would be promoted through the DoNs.
- It was agreed the Midwifery Leaders Group will develop a national policy, in conjunction with the GMs HR, on support for midwives following sentinel and/or adverse events, including the ability to provide special leave if needed.
- The introduction of the Career Pathway for Midwives supports the professional growth of the workforce and the importance of career progression to both parties. DHBs are committed to moving people onto, and through, the Designated Senior Midwives Scale when opportunities to progress career aspirations arise.

The DHB bargaining team has listened to the issues that MERAS bought to the table and have endeavoured to deliver an offer that meets a number of these issues raised by MERAS.

We look forward to a positive outcome of your ratification meetings.

Yours faithfully

Gretchen Dean

**DHB Advocate for MERAS Bargaining**

## DHBS/MERAS MECA
## 1 February 2021 – 12 February 2023

## TERMS OF SETTLEMENT

Please note: If a clause is not mentioned in the summary of changes to the MECA, shown below, then it remains unchanged from the DHBs/MERAS MECA 1 February 2018 – 31 January 2021.

| Clause No | Clause Title | Change |
|---|---|---|
| 2.0 | Coverage and Application | The second sentence is replaced with the following:<br>"This MECA shall apply to all midwives who are members of MERAS and who are employed as Midwives, Senior Midwives, or Maternity Care Assistants by the DHB party to this MECA. |
| 3.0 | New Employees | The following replaces the first paragraph of Clause 3.<br><br>"The parties agree that a new employee who is not a member of MERAS and who is covered by the coverage clause of this MECA, shall be offered the same terms and conditions as this MECA for the first 30 days of employment. The new midwife or maternity care assistant will also be given an active choice form during the first 10 days of employment to be returned within the first 30 days.<br><br>New midwives and maternity support workers covered by this MECA will be informed of the following:<br><br>a. That there is a MECA in place and they are given a copy of this;<br><br>b. That they may join MERAS, which is a party to this collective agreement;<br><br>c. How to contact MERAS and that, unless the midwife objects in the returned active choice form, the employer will provide certain information about the midwife to MERAS;<br><br>d. That they will be bound by the MECA, if they join MERAS;<br><br>e. That in any case, they will be offered the terms and conditions of the MECA, and will have 30 days to decide if they wish to join the MERAS;<br><br>f. That, after 30 days, if they decide not to join MERAS, their terms and conditions may be renegotiated at that time." |
| 4.0 | Definitions | New definition for Maternity Care Assistant as follows:<br><br>Maternity Care Assistant means an employee who works in auxiliary role to the midwifery team, and is able to perform tasks in their position description relating to patient care and housekeeping and |

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| | | works under the direction of a registered midwife. The employee needs to be enrolled in a New Zealand Bachelor of Midwifery programme. |
| 6.0 | Term | Replace "1 February 2018" with "1 February 2021" and replace "31 January 2021" with "12 February 2023 (and will come into force on the date the MECA is ratified)." |
| 8.4 | Meal Breaks and Rest Periods | In Clause 8.4 (c) add in a new sentence.<br>"This shall include the second meal break in a 12-hour shift where it is unrelieved." |
| 8.4 | Meal Breaks and Rest Periods | In Clause 8.4 (e) add in a new sentence.<br>"The first rest break shall occur before 4 hours of the shift start, the second rest break between 6 and 8 hours of the shift start." |
| 10.0 | Salaries | Increase salary scales as follows:<br>• A flat rate salary increase of $1,200 on each step of the Registered Midwives Scale and Designated Senior Midwives Salary Scale grades 2 through to 4, effective from 1 August 2021.<br>• A flat rate salary increase of $1,200 per step for all employees (other than Caseload Midwives) effective from 1 August 2022.<br>• For Caseload Midwives, a flat rate salary increase of $1,200 effective from 1 August 2021 and effective from 1 August 2022 the introduction of a new step of $101,199 (effectively a $1,200 increase) from 1 August 2022.<br>• The introduction of Maternity Care Assistants under coverage of the MECA who are remunerated on a scale that mirrors the Health Care Assistants in the NZNO MECA.<br>• Delete Step 1 rate from Community Midwives pay scale.<br><br>See Appendix 1 for the new salary scales. |
| 10.0 | Salaries | Delete all words after the Caseload Midwives salary scale and replace with the following:<br>"Progression: By annual increment at anniversary date, subject to satisfactory performance which will be assumed to be the case unless the employee is otherwise advised. Those employees who have been on step 1 for more than 12 months will move to step 2 on 1 August 2022. Otherwise they will move on their anniversary date." |
| 10.2 | Midwifery Career Pathway | Replace current clause with the following:<br>The Career Pathways for Designated Senior Midwives is attached as Appendix C.<br>The goal of the job scoping exercise is to define a consistent grading decision for positions of a similar nature across DHBs.<br>Where a DHB determines a Midwifery role is to be a designated position, the parties will engage in a job-scoping exercise through a process of consultation. In particular: |

