NEW ZEALAND NURSES ORGANISATION

"Holding Up"

The first biennial NZNO Employment Survey

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Contents

Acknowledgements

The New Zealand Nurses Organisation, and the author, would like to ***fully*** acknowledge the Royal College of Nursing, and the researchers Jane Ball and Geoff Pike from Employment Research Ltd for their support and permission to replicate the RCN 2008 Employment Survey here in New Zealand.

We would also like to thank all the members of NZNO who gave up their time to answer this questionnaire, and for the insights that they have provided.

Summary

This survey was based on the UK Royal College of Nurses Employment Survey, which has taken place every year for the last 21 years. The questionnaire was modified (with the RCN's consent) to address the differences in terminology and structures required for use in New Zealand, but where possible was kept the same to allow comparisons, and to reflect the extensive experience and incremental development of the questions. The survey was sent to a computer generated random sample of members of the New Zealand Nurses Organisation in December 2008. It is hoped that the NZNO Employment Survey too will be repeated biennially and that this will allow the impact of changes within New Zealand nursing to be documented, and their implications to be explored.

NZNO represents 42,000 members (nurses, care givers and midwives) Questionnaires were not sent to midwives, as they had recently been separately surveyed. The membership of NZNO is broadly representative of the nursing workforce in New Zealand, covering nurses and care givers working in all employment sectors and roles.

Profile of the nursing workforce

The nursing workforce is in a period of rapid and profound change related to demographics; most notably an increase in the number of overseas trained nurses, particularly those working in care homes. There are also ongoing changes to the regulatory structures, roles and scopes of practice, and to the education of nurses. It is important to be able to understand the effects these have on the workforce as a whole. While other data about age, ethnicity, gender and qualifications exist, this survey also documents the proportions of such nurses, their employers and job titles. This allows comparisons with other items in the survey, such as pay, working patterns, second jobs, career plans and perceptions of nursing roles and careers.

Pay

Despite the "pay jolt" delivered to nurses employed under the District Health Board Multi Employer Collective Agreement in 2004, across all sectors and roles nurses agree or strongly agree that they are poorly paid. For those working in other sectors (Primary Care, Maori & Iwi employers) the pay gaps with DHB nurses are perceived as unfair. There are large disparities in pay between sectors, and also perceived gaps between nurses and other comparable professionals.

Working hours

While on the whole nurses are satisfied with their hours, very large numbers work part time or casual hours. This is particularly associated with the need for work life balance, child care responsibilities and a desire not to work rostered and rotating shifts. There is evidence of a large pool of part time workers who are prepared to regularly work additional shifts. This has implications for staffing levels and also for enabling employers to manage their nursing workforce with higher patient contact time than previously. Where the services rely on this preparedness, it is important that the goodwill is built on

and maintained. The assumptions based on the continued existence of a pool of semi-retired nurses prepared to work small numbers of shifts may also need to be robustly tested if the longer term workforce planning is to be adequate.

Workloads and staffing

While in New Zealand specific staff to patient ratios are not mandated or expected, it is clear that many nurses feel the workload and pressure caused by increasing numbers and higher acuity of patients, combined with a perceived lack of experienced staff, high vacancy rates, and the inability to cover vacancies, holidays and sickness is contributing significantly to reduction in job satisfaction, and to increased stress. Where this leads to nurses leaving the profession, dropping their hours, or becoming ill, this has the potential to become a vicious cycle. Continued reduction in satisfaction with the quality of care given, and the knock-on effect on ability to take leave or attend training will also have long term implications. Perceptions by the public of the roles and value of nurses may also deteriorate as quality of care, and quantity of attention inevitably decline.

Job change

There is a high level of staff turnover, with better pay, better hours and dissatisfaction with previous staffing levels cited as the most common drivers for change. The aging profile of the workforce also means many will be coming up to retirement within the next ten years. This survey did not ask about retirement plans, and it could be that the differences in pension provision may make New Zealand significantly different from the UK, where many nurses can retire on a full NHS pension from 55 years old.

Continuing Professional development

There are huge differences between the amounts of paid time spent on Professional Development – from none to months, and very different rates of access to mandatory training on topics such as infection control or cultural safety. Patterns of access to paid Professional Development related to role and employer were discernable, and while nurses have always put their own time into their development, those with children clearly find the competing calls on their time stressful. Equally, access to regular appraisals was very patchy, with many answering “never” to the question related to their last appraisal. Interestingly, two managers had never had appraisals, both stating that they *were* the manager. Further exploration of the support and development needs of nursing leaders would be useful.

Morale

While it is really valuable to have been able to draw on the extensive experience from the RCN survey of items related to general morale of the nursing workforce, it will be necessary to be able to have repeated measurement of these items in a New Zealand context to be able to track changes over time, and to be able to relate the morale of nurses with other comparable professional groups in New Zealand.

Scores in the NZ survey were universally more positive than in the RCN survey – only time will tell whether this relates to the state of the nursing workforce, or has more to do with the national psyches or prevailing zeitgeist.

The New Zealand survey found that views of pay, work-life balance and workload are generally negative, though unlike the UK nurses, there remains a resilience and optimism about nursing as a career, particularly job security and job satisfaction.

A number of very insightful comments were also received related to wider aspects of balancing family and career needs, particularly relating to the need to demonstrate competence after return to work, and the need for more flexible shift options.

1. Introduction

1.1 The 2008 NZNO Employment Survey

This report documents the results of a survey of a random sample of NZNO members. A 5% sample was drawn by computer from the 42,000 membership, representing nurses and care givers from across New Zealand. Any midwives selected were replaced by a second selection, as they had been recently extensively surveyed.

The questionnaire was adapted for use in New Zealand from the UK RCN 2008 employment survey (parts of which have been standardised since 1992) allowing for international comparisons to be made. NZNO membership is largely representative of the New Zealand nursing workforce as a whole, and it is hoped that the results will provide a useful picture of the employment and morale of nurses.

1.2 Context

This is the first large scale survey on this topic since the 2004/5 Multi Employer Collective Agreement (MECA) for nurses, hospital midwives and health care assistants employed by District Health Boards (DHB's), which was heralded as bringing the pay of nurses into line with similar professionals in New Zealand, and to have the potential to significantly impact on the nursing labour market as a whole.

The report: "Pay Jolt? The impact of the 2004/5 NZNO Employment Agreement", published in April 2008 by James Buchan and Nicola North, reviewed available data on the NZ nurse labour market and case studies with managers and staff in two DHBs. The report concluded that there had been improvements in the staffing levels, status, morale and pay of nurses. However, prior to the 2004 MECA, there was evidence of "low levels of participation, concern about staffing levels, occupational detachment and potential lack of competitiveness in international labour markets" which had provoked concern about deep seated and long-term problems. This survey therefore had the potential to describe a snapshot of the perceptions of the workforce four years on.

The RCN 2007 survey reported on the effects of a fundamental review and change to nurse pay scales and job descriptions in the NHS ("Agenda for Change") over a similar time period. The UK represents a significant source and destination country for nurse migration to and from New Zealand, so comparisons with the RCN survey are therefore timely.

The structure of this report draws *heavily* and *intentionally* on the RCN report "Holding On: Nurses' Employment and Morale in 2007" by Jane Ball and Geoff Pike, published by the RCN.

1.3 Method

A postal survey of NZNO members was undertaken in December 2008. Midwives were excluded from the 5% random sample on this occasion. Questionnaires were sent with a covering letter and a freepost envelope. Participants were also given the option of returning a separate slip for entry to a pre-Christmas ballot.

Questionnaire design

NZNO wishes to thank the RCN, and Jane Ball / Geoff Pike from Employment Research Ltd for their permission to use and adapt the questionnaire. The RCN survey was extensively and iteratively adapted for use in New Zealand in consultation with the NZNO Professional Nursing Advisory team, and cognitive testing and piloting was also undertaken at the NZNO annual conference. The questionnaire covers core employment issues (contracts, hours, pay, job change) along with demographic details, and items related to plans for, and perceptions of, working life. The attitudinal rating scales were kept as similar as possible to the standardised RCN set to allow comparisons. The main changes related to UK-NZ differences in employers, titles, qualifications and Safe Staffing-specific questions.

Sample and Response rate

2046 questionnaires were sent out, 37 were returned as not known at the address available. 805 questionnaires were returned, giving a response rate of 40%. This is considered a good response rate for a detailed questionnaire where no reminder is sent out.

1.4 Report structure

The results are given for all respondents. Individual analyses exclude missing data, and this is indicated where applicable.

Chapter 2 details the demographic and employment profiles of the respondents

Chapter 3 examines pay

Chapter 4 describes working and shift patterns

Chapter 5 captures workload issues

Chapter 6 summarises the changes in employment, and plans for future changes

Chapter 7 explores patterns of training and development

Chapter 8 utilises a combination of the attitudinal scales and the qualitative comments to present a picture of the morale of the workforce

Chapter 2: Respondent Profiles

Not all the respondents are currently working as nurses. However, given the fluidity of the workforce, the moves in and out of retirement, and the small numbers involved, no respondent was excluded from the analysis, except than in many items, “blank” , “missing” or “Not Applicable” were accounted for statistically.

2.1 Employment situation

The numbers and percentages of respondents in each category are shown below.

Table 2.1 Respondent profile by employment status

	Number	Percentage
Employed, working	734	91.52
Employed, maternity leave	21	2.57
Employed, sick	5	0.61
Student	11	1.34
Semi-retired	15	1.83
Not employed (unemployed, career break, retired)	8	0.87
Not in nursing employment / other	8	0.87
Total respondents	802	100

2.2 Age profiles

The ages, percentages and comparative figures for the Nursing Council of New Zealand are shown in the table below.

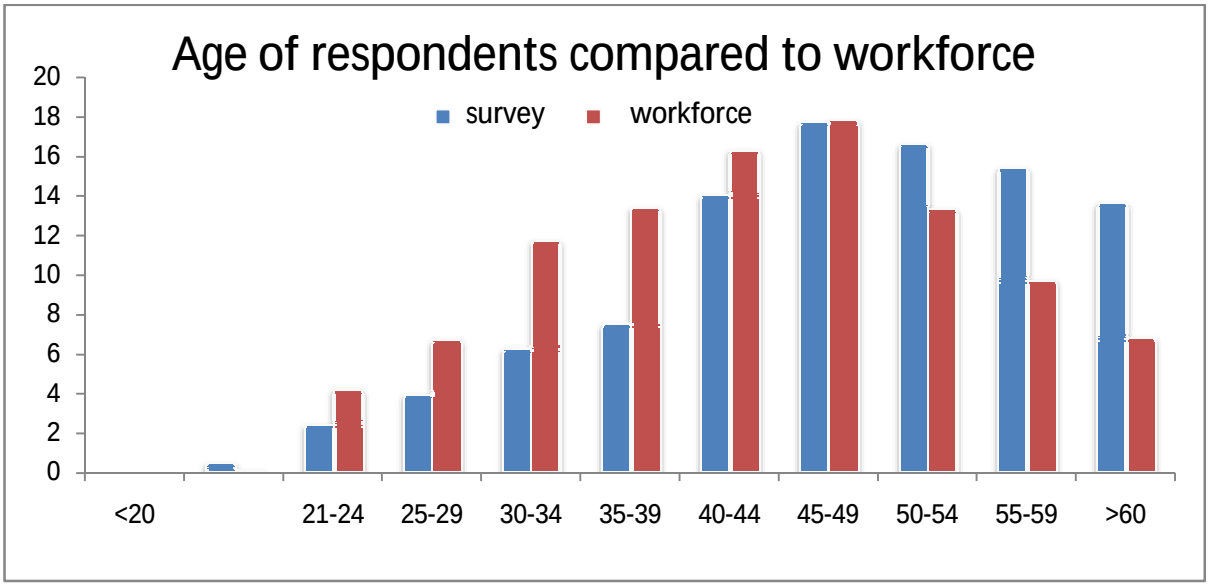
Table 2.2 Respondent age profile compared to Nursing Council age profile

Age	Number	Percentage (survey)	Percentage (Nursing Council 2007)
Under 20	4	0.5	0.1
21-24	19	2.42	4.2
25-29	31	3.94	6.7
30-34	50	6.23	11.7
35-39	61	7.60	13.4
40-44	114	14.21	16.3
45-49	143	17.79	17.8
50-54	134	16.7	13.3
55-59	123	15.3	9.7
60-64	75	9.55	6.8
65-69	25	3.18	-
>70	7	0.89	-
missing	16	2.1	0
total	802	100	100

This is displayed in graph 2.2 below. The graph shows that there is a slight over representation of older nurses in the survey compared to the population described by

Nursing Council (designated “workforce”) This is a frequent finding from survey responses.

Graph 2.2 Age of respondents



The RCN report highlighted the younger profile of overseas trained nurses in the UK, and this was therefore tested. The results are shown below.

Table 2.3 Age of respondents who trained overseas (OST)

Age	Percentage Overseas trained	Percentage workforce (Nursing Council 2007)
Under 20	1.3	0.1
21-24	2.6	4.2
25-29	6.8	6.7
30-34	10.3	11.7
35-39	12.9	13.4
40-44	14.3	16.3
45-49	17	17.8
50-54	14.9	13.3
55-59	6.2	9.7
Over 60	13.6	6.8
total	100	100

This demonstrates that either overseas trained *younger* nurses are more likely to return surveys than their new Zealand trained age matched cohorts, or that the age range of OST nurses is significantly younger than the average, or both. Some of those however are in a much older bracket – this will be examined in more detail later. The figures are presented graphically below.

