RCM EMPLOYMENT RELATIONS PUBLICATION

Continuity Models: The 'Nuts and Bolts'

Scotland

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 The Best Start: A Five-Year Forward Plan for Maternity and Neonatal Care in Scotland, and has actively engaged with the development and on-going implementation of the review and its recommendations. The RCM is also clear and consistent that translating this vision into reality requires sufficient staff with the time and resources to implement the recommendations:

The existence of midwifery and wider team staff shortages must be addressed as the key priority by any maternity service. Services that are currently unable to provide safe staffing levels will not be able to safely introduce this system change. 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 acclimatised 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.

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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 the any 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 that would normally work one weekend in every 4 and undertake 1 on call session in-between 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 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 any 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 will be 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.

(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 continue 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 doesn't have to = enforced overtime

So- 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 call out 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.

The principle of full case-loading is that your caseload hours should align to your contracted hours without the need to work any extra.

AFC Annex G: Good practice guidance on managing working patterns

An important aspect of managing the provision of emergency cover outside normal hours is ensuring good management practice and, where necessary, ensuring appropriate protocols are put in place. This should reduce the difficulties arising from the unpredictability within the system.

Similarly, in line with good working practices, employers should ensure that staff are given adequate time to be made aware of their working patterns, as a guide, 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 (within a 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 AGREEMENTS: SCOTLAND: PCS(AFC)2015/3

This agreement came into effect on 1st October 2012 to cover situations where staff are 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.

Staff are then eligible to receive an on-call availability allowance which will recognise their availability to provide such cover.

For on-call purposes, the working week is split into a maximum of 9 on-call sessions:

- Monday to Friday – 1 session each day (each session should be no more than 16 hours)
- Saturday and Sunday - 2 sessions each day (each session should be no more than 12 hours)
- Public holiday – 2 sessions each day (each session should be no more than 12 hours).

Staff who are called into work will be paid according to the duration of the call out (including travelling time), rounded up to the nearest 15 minutes. The call out time will be calculated from **when the member of staff leaves** to when they return home (or other agreed base). Telephone calls are counted as work.

Payment for work done will be at the **post holder's substantive rate** and will be **paid at time plus a half** with the exception of work done on general public holidays which will be at double time.

Staff should have the option to take Time off in Lieu (TOIL) rather than payment for work done in line with paragraph 3.5 of the Agenda for Change NHS Terms and Conditions of Service Handbook. TOIL would 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 9 locally agreed weekly session times are:

- *8am-8am Monday- Saturday morning = 5 sessions*
- *8am Saturday-8pm Saturday*
- *8pm Saturday- 8amSunday*
- *8am Sunday- 8pm Sunday*
- *8pm Sunday- 8am Monday = 4 sessions*
- *This details the 9 sessions per week including 4 sessions for the weekends.*

You are rostered to work Monday- Wednesday 8am-4pm with an on-call period on the Monday night (4pm-8am) and then work Saturday and Sunday 8am-4pm with an on-call both nights.

Q- How many on-call sessions would you be paid for that week?

A- 5 sessions should be paid.

- *You are paid for one session of 16 hours starting on the Monday at 4pm- Tuesday 8am .*
- *You are then paid for 1 session of 4 hours from 4pm-8pm on the Saturday.*
- *Your next session is for 8pm Saturday- 8am Sunday.*
- *The next session is paid for 4pm Sunday-8pm Sunday.*
- *The final session is paid for 8pm Sunday- 8am Monday.*

5. ORGANISATIONAL CHANGE

Protection of Pay and Conditions of Service- NHS Scotland

National and Local Board Organisational Change Policy = Staff will suffer no detriment to their terms and conditions of service.

If a member of staff subject to organisational change would likely experience a reduction in earnings, no detriment pay protection will apply. This includes the basic wage or salary plus any enhanced payments in respect of regular overtime, shift work, on-call and all other additional duty payments.

This is calculated as a weekly or monthly average over an agreed reference period of work, prior to new arrangements being in place.

Full protection of pay is applicable until:

- The employee is appointed to a post in which the normal basic wage or salary is equal to or exceeds the protected pay.
- The employee moves on their own application to a post with a basic wage or salary, which is lower than that of the existing post.

Any additional earnings beyond basic pay (post-change) will be remunerated at the rate appropriate to the new post, however they are then off-set against the protected pay and any excess earned beyond that is paid alongside the level of pay protection in place,

Protection of earnings is conditional on the employee undertaking any reasonable requests to work up to the level of protection to which protection of pay applies.
Protection of earnings is also conditional on the employee accepting any subsequent offer of another suitable post, which attracts a basic wage or salary in excess of the basic wage or salary applying to the new post.

Example Scenario

You currently work in an early pregnancy unit that is open Monday- Friday 9am-5pm. It also opens on a Saturday from 9am-2pm and this is covered with a reduced number of staff to cover emergencies or overspill only. This arrangement has meant that you worked on average every 2nd Saturday. A recent audit of falling patient numbers on Saturdays has led to a proposed service change to cease opening the unit on Saturdays. The attendance numbers were so low, that it seems more appropriate for maternity triage or ward based staff to respond to the few women that would require care at weekends.