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| | | (a) The DHBs will consult with Designated Senior Midwives and MERAS to ensure the position descriptions used in the job-sizing are current;<br>(b) The DHBs will consult with MERAS regarding the relative job sizes as described by an agreed gender-neutral job evaluation tool;<br>(c) The parties will use a mutually agreed process to scope any new Designated Senior Midwifery positions established in DHBs, to ensure consistency<br>(d) Either party has the ability to appeal a job sizing outcome through the mutually agreed process.<br>e) if the DHBs have a position that is similar to one that has already been scoped and, after consultation with MERAS, the same grading will apply without the position going through the scoping process |
| 13.0 | Travelling Expenses and Incidentals | In the first paragraph after "costs" add in the words "including accommodation" |
| 15.0 | Public Holidays | In Clause 15.6 change the clause reference from "12.4" to "15.4" |
| 16.0 | Annual Leave | In d) Conditions add in a new "v" as follows:<br>"Employees must be able to take at least two weeks continuous leave at some stage during the year. Annual leave will ideally be planned with leave approved during peak periods trying to ensure all midwives get a break." |
| 18.0 | Sick Leave | Add the following note:<br><br>It is not intended that anything in this document will reduce a midwifes entitlement under statute, including changes to sick leave entitlements post 24 July 2021<br><br>The entitlements and obligations within this clause have been agreed in anticipation of significant changes to the Holidays Act 2003 and are neither intended, nor are to be interpreted, as providing for more minimum statutory sick leave than 10 days within each relevant entitlement period.<br><br>Amend 18.1 (a) to include bolded text as identified below:<br><br>(a) On appointment to a DHB, a fulltime employee shall be entitled to ten (10) working days leave for sick or domestic purposes during the first twelve months of employment, and up to an additional ten (10) working days for each subsequent twelve- month period. **While the minimum sick leave entitlement under the Holidays Act 2003 is five days** the entitlement shall be pro-rated for part time employees except that a part time employee shall receive no fewer than five (5) working days sick leave for the first twelve months of employment and a minimum of five (5) additional working days for each subsequent twelve- month period. **The employee shall** |

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| | | **be paid for minimum statutory sick leave entitlements as prescribed in the Holidays Act 2003. Additional contractual or discretionary sick leave that is taken or approved shall be paid at the normal rates of pay (T1 only).**<br><br>Add new last sentence to the current Clause 18 (d), the following:<br>"The first five (5) days of discretionary leave shall be approved on the same basis as leave under clause 18."<br><br>Add after last sentence in Clause 18.1 (e) the following:<br>"The parties agree that extenuating circumstances will include instances where an employee has exhausted their sick leave entitlement as a result of top-ups to earnings related compensation in accordance with Clauses 30.2 to 30.4." |
| 20.0 | Parental Leave | 20.9 (c) delete the sentence as follows:<br>"However, parental leave will not contribute to Retiring Gratuities allowance calculations." |
| 24.0 | Family Violence Leave | Replace Clause 24.0 with the following:<br>"The employer is committed to supporting staff who experience family violence, and staff seeking to address their issues with violence as and when occurrence of the violence is raised with the employer.<br><br>Employees affected by family violence have rights under the Employment Relations Act 2000, Holidays Act 2003 (relating to Family Violence Leave (ss72A-72)) and the Human Rights Act 1993.<br><br>In addition, any staff member experiencing family violence should talk to their manager or Human Resources Department regarding the support available under the DHB's Family Violence (or equivalent) policy." |
| New 25.0 | Public Health Emergency | New Clause<br><br>25.1 The following provisions apply where there is a Public Health Emergency (PHE) declared by the Director-General of Health under the relevant legislation. These provisions shall also apply as applicable to civil defence emergencies declared under the relevant legislation.<br><br>25.2 The parties acknowledge that the public health system will likely be a critical part of the national/regional responses to a PHE.<br><br>25.3 If required as part of a response, the parties recognise the urgency of any response and the need for flexibility in how services are delivered, and accordingly temporary changes may be made to how work is organised without the need for a |

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| | | formal change management processes specified in the MECA. The DHB will engage in good faith with the union prior to progressing any PHE response.<br><br>25.4 The principles around any such changes are:<br>a. Where available, Services will work with their staff including MERAS workplace representatives, to develop the most clinically appropriate staffing arrangements to keep patients and staff safe during a PHE<br>b. These arrangements could include ways of working that are outside of the standard provisions of the MECA hours of work clauses provided that:<br><br>25.5 The rostered ordinary weekly or fortnightly hours of work do not exceed the current maximums without the agreement of the affected employee(s)<br>ii. No employee shall have their pay reduced while they are working such arrangements<br>iii. Additional hours of work beyond those reflected in the salary category shall be remunerated in accordance with the relevant provisions of the MECA, and MECA penalties for minimum breaks, overtime, penal time etc will continue to operate<br>iv. The alternate arrangements shall only continue in force for the period necessary and required by the DHB's PHE response, following which the pre PHE status quo will be reinstated<br>v. The union shall be informed of any arrangements operating under this provision.<br><br>25.6 The parties recognise the potentially heightened focus on ensuring staff do not attend work when they themselves (or their dependents) may be unwell, or at a higher risk (e.g. underlying medical condition or pregnancy) during a PHE. To support this, the DHBs will take a permissive approach to access paid special leave.<br><br>25.7 Where staff are required to stay home when they are well, but required to isolate or quarantine, then they shall receive special leave pay which will not be recorded as sickness.<br><br>25.8 The parties commit to national oversight and engagement on the operation of this clause and other operational matters related to PHE responses, which may include provision of agreed national guidance<br><br>Re-number remaining clauses. |