Graph 2.3 Age of Overseas Trained respondents

2.4 Caring responsibilities

Responsibilities	Female (number)	Female %	Mean age of nurse
Dependent Children	309	41.7	44.4
Adults with care needs	105	14.1	52.1
Both	42	5.6	
	Male (number)	**Male %**	**Mean age of nurse**
Dependent Children	15	42.85	41.2
Adults with care needs	4	11.4	44.5
Both	1	2.8	

The proportion of nurses (male and female) with caring responsibilities is remarkably similar to those responding to the RCN survey. i.e. 42% (NZ) compared to 47% (UK) have dependent children living with them, and around 6% (NZ) compared to 7% (UK) have responsibility for both children and adults. The smaller percentage of men with responsibility for adults with care needs may also reflect their slightly lower age profile. These numbers have implications as the workforce demographics show increasing age (& consequent responsibilities) that might affect the labour supply.

2.5 Gender

The gender of respondents compared to the Nursing council data is shown below in table 2.5

Table 2.5: Gender of respondents compared to Nursing Council data (Nov 2008)

Gender	Respondents (%)	Workforce (%)
Female	92.5	93
Male	4.53	7
Missing	2.97	-

2.6 Chosen Identity

Table 2.6 Chosen Identity

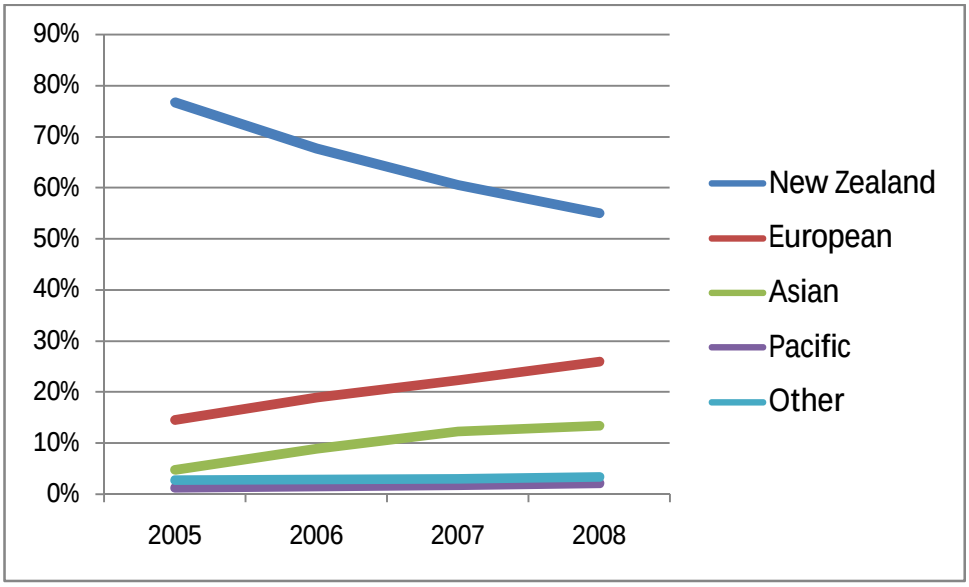
Response	number	percentage
NZ Maori	51	6.25
NZ European	584	73.92
Other European	57	6.98
Samoan	3	0.37
Niueaun	1	0.12
Cook Island Maori	2	0.24
Tongan	2	0.24
Fijian	5	0.61
Other Pacific	1	0.12
South East Asian	14	1.77
Chinese	14	1.77
Indian	9	1.1
Other Asian	8	1.05
Other	24	3.16
Total Valid	790	100

This question, though standard in many situations, proved contentious for some. In addition to missing data, questions were written as to why the question was relevant, and many chose to identify as other, often citing “New Zealander”. Many who had initially trained overseas now identify as New Zealander or NZ European, though others retained another identity (particularly constituent countries from the UK such as Scottish or Welsh) Where people had identified more than one identity, the least commonly reported identity was recorded. Two frequent double identities were Maori + NZ European and Fijian + Indian. While this is less accurate, and important to capture, this was done in this case to allow comparisons with other data sets. The original data remains available.

The identity of members of NZNO has changed considerably over the last few years, as the proportion of overseas trained nurses has increased. The biggest increases have come from Asia (particularly from the Philippines) and from Europe (particularly the UK). The graph below shows these changes, data was taken from the NZNO membership

data base in December 2008. Membership encompasses care givers and midwives in addition to both registered and unregistered nurses.

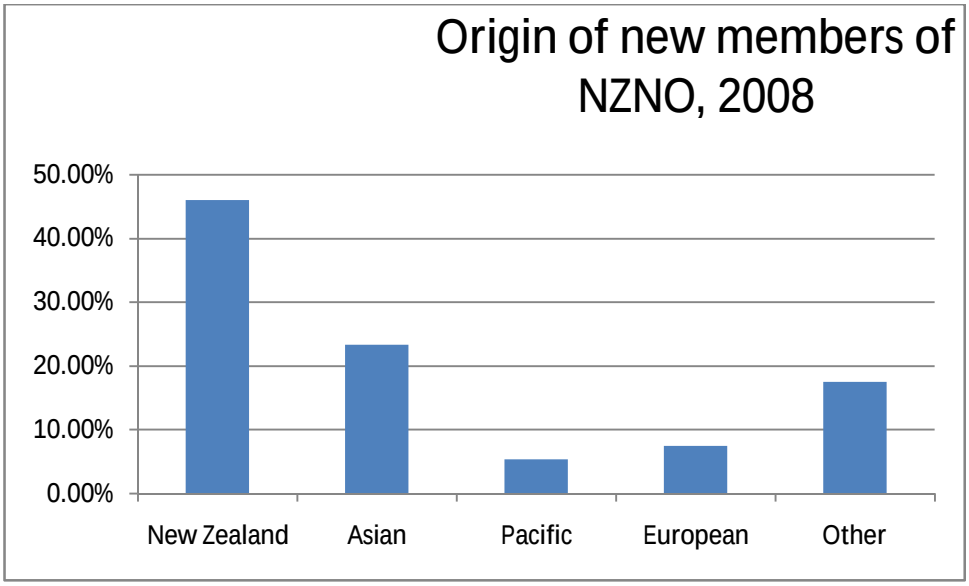
Graph 2.6 Origin of NZNO membership, changes 2005-2008



With the percentage of overseas trained nurses having increased from around 22% to 45% in the space of 3 years, the experience, views and plans of this group are particularly important to understand – particularly their longer term plans.

The percentage of new members of NZNO coming from each area in 2008 is shown below.

Graph 2.7 Origin of new members



2.8 Overseas Trained Nurses (OTN)

The results of the three questions specifically asked of OTN are shown in table 2.8 below. With hindsight, a supplementary question on how long they have been working in New Zealand would have been useful, as the age profile, and chosen identity of NZ European or New Zealander may indicate a cohort who have settled much longer than others. The implications of newer migrants being unsure of their employment plans, or not *confidently* deciding they might stay till they retire, has implications for the workforce longer term, given the reliance on OTN and the migration of New Zealand trained nurses, particularly to Australia.

Table 2.8 Overseas Trained Nurse questions	**Number**	**Percentage total**
Trained Overseas	62	7.9
	Number	**% OTN**
Undertook further training	27	43.5
Recruited as nurses in country of origin	18	29
Plan to work in NZ till retirement	28	45
Unsure of plans	17	27.5
Expectations of nursing in NZ met	18	29

(Responses from this cohort are analysed in relation to pay, qualifications, and attitudinal scales in later sections)

2.9 Qualifications

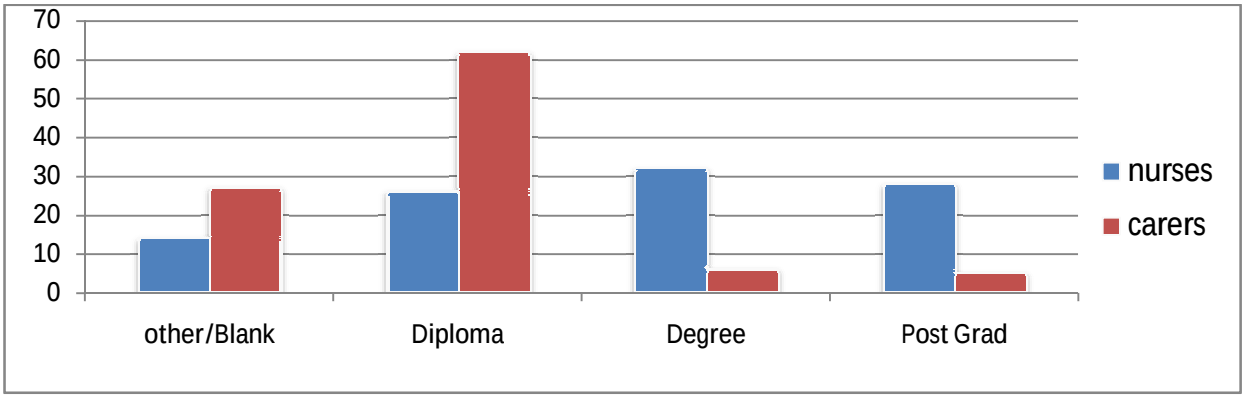
A variety of different qualifications are held by nurses and carers in New Zealand. Although exact comparisons are difficult, broadly, they can be divided into Diploma/ Certificate level (including hospital training in the past), Degree level, and post graduate level (including post graduate certificates through to master and PhD. “Other” qualifications were re-coded. (There were many missing fields for this question, and blank was recorded only if none was selected, or the other qualification was unrelated to nursing.) Broad categories are shown in Table 2.9 below.

Table 2.9 Qualifications

	number	**Blank / Other**	**Diploma**	**Degree**	**P Graduate**	**Masters / PhD**
All employed as nurses	606	85	158	195	133	35
All employed as nurses %		14%	26%	32%	22%	6%
All employed as carers	114	32	71	7	6	0
All employed as carers %		27%	62%	6%	5%	0
Total	720	117	229	202	139	35
Total %		16%	32%	28%	19%	5%

Qualifications of nurses and carers are shown in graph 2.9 below. All post graduate qualifications have been combined.

Graph 2.9 Broad qualifications by role



Amongst nurses, the qualifications related to age profiles are of particular interest. Designations are as for the previous table. Very many held a number of different qualifications, where ascertainable, the highest qualifications as judged *by academic standards* have been selected. This reflects researcher bias.

Table 2.10 Highest Qualifications by age for nurses, by age group.

Age group	number	Blank/Other	Diploma	Degree	Post Graduate
<30	55	2%	2%	62%	34%
31-40	109	1%	30%	42%	27%
41-50	197	10%	23%	33%	61%
51-60	190	23%	30.5%	22%	24.5%
>60	55	38%	38%	15%	9%
Total	606				
%		14%	26%	32%	28%

It can be seen that the Degree has replaced the Diploma / Certificate / Hospital training as the main qualification in the younger age groups. It is interesting to note that the respondents in the 40-50 age group possess the highest percentage of post graduate qualifications. A very large number of these were additional to Diplomas / Certificates and were in the absence of degrees, suggesting that many have upgraded their initial training after experience as nurses, perhaps in response to a requirement for a degree or post graduate qualification in the job market. There may also be a bias amongst postgraduates to return surveys, perhaps appreciating the need for research!

By role, the 35 respondents with masters and PhDs were disproportionately employed outside direct clinical nursing: some as educators, managers, and government advisory roles. 17 were employed as RNs, Clinical Nurse Specialists or Nurse Practitioners.

Of the 4 respondents who identified as Service Managers, 1 had a degree, 2 had RGON and 1 an Enrolled nursing qualification. Qualifications were broadly correlated with wages: as seen in table 2.7.3 below.

Table 2.11 Wages by qualification

Highest Qualification	(valid) number	Mean hourly wage ($)
Masters / PhD	35	$33.18
Post Graduate (not M /PhD)	139	$29.19
Degree	202	$26.62
Nursing Diploma / Certificate	229	$26.13
Care giving, qualified	87	$20.09
Care giving, unqualified	27	$17.06
All (valid for salary)	664	$26.89

Wages are also correlated with role, and this may be independent of qualifications. Increasingly, formal qualifications rather than experience in the absence of formal qualifications are required for more senior and higher paid jobs. Many respondents withheld their salary details. Pay is analysed in far more detail in chapter 3. By comparison with the RCN survey, New Zealand nurses report a higher proportion holding post graduate qualifications, though similar percentage have masters or PhD. This might reflect differences in definitions, opportunity for further study, value placed on further study, or a combination of all factors.

2.12 Current job and employer

The main descriptors of the employment of the respondents are shown below. All categories with fewer than 1% of respondents are not shown separately but are available in the Appendix.

Table 2.12 main employers (ES = this survey, NC = data from Nursing Council Nov 08)

Employer Main job	n	% ES	% NC	Mean age	Mean salary	Mean hours / week	% working 36+ hours
Rural DHB	38	5		48.15	24.5	28	31.5%
Urban DHB	304	40.58	47.3	44.79	27.02	32.19	43.42%
Community DHB	85	11.3	6.6	47.08	28.7	32.45	41.1%
Private surgical hospital	39	5.2	8.2	50.1	29.27	27.17	15.3%
Aged Care	81	10.8	9	48.9	21.61	29.25	27.1%
GP	92	12.2	11	51.62	27.27	28	22.8%
Nursing Agency	8	1	1.7	40.4	22.12	39	25%
Maori & Iwi provider	16	2	.95	46.5	26.06	37.8	62.5%
Educational institution	12	1.6	1.8	48	33.32	37.2	41.7%
Other	78	11	13.5	47.6	29.	29	26%

The figure of at least 36 hours per week was chosen as implying “full time” for an employer – however, this number varies widely between employers. As will be presented later, many who do not work “full time” in their main contract often do other shifts (either for the same or different employers) on a regular/casual basis. The existence of a pool of part time nurses allows the casualisation of positions, as employers are more likely to be able to cover holiday, sickness and training time without employing cover nurses themselves, or paying the higher costs associated with employing agency nurses. Such cover is often paid at the same rate as the normal salary. (More detail is given in chapter 3) The ease of finding appropriate cover is likely to vary geographically and by specialisation.

