RCM EMPLOYMENT RELATIONS PUBLICATION

Continuity Models: The 'Nuts and Bolts'

England and Wales

THE ROYAL COLLEGE OF MIDWIVES

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The 'framework' of how we should work.

The RCM supports the vision for maternity services set out in Better Births, the report of the National Maternity Review, and has actively engaged with the subsequent maternity transformation programme in England. The RCM is clear and has consistently stated that translating this vision into reality requires sufficient staff with the time and resources to implement the recommendations set out in Better Births. Midwives working within this model should not be expected to cover for shortages in other areas.

The existence of midwifery and wider team shortages must be addressed as the key priority by any maternity service. Implementation will require at least a temporary increase in staffing to enable the transition to happen smoothly and safely – with supported study time, dedicated project management and leadership roles and smaller caseloads as midwives become acclimatized to new ways of working. Obstetric units need to have an appropriate level of 'core' staffing to ensure that continuity midwives are not regularly being called in to cover peaks in activity.

This guidance aims to support RCM Workplace Representatives and members involved in implementing, supporting or providing continuity of carer models, to ensure their pay, terms and conditions are fair and adequately reflect working patterns and service demands. Midwives should have the autonomy to develop their own working patterns which recognise their employment rights, work-life balance and supports their own health and wellbeing.

Contents

1. European Working Time Directive (WTD)

The Working Time Directive (WTD) is **EU legislation** intended to **support the health and safety** of workers by setting **minimum requirements** for working hours, rest periods and annual leave. The Directive was **enacted into UK law** as the Working Time Regulations from 1 October 1998.

The main features are:

- An average of 48 hours working time each week, measured over a reference period of 17 weeks
- 24 hours continuous rest in 7 days (or 48 hrs in 14 days)
- A 20 minute break in work periods of over 6 hours
- 5.61 weeks annual leave (pro-rata for part-time staff)

Further features are:

- A rest period of **not less than 11 hours** in each 24 hour period. In exceptional circumstances, where this is not practicable because of the contingencies of the service (call out if on-call), daily rest may be less than 11 hours. Local arrangements should be agreed to ensure that **a period of equivalent compensatory rest is provided.** *If a rest break has to be interrupted or delayed (e.g. to ensure continuity of care or in an emergency), compensatory rest must be taken immediately after the end of the working period*
- An **uninterrupted weekly rest period** of 35 hours (including the eleven hours of daily rest) in **each seven day period.**
- **Staff who are on-call**, i.e. available to work if called upon, will be regarded as working from the time they are required to undertake any work-related activity. Where staff are on-call but otherwise free to use the time as their own, this will not count towards working time. *However once called to undertake any work this IS working time.*

Example scenario

You are full time and work a fixed rolling rota over 4 weeks that includes 1 week where you work 4 x 12.5 hour day shifts Monday-Thursday and then commence 2 nightshifts at 7pm on the Sunday evening.

Q- Is this compliant with the WTD 48 hour week, as it would mean exceeding 48 hours between the Monday to Sunday period?

A- Yes it is compliant. The 48 hours in an average number per week over a 17 week rolling reference period, therefore provided you did not exceed 816 hours of work in any 17 week period you would remain compliant with the maximum weekly hours of the WTD.

2. Case law

This is a part of common law, consisting of judgments given by higher courts in interpreting the statutes (or the provisions of a constitution) applicable in cases brought before them. Called precedents, the outcome decisions are then requisite on all courts (within the same jurisdiction) to be followed as the law in similar cases. Over time, these precedents are recognised, affirmed, and enforced by subsequent court decisions, thus continually expanding the common law.

So, what about on-call time – is this work?

The impact of the SiMAP (2000) and Jaeger (2003) cases:

Two cases before the European Court of Justice (ECJ) clarified that **time spent 'resident on-call' counts as work**. The cases were brought by a Spanish medical union and a German doctor. In both cases, the ECJ ruled that **on-call time, when a doctor is obliged to be resident in a hospital** or health centre, **counts as working time**.