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| Part 5 | Provisions Relating to Education, Training and Development | Delete (c) and replace with the following:<br><br>"Each DHB shall commit each financial year (that being 1 July to 30 June) a sum of $1,000 per MERAS midwife (headcount), accessible by MERAS members only, to enable midwives to meet approved professional development requirements. This is effective from 1 July 2021"<br><br>**CPD Fund Administration**<br><br>a) The pool shall only be available to members of MERAS.<br><br>b) The pool shall be administered by the department in each respective DHB by the Director of Midwifery or the Midwifery Lead (in line with delegated authority)<br><br>c) Management of the pool must ensure:<br>• Continuing professional development is achieved and maintained by Midwives, and<br>• be managed in a fair, transparent and consistent manner by a CPD Committee comprising management and MERAS workplace delegate.<br><br>d) The CPD committee shall maintain a standard reporting record that includes:<br>• Full financial records detailing the level and use of expenditure, and<br>• Any declined applications and the reason for declination, and<br>• Any approved funding over and above the CPD pool<br>• The reporting record shall be made available to MERAS on request. |
| 30.0 | ACC and Accidents | The following clause replaces paragraphs 2 and 3 of Clause 29.0 as new Clause 30.<br><br>Retain paragraph 1 as Clause 30.1 and head up: Transport of Injured Midwives.<br><br>Replace paragraph 2 as Clause 30.2:<br>"Where a midwife is incapacitated as a result of a workplace accident (except where the accident is a workplace assault – see below), and that midwife is on earnings-related compensation, then the employer agrees to supplement the midwife's compensation by 20% of base salary during the period of incapacitation. This leave shall be taken as a charge against untaken sick leave entitlement (including any entitlement transferred from previous employment with another DHB), to the extent entitlement exists. The employer may agree to reimburse midwives for treatment and other expenses or for financial disadvantage incurred as a result of a work-related accident. This agreement will be on a case-by-case basis.<br><br>New Clause 30.3: "Where a midwife is incapacitated as a result of a workplace assault, and that midwife is on earnings related |

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| | | compensation, then the employer will supplement the midwife's compensation by 20% of base salary during the period of incapacitation. This top up payment shall not be debited against the midwife's untaken sick leave entitlement. The employer will reimburse the midwife for any costs incurred that are part charges for ACC agreed treatment and other associated ACC expenses.<br><br>Re-number 3rd paragraph as Clause 30.4: "For non-work-related accidents, where the midwife requests, the employer shall supplement the midwife's compensation by 20% of base salary and this shall be debited against the midwife's sick leave." |
| New 45.0 | Bargaining Fee | New clause<br>45.1 It is agreed that a bargaining fee shall be applied to those employees whose work is covered by this Agreement but who are not members of MERAS and who are not members of another union, and who do not otherwise opt out of this clause, in accordance with the Employment Relations Act 2000 (S.69P and following).<br><br>45.2 For the purposes of this clause:<br><br>(a) the "bargaining fee" shall be set at 100% of the current MERAS membership subscription rate is $11.19 per fortnight. For midwives who earn less than $25,000 per annum the rate is $5.60 per fortnight. The bargaining fee is paid each pay period, and shall not increase during the term of this clause;<br><br>(b) the date the bargaining fee commences is 14 days after the expiry of the specified period as advised to the affected employees in accordance with S.69R.(1)(c) of the Employment Relations Act 2000;<br><br>(c) an "affected employee" is one<br><br>(i) whose work is covered by the coverage clause of this Agreement and<br><br>(ii) whose terms and conditions of employment comprise or include the terms and conditions of employment specified in this Agreement and<br><br>(iii) who is not a member of the union and<br><br>(iv) who is not a member of another union and<br><br>(v) who is not an employee who has opted out.<br><br>(d) An "employee who has opted out" is one who would otherwise be an affected employee but who has notified the employer by the end of the specified period that she/he does not wish to pay the bargaining fee, and |

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| | | whose terms and conditions of employment remain the same until such time as varied by agreement with the employer.<br><br>45.3 The employer shall at the end of the specified period deduct the bargaining fee from the wages of each affected employee and remit it to the union in the same manner in which union subscriptions are deducted and remitted to the union.<br><br>45.4 Nothing in this clause applies to new employees, that is, those who are employed after this Agreement has come into force.<br><br>45.5 This clause shall expire on 12 February 2023. |
| Other | Midwifery Career Pathway | The Midwifery Career Pathway (see below) has been included in the Terms of Settlement and the new titles will be included in the MECA under Appendix C. |
| Appendix B | Rostering Principles Guidelines | Include a copy of the MERAS Rostering Principle Guidelines as Appendix B. The Rostering Principles will be included in the MECA. |
| Signatures | | Update the signature page as follows:<br>Delete Geraint Martin and replace with Margie Apa<br>Delete Helen Mason and replace with Peter Chandler<br>Delete Derek Wright, Interim and replace with Kevin Snee<br>Delete Kevin Snee and replace with Keriana Brooking<br>Delete Dale Oliff (Acting) and replace with Fionnagh Dougan<br>Delete Julie Patterson (Interim) and replace with Fionnagh Dougan<br>Delete Peter Bramley and replace Lexi O'Shea (Acting)<br>Delete Craig Climo (Acting) and replace with Dale Oliff<br>Delete David Meates and replace with Peter Bramley<br>Delete Nigel Trainor and replace with Jason Power |

The parties agree that the above terms of settlement confirm all of the changes that were agreed at negotiations between MERAS and the DHBs.