Staff working for rural DHBs had the most stable employment history, while those working for agencies, were (not surprisingly) the most flexible. All categories however had huge variation, the ranges were from weeks in post through to 45 years, so other than to say nurses change their employers and posts more frequently than many other professions, conclusions are difficult to draw. Data from DHB HR departments on turn over, rates of vacancy and numbers of applicants per job advert may illuminate this. The costs of job change to employers (of induction, training, and the cost of recruitment) are sometimes hidden by the savings made by having empty positions on the books. The figures are very comparable with those in the RCN survey

2.13 Job title

The number and range of job titles of the respondents are shown below.

Table 2.13 Title

Job title	number	percentage	Job title	number	percentage
Registered Nurse	357	44.6	**PI or Maori Care Giver**	1	0.1
Service Manager	6	0.8	**Health care assistant**	31	3.9
Nurse Practitioner	6	0.8	**Health Care Worker**	24	3.0
Community Nurse	16	2.0	**Nurse assistant**	7	0.9
Clinical Nurse Specialist	30	3.7	**Duly Authorised Officer**	1	0.1
Educator	16	2.0	**Maori & iwi nurse**	2	0.3
Director Of Nursing	2	0.3	**Pacific Island Nurse**	2	0.3
Enrolled nurse	36	4.6	**Practice Nurse**	97	11.6
Charge Nurse	53	6.7	**Phlebotomist**	1	0.1
Public Health Nurse	6	0.8	**School Nurse**	3	0.4
Ass. Charge Nurse	1	0.1	**Manager**	1	0.1
District Nurse	16	2.0	**blank**	16	2.0

Mental Health Nurse	20	2.5	**Other**	47	5.9

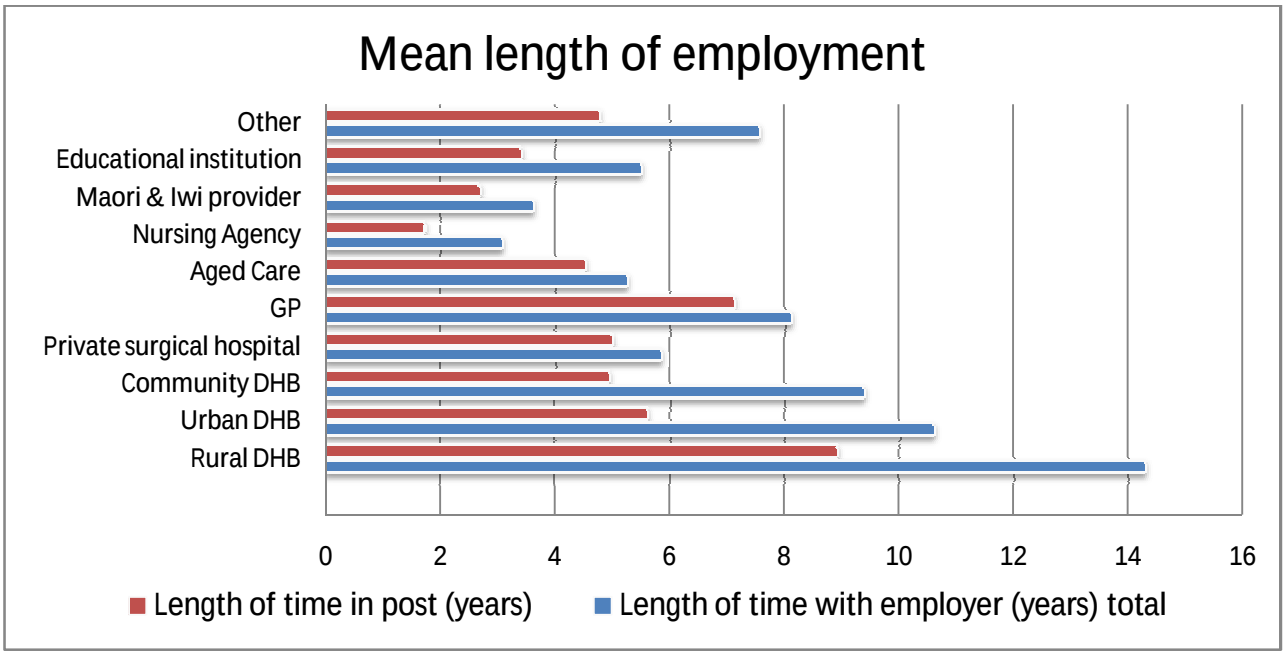
2.14 Turn over

Questions related to the length of time nurses had been employed by their current employer, and in their current roles were examined by main employers. This revealed considerable job change, both to different jobs with the same employers, and to different employers. Nicola North also identified "churn" within DHBs . While this is not necessarily a negative phenomenon (representing career advancement and acquisition of new skills and experience) it does come at the cost of vacancies, increased workload, lack of speciality skills and continuity for both patients and colleagues, particularly in the more senior roles. The figures are shown in table 2.11 and graph 2.11 below.

Table 2.14 Turn over by employer

Employer Main job	n	Mean Length of time with employer (years)	Man Length of time in current job (years)
Rural DHB	38	14.29	8.9
Urban DHB	304	10.59	5.59
Community DHB	85	9.37	4.92
Private surgical hospital	39	5.83	4.98
GP	92	8.10	7.10
Aged Care	81	5.24	4.51
Nursing Agency	8	3.06	1.7
Maori & Iwi provider	16	3.60	2.66
Educational institution	12	5.48	3.39
Other	100	7.54	4.76

Graph 2.14 Turnover by employer



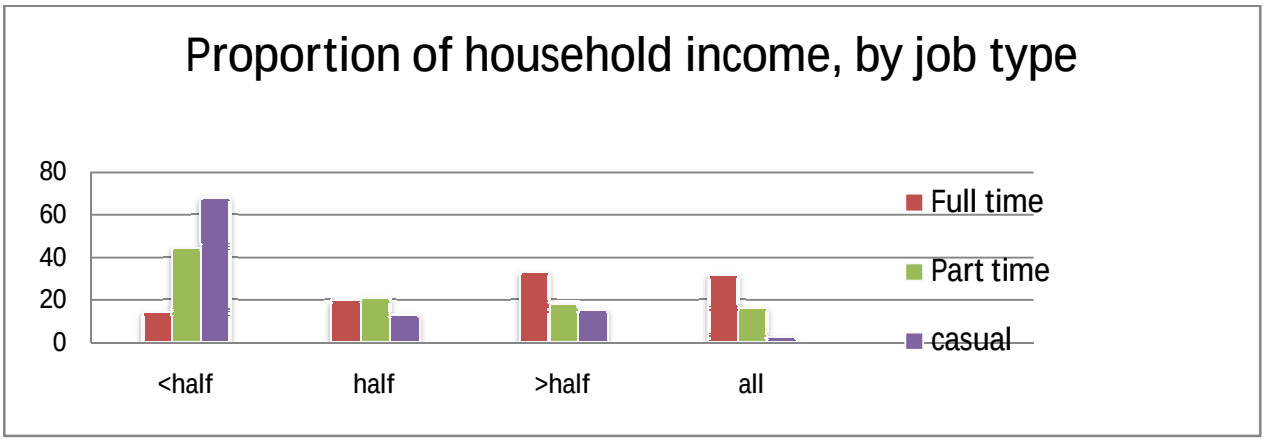
2.15 Household income

Table 2.15 below, shows the proportion of household income that nurses contribute, separated into those who work full time, part time (including job share) and casual. As would be expected, there is an inverse correlation between the hours worked, and the proportion of the total household income that the nurse's salary makes up.

Table 2.15 Proportion of household income (percentage)

job type	Total (n)	<half	half	>half	all	missing
Full time	288	1.4%	22.5%	37.5%	37.1%	1.4%
Part time	397	43.8%	20.65%	17.88%	16.12%	1.5%
casual	41	63.4%	17%	14.6%	2.4%	2.4%

Graph 2.15 below shows this by percentage



When these are given as percentages, irrespective of hours, the figures are similar for nurses working in the UK. This is shown in the table below.

Table 2.16 New Zealand / UK comparison

Proportion of household income	Percentage (NZ)	Percentage (UK)
less than half	31.6	27
half	19.6	25
more than half	23.5	25
all	21.5	23

There is also, as expected, a strong link between part time working and the reporting of dependent children living at home. This is shown in the table below.

Table 2.17

Dependent children	Work full time	Work part time
Yes	39%	59%
No	45%	54%

The patterns of working are explored in more detail in chapter 3.

Key Points: Chapter 2

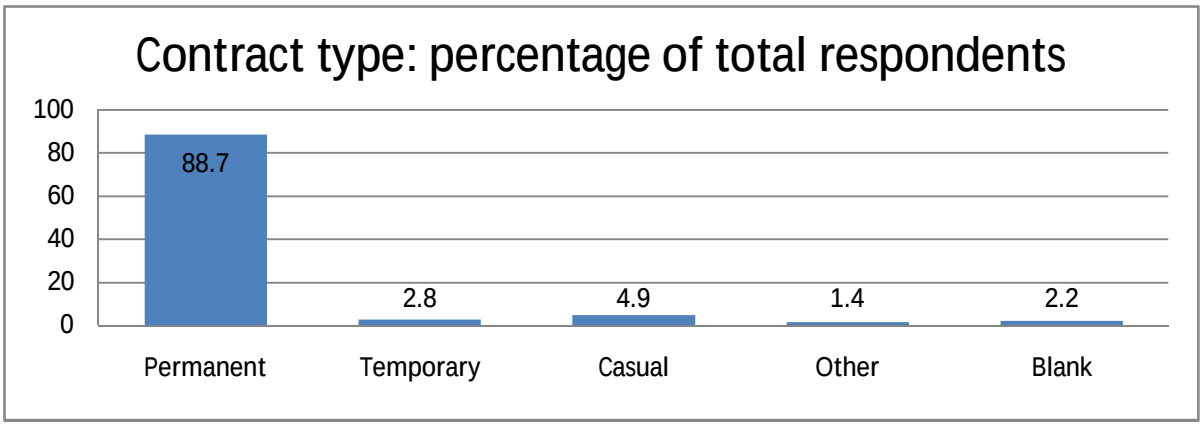
- The age profile of nurses in New Zealand has profound work force planning implications.
- 8% of respondents first trained overseas. This proportion is likely to continue to grow unless other wider global events change the trends seen over the last few years.
- There is considerable change both within and between employers in the nursing workforce in New Zealand.
- Of the established main employer groups, care homes show the greatest turn-over of staff, and the fewest highly qualified staff.
- The nursing workforce in New Zealand is more highly qualified than that in the UK (especially considering the UK survey was of registered nurses only)
- Nearly half of respondents have caring responsibilities for children or for elderly relatives or other adults.

Chapter 3: Pay and Employment agreements

A study of the impact on pay and labour market behaviour of the 2004 MECA for nurses, hospital midwives and healthcare assistants employed by District Health Boards has been reported. (Buchan and North, 2008) This employment survey provides additional information about the salaries, working patters, contracts and awareness of MECA among NZNO membership. It also allows detailed comparisons of nurses employed in different sectors, and the relative wages of care givers and nurses other than registered nurses. The 2004 MECA is due to be re-negotiated in 2010, and a Primary Health Care MECA is in the process of ratification and a Maori and Iwi Provider MECA is under negotiation.

3.1 Contracts and Employment Agreements

Graph 3.1 Employment contract status



The majority of respondents hold permanent contracts. Those on temporary contracts had often been employed on particular projects. There was no particular type of employer for whom temporary or casual contracts predominated, though there was a slight over-representation of those employed in General Practice compared to the total (18.2% of those employed in General practice, versus 12.2% of the whole sample)

While only 3 out of the 39 respondents with casual contracts were employed by nursing agencies, 4 out of the 8 who worked for agencies had permanent contracts with the agency. Comments related to these respondents often cited flexibility and home / life balance as being their prime reason for choosing agency work.

3.2 Employment Agreements

Table 3.2

Knowledge of Employment Agreement	Number	Percentage
Yes	726	90.5
No	30	3.75
Uncertain	30	3.75
Blank	16	2.0
Total	802	100
Type of Employment Agreement	**Number**	**Percentage**
Multi Employer Collective Agreement	527	72.5
Single Employer Collective Agreement	61	8.4
Individual Agreement	128	17.6
Blank / unsure	10	1.3
Total	726	100

This table illustrates that most were aware of whether they were employed under an agreement, and if so, what sort of agreement they are employed under. Most DHB employed staff were aware of the DHB MECA, though very few named particular MECA.

3.3 Rates of pay

Tables in this section examine the rates of pay in relation to agreement type, nursing registration, job title, and perceptions of satisfaction with pay.

Because of the very small numbers, those who stated they were not employed under an agreement were excluded from the analyses. The number of valid cases refers to those who gave details of their hourly rate of pay.

