MERAS update – the MERAS National Representative Council

Caroline Conroy, MERAS Co-Leader (Midwifery)

Welcome to the first MERAS Midwifery News update for 2018. Most you will be aware by now that the MERAS National Representative Council (NRC) has reviewed the staffing needs for MERAS and opted for a co-leadership model. I am delighted to have been appointed as the co-leader (Midwifery) and we are currently completing the recruitment process for a co-leader (industrial).

You may be wondering what the role of the National Representative Council (NRC) is and who is on the council. The NRC is the governance board for MERAS. Its members oversee the functions of MERAS, approve the budget, membership fees and the work programme for the year. The representatives on the NRC also have a role as a sounding board during the development of strategic documents and priorities for the union. The members of the NRC are selected from amongst the MERAS workplace representatives around the country and also include two midwifery advisor representatives from the New Zealand College of Midwives. The College representatives provide an important link between MERAS and NZCOM, recognising the history of MERAS and its establishment as the industrial arm of NZCOM.

The current NRC representatives are:

Chairperson, Kelly McConville Kelly joined the NRC in 2004. She is one of eight MERAS workplace representatives at Counties-Manukau DHB. Kelly has worked at Counties Manukau as a midwife for 16 years and is employed in the Birthing and Assessment Unit at Middlemore Hospital and provides DHB community midwifery care for women at Auckland Regional Women's Correctional Facility.

Kelly is very proud of the growth she has seen in MERAS membership and the opportunities MERAS provides to represent and advocate for midwives nationally. Kelly continues to identify ways to give midwives a greater voice and strives to make positive changes to improve midwifery staffing, pay, working standards and workplace conditions. Kelly is a member of the current MECA negotiating team.

Financial portfolio, Kathy Anderson Holding the financial portfolio for the NRC Kathy takes the lead on reviewing the financial reports and liaises with the financial manager. Kathy has been a midwife for 40 years, she became a core midwife almost five years ago and works at Christchurch Women's Hospital after having spent 21 years as an LMC. Kathy saw the importance of midwives having their own voice in their work place and quickly became a MERAS workplace representative. Kathy has the invaluable support of three other MERAS work place representatives at Christchurch Women's. Their current focus is working to increase the Midwifery FTE in their work place to create safe staffing levels, to boost the ability of midwives to provide the care they were trained to provide to women and babies and improve job satisfaction.

Bronwyn King has been a MERAS member from the beginning of the union's journey representing midwives. Bronwyn has worked at the Nelson Marlborough DHB for 35 years in roles such as a DHB caseloading midwife and more recently as a core midwife in Nelson Maternity. Bronwyn is one of two MERAS workplace representatives at Nelson and has been on the NRC for many years as the representative for Nelson Marlborough, West Coast and South Canterbury DHBs. Bronwyn enjoys the collegial support the NRC provides and feels better able to assist midwives in her workplace with current information, promoting the valuable work MERAS is doing for midwives nationally.

Michelle Archer is the NRC representative for Southern DHB. Michelle is one of two MERAS workplace representatives at Dunedin hospital, known as Queen Mary. Michelle has been a midwife since 2002 working first as an LMC and for the last six years as a core midwife at Queen Mary. Michelle has been a MERAS workplace representative and on the NRC for the last two years. Michelle enjoys advocating for her midwifery colleagues and the midwifery profession. Michelle is a member of the current MECA negotiating team.

Victoria Christian joined the NRC in 2017 as the representative for Waitemata DHB. Victoria has worked at North Shore hospital ever since she graduated as a midwife nearly 4 years ago. Victoria became one of two MERAS representatives at North Shore Hospital 2 years ago and her focus has been on addressing the concerns of her midwifery colleagues and creating a positive workplace. Recently Victoria was involved in a working party at North Shore to review and provide advice on midwifery staffing levels to senior managers, and is hoping this will lead to an increase in midwifery staffing. As an NRC member she wants to ensure MERAS's vision meets the expectations of its members.

Pauline Andrews has been a member of MERAS since it's foundation in 2002 and has been a MERAS workplace representative at Whangarei Hospital (NDHB) for eight years working alongside other MERAS representatives. Pauline has been the Northland representative on the NRC for the last five years. Pauline has been a midwife for 29 years and has worked at Whangarei Hospital for the last 12 years. Pauline is committed to the principles of safe, healthy rostering and values the opportunity to represent her midwifery colleagues.

Debbie Eaglen Debbie has been a MERAS workplace representative at Auckland Hospital since MERAS formed in 2002. Debbie is one of seven MERAS workplace representatives at Auckland and joined the NRC in 2017. Debbie works as a core midwife on the antenatal / postnatal ward and a lactation consultant at Auckland Hospital. Debbie is currently a member of a working party developing a professional development pathway for midwives at Auckland Hospital.