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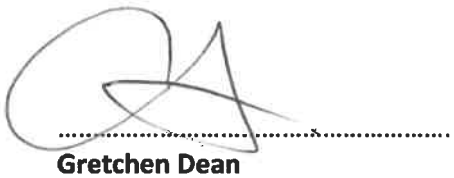
**Jill Ovens** **Date:**

**On Behalf of MERAS**



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**Gretchen Dean**
**On behalf of the DHBs**

8.7.2021

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**Date:**

**Appendix 1-**

**Salary Scales**

**10.0** ***Salaries***

**Registered Midwives,**

| Registered Midwife scale | Current | 1 August 2021 | 1 August 2022 |
|---|---|---|---|
| Step 7 | 78,353 | 79,553 | 80,753 |
| Step 6 | 76,071 | 77,271 | 78,471 |
| Step 5 | 73,857 | 75,057 | 76,257 |
| Step 4 | 66,473 | 67,673 | 68,873 |
| Step 3 | 62,915 | 64,115 | 65,315 |
| Step 2 | 59,222 | 60,422 | 61,622 |
| Step 1 (New Grad) | N/A | | |

"Progression: By annual increment at anniversary date, subject to satisfactory performance which will be assumed to be the case unless the employee is otherwise advised."

| Caseload Midwives (penals and overtime do not apply with the exception of penals on public holidays) | Current | 1 August 2021 | 1 August 2022 |
|---|---|---|---|
| Step 1 | 98,799 | 99,999 | 99,999 |
| Step 2 | | | 101,199 |

"Progression: By annual increment at anniversary date, subject to satisfactory performance which will be assumed to be the case unless the employee is otherwise advised."

| Maternity Care Assistants | 1 August 2021 | 1 August 2022 |
|---|---|---|
| Step 4 | 50,681 | 53,359 |
| Step 4 | 48,698 | 50,773 |
| Step 2 | 46,979 | 48,179 |
| Step 1 | 44,110 | 45,310 |

"Progression: By annual increment at anniversary date, subject to satisfactory performance which will be assumed to be the case unless the employee is otherwise advised."

**Community Midwife Scale**

| Community Midwives | Current | 1 August 2021 | 1 August 2022 |
|---|---|---|---|
| Step 8* | 83,994 | 85,194 | 86,394 |
| Step 7* | 79,980 | 81,180 | 82,380 |
| Step 6* | 78,411 | 79,611 | 80,811 |
| Step 5 | 73,857 | 75,057 | 76,257 |
| Step 4 | 66,473 | 67,673 | 68,873 |
| Step 3 | 62,915 | 64,115 | 65,315 |
| Step 2 | 59,222 | 60,422 | 61,622 |
| Step 1 | 54,709 | - | - |

Progression: By annual increment at anniversary dates steps 1 to 5 inclusive. Thereafter progression is annual at anniversary date, subject to satisfactory performance which will be assumed to be the case unless the employee is otherwise advised (*)

All steps on this scale attract Professional Development allowances as provided for in the MECA.

**Designated Senior Midwife Salary Scale**

| GRADE | STEP | Current | Effective 01/8/2021 | Effective 01/8/2022 |
|---|---|---|---|---|
| Grade 2 | 1 | 80,757 | 81,957 | 83,157 |
| Grade 2 | 2 | 82,339 | 83,539 | 84,739 |
| Grade 2 | 3 | 86,442 | 87,642 | 88.842 |
| Grade 3 | 1 | 87,973 | 89,173 | 90,373 |
| Grade 3 | 2 | 91,358 | 92,558 | 93,758 |
| Grade 3 | 3 | 97,583 | 98,783 | 99,983 |
| Grade 4 | 1 | 93,048 | 94,248 | 95,448 |
| Grade 4 | 2 | 96,432 | 97,632 | 98,832 |
| Grade 4 | 3 | 102,810 | 104,010 | 105,210 |
| Grade 5 | 1 | 98,121 | 98,121 | 99,321 |
| Grade 5 | 2 | 101,509 | 101,509 | 102,709 |
| Grade 5 | 3 | 108,037 | 108,037 | 109,237 |
| Grade 6 | 1 | 101,509 | 101,509 | 102,709 |
| Grade 6 | 2 | 104,891 | 104,891 | 106,091 |
| Grade 6 | 3 | 111,523 | 111,523 | 112,723 |
| Grade 7 | 1 | 104,891 | 104,891 | 106,091 |
| Grade 7 | 2 | 108,275 | 108,275 | 109,475 |
| Grade 7 | 3 | 113,794 | 113,794 | 114,994 |
| Grade 8 | 1 | 110,480 | 110,480 | 111,680 |
| Grade 8 | 2 | 116,464 | 116,464 | 117,664 |

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| **Grade 8** | **3** | 122,450 | 122,450 | 123,650 |
| **Grade 8** | **4** | 132,286 | 132,286 | 133,486 |

**Progression:** Movement through steps within a Grade shall, subject to satisfactory performance (see 10.1 (d), be annual on the anniversary date of appointment to the designated senior position. Movement between Grades shall be on the basis of appointment to a higher graded position.