Table 3.3 Rates of pay by agreement type

Agreement type	Valid n	Mean hourly rate ($)	Standard deviation	95% CI
MECA	448	26.92	5.29	16.34-37.50
SEA	57	26.16	5.23	15.69-36.61
IA	122	27.46	6.08	15.30-39.62
All	627	26.87	5.49	15.89-37.85

This demonstrates the wide variation in rates of pay, with the widest variation being amongst those on individual agreements.

Separating out the hourly rate by whether nurses were registered with the Nursing Council (i.e. regulated nurses versus others)

Table 3.4 Rates of pay by Nursing Council registration (i.e. regulated nurses)

Regulated	Valid n	Mean hourly rate ($)	Standard deviation	95% CI
Yes	620	27.80	4.64	18.52-37.08
No	170	17.70	4.73	8.24*-27.16

* minimum wage for this group in practice (as opposed to 95% confidence interval) was however $12.55

The table below shows mean rates of pay by title, also giving the variability:

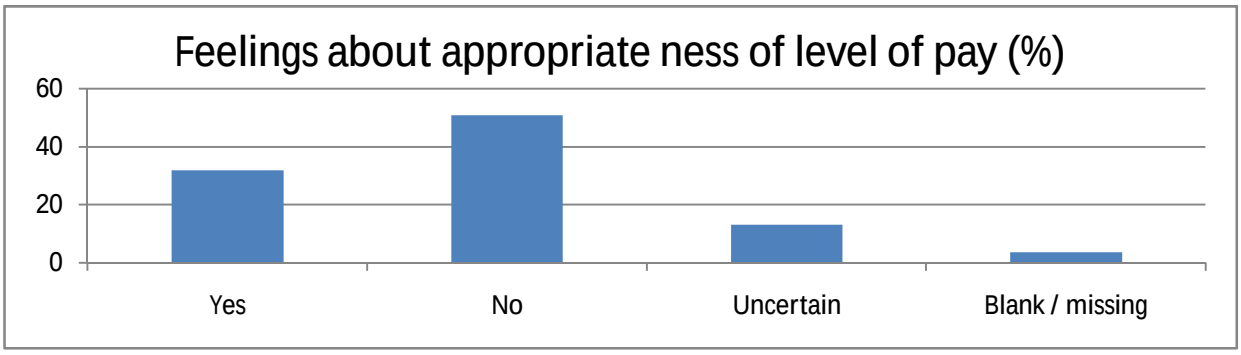
Table 3.5 Pay by job title

(Enrolled nurses and Nurse Assistants combined as regulated 2nd level nurses.)

Title	Valid (n)	Mean hourly rate ($)	Median hourly rate ($)	Standard deviation
Registered Nurse	312	26.69	27.73	2.6
ENs and N Assistants	36	21.61	21.05	2.65
Unregulated Care Givers	52	16.46	16.4	2.7

Question B5 asked whether respondents thought their current pay was appropriate given the role and responsibilities. The response is shown below, with fewer than 32% thinking their pay was appropriate.

Graph 3.6 Satisfaction with pay



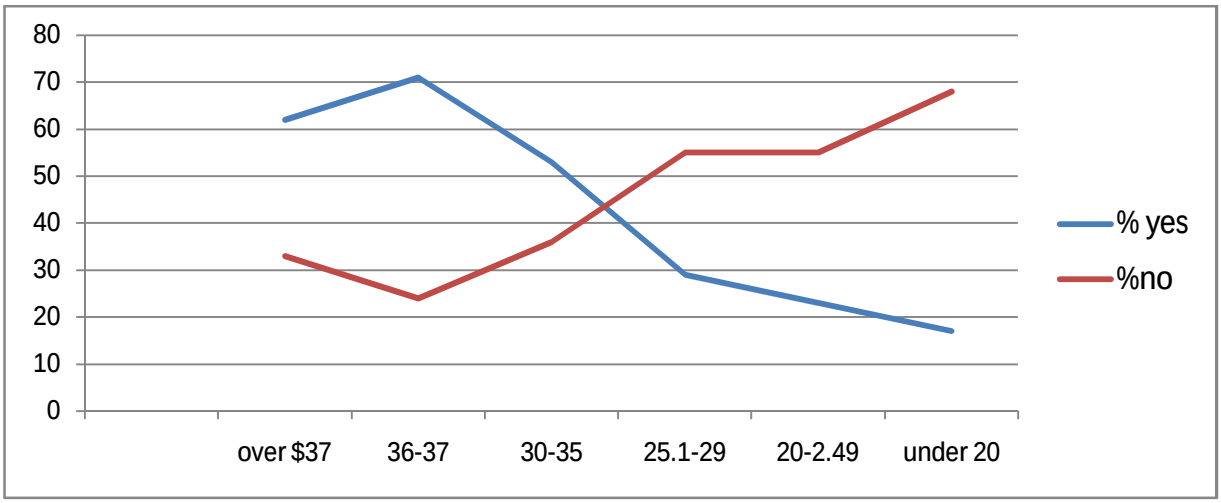
There was only a very loose connection between feeling paid adequately for role, and actual mean rates of pay, with those paid more being slightly more likely to be satisfied with pay as shown below.

Table 3.6 satisfaction with pay

Feelings about appropriateness of pay	Mean hourly rate ($)
yes	28.92
no	25.95
uncertain	25.61

The correlation becomes clearer when shown graphically, as below. The relative dissatisfaction with pay for those above $37 may reflect their perception that the role and responsibility are disproportionately under-compensated by the extra dollars per hour. More detailed data is required to be able to match and correct for additional confounders such as age, or duties.

Graph 3.7 Satisfaction with pay by actual pay



To explore this a little further, 10 discrete roles were selected and examined for mean hourly pay, and percentage who feel they are adequately rewarded.

Table 3.7 Satisfaction by title and pay

Title	Valid number	Mean hourly rate	% agree paid adequately
Director of nursing	2	$39.6	0% (neither)
Clinical nurse specialist	30	$33.72	50%
Charge nurse	53	$33.61	38%
District nurse	16	$29.62	43%
Manager / service manager	7	$28.30	57%
Mental health nurse	20	$27.75	40%
Practice nurse	92	$27.40	37%
Community nurse	16	$27.15	37%
Registered Nurse*	96	$26.68	86%
Enrolled nurse	36	$21.60	33%

(* where people recorded their job title as registered nurse, not by whether they were registered with the nursing council)

More research is required to determine if these perceptions reflect difficulties employers face in filling these roles at the pay rates available, or if they influence career choices. Individual variations and small numbers mean caution should be taken in the interpretation however. Chapter 8 will compare overall satisfaction ratings with the different roles, as pay may be only one of many factors.

Three additional statements were included in the attitudinal series, which reflect opinion on pay. These are:

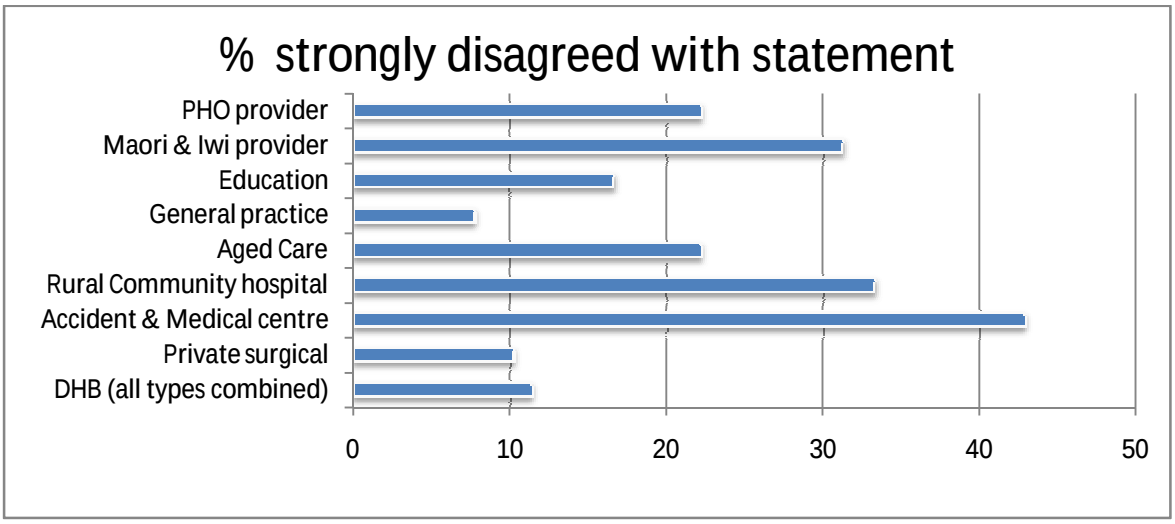
- I could be paid more for less effort if I left nursing
- Considering the work I do I am well paid
- Nurses are paid well compared to other professions

(The scoring for the first statement options were reversed for analytical purposes)

These are more fully explored in a later chapter, but broadly, while fewer New Zealand nurses than UK nurses STRONGLY felt undervalued (3.5% sum all items, versus 33% sum all items) 67.5 % agreed **or** strongly agreed with the three statements linked to feeling financially undervalued. This was particularly striking for the statement related to pay relative to other professions, where 81.4% felt undervalued. By employer type, the figure below shows the percentages of respondents who strongly disagreed with the statement "Considering the work I do I am well paid"

These are shown in graph 3.8 below

Graph 3.8 response to statement "Considering the work I do I am well paid"



3.9 Additional employment

A lower proportion of New Zealand nurses versus UK nurses have additional employment – around 20% compared to 26%. However, this should be interpreted with caution as 47% of nurses worked additional hours (paid and unpaid) for their main employer. Mean number of hours per week was 14, range 1-60 hours. In the UK, additional employment was more commonly found in migrant nurses, who are often the main wage earners for the family. This was tested in the New Zealand survey, and no real differences between NZ and overseas trained nurses holding of additional employment was seen. See table below.

Table 3.9 Those with additional paid employment

Where initially trained	Where working	% with additional jobs	% of these citing income as a key reason
New Zealand	New Zealand	19.2%	45%
Overseas (to NZ)	New Zealand	21%	47%
UK	UK	26%	70%
Overseas (to UK)	UK	41%	96%

The nature of additional employment varied widely. 27% of the 156 respondents who reported additional employment had full time contracts with their main employer, compared to 65% who had part time or job share contracts, and 8% who had casual contracts. The percentages and broad categories are shown in the table below. A large number of different jobs were described under the category “other”, some of which were health care related, some not.

Table 3.10 Additional employment types chosen

Additional employment	Percentage	Percentage UK study
Aged Care	6	2
Casual other employer	1	19
Casual with same employer	10	42
Nursing agency	9	9
Self -employed	11	-
Non-nursing	4	10
Other nursing	45	30
Other / Blank	14	-
total	100	*

* approximate categories , weighted cases in UK study mean % not exact. There are differences in how additional shifts for the same employer are accounted for – in the UK, those who chose regular additional shifts for their employer opt to join a bank / pool of nurses, whereas in NZ there is more of a culture of covering shifts on the usual wards if required. This probably accounts for the majority of the difference seen. Self employment for nurses is very rare in the UK.

Working hours and patterns are examined in more detail in chapter 4

Key points Chapter 3

- There is clear dissatisfaction with the rates of pay, at all levels

- While there is wide variation in rates of hourly pay, related to role, title, registration and employment agreement, most nurses are paid within quite narrow pay bands ($16-$38 per hour)

- Approximately 20% have other paid work, with nearly half of those citing the need for additional income as the main reason.

Chapter 4 Working patterns

This chapter describes the working patterns of respondents: contract hours, excess hours, shift patterns and total reported working hours.

Since The Pay Jolt paper by Buchan and North, concern has arisen that one of the unintended consequences of a pay rise for nurses employed by DHBs was that the number working full time fell, with nurses preferring to work fewer hours for the same take home pay, rather than to continue their hours and earn more. The tax thresholds also perhaps encourage this trend. Nurses involved in childrearing, and those nearing retirement also benefit from more flexible working hours.

The qualitative data (see chapter X) also support the use of part time hours to cope with less tolerable working conditions, along with strong desire to maintain both work-life balance and work-family balance. For employers, access to a willing pool of casual trained staff is of benefit, particularly to cover sickness, training leave and holidays. However, proportionately, having a large number of part time staff can increase the time required for induction, training, supervision, appraisal and team meetings compared to direct patient care hours available per staff member. This is balanced against the risk of long vacancies requiring cover, and can allow for mentoring, and continuity.