For example, a doctor who is required to be resident on-call within the workplace, but is actually asleep, counts as working because they are required to be on-site.

How would this Case Law apply to midwives?

If a colleague in a remote location is absent from work either on annual leave or sickness absence in a location where being resident is the only way to ensure necessary cover for women in your care; you could be asked to be resident away from home in some way to support providing cover.

Example scenario

You are a community midwife working part- time who would normally work one weekend in every 4 and undertake 1 on call session inbetween your rostered shifts each week. You have 2 colleagues that work in a remote area and provide intrapartum care in a small birth unit for around 10 women per year. One of these colleagues is going on sick leave for approximately 3 weeks for a minor

operation and recovery. Your team have been advised that you will all need to support the other midwife there to provide the intrapartum care during this time, however, as most of you live at least 2-3 hours drive away, you have been told that you are required to reside in the staff residencies at the community hospital during the period you are on-call.

Q- If you were rostered to work from 9am-5pm, then on-call from 5pm until 9am the following day, what pay should you receive for this?

A- As you are unable to pursue your own activities away from work during your period of 'on-call', due to having to remain on site to be within traveling distance for calls, then you should be paid your hourly rate of pay for the duration of the time you are required to be there. If your weekly hours exceed 37.5 then an hours over that should be paid at overtime rate.

3. Agenda for Change terms and conditions of service

AFC Section 10: Hours of the working week

The standard hours of all full-time NHS staff covered by this pay system is 37½ hours, excluding meal breaks. Working time will be calculated exclusive of meal breaks, except where individuals are required to work during meal breaks, in which case such time should be counted as working time.

The standard hours may be worked over any reference period, e.g. 150 hours over four weeks or annualised hours, with due regard for compliance with employment legislation, such as the Working Time Regulations.

AFC Section 2: Maintaining Round the Clock Service

Any extra time worked in a week, above standard hours, will be treated as overtime *(such as call out).*

(Section 3.5: Staff may request to take time off in lieu as an alternative to overtime payments. However, staff who, for operational reasons, are unable to take time off in lieu within three months must be paid at the overtime rate)

Staff cannot receive unsocial hours payments and payments for on-call and other extended service cover for the same hours of work.

Where teams of staff agree rosters among themselves, including who covers unsocial hours shifts, it will be for the team to decide how these shifts are allocated, provided the team continues to provide satisfactory levels of service cover.

This agreement *(AfC in relation to planning round the clock cover)* may be used retrospectively or prospectively. It will be for local partnerships to decide which option best meets local operational needs.

Where the system is used prospectively **an unforeseen change payment of £15 will be available**. This will be used **where it is necessary for employers to ask staff to change their shift within 24 hours of the scheduled work period**. The payment is not applicable to shifts that staff agree to work as overtime, or that they swap with other staff members. It is not available, in any circumstances, in the retrospective system.

On-Call rostering

There are 3 options in how rostering could be applied:

- Fully roster all hours to provide 24/7 cover within small team
- Roster hours as 37.5 per week (or equivalent) and undertake on-call to cover intrapartum care during non-rostered periods. This could then be paid as extra/overtime or taken back as time off in lieu at the choice of staff member.
- Part roster a % of hours for routine antenatal and postnatal care and leave a surplus to off-set against call out hours when on call. This would need to be done in a short reference period such as 4 weeks to ensure that excess overtime or contracted hours are not accrued. Staff would still have set periods of on-call and be paid the allowance for this, however when called out these hours could be offset against the non-rostered surplus.

In line with the principle of full caseloading. Caseload working hours should align with contracted hours without the need to work any extra.

AFC Annex G: Good practice guidance on managing working patterns

An important effect of managing the provision of emergency cover outside normal hours is ensuring good management practice. Where appropriate, robust protocols should be put in place and adhered to.

Similarly, in line with good working practices, employers should ensure that staff are given adequate notice of their working patterns, at least four weeks before they become operational.