**Appendix B**

**Rostering Principles**

## MERAS Roster Principles

# Principles

The parties agree that to the extent they are capable they will ensure Midwifery workforce planning and rostering meets patient and maternity care service requirements, whilst providing sufficient education opportunities and a reasonable work/life balance for employed midwives (MERAS MECA 1.2 o)

The appropriate budget is funded so that the agreed staffing numbers can be provided each shift.

**Definitions:**

**Roster:** means a list of midwives and the shifts they are required to work over a period of time (MERAS MECA definitions)

**Roster request:** this is generally an indication by the midwife as to particular days that she would like off duty, or where she would like to work a particular shift on a day. Roster requests are not the way to indicate a preferred shift pattern (see semi-self-rostering)

**Semi-self-rostering**: this is where midwives might indicate their preferred roster pattern on the draft roster. In these situations, midwives should still indicate roster requests as the roster coordinator may need to adjust the indicated roster pattern.

**Shift preference**: this is where midwives have a preference to work particular shifts or days of the week. Shift preferences can often be supported where these are unpopular shifts (eg nights).

**Set roster pattern**: this is where there is an agreement for a midwife to work set days of the week each roster or a set roster pattern (rolling roster). This is generally done as a roster preference rather than being employed to just do those days or shift patterns. These roster patterns should have a review period to ensure they continue to meet the needs of the service and the midwives as staff needs change.

# Development of the Roster

- In designing and implementing shift rosters to meet service needs, the employer will work with the midwives involved to ensure the disruption, personal health effects and fatigue associated with shift work is minimised (MERAS MECA 8.0)

- Rosters will be published not less than 28 days prior to when they apply and then can be changed only by mutual agreement. Less notice may be given in exceptional circumstances (MERAS MECA 8.0)

- An agreed system (such as draft roster) is in place for midwives to record roster requests, shift preferences and preferred shift patterns before the roster is developed.

- Every effort should be made to accommodate roster requests.

- Any approved education days, annual leave or meetings will be noted on the draft roster.

- Midwives who do not have approved shift preferences should expect a balanced allocation of shifts in any roster based on hours worked. For those doing 8 hour shifts a third of shifts will be AM, a third PM and a third night shift. For those working 12-hour shifts, 50% will be days or nights.

- The number of shift changes between any period of work (a run of shifts between days off) should be minimised unless more are requested to a maximum of 2 shift changes in any period of work.

- Midwives should not be rostered one-off night shifts except where this has been requested by the midwife.

- Rosters may be for a 4 or 6 week period with hours rostered within every two week period to reflect the pay periods. In specific instances the ordinary hours for a full-time midwife may be averaged over a roster cycle greater than one fortnight (MERAS MECA 8.2 a).

- The development of the roster may be delegated to a midwife to complete but the Midwife Manager has final sign off.

- The roster will be developed in the week prior to publication date.

- The roster should be completed for those midwives who work most hours first, ensuring they have a fair and evenly distributed roster pattern with a variety of days off.

- Midwives should anticipate to work at least one and a half weekends each 4 week period unless their preference is to work more or less.

- Once the roster is complete midwives may swap shifts with colleagues, but this needs to be approved by the Midwife Manager and 48-hours' notice given.

- Where there are gaps in the roster these shifts should be offered to permanent part-time midwives in the first two weeks after the roster is published and then those remaining shifts should be offered to casual midwives (MERAS MECA 8.2 f)

- Rosters should ensure skill mix is balanced across shifts and that there is an experienced midwife familiar with the ward area rostered each shift who is able to provide clinical leadership.

- Rostering should ensure that new graduate midwives, those on orientation or midwives who do not meet the criteria for QLP confident domain are not the senior midwife on the shift. Where this cannot be achieved redeploying midwives from another ward area should be considered, otherwise the Duty Manager should be notified, and an incident report completed.

## Rostering Flexibility

- Due to the nature of the midwifery role, flexible hours of work arrangements may enhance the continuity of services provided to women, as well as lead to a greater sense of job satisfaction for midwives. Accordingly, the parties agree that the employer and midwives will be open to exploring alternative rostering arrangements, where these alternative rostering arrangements may enhance service provision and job satisfaction for midwives (MERAS MECA 8.0).

- Where midwives personal circumstances limit the days/ nights they can work consideration may be given to set roster patterns where these do not adversely impact on the roster of others (such as the same days/ nights of the week)

- Where midwives have shift preferences, these should be supported where they are beneficial to the service (e.g. night shifts).

- Prior to commencing parental leave, a midwife may request changes to their roster where they are struggling to maintain their health through working nightshifts. The employer will make reasonable endeavours to accommodate such requests should they be made (MERAS MECA 32.0).