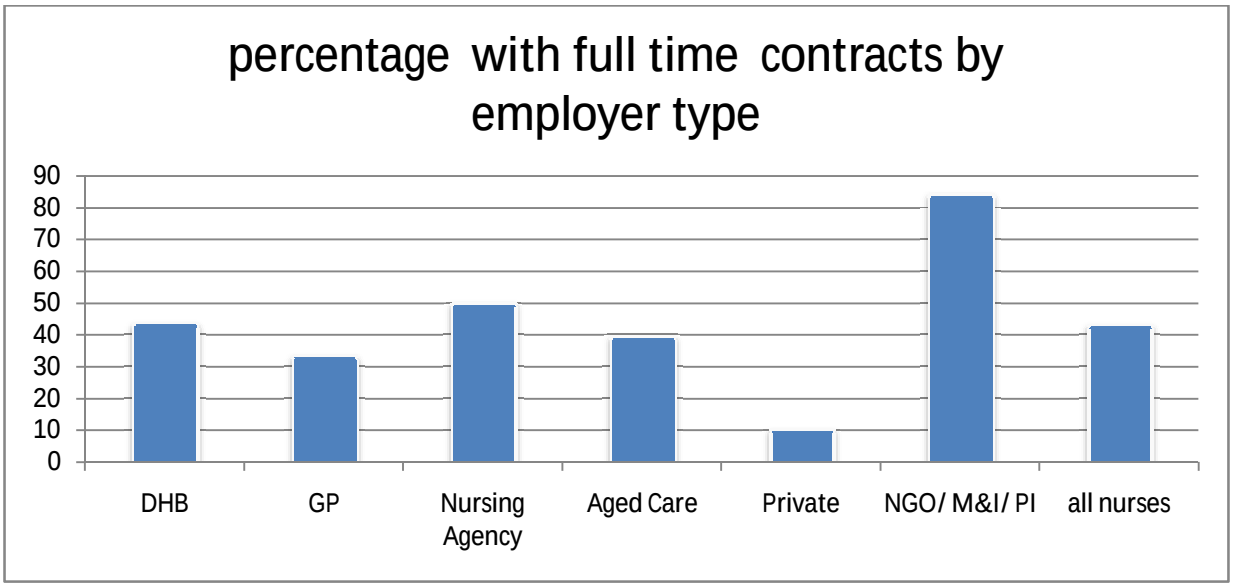
Table 4.1 Type of Contracts

Contract	Number	Percentage
Full time	335	41.6 %
Part time	391	48.6 %
Casual	38	4.7 %
Job Share	16	1.98 %
Blank / missing	25	3.1 %

41% Hold full time contracts. This is a much lower overall percentage than in the UK, where nearer 60% work full time. Of those who said they had full time contracts, 62% work 40 hours. The average number of hours was 38.55 per week. Of the 9 whose hours were in excess of 45 hours per week, 3 worked for agencies, 1 in education, 1 in aged care, and the rest in DHBs. All 17 men worked full time. In the UK, 88% of male nurses work full time.

There were large differences in the proportion of nurses employed in the different sectors who hold full time contracts. This is shown in the graph below.

Graph 4.1 Full time contract by employer



Seeking to find patterns of working linked to other caring responsibilities, the average ages and contract hours were analysed and are shown below.

Table 4.2 Additional caring responsibilities

Part time workers n=401	**%**	**Mean age**
Responsibility for dependent children	44	44
Responsibility for adults with care needs	14	53
All		49
Full time workers n=328	%	Mean age
Responsibility for dependent children	39	44
Responsibility for adults with care needs	14	48
All		45

Table 4.3 Actual hours worked

Contract type	**number**	**Mean weekly hours worked**	**% working extra hours**	**Mean weekly extra hours**	**Mean weekly total hours**
Full time	335	38.55	47%	8	47
Part time	391	25.22	49%	7	32

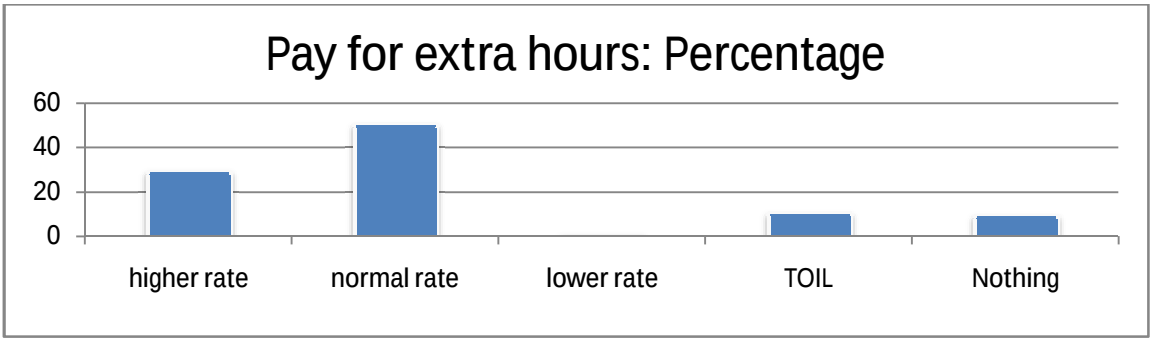
There was a large range of extra hours worked by both full and part time workers, from 1-60 hours. The mean and mode of extra hours indicate that in the majority of cases it is mostly whole extra eight hour shifts that are worked. Respondents who identified as anything OTHER than NZ European were slightly more likely to be younger (43.59 vs 47.8), and more likely to work full time (59% vs 45%) Part time

nurses in New Zealand work longer hours (32 per week) than their counterparts in the UK, where 29.1 hours per week is the average, once excess hours and additional jobs are added.

4.4 Additional Hours

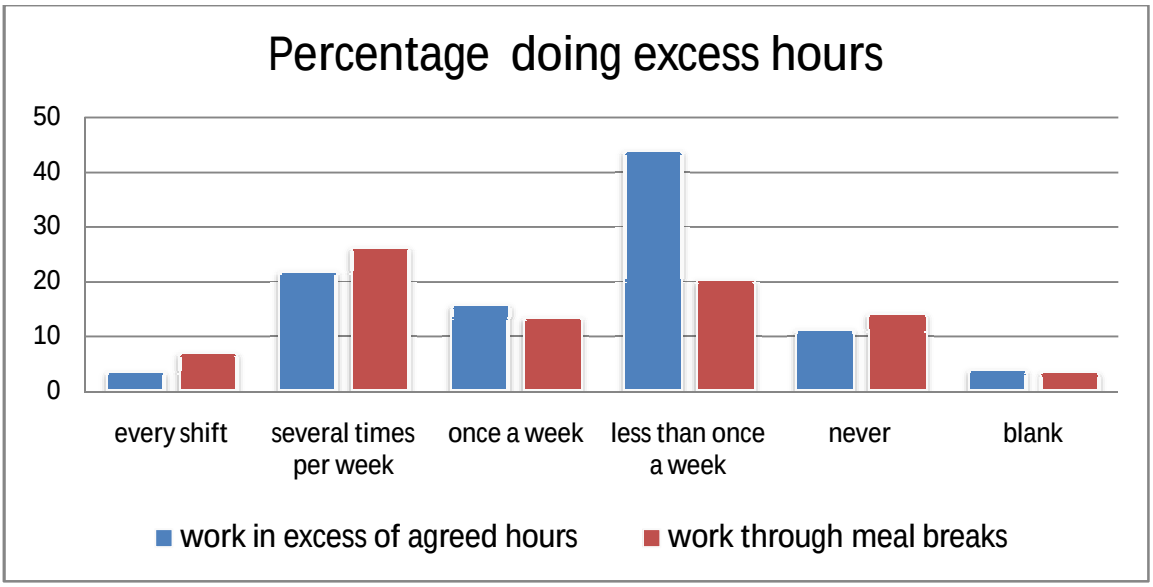
The remuneration offered for working extra hours is shown in the graphs below. Many were only offered any recompense if they worked full shifts in addition to their usual hours. Many of the 191 nurses who worked an average of 3 hours extra per week received no pay. This included working over meal breaks and at the ends of their official shifts.

Graph 4.4 Payment for extra hours



In addition, the frequency of working excess hours was explored. The results are shown in the graph below.

Graph 4.5 percentage and frequency of excess hours



4.6 Working hours and shift patterns were also explored.

4.6 Work patterns

Work pattern	Valid number	percentage
Office hours	308	40%
Shifts	380	49%
Flexi / casual	82	11%

4.7 Shift length

Shift length	Valid number	Percentage
<8 hour	27	7%
8 hour	246	67%
8-12 hour	55	15%
>12 hour	39	11%
Total	367	100

4.8 Shift type

Shift type	Valid number	Percentage
Days only	88	23.5%
Nights only	44	11.6%
Mix day and night	239	64.4%
other	2	0.5%

Where nurses work shifts rather than office hours, the commonest pattern by far is still the 8 hour shift, with rotating mix of day and night shifts. Those working day shift only were more likely to work for private surgical hospitals, GPs and aged care than for DHBs.

4.9 Working hours satisfaction

Most respondents, in common with their UK counterparts, were positive about their working hours. Two items from the array of statement related to working hours:

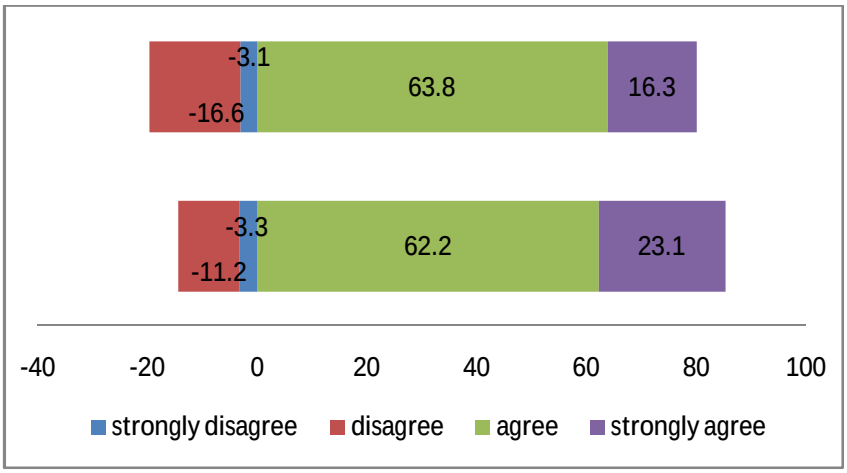
85% agreed or strongly agreed that they were "*Happy with their choice of shifts*"

80% agreed or strongly agreed that they were "*able to balance home and work lives"* The results are shown graphically and in more detail below.

Graph 4.9 Views of working hours (percentages)

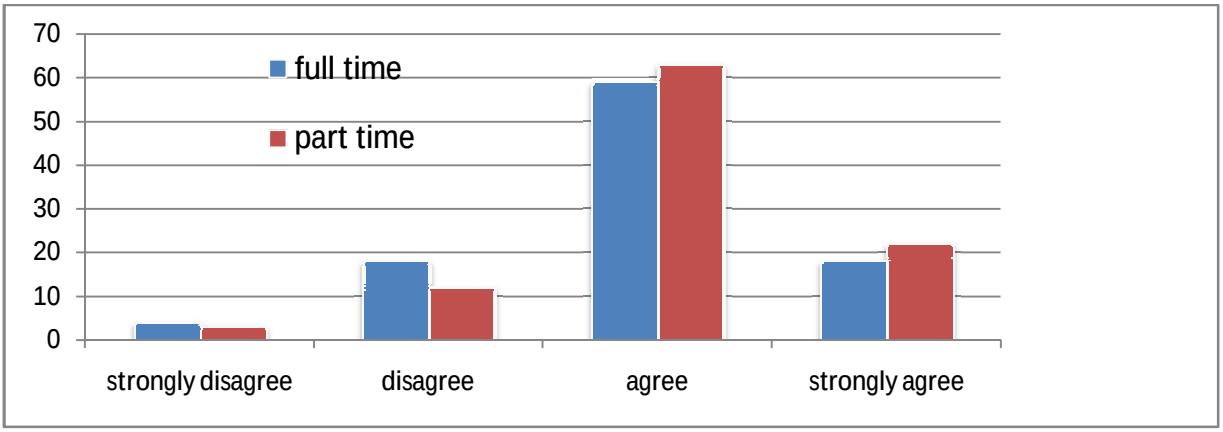
Happy with my choice of shifts"

"able to balance home and work lives"

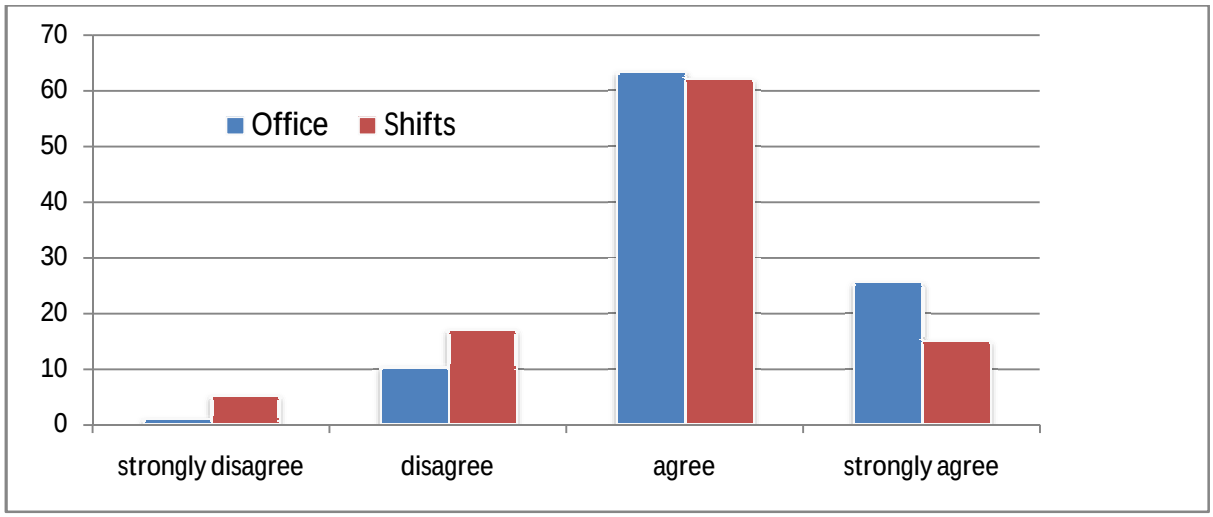


There was only a very slight difference between the views of full time and part time worker, it was interesting to note that part time workers were marginally more satisfied with their working hours than full time worker. This is shown below.

Graph 4.10 Composite % satisfaction (agreement with the two statements above) **by contract type**.