Alison Eddy and Lesley Dixon are the NZCOM Midwifery Advisor representatives on the NRC. They provide a link between the wider professional and equity issues facing midwifery and the work of MERAS. MERAS and the College work closely together on workplace issues affecting employed midwives.

MERAS
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David Clark
Minister of Health
Parliament Building
12th March 2018

(sent by email)

Dear David

I listened to your interview with John Campbell on Tuesday 6th March. During the interview you made comments about the pay rates of employed midwives indicating that they were paid between $66,755 and $120,000. As the Co-Leader (Midwifery) for MERAS, I would like to correct some of the information that you have been provided.

DHB employed midwives have a fulltime equivalent salary that starts at $49,449 for a new graduate midwife with a stepped increase each year for a total of 5 steps to the amount of $66,755. For the majority of employed midwives they will remain on Step 5 for the remainder of their career.

There is a professional development framework in place as part of the MECA called the Quality Leadership Programme (QLP) which midwives may choose to apply for and this can provide an additional $3000 or $4500 per year pro rata if they meet the criteria.

Employed midwives are a small workforce within the DHBs and outside of the five larger tertiary hospitals there are very limited opportunities for midwives to progress to senior midwife or DHB community midwife positions. In most secondary units there are about 4 senior midwife roles and in primary maternity units there is one.

Most of these roles are paid on the lower Grades of the senior nurse/midwife pay scale and there is no provision currently in the DHB MECA for any midwife to be paid $120,000 as a base salary.

To earn $66,755 a midwife needs 5 years midwifery experience after completing a 4 year equivalent degree. The roles, responsibilities and skills that an employed midwife has as part of their scope of practice enable them to work in a complimentary role with Obstetric specialists each with their own sphere of expertise. As a result of this most maternity units do not employ house-surgeons and some also have no registrars. Many pregnant women and their babies progress through their entire pregnancy and postnatal period in and out of hospital receiving all their care from LMC and hospital midwives without never needing to be referred to a doctor.

Historically employed midwives pay rates have been aligned with nursing pay rates yet employed midwives have a different scope of practice, greater clinical responsibility and a degree which costs more and takes more hours to complete than nursing.

Since its inception just over 11 years ago MERAS has been keen to have a separate pay scale for employed midwives that reflects their scope of practice, roles and responsibilities. Membership of MERAS has grown quickly during that time with midwives understanding that MERAS is the only union that can achieve this goal. MERAS is due to restart negotiations on its DHB MECA soon. The historical alignment of pay rates to nursing devalues the role of the employed midwife. Nurse practitioners earn $104,253- $114,967 (Grade 8 senior nurse) with their extended practice similar to the basic responsibilities and skills of a hospital core midwife, yet DHB's have failed to acknowledge the skills of midwives and only pay a core midwife up to $66,755.

Pay rates are not the only issue that concern employed midwives, excessive workload have a negative impact on hospital midwives with this being a factor for many midwives leaving the employed setting (some even leaving the profession) or reducing their working hours, both of which impact on the current midwifery shortage.

The birthing suite of a maternity unit functions very much like an Emergency Department with unpredictable workloads that change within a matter of minutes from quiet to 'code red'. Many birthing suites are staffed with the minimum number of midwives which can make it difficult for midwives to provide care at times of peak workload, it can delay the commencement of inductions of labour (which have increased in recent years), delay LMC midwives being able to 'hand over' secondary care and has an impact on the 1:1 care that should be provided in labour and is known to improve outcomes and reduce interventions. The budgeted midwifery staffing levels in maternity wards are no better with them failing to acknowledge that this is the only ward in a hospital that has two patients in each bed space – the mother and baby. The traditional staff to patient ratios' have not been adjusted in line with the increasing acuity of the workload due to a reduced length of stay, increasing complexity and increased obstetric and neonatal interventions.

MERAS prides itself on being a solution focused union and developed the 'MERAS staffing standards for maternity facilities' document a few years ago in consultation with its members who range from new graduate midwives to Midwifery Leaders. This document outlines how midwives believe maternity units should be structured and staffed to ensure midwives are able to provide quality care to women and babies. Many maternity managers and Midwifery Leaders also support the vision outlined in this document but have difficulty making it a reality due to current financial constraints.

MERAS hopes that you can provide the funding to support DHBs to fully implement the MERAS 'staffing standards for maternity facilities' document and improve pay rates for employed midwives to reflect their skills, responsibilities and scope of practice.

There is a symbiotic relationship between employed midwives and LMC community midwives. Maternity services work best when there are sufficient and well supported midwives in both maternity units and the community to support the needs of women. The implementation of the co-design funding model for LMC midwives is also important in assisting midwifery to provide an integrated and more sustainable service for all women.

I would be very happy to discuss the current situation for employed midwives further if this would be helpful.

Kind regards
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