## Hours of work and rest periods

- Midwives will normally work 8 or 12 hours shifts except that by mutual agreement between the employer and the midwife they may work shifts of no less than 4 hours and up to 12 hours. Duty hours must be consecutive except for unpaid meal breaks (MERAS MECA 8.2b).

- Except in an emergency, no midwife shall work more than seven shifts equal to or less than 8 hours, five 10 hour shifts or four 12-hour shifts (MERAS MECA 8.2 C)

- Every midwife shall have at least two periods of at least 24 hours off duty each week and except in the case of emergencies or by agreement, these shall be consecutive. Wherever three consecutive 12-hour shifts are worked, a minimum of 3 consecutive 24-hour periods off duty will be provided if possible. If four consecutive 12 hour shifts or five 10 shifts are worked a minimum of 3 consecutive 24-hour periods shall be granted. Notwithstanding the foregoing, these off-duty periods may fall separately no more than once every four weeks at the request of the midwife or/by mutual agreement to facilitate rostering (MERAS MECA 8.2 d)

- A break of at least twelve continuous hours must be provided wherever possible between two periods of a full shift or more (MERAS MECA 8.3 a)

- No 12-hour roster shall contain breaks between shifts of less than eleven consecutive hours. No 10-hour roster shift shall contain breaks between shifts of less than nine consecutive hours, then the payment provisions of clause 8.3 shall apply. Note if the midwife requests a lesser break, the overtime payments will not apply (MERAS MECA 8.3 b)

- If a break of at least nine consecutive hours cannot be provided between periods of a full shift, the shift is to be regarded as continuous until a break of at least nine continuous hours is taken, and shall be paid at overtime rates, with proper regard to the time at which it occurs and the amount of overtime which precedes it (MERAS MECA 8.3 e)

- Time spent off duty during ordinary working hours solely to obtain a nine-hour break, shall be paid at ordinary time rates. Any absence after the ninth continuous hour of such a break, if it occurs in ordinary time, shall be treated as normal absence from duty (MERAS MECA 8.3g)
-
- The start/ finish times of shifts may be adjusted in discussion with affected staff and MERAS to create alignment where possible between 8 and 12-hour shifts.

## Annual Leave and Education Leave

- All midwives should be given a fair opportunity to attend educational opportunities. Prior approval needs to be sought where these will occur in working hours.

- An annual leave planner should be available to assist midwives in leave planning.

- Access to leave during school holidays and other peak times should be planned early and allocated in a fair way.

- All midwives should have the opportunity to have at least one period of 2 weeks annual leave every year.

## On-call provisions

- In the interests of healthy rostering practices, the parties agree that the allocation of on-call time should be spread as evenly as practicable amongst those required to participate in an on-call roster (MERAS MECA 8.6 a)

- In services where the employer's operational requirements and staffing permit, midwives working seven- day rosters should not be rostered on call on their rostered days off. The parties accept that this will not always be possible (MERAS MECA 8.6 f)

- Except by mutual agreement or in emergencies, no midwife shall be required to remain on call for more than 40% of the midwife's off-duty time in any three-weekly period. The off-duty time excludes days off (MERAS MECA 8.6 d)

- A midwife who is required to be on call and report to duty within 20 minutes on average shall have access to an appropriate locator or cell-phone (MERAS MECA 8.6 g)

- In any maternity service where on-call is required, agreement should be reached between the midwives and midwife manager as to how the on-call should be allocated, the purpose for the on-call and how any shift hours are covered where the midwife cannot work these due to the impact of call-back hours.

- Factors to consider when developing on-call provisions include:

    - On-call can occur before or after a rostered shift
    - Midwives should not be rostered on-call after a night shift or between two 12- hour shifts
    - Do not create a situation where a midwife could complete a 12- hour shift and then due to call back end up working more than 16 hours (i.e. a midwife could potentially choose to be on-call for 4 hours after a 12-hour day shift and then someone else take over the night on-call).
    - On-call periods do not need to mirror the shift hours so could be rostered in small blocks such as 4 hours or 8 hours (overnight).
    - Where possible midwives who work 1.0fte should be exempt from compulsory on-call requirements
    - A midwife needs to consider 'fitness to continue working' after she has worked for a 12-hour period which may have started during her period of on-call & call-back.
    - Agree how a rostered shift or part of will be covered if a midwife cannot work all or some of that shift due to a period of call-back and 'fitness to continue working' considerations
    - Midwives who work on casual contracts can participate in on-call rosters

    - The frequency and time of call-back hours should be monitored and other options instead of on-call explored when call-back becomes frequent.

    - If a call back of less than a full shift is worked between two periods of a full shift or more, a break of nine continuous hours must be provided, either before or after the call-

back. If such a break has been provided before the call-back it does not have to be provided afterwards as well (MERAS MECA 8.3h)

# Midwifery Career Pathway

## Background

The Midwifery career pathway is a key component of work being undertaken to support the retention of midwives, as recommended in the Midwifery Accord (April 2019). This work informs the work of the Senior Midwives Working Party (a working party agreed to as part of the DHB/MERAS MECA terms of settlement).

This Midwifery Career Pathway is a joint project between the DHB Midwife Leaders and MERAS, supported by the New Zealand College of Midwives. Changes to the pathway can only be made through the agreement of both parties.