You are concerned that your Saturday working currently adds around £70 per month (unsocial hours payments) to your pay and you rely on this to fulfil your regular financial commitments.

Q- What will happen with your pay?

A- As this is organisational change and your employer is making changes to your regular pattern of working, you would be entitled to 'pay protection'. This means that as part of the change an agreed reference period would be determined (usually the 12 weeks prior to an agreed date preceding the change) and all of your hours in that period should be calculated and then a monthly average worked out. This would then be your level of pay protection and you would be guaranteed to receive this in addition to basic pay as your minimum pay every month regardless of the unsocial hours you worked. If you did then work some ad hoc Saturdays thereafter, you would not be paid for these twice; instead your ad hoc Saturday pay is absorbed into the protected amount (off-set) and you are only additionally paid any amount that exceeds the protected amount.

It currently varies on a board by board basis as to whether any night or Sunday hours would also be offset against your protected amount, or whether offsetting only occurred on a like-for-like basis i.e. protection for Sunday hours only off-set against future Sunday hours not any night or Saturday hours.

6. ROSTERING POLICIES

A number of NHS Boards have developed their own local 'rostering policies', which outline the principles of nursing and midwifery rostering across their services. These should be compliant with the Working Time Directive, but may also set down additional parameters for managers and staff to apply within local rostering.

Example Content

- The number of consecutive long shifts for staff to work will not exceed 3.
- Night Duty should not exceed a maximum of 4 consecutive shifts within a 7 day period (i.e. up to 8 in a 2 week period).
- 2 days off **must** follow night shift
- Each roster must include a target level of 16.5% of planned leave (annual leave at 14.5% / study at 2.0%) unless the Senior NMAHP / Service Manager agree a local variation due to recognised reduction in demand / activity
- Teams of less than 7 WTE will exceed 14.5% with 1 WTE on annual leave, so will require to "buddy" with another team and overall annual leave maintained at 14.5%. Alternatively, a local plan for management of workload during annual leave should be agreed with the Senior NMAHP / Service Manager.

Example Scenario

You have requested to work 3 x 12.5 hour nightshifts from Wednesday-Friday night, finishing at 8am on a Saturday morning. You have also requested to work 3 x 12.5 hour days the following week starting at 8am on the Tuesday.

Q- Based on the examples above, would this request be compliant with the rostering policy?

A- Yes, after nights there must be 2 days off, which would be achieved.

7. SAFE STAFFING LEGISLATION

This is a Scottish Government Proposal to introduce legislation that will require organisations providing health and social care to:

- Apply nationally agreed, evidence based workload and workforce planning framework, methodologies and tools.
- Ensure that key principles - notably consideration of professional judgement, local context and quality measures - underpin workload and workforce planning and inform staffing decisions.
- Monitor and report on how they have done this and provide assurance regarding safe and effective staffing.

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 right number and mix of staff in place, with the right skills to enable the provision of safe high quality care.

The legislation process is on-going at the time of writing.

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. She initially attended the woman at 8pm (having finished her 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. She returned to the staff office after this. You had covered her community visits for the morning, but were unable to find cover for her 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 she 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 she would stay on and do this and go home straight after her clinic.

You did consider suggesting that you cover her clinic and possibly reschedule both your own non-urgent plans and this particular woman, but as she was so keen to cause minimal disruption you left her to continue with her 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 she would call the lab for the results later and advise her on next steps once he/she had the results, but if there was no call received 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. The Midwife did not make the call for the results to the laboratory and was on 2 days off work 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 she had not followed this up after the clinic as intended and immediately called the woman. The woman advised her that she had been having mild headaches therefore has 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 at the hospital.

On assessment at the hospital the woman by then had significantly raised BP and a non-reassuring CTG. Following thorough assessment 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 she may have breached any of the above areas?

A- Yes, although, this midwife could offer some mitigation in relation to her lack of timely action by outlining how she was excessively tired, which had affected her 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 she had. Nevertheless, this midwife should have recognised that her level of fatigue was impairing her judgement and memory, thus rendering her standard of practice to be at risk. By not doing this and going home to take rest after her 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, she 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, in the course of your work.

USEFUL RESOURCES

The Code for Nurses and Midwives
https://www.nmc.org.uk/standards/code/

Agenda for Change Handbook
http://www.msg.scot.nhs.uk/wp-content/uploads/AfC-Handbook-Master-Scottish-March-2017V2.pdf

Working Time Regulations. Health and Safety Executive
http://www.hse.gov.uk/contact/faqs/workingtimedirective.htm

Arrangements For Agenda For Change Staff Who Undertake On-Call Duties Scotland PCS(AFC)2015/3
www.sehd.scot.nhs.uk/pcs/PCS2015(AFC)03.pdf

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