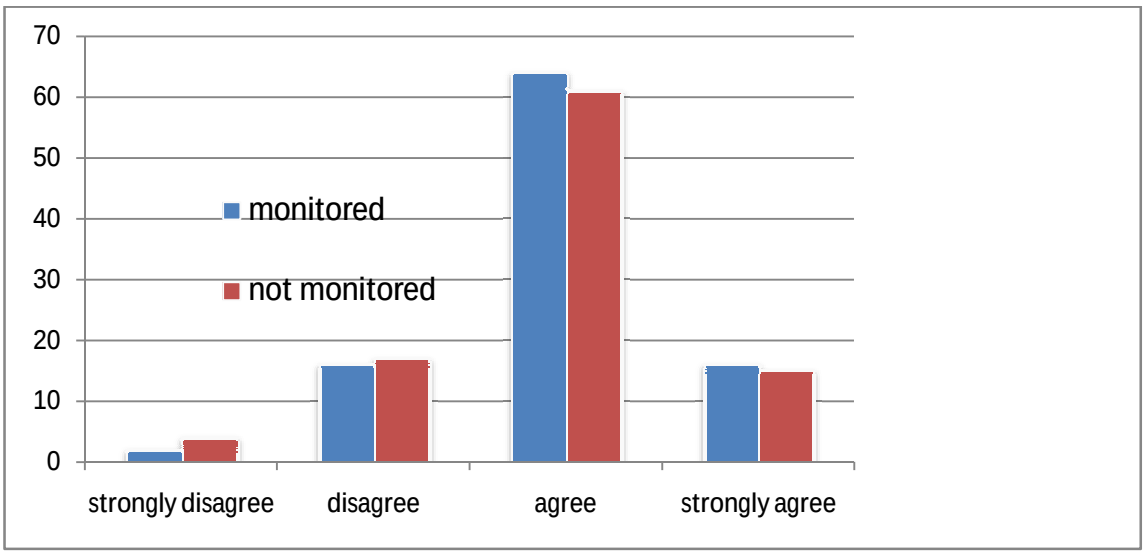
Graph 4.11 Composite percentage satisfaction with hours by work pattern



Workers who work office hours are marginally more satisfied with their working hours than those who work shifts. The necessity to do night shifts was frequently cited in the comments sections as a cause of stress and interference with family / work life balance. More detail is required to examine if particular rosters are more damaging or disrupting than others – for example, regular weeks on and off nights, compared to rolling programmes where night shifts were on different nights of the week. The small number who work permanent nights were more likely to be very satisfied with their hours than those who worked mixed shifts.

4.12 Control of total hours worked

Where worker's total number of hours were monitored and regulated by their employers, there was marginally higher satisfaction with shifts and work life balance. This is shown below.



Some reported working extremely long hours (60-80 per week?) though more detail would be required to tease out whether this was on site, partly on call, or even whether respondents mistakenly reported fortnightly hours. Occasionally it was obvious on processing the outliers that this was the case, and the numbers were adjusted to allow weekly comparison, however, in some cases it appeared to be hours per week that were being recorded.

Key points, Chapter 4

- Mostly, New Zealand nurses are happy with their choice of work patterns.
- The majority of shifts are 8 hour shifts
- A large number of employers / roles allow those who choose to work “office hours” and day only shifts to find jobs that meet their needs.
- There may be a small number of nurses who work dangerous numbers of hours, either with the same of different employers.
- Considerable numbers of nurses work extra hours, and through breaks / meals without extra pay.

Chapter 5 Workload and staffing

Unlike the UK survey, no questions were included about staffing ratios. This is due to a safe staffing approach that is not based solely on ratios. Knowledge of, and attitudes to Safe Staffing are presented.

The questions about how nurses' time is spent were analysed using a median weighting system to give approximate percentages of what respondents felt their work lives consisted of. The results for the four largest groupings are shown. The results should be interpreted with some caution, as it is likely the terms were interpreted differently and the percentages were guessed at rather than captured using time diaries or other more precise methodologies. Overall, responses often added up to considerably more than 100%, and there were also large numbers of missing variables. The aggregated percentages reported in the RCN survey are shown for comparison. Additional activities were explored in the NZ survey.

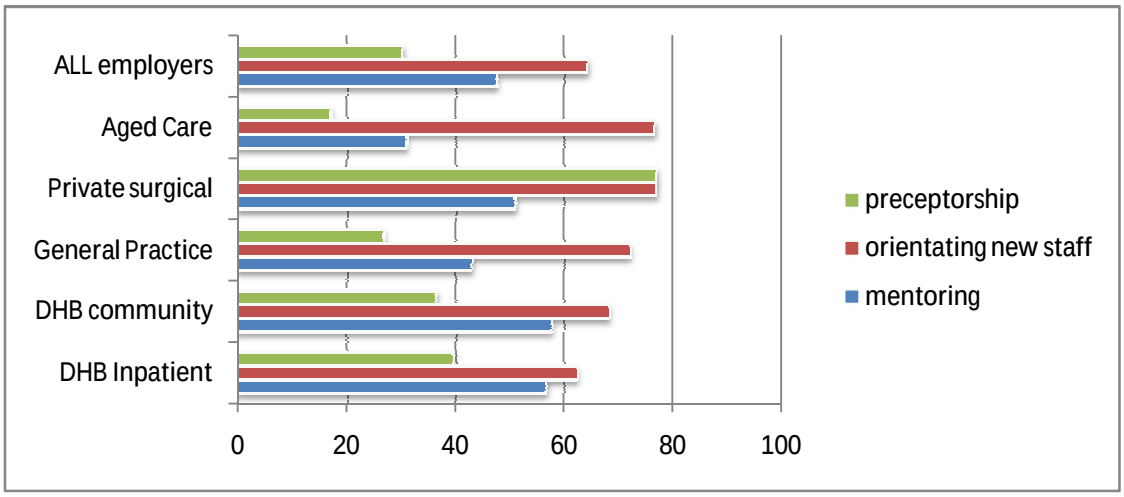
Table 5.1 Percentage of time spent on various activities, by title

Roles	clinical	management	Patient education	cleaning	admin	research	P D
Registered nurse	70	7	8	3	6	1	5
Charge nurse	33	26	12	3	13	2	7
Practice Nurse	54	5	8	6	13	2	9
Health care worker	81	2	2	17	2	0.2	4
All NZ respondents	59	9	9	7	10	1	8.5
RCN ALL	73	14	9	-	-	2	-

5.1 Additional responsibilities

The graph below shows the percentage involved in mentoring, orientating new staff and preceptorship. This is broken down by some of the larger employment groupings. A majority of staff in all roles and settings were responsible for orientating new staff. Definitions of mentorship may need to be more explicit in the next survey, as these numbers were surprising to the NZNO Professional Nursing Advisor team.

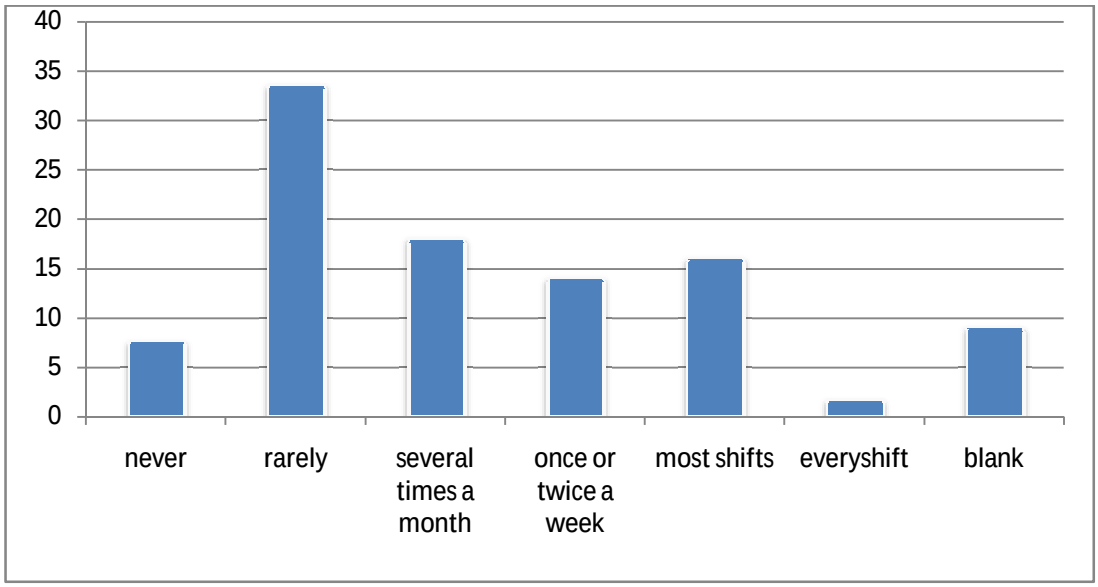
Graph 5.1 Additional responsibilities, by employer



5.2 Views of workload and staffing

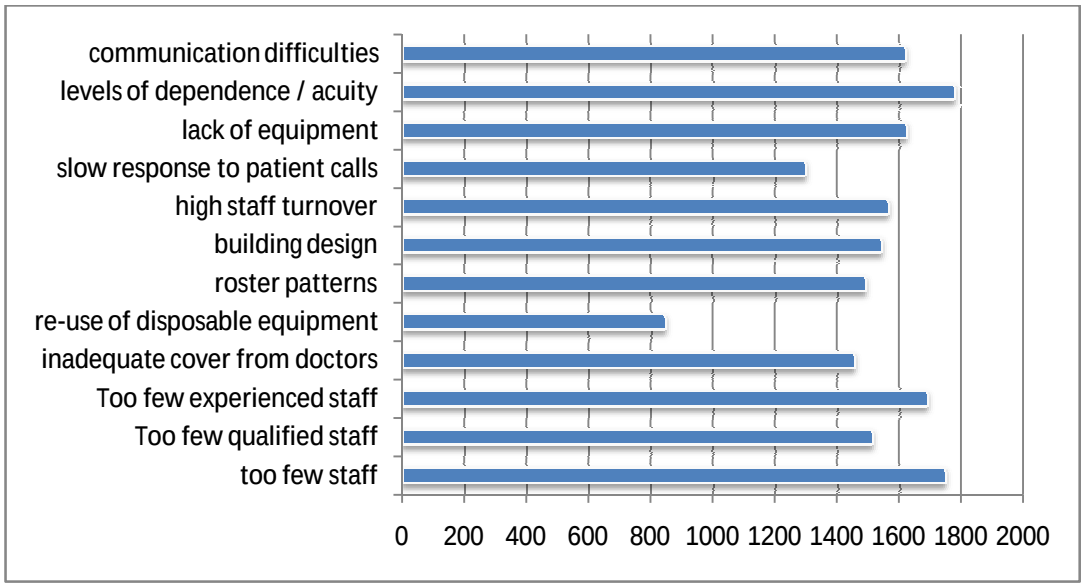
Questions in section E specifically addressed issued to do with staffing levels. The first found that 43.5% felt there were enough nurses where they worked to meet patient needs. The graph below shows how often respondents felt patient care was compromised where they work. (percentages)

Graph 5.2 Views of patient care compromise, percentage



A weighting score was derived from the matrix of conditions leading to care being compromised. The higher the score, the bigger the problem was felt to be. (Possible scores range from 700-3500) This is shown in graph 5.3, below.

Graph 5.3 Causes of compromised patient care



The highest risks were perceived to be associated with shortages of (experienced) staff, levels of dependency, and communication difficulties. Communication difficulties require further work to explore what nurses understand by this – communication between nurses especially the increased numbers of OTN?) between others in the health care teams, across systems, or between nurses and patients.

Specific questions examining awareness of, and agreement with the NZNO safe staffing campaign were also asked. The results are shown in table 5.4 below. More people agreed with the campaign process than answered that they were aware of NZNO campaign. This might just indicate that they knew about the campaign but did not associate it with NZNO.