The pathway recognises the unique way that midwives work and their ability to transition relatively smoothly from employed to self-employed practice and vice versa. Having a clear professional pathway enables midwives to achieve their career goals, supports retention of experienced midwives and supports a more engaged and motivated workforce.

## Career domains

Although the career pathway for each individual practitioner will vary there are 4 main career domains: Clinical, Education, Management and Research/Quality. There is no intention to confine midwives to one domain but to illuminate the pathway to career progression in each domain and across domains. Leadership may also be considered a domain but in reality leadership exists at all domains and starts from the beginning of a midwife's career, with some DHBs exercising shared leadership models. Progression to designated leadership roles are described in the final section of this document culminating in the Director of Midwifery role.

## Overview of career domains and progression pathways

| Clinical | Education | Management | Research / Quality |
|---|---|---|---|
| Core, Community or employed Caseloading midwife on QLP Competent Domain | | | |
| Core, Community or employed Caseloading midwife on QLP Confident Domain | | | |
| Core, Community or employed Caseloading midwife on QLP Leadership Domain | | | |
| Midwife Specialist | Midwife Clinical Coach | Clinical Midwife Coordinator | Research Midwife |
| | Midwife Educator | Clinical Midwife Manager | Midwife Coordinator |
| Midwife Consultant | | Midwife Manager | Midwife Researcher or Fellow |
| Leadership | | | |
| Associate Director of Midwifery, Deputy Chief Midwife, Midwife Advisor, Midwife Researcher, Midwife Fellow, Midwife Manager | | | |
| Director of Midwifery / Chief Midwife | | | |

**Progression through the pathway**

Midwives can have many careers within the profession, for example self-employed LMC, core midwife, Midwife Educator, Midwife Researcher. The pathway outlines the building blocks between and within the career domains to help midwives make appropriate career development choices to enable them to progress and achieve their career goals.

## Roles and titles

For midwives to achieve their career goals they need to be able to visualise their career pathways. In order to make these pathways more transparent it is important to coalesce some of the numerous roles and titles in use in Aotearoa. Therefore it is proposed that there is agreement on titles and broad definition of these roles in order to achieve national consistency. It is not anticipated that all DHBs will have all roles but that if the roles exist then the role will be comparable. The pathway also describes which roles would be considered senior midwife roles and included in the senior midwife salary scales.

## Naming criteria

Historically the choice of titles for employed midwives has been governed by the broad range of NZNO approved titles and by local variations of these titles. At times the titles have grown in length to a point where they lose their meaning e.g. Associate Clinical Charge Midwife Manager. In reviewing midwifery titles the following principles were followed:

1. All titles should include the word "midwife" to make it an explicit midwifery role
2. No title to be longer than 3 words, although some titles have a hyphenated descriptor such as Midwife specialist – complex care, which will elongate the title when written in full.

It is anticipated that these title changes will be bought in at appropriate times, although some DHBs may choose to transition to the new titles immediately once approved.

## Career domains and progression pathways

The tables below describe the role titles, scopes of these roles and progression steps to move between the roles. The darker shaded roles are designated senior midwife positions.

## Clinical career pathway

| Clinical Domain | Scope of role | Courses & experience |
|---|---|---|
| Core, Community or employed Caseloading midwife on QLP Competent Domain | Clinical practice and development of clinical and professional confidence | • MFYP<br>• Return to practice programme<br>• DHB orientation package |
| Core, Community or employed Caseloading midwife on QLP Confident Domain | Confident practitioner in a range of settings. May take on a champion role in an area of practice. | • QLP confident domain and elective education in areas of interest |

| | | |
|---|---|---|
| Core, Community or employed Caseloading midwife on QLP Leadership Domain | Experienced practitioner, may co-ordinate shifts, undertakes resource or champion roles in an area of clinical practice. | • QLP leadership domain and elective education in areas of interest. Takes a leadership role in a project or area of practice<br>• Education in cultural safety, enacting Te Tiriti o Waitangi and health equity. |
| Midwife Specialist | Developing in year one then, once postgraduate education is completed, demonstrates expertise and leadership in area of clinical practice (e.g. diabetes in pregnancy, lactation, complex care). Contributesto staff education | • Post-grad papers /diploma /degree to support development of clinical expertise<br>• Education in cultural safety, enacting Te Tiriti o Waitangi and health equity. |
| Midwife Consultant | Demonstrates expertise and leadership in a broad sphere of clinical practice. Directs and enables quality improvement. Shares knowledge and supports all members of the MDT from a midwifery perspective. | • Completed Masters degree<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity<br>• Leadership & advocacy skills<br>• Quality improvement skills<br>• Professional credibility |