Example scenario

You have been transferred from the labour ward to community, in order to support implementation of full case loading. You are contracted to work 30 hours per week. Your small team of 5 midwives must ensure that there is 24 hour cover to support intrapartum care for all women within your combined caseloads.

Q- Could you roster yourself to work 5 hours per day over 4 days (20 hours) (to cover routine antenatal and postnatal care), on 2 of which you will undertake an on-call session between rostered shifts; and then the 1st 10 hours of any call outs would be deducted from (off set against) your contracted hours?

A- Yes, this is one option, which would then be a combination of prospective and retrospective rostering. You would need to locally agree a reference period to monitor the contracted hours. This could be done on a 4 weekly basis where you roster 80 hours and leave 40 available to offset against any periods of call out (you would still be paid on-call availability allowance for those on-call sessions). If your call out periods exceeded 40 hours combined then this should be paid to you as extra hours (overtime), however you would not be paid at overtime rate until you exceeded 70 hours of call out. The reason for this is that overtime rate is only paid once you exceed 37.5 hours of work per week (in this case averaged over 4 weeks). If you only had 29 hours of call out in the 4 week period, the remaining 11 non-rostered hours could be carried over to the next rostering period and either rostered in or available for any call outs. There would need to be stringent monitoring of this approach in order to ensure that you don't accrue backlog of hours owed to service or that you are not finding yourself doing a significant amount of regular overtime.

4. On call arrangements: England and Wales AfC annex 29

Since 1st April 2011 on-call payments have been agreed locally and should be consistent with principles set out in the Agenda for Change Handbook.[1]

Staff are defined as on-call when, as part of an established arrangement with their employer, they are available outside their normal working hours – either at the workplace, at home or elsewhere – to work as and when required.

1 Note some midwives are still paid on the old Whitley system for on calls they were never transferred over to Agenda for Change payment for on calls.

Payment should reflect the availability for being called. There are three types of availability, at home ready to be called out or to undertake work at the workplace, at work ready to undertake work, sleeping in at a workplace. If an employee is required to be on-call outside their normal working hours they should be entitled to a pay enhancement.

That part of the week covered by on-call arrangements should be divided up into appropriate periods for the purposes of calculating the frequency of on-call availability. For example each week divided into nine periods of at least 12 hours.

Staff who are called into work will be paid travelling time, at the rate agreed for on-call work done. Payment for work done, including work done at home, should be made at the appropriate hourly rate as per the Agenda for Change handbook. Staff should have the option to take time off in lieu rather than payment for work done in line with paragraph 3.5 of the Agenda for Change NHS Terms and Conditions of Service Handbook. time off in lieu will be at plain time rate.

Example scenario

You work full time over 5 days and usually do 2-3 on call sessions per week. The on calls are split between a first and second midwife on call and the on call period is of 12 hours.

ON: *9am-5pm providing day cover and carrying out routine work (visits, class, admin)*
OC1: *off during the day, starting cover at 7pm as first midwife on call*
OC2: *early shift and second midwife on call from 7pm (mainly second for homebirth)*

An example week would be:

Monday	Night first on call OC1	7pm-8am
Tuesday	Day shift ON	9am-5pm
Wednesday	Night second on call OC2	7pm-8am
Thursday	Day shift ON	9am-5pm
Friday	Day shift ON	9am-5pm

If called out the day shift (ON) becomes a recovery day.

5. Organisational change

An employer has a duty to 'meaningful' consultation when embarking on organisational change, meaning employees views should be taken account of not just listened to. ACAS guidance states that employees should be involved in change at the earliest stage, communication should be clear, accessible and honest, training and counselling should be provided.

The Social Partnership Forum (SPF) has developed guidance stating that staff and their unions should be involved in the development and implementation of system transformation that impacts on them. Messages related to system change should be clear and transparent and developed in partnership. Guidance and procedures relating to impact on staff should continue to ensure transparency, equitability, fairness and equality. Wherever possible organisations should work together to manage the impact of organisational change on staff.