Table 5.4 Safe Staffing

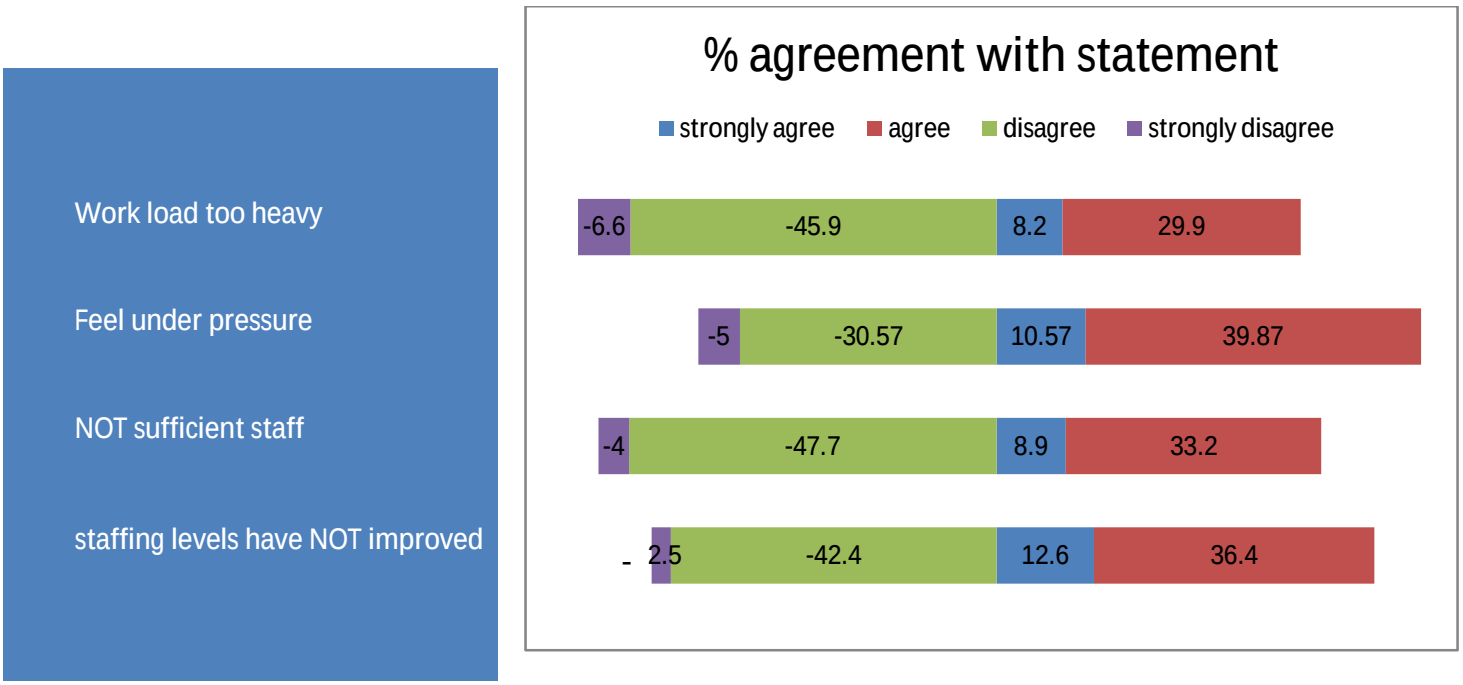
Question	% YES	%NO	% BLANK & N/A
Are you aware of the NZNO Safe Staffing campaign?	65.5	26.7	7.8
Do you agree with the Safe Staffing campaign?	71.5	3.5	24.9
Do you feel comfortable reporting unsafe levels of staffing?	72	20	8

The survey also indicates that there are many (20%) who express discomfort with the reporting of unsafe staffing levels.

The figure below is a summary of the responses to the 4 items in the views section related to workload and pressure at work. There is a fairly even split, with slightly more respondents feeling *strongly* that workload was too heavy or feeling under pressure

than felt s*trongly* that the work load was not too heavy (NOT was inserted at analysis to be able to compare the items visually) Cognitive pre-testing showed no problems with understanding the orientations of questions.

Graph 5.5 views of workload



However, there was significant variation between employers and roles. 79% of those working in private surgical hospitals agreed with the statement *"there are sufficient staff to provide good care"* This compared with 47% of those working in aged care. 49% of those working in DHB hospitals agreed with the statement. By role, Practice Nurses were most comfortable with staffing levels, with 72% agreeing with the statement, compared to only 52% of RNs , and 54% of Health Care Workers, Health Care Assistants and Nurse Assistants combined.

Key points chapter 5

- Nurse and care givers are engaged in a wide range of activities, with the majority of time still spent on direct clinical work. Outside management or non clinical posts, the proportion of time spent on direct care was for lowest Practice Nurses.

- Administrative tasks were the next most time consuming for regulated nurses in clinical posts.

- Private surgical employees and those employed in DHBs were most likely to have additional responsibility for others – mentoring colleagues, students, or orientating new staff.

- Although 40% felt patient care was rarely or never compromised, a range of issues was identified which regularly or always led to compromised care.

- The most worrying issues for respondents were too few staff, and too highly dependent patients. The least reported issue was the re-use of single use equipment

- More than half felt under pressure at work, and that workloads were too heavy.

- There is widespread knowledge of, and agreement with the safe staffing campaign amongst respondents. However, many commented on the difficulties in practice that the campaign brings out.

Chapter 6: Job change and career progression.

As shown in chapter one, there have long been changes in positions with the same employer, with many respondents changing jobs frequently. Question G 3 asked *"Have you changed jobs in the last 12 months?"* 146 (18.5%) answered yes. This is very comparable with turnover in the UK. The mean age of those answering yes was 45.6, not significantly different from the sample as a whole .The following table details the reasons selected for changing jobs. The rank order importance of each reason is also shown. This was determined by counting the number of times each was selected as first or second most important reason.

Table 6.1 Reasons for last change of job

Reason for job change	times mentioned	Importance to NZ sample overall	Importance to UK sample
Gain different skills	51	1	1
Change in hours	38	2	5
Stress / workload of previous job	39	3	7
Better pay	37	4	4
Better prospects	47	5=	2
Dissatisfied with previous job	40	5=	6
Bullying / harassment	21	7	14
Better terms and conditions	22	8	-
Distance home to work	14	9	8
Personal / moving area	9	10	10
Family reasons	18	11=	11
Educational opportunities	20	11=	-
Health problems	6	13	15
Promotion	33	14	3
Redeployment	2	15=	18=
Semi-retirement	3	15=	16
Previous workplace closed	0	-	18=
Redundancy	0	-	-

There were three fairly distinct patterns –

1. Those who changed primarily for career reasons (skills, education, promotion, pay and prospects)
2. Those who changed because they didn't like their previous jobs (dissatisfaction, workload /stress, bullying)
3. Those who changed for personal reasons (hours, family, distance, health)

Compared to the UK, the importance of stress and bullying appears to be more prominent as a reason to change jobs. What is clear is that retention could be improved by accommodating flexible working patterns better, by reducing bullying and stress, and by improving educational opportunities and opportunities for career progression. 9.4% are currently seeking work or a change of job, 20% selected nursing outside New Zealand as one of their preferred options. The comparable figure from the RCN survey was 25% who were actively seeking a new job. The numbers in the NZ survey were too small to draw conclusions about the importance of age, time since qualification of gender in the groups seeking a new post, though the data are available.

In table 6.2 below, column 3 shows the numbers employed in each employer group, and the percentage of these who are seeking a new job away from their current post. Column 4 shows the percentage *of the total wanting a new job's* preferred employer. (i.e. column 4 is **not** related to current employer)

Table 6.2 Those seeking new jobs (* are included in *Other* section)

Current Employer	Number employed	Percentage seeking new jobs	Preferred employer
DHB	472	7%	62%
Private surgical hospital	39	8%	-*
Aged Care	81	9%	12%
GP	92	10%	-*
Nursing Agency	8	25%	27%
Maori & Iwi provider	16	12.5%	-*
Educational institution	12	8%	0
Non – nursing	-	-	17%
Working outside NZ	-	-	20%
Other *	-	-	27%
Valid TOTAL	720	10.2%	-

Those who work for agencies, by definition need flexibility, or may be between ideal jobs. The numbers of those other than DHB employed who are seeking change are too small to draw real conclusions. The large number who would choose employment with a DHB will include those who want a change of post with their current employing DHB, and with other DHBs. This survey did not ask specifically about retirement – but given the age profile and the finding that 15 were working post retirement, this is an area that deserves further in depth exploration because of its importance to workforce planning.

Key points chapter six

- There is considerable movement in the nursing workforce, between and within employers.
- Those working for nursing agencies are more likely to be seeking a new job – perhaps working for agencies while looking for their preferred options.
- 2% **of the total nursing workforce** would like to work overseas.
- Opportunities to learn new skills are important to nurses
- Choice of hours, and dissatisfaction with workload, stress and bullying all contribute to nurses changing jobs.

Chapter 7 Continuing Professional Development.

The questions in this section relate to the amount of time spent on continuing professional development, how this varies between nurses and employment groupings, and the extent to which nurses are supported in their professional development. Where answers were given in hours, these were rounded to half days.

Table 7.1 Time spent on CPD

	Days spent on CPD last year	Days employer paid for
Mean days	9.28	5.94
mode	3	3
Standard Deviation	22.8	16.13
Valid number	760	759

The high standard deviation is a measure of the large variation between respondents.

Once all readings 2 standard deviations or more were excluded (as being outside the 95% confidence intervals) a total of 461 respondents (or 61%) had all time paid for by their employer. We had not asked about the costs of fees or expenses, this may be included next time. Exceptions included those on Net P programmes. Sixty nine recorded that they spent no time on CPD last year. Thirty eight of these were registered, employed nurses (three retired but working) – a further six were sick, studying, or on parental leave. The rest were Care Givers, Health Care Workers, or other workers. Of the ten respondents who recorded greater than 54 days spent on CPD (more than 2 SD of the mean), 3 were employed in the education field, 5 were RNs and 2* were Mental Health Nurses, all employed by DHBs. Paid for training time by job title is shown below

The mean number of days spent on CPD by nurses who originally trained as nurses overseas was 8. The difference is not significant.

Table 7.2 Paid time spent on CPD by job title

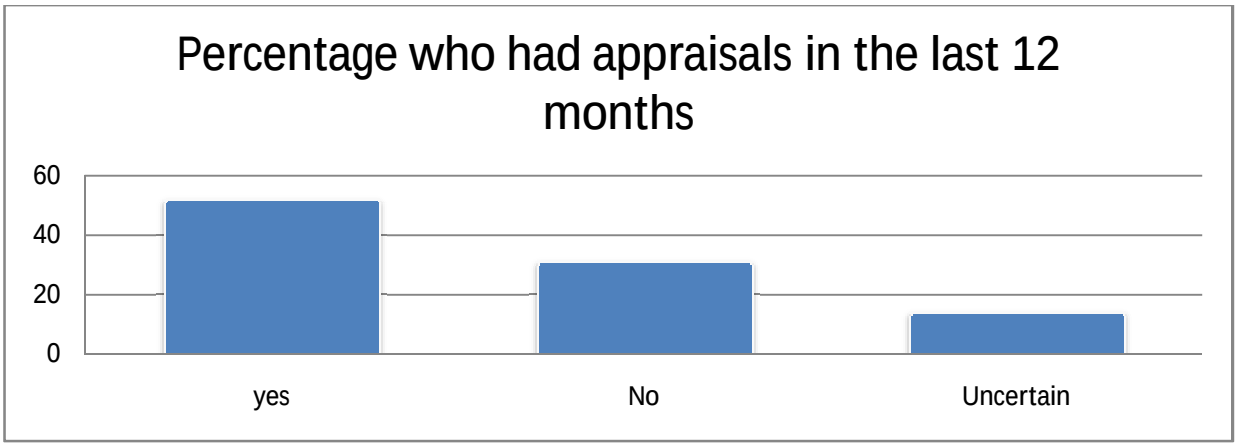
Job title	Valid number	Mean paid for days
Clinical N Specialists & Charge nurses	85	5.6
Registered nurses	357	5.14
Practice Nurses	97	5.4
Mental health nurses	22	6.1*
Enrolled nurses & Nurse Assistants	43	4.9
HC workers & H C Assistants	55	1.94
TOTAL	759	5.94

* The 2 MHN who had 100 & 300 days paid for last year were excluded from mean as complete outliers.

One issue picked up in the qualitative responses (reported on later) that related to CPD was the difficulty those on maternity breaks had in maintaining their CPD requirement. Comments from a couple of semi-retired nurses were to the effect that the CPD requirements were a real disincentive to carry on doing a few casual shifts. The balance between flexibility in the workforce, and the regulatory requirements / need to ensure safe practice and updated knowledge is an important one for workforce planning. Encouraging trained nurses to return to work, even part time, would have a large potential for reducing critical shortages. Of the 129 who had **no** professional development time funded by their employers, 37 worked in aged care, 31 for a DHB, 11 for a GP and the rest for the whole range of employers. There were several comments in the qualitative answers related to a perception that access to training opportunities was seen as unfairly distributed.

7.3 Development reviews / Appraisal and Training Plans

Graph 7.3 Development reviews / Appraisals



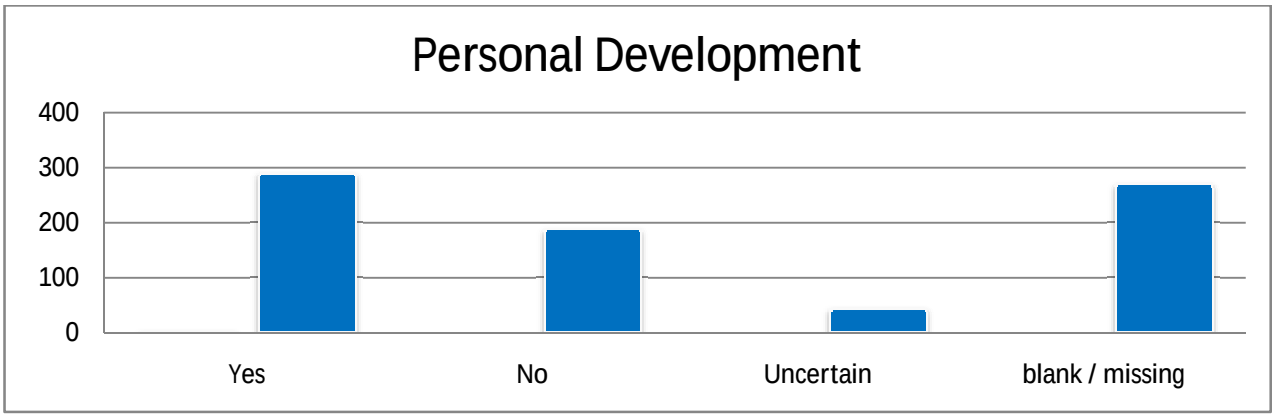
Fifty two percent of respondents have had an appraisal / development review in the last 12 months. Of the 250 who had not had a review, and who recorded the approximate date of their last review, these are shown below.

Table 7.4 Length of time since last appraisal

Date of last appraisal	number	Percentage (of "no", above)
Never / None	23	9
Less than 2 years ago	51	20
2-5 years ago	26	10.5
5-10 years ago	14	5.5
blank	136	55

Less than half respondents had personal development plans, and fewer of these reported their managers being involved in drawing up their plan, though there was a high number of missing responses.