**Education career pathway**

| Education Domain | **Scope of role** | **Courses & experience** |
|---|---|---|
| Midwife on QLP Leadership Domain | Supports and educates new graduates and new employees and takes a preceptorship or mentoring role. | • QLP Leadership domain<br>• Preceptor course<br>• Mentoring course<br>• Adult education course<br>• Education in cultural safety, enacting Te Tiriti o Waitangi and health equity |
| Midwife Clinical Coach | Provides practical clinical education within the workplace and supports the DHB midwifery education programme. Works closely with new graduates, midwives returning to practice, LMCs, new staff and those wanting to improve or enhance clinical skills, in a supernummery capacity. | • Demonstrated experience in the appropriate clinical setting<br>• Completed or working towards post-grad papers in adult education<br>• Education in cultural safety, enacting Te Tiriti o Waitangi and health equity |
| Midwife Educator | Coordinates and delivers midwifery education to enable midwives to meet Midwifery Council and DHB requirements as well as providing opportunities for professional development. Is recognised for | • Completed post-graduate paper in adult education, working towards Masters degree<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, |

| | | |
|---|---|---|
| | clinical expertise. | and health equity |

## Management career pathway

| Management Domain | Scope of role | Progression steps |
|---|---|---|
| Midwife on QLP Leadership Domain | Confident or leadership practitioner. May co-ordinate shifts to gain experience. | • QLP Leadership domain<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |
| Clinical Midwife Coordinator | Coordinates ward or unit on a shift providing triage and clinical leadership.<br>Clinical expertise<br>Often senior midwifery role out-of-hours in medium sized secondary maternity units<br>Reports to a CMM/MM | • Completed shift coordinators course<br>• Undertaking foundations in management papers or similar courses<br>• Post graduate papers or courses to support development of clinical leadership<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |
| Clinical Midwife Manager | Coordinates ward or unit on a shift in tertiary or larger secondary maternity units.<br>May be on the AM shift in medium secondary units as a support to the Midwife Manager<br>Conducts performance appraisals and often manages a team of staff.<br>Clinical Expertise<br>Have delegated responsibilities or a portfolio of responsibility.<br>Reports to MM | • Professional credibility<br>• Management & leadership papers<br>• Post graduate papers working towards Masters<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |
| Midwife Manager | Manages a maternity unit, ward or service. Has budget responsibilities, hires staff, completes performance appraisals and manages complaints. Ensures ward, unit or service operates safely and efficiently. In larger units may have CMM(s) reporting to them.<br>Reports to Operations Manager or Director of Midwifery where they have the operations manager role as well. | • Post graduate management papers, working towards Masters<br>• Financial management development<br>• Leadership experience<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |

**Research and Quality improvement career pathway**

| Research and Quality improvement Domain | Scope of role | Courses & experience |
|---|---|---|
| Midwife on QLP Leadership Domain | Performs at the level expected of a midwife who meets the criteria for QLP leadership domain.<br>Takes on a champion or resource role in an area of practice which may include participation in audit or research | • QLP Leadership domain<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |
| Research Midwife | Takes a lead role in a research study.<br>Involved in collecting data for multi-centre trials | • Courses or papers to develop skills in research or project management<br>• Working towards or completed post graduate study or Masters degree<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |
| Midwife Co-ordinator – *Programme* | There is a range of roles that have been developed to support quality improvement such as PMMRC, BFHI, and MQSP, project management/ coordination. These roles generally do not have direct staff reports and report to the Director of Midwifery or a Midwife Manager. | |
| Midwife Researcher or Fellow | This may be a joint appointment between a School of Midwifery and a DHB maternity service.<br>The midwife in this role would lead midwifery research project(s) with a strong academic focus. | • Masters degree or PhD and research experience<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |

# Leadership career pathway

| Leadership domain | Scope of role | Courses & experience |
|---|---|---|
| Midwife on QLP Leadership Domain | Undertakes leadership activity as part of QLP programme<br>Takes on champion role and develops project management and quality improvement skills | • QLP Leadership domain<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity |
| Any senior midwife role in clinical, education, quality or management | A part of any senior midwife role takes on leadership tasks and develops skills in leading clinical practice and/or operational service delivery | • Undertaking foundation of management & leadership<br>• Undertaking post graduate midwifery papers that support clinical expertise or area of leadership<br>• Working towards Masters<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity<br>• Experience of working in a |

| | | |
|---|---|---|
| | | broader strategic role e.g. NZCOM, MERAS, Midwifery Council |
| Midwife Advisor, Associate Director of Midwifery*, Deputy Chief Midwife*<br><br>*These titles should only be used where they report to a Director of Midwifery or Chief Midwife | Provides advanced leadership on a designated aspect of midwifery care or a broader portfolio such as:<br>Midwife Advisor - Hauora Māori<br>Midwife Advisor – Primary Care<br>Midwife Advisor – Clinical Practice<br>Reports to the Director of Midwifery<br>An Associate Director of Midwifery or Deputy Chief Midwife work closely with the Director of Midwifery or Chief Midwife | • Completed Masters degree<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity<br>• Leadership & advocacy skills<br>• Project management skills<br>• Specialist experience in cultural support and development<br>• Professional credibility |
| Director of Midwifery, Chief Midwife | The Director of Midwifery is responsible for the clinical, professional and operational leadership of midwifery in the DHB.<br>The Director of Midwifery/ Chief Midwife is the senior midwife for a DHB reporting directly to the CEO or COO.<br>These roles participate in national forums relevant to midwifery | • Masters degree / PhD<br>• Education in cultural safety, enacting Te Tiriti o Waitangi, and health equity<br>• Professional credibility<br>• Proven leadership skills |