In 2017 NHS England published the Next Steps for the Five Year Forward View including a commitment to 'de-risk' change for staff, through the development of a staff passport. This work is being taken forward by the SPF.

Pay protection and change management policies etc. are locally negotiated. If organisational change results in a change of employer TUPE or equivalent applies.

6. Rostering policies

A shortage of 3,500 midwives and increasing demand on maternity services means Directors and Heads of Midwifery (DOMs/HOMs) need to carefully deploy their resources and develop systematic, evidence based responses to these challenges. For services experiencing staff shortages or recruitment problems DOMs/HOMs must support midwifery managers to develop effective workforce planning and rostering arrangements.

NICE guidelines recommend that there is a senior midwife accountable for rostering, responding to gaps in the rota and ensuring an appropriate skill mix and forward planning. E-rostering is used in many units and is a vital tool in ensuring safe staffing but should contribute to flexible working. It should be introduced following consultation with staff and include appropriate training.

NHS Improvement produced guidance in 2016 stating that budgets should have a 'headroom' allowance to cover the fact that staff hours are not just used for fulfilling demand but for annual leave, study leave, sickness absence etc. it states headroom should be between 22% and 25%. It also states that good practice is to ensure timetables are available six weeks ahead.

Policies should include a time owing process (for booking and taking it back), highlight rest periods and time between shifts e.g. 11 hour rest period before next shift, ensure shift and break times conform to European Working Time Directives.

It is the RCM's view that organisations should make every effort to grant midwives' and maternity support workers' flexible working requests, and offer a range of shift patterns and lengths, with the aim of retaining staff.

7. Safe staffing

NICE published guidelines for safe midwifery staffing in maternity settings in February 2015 following a number of high profile reports of incidents of poor and unsafe patient care.

The RCM has produced guidance on implementing the guidelines and recommends that Birthrate Plus (BR+) provides the most robust and proven methodology for determining midwifery staffing establishments. BR+ measures workload for midwives arising from the needs of women from initial contact to final discharge.

Measuring demand for care is undertaken through the retrospective allocation of women and babies to five outcome categories based on a composite of clinical factors of process and outcome.

There is growing **research evidence demonstrating the link between nursing and midwifery staffing and patient outcomes** (including mortality rates, patient safety, patient experience and other quality of care measures); staff experience and morale; and the efficiency of care delivery.

It is vital to have the right number and skill mix of staff in place to provide safe, high quality care.

8. NMC Code

Below are some key areas of the NMC Code that should be specifically considered in relation to your own practice around working hours.

"The Code contains the professional standards that registered nurses and midwives must uphold. UK nurses and midwives must act in line with the Code, whether they are providing direct care to individuals, groups or communities or bringing their professional knowledge to bear on nursing and midwifery practice in other roles, such as leadership, education or research. While you can interpret the values and principles set out in the Code in a range of different practice settings, they are not negotiable or discretionary"

Preserve safety

You make sure that patient and public safety is protected. You work within the limits of your competence, exercising your professional 'duty of candour' and raising concerns immediately whenever you come across situations that put patients or public safety at risk. You take necessary action to deal with any concerns where appropriate.

- **13.4** take account of your own personal safety as well as the safety of people in your care.
- **20.4** keep to the laws of the country in which you are practising
- **20.9** maintain the level of health you need to carry out your professional role.
- **25** provide leadership to make sure people's wellbeing is protected and to improve their experiences of the healthcare system

To achieve this, you must:

- **25.1** identify priorities, manage time, staff and resources effectively and deal with risk to make sure that the quality of care or service you deliver is maintained and improved, putting the needs of those receiving care or services first.