Graph 7.5 Personal Development



7.6 Mandatory training

88 respondents had attended all seven of the listed mandatory training within the last year. Percentages were calculated only on the 722 respondents who answered this question.(the 88 “all” were added to each of the separate item counts) Non-responders may have primarily been in non clinical roles, or may just not have attended any training. A future repeat of this survey would seen to ascertain which.

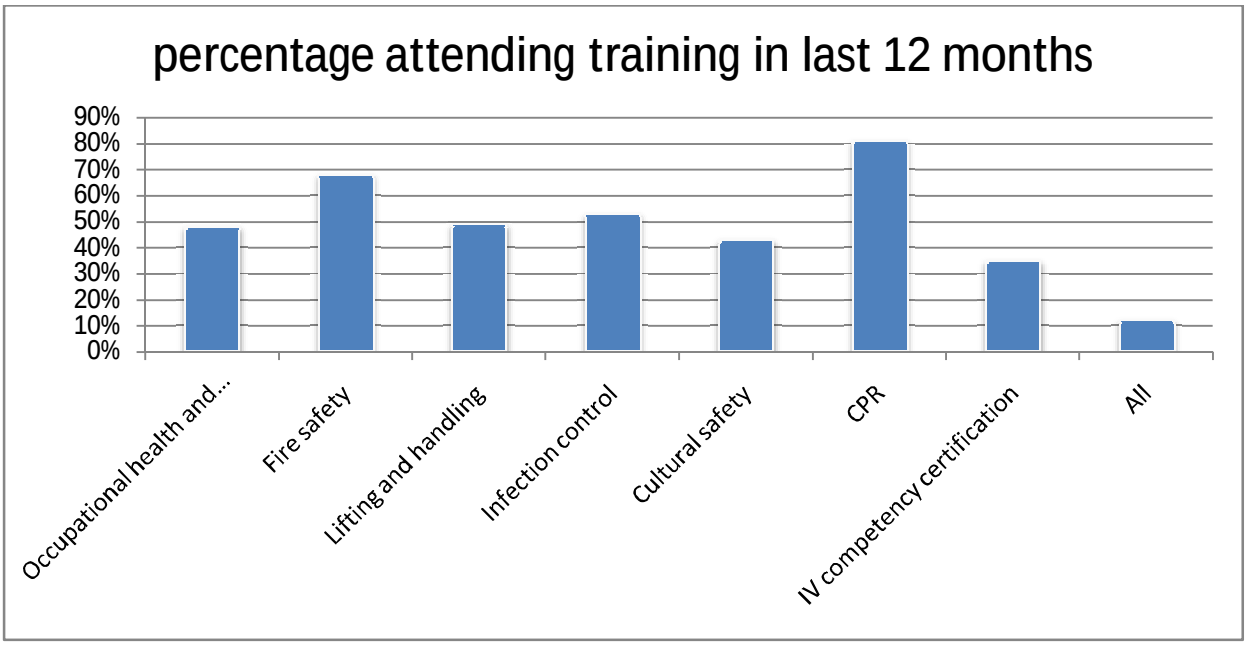
Table 7.6 Mandatory training

Training	number	percentage	Percentage U.K.
Occupational health and safety	347	48%	63%
Fire safety	493	68%	78%
Lifting and handling	356	49%	71%
Infection control	381	53%	59%
Cultural safety	312	43%	N/A
CPR	585	81%	80%
IV competency certification	256	35%	-
All	88	12%	-*

For some of the elements, annual updates are not required. For example, IV competency certification is required 3 yearly, so about one third of respondents per year appears entirely appropriate.

Mandatory Training in the NHS training is a key performance indicator for NHS Trusts, upon which funding partly depends. These are shown in the graph below.

Graph 7.6 Mandatory training



There were large disparities in the attendance of training by both employer type and by title. Due to the very small numbers in some categories, results are only shown for the larger samples, and to give a broad outline of the trends related to training. A subset of those who had attended at least 5/7 topics were classed as the high access to training subgroup. Another group who had either no or only one topic were classed as low access subgroup. These were then analysed in comparison to the total group, and the results are shown in the tables below.

Table 7.7 High access by employer type

Employer type	number	Percentage of total for type
All DHB	179	42
Private hospital	25	64
Aged Care	36	44.5
General Practice	29	31.5
Maori & Iwi providers	4	25

Table 7.8 High access by title

Job title	number	Percentage of total for title
Registered Nurse	172	49
Enrolled nurse & Nurse Assistant	19	51
H C Worker & H C Assistant	33	53
Charge Nurse	21	40
Practice Nurse	28	30
Mental Health nurse	2	10.5

Table 7.9 Low access by employer type

Employer type	number	Percentage of total for type
All DHB	75	17.5
Private hospital	1	2.5
Aged Care	3	4
General Practice	34	37
Maori & Iwi providers	5	31

Table 7.10 Low access by title

Job title	number	Percentage of total for title
Registered Nurse	42	12
Enrolled Nurse & Nurse assistant	6	17
H C Worker & H C Assistant	9	14.5
Charge Nurse	5	9
Practice Nurse	35	43
Mental Health nurse	3	16

From this limited sample, it would appear that the poorest access to training is in General Practice and Maori & Iwi providers, and the best in private hospitals. Practice nurses and mental health nurses access least of this set of mandatory training.

A future survey will make more explicit the difference between time spent on CPD and that spent on mandatory training. Also, even clearer request for the number of DAYS spent training, as more than half reported hours, and there may therefore have been ambiguity as to whether respondents of high days (where days / hours was not specified) may have meant hours. Hours were manually converted before analysis.

Key points chapter 7

- Considerable variation exists between employers and roles as to how much time for training and development is paid for.

- Variation also exists in the number of appraisals and personal training plans carried out in the different employment sectors.

- Even mandatory training (which is by definition usually delivered in-house, in very short sessions, and at the work site) is patchily delivered

- Given the high priority placed by nurses on the development of new skills, haphazard access to training planning, and to time for training may contribute to high staff turnover in particular settings.

- Further study is required to discover whether perceptions of fairness related to access to training is a significant source of dissatisfaction.

Chapter 8: Morale in 2008

This chapter describes the views of nurses, and is based on the analysis of the set of 30 Likert scales of questions related to careers, workload, pay, and nursing as a profession, and on the additional comments supplied at the end of the questionnaire.

The majority are identical to those used in the RCN survey, a few are changed slightly on advice following piloting (but are essentially the same in meaning), and there are a couple of extra statements towards the end. The percentage shown are the sum of those agreeing or strongly agreeing with the statement. The statements have been broadly themed, in line with the RCN survey to allow comparison. Percentage agreeing with statement in each theme block were reported in reverse to allow easy comparison. (For example, the % disagreeing with "*I would leave nursing if I could"* are shown instead as % agreeing with "*I would NOT leave nursing if I could, to allow comparison* with " *I would recommend nursing as a career")*

The summary of the themes reveals that New Zealand's nurses are post positive about the quality of care they deliver, nursing as a career, career progression, job security and job satisfaction. They are less positive about access to training, choice of hours and the extent of bullying. They are least positive about workload and pay, especially in comparison with other professionals.

Compared to the RCN survey, New Zealand nurses are more positive about most aspects of nursing as a career. It will be interesting to plot changes in these parameters as the survey is repeated in years to come. It would also be interesting to compare NZ nurses with other NZ workers, as there may be wider differences in outlook, expectations, and job market that also explain the differences between the two surveys. There were a few particular patterns associate with either employer type or roles:

- Aged care and Maori & Iwi employed respondents were more likely to strongly disagree with the statement "*Considering the work I do I am paid well"*

- Charge nurses and service managers were over represented in the group who strongly agreed with the statement *"I feel under too much pressure at work"*

- Practice nurses were over represented in the group of respondents who strongly agreed the they were *"unable to take time off for training"*

- Prison nurses and mental health nurses were over represented in the group strongly disagreeing with the statement *"Bullying and harassment is not a problem where I work"*

- There was little correlation between actual pay and feeling poorly paid compared to other professions, or between actual days paid to attend education / training and feeling unable to take time off for training.

Table 8.1 Positivity scores

Themes / Statements	Percentage agreeing	Mean "positivity" score
1. Nursing as a career		
I would recommend nursing as a career	81.4	
I would (NOT) leave nursing if I could	70.44	
I am (NOT) in a dead end job	86.24	mean **77%**
2. Career progression		
It will be difficult to progress from my current salary	29.9	
Career prospects are becoming less attractive	39.36	mean **65%**
3. Bullying / Harassment		
Bullying & harassment is not a problem where I work	62.15	
I'd be treated fairly if I reported being harassed	60.12	mean **60%**
4. Working hours		
I am happy with my choice of shifts	74.75	
I feel able to balance home and work lives	77.4	mean **76%**
5. Job satisfaction		
Most days I am enthusiastic about my job	87.7	
I feel satisfied with my present job	77.07	
I feel my work is valued	75.91	
I feel part of a team	87.38	
I am able to practice autonomously	82.03	
My opinions about nursing are valued by my manager	71.83	Mean **80%**
6.Pay		
(NOT) paid more for less effort if I left nursing	23.81	
I am well paid considering the work I do	36.55	
Nurses are paid well compared to other professionals	17.57	Mean **26%**
7. Quality of Care		
The quality of care provided where I work is good	87.77	Mean **88%**
8. Job security		
Nursing will continue to offer me a secure future	87.0	
I am (NOT) worried I may be made redundant	84.7	
I would find it easy to get another job with my skills	73.48	Mean **82%**
9. Training		
I am (ABLE) to take time off for training	71.58	
I am able to keep up with developments to do with my job	75.48	
I have regular dialogue about my work with my manager	62.03	Mean **69%**
10. Workload		
My workload is (NOT) too heavy	44.94	
I am (NOT) under too much pressure at work	51.7	
(NOT) too much time is spent on non-nursing duties	56.28	
There are sufficient staff to provide good care	55.15	
Nurse staffing levels have improved over the last year	35.6	Mean **49%**

The score for the two questions related to bullying and harassment were consistent. Although 62 % felt bullying was not a problem where they work, 38% did think it was a problem. Bullying also featured in the reasons many had changed jobs in the past, and many of the qualitative statements (or hand written additions to the questionnaire) indicated that previous places of employment had been badly affected by a culture of bullying. There has been a steady improvement in the RCN scores for bullying since a zero tolerance and mandatory staff training / harassment policy was introduced across the NHS.

Qualitative comments

A final section invited free text comments related to any aspects of working as nurses and care giving, and about nursing as a career. 30.5 % of respondents added comments, and these were read and classified into broad themes. The most commonly represented themes are shown, in order of frequency. All comments are available in the appendix (identifiers removed)

Table 8.2 Qualitative themes

Themes	Number
1. Pressure	
Workload, stress, patient ratios, pressure, high staff turnover , sick leave	70
2. Pay	
Salary, especially compared to others or overseas, having to pay for parking, stamps, own cell phone, unpaid overtime and no meal breaks	63
3. Positive comments	
General: love the job, great team, positive about NZNO	47
4. Poor management and bullying	
Too many managers, too poorly trained, bullying managers, too many changes in managers, bullying by colleagues un-tackled	40
5. Hours	
Largely concerned with shift working and lack of flexibility /job share, difficulties around child care, compulsory night shifts, and lack of available cover. Work life / family balance	25
6. Quality of care	
Concern about not being able to deliver quality care, unsafe working	25
7. Roles	
Too much paperwork, cleaning & admin , time taken on staff orientation etc	14
8. NZNO related	
NZNO response or staff poor, slow, MECA slow, Safe Staffing not working,	12
9. PDRP	
Difficulties fitting in hours, return to work after childcare, costs, bureaucracy	11
10. Overseas trained (OTN) nurses	
a) Nursing in NZ bad experience, qualifications & skills not recognised or used, discrimination	9
b) Difficulties understanding OTN, anti- OTN wearing NZ medal	4

In terms of important industrial messages for NZNO, there is high concern still about pay rates, about the slowness of implementation of MECA agreements, and about conditions in MECA not being upheld. One source of dismay was the loss under the MECA of the right to unlimited sick leave. The Comments also lend support to anecdotal evidence that nurses choose casual and reduced hours as alternatives to having to do shift work, particularly night shifts which are difficult for those with children. The onerous nature of PDRP, particularly for those returning to work, who have been ill or have been having parental breaks, together with dissatisfaction about the Nursing Council's processes was also frequently mentioned.

The issues (both ways) of the impact of much higher numbers of overseas trained nurses in the New Zealand workforce will need careful management.

Key issues Chapter 8

- Comparative pay remains the biggest source of dissatisfaction for nurses
- Workload, stress, bullying and lack of job satisfaction also contribute to lower morale
- Confidence in job security and abilities to get other jobs remains high, though this will also depend on continued investment in healthcare, and uncertainty in the wider economy
- The importance to respondents of negotiations and implementations of MECA remains extremely high
- Individual respondents were occasionally very dissatisfied with the service or support they had received from NZNO

References

1. Holding On – Jane Ball and Geoff Pike, 2008 available from the RCN
2. Pay Jolt – NZNO Nicola North and James Buchan, 2008 available from NZNO
3. Turnover amongst nurses in New Zealand's district health boards: A national survey of nursing turnover and turnover costs - North, N.; Rasmussen, E.; Hughes, F.; Finlayson, M, 2005 New Zealand Journal of Employment Relations, vol. 30, pages 49-62