Example scenario

You are a Senior Charge Midwife/ Team leader in a community team, and come into work one morning to hear that one of your team was called out to a homebirth during the night. They initially attended the woman at 8pm (having finished their rostered shift at 5pm) and was able to leave her at 9pm before being called again at 3 am and remaining with her until 9am. The midwife returned to the staff office after this. You had covered their community visits for the morning, but were unable to find cover for the antenatal clinic that afternoon; you were supposed to be interviewing a staff member from another team that afternoon as part of an investigation. The midwife advised you that they had some paperwork to complete and was anxious to see a particular woman due at the clinic that afternoon, owing to some complex social problems she had; therefore would stay on and do this and go home straight after the clinic.

You did consider suggesting that you cover the clinic and possibly reschedule both your own non- urgent plans and this particular woman, but as the midwife was so keen to cause minimal disruption you left them to continue with their working day as planned.

Later that afternoon the team midwife saw 7 antenatal women before going home. One of the patients had a clinical concern that resulted in unplanned bloods tests and possible revised plan of care once results were available. The midwife had advised the woman that they would call the lab for the results later and advise her on next steps once the results were available, but if there was no call then the woman was to assume that she should just return to the antenatal clinic the next week. The team midwife then went home and fell asleep. They did not make the call for the results to the laboratory and were off work for 2 days thereafter. On return to work the midwife had a number of blood results to review from the clinic earlier that week. These were reviewed after doing some postnatal home visits and it was then noted that the woman from the clinic 2 days previously had abnormal results. The midwife then remembered that they had not followed this up after the clinic as intended and immediately called the woman. The woman stated that she had been having mild headaches therefore had rested a lot, however she was now wondering if the baby was perhaps moving a bit less. The midwife immediately referred her to the maternity assessment unit at the hospital.

On assessment at the hospital the woman was found to have significantly raised BP and a non-reassuring CTG. A decision was made to proceed to deliver the baby by emergency caesarean section. The baby was born in poor condition and transferred to the neonatal unit.

Q- If the woman was to refer the midwife to the NMC for failing to follow up on her blood results sooner, among other areas of the Code, could it be considered that they may have breached any of the above areas?

A- Yes, although, this midwife could offer some mitigation in relation to the lack of timely action by outlining how they were excessively tired, which had affected their performance. There also appeared to be a reasonable clinical plan that had not been followed through on, owing to the excessive hours worked leading up to going home and the lack of rest they had. Nevertheless, this midwife should have recognised that their level of fatigue was impairing their judgement and memory, thus rendering the midwife's standard of practice to be at risk. By not doing this and going home to take rest after the call out ended, the midwife potentially breached section 25.1 of the Code.

Q- Would the Senior Charge Midwife's / Team Leader's actions be in breach of any areas of the Code?

A- It could be considered that by knowingly taking no action to prevent the team midwife from continuing to work on after extended call out between shifts, they may also have breached section 25.1 of the Code.

The only persons that can ultimately decide whether a registrant has breached the NMC Code are the NMC themselves. Nonetheless, applying the Code to all scenarios you may encounter in the course of your role is essential to support your ability to act within it.

Useful resources

The Code for Nurses and Midwives
http://ow.ly/bVfQ30mtpYy

Agenda for Change Handbook
http://ow.ly/bVfQ30mtpYy

Rostering: Good Practice. NHS Improvement, 2016
http://ow.ly/uzYP30mtq7d

Working Time Regulations. Health and Safety Executive
http://ow.ly/cmvV30mtq8J

Supporting System Change. Social Partnership Forum, 2017
http://ow.ly/fU8W30mtqaw

How to manage change. ACAS, 2014
http://ow.ly/o5pM30mtqcG

Safe midwifery staffing for maternity settings. NICE guideline [NG4], 2015
http://ow.ly/Le5c30mtqfs

Working with Birthrate Plus. Jean A Ball, Marie Washbrook, RCM
http://ow.ly/96uy30mtqhk

Birthrate Plus: What it is and why you should be using it. Jean A Ball, Marie Washbrook, RCM, 2012
http://ow.ly/fpfz30mtql0

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