

# **NURSING WORKFORCE STRATEGY**

**December 2006**

## Foreword

District Health Boards have a significant interest in the future workforce that will support health service delivery both as funders and providers of health services. In October 2005 District Health Board Chief Executives launched Future Workforce, a strategic workforce plan to guide DHB workforce activity over the next five years.

As part of Future Workforce, six strategy groups have been established around key health and disability workforces including one for the Nursing and Midwifery workforces. For Nursing and Midwifery the Strategy Group provides an overview, with sub-groups considering the specific issues for each workforce. Membership of the group is drawn from District Health Boards, with support from DHBNZ and external advisors.

The Strategy Group acknowledges the significant other sector work on the nursing workforce, both underway and already completed. The purpose of this discussion document is not to replace this work but to bring together an overview as a basis for action. The draft discussion document was released in June 2006 for comment, and the Strategy Group is delighted with the number of responses received. Following consideration of feedback this document has been amended to reflect the constructive comments that were received. I am pleased to be able to present this paper to the sector as a foundation point for the future.

The nursing workforce is by far the single largest professional group in the health and disability sector and arguably has the greatest potential to respond to the challenges that face the sector in delivering care to a population that is ageing and where the incidence of chronic conditions will increase until our current responses to these trends start to have an effect. Nurses are a varied workforce group but with a skill set that allow them to make a significant contribution to care across a variety of settings and with a scope of practice that intersects with many other professional and non-professional groups. The potential for advancing health and disability outcomes is therefore enormous through understanding and developing of this resource.

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# EXECUTIVE SUMMARY

## 1. Purpose

The development of the Nursing Workforce Strategy paper has been led by the Nursing and Midwifery Workforce Strategy Group set up under District Health Boards' strategic workforce plan, *Future Workforce*. District Health Boards (DHB) have set up six strategy groups as an initiative within *Future Workforce* to provide a sector focus for the development of key health workforces

The purpose of the paper is to identify the action priorities for nursing workforce development that DHBs will seek to progress working with the nursing profession and other key stakeholders over the next three to five years. The paper explores the population and service drivers influencing nursing workforce development, provides a snapshot of the current nursing workforce and identifies issues and development themes. Priority actions are recommended to address identified issues and development themes.

## 2. Current Nursing Workforce

The nursing workforce is the health sector's largest (approximately 52%) qualified professional workforce and includes both generalist and specialist nurses. Based on 2004 figures there are approximately 46,700 registered nurses and 8,200 enrolled nurses/nurse assistants holding current practicing certificates (NCNZ).

This analysis has identified a number of issues facing the present nursing workforce including:

- Issues around workforce numbers - although a shortage of nurses has not been demonstrated due to the lack of robust information there are questions around supply and retention
- Workforce participation- 39% work 3 days or less per week probably due to the predominantly female nature of the workforce
- Nursing is an ageing workforce - 25% over the age of 50.
- More than half of registered nurses are not registered as a comprehensive nurse having qualified under an apprenticeship system in a narrower scope of practice
- The workforce is not representative of the ethnic make up of New Zealand's population
- The workforce is not evenly distributed across the country with below national average nurse: population ratios in Auckland, the Central North Island and Southland. Above average ratios are evident in Canterbury, West Coast, Otago and Wellington. The national average is 853.5 per 100,000 population
- Although the future of health services will be more in primary and community settings 43.5% of nurses work in a hospital based secondary or tertiary service with only 16.7% working in a primary health role. 13.6% of nurses work in the aged care sector (NZHIS, 2005).

## 3. Drivers for Change

Nursing is a key workforce to the future of New Zealand's health and disability services as the sector responds to a range of population and social drivers. Population change, most importantly an expected significant increase in service demand due to population ageing and the related impact of increased rates of

chronic illness and patient complexity, will influence the skills and scope the sector needs from the nursing workforce. New Zealand's changing ethnic mix will also be important. Future service development priorities include primary care, mental health, chronic care management, and intellectual disability

Government strategic directions such as *ageing in place*, strengthening primary health care and reducing disparities will also shape the sector's workforce needs. Population based approaches will be a service emphasis.

Future services and future health workers will need to be responsive to new technologies and the higher expectations of more informed consumers. Continuity of services across the continuum of care will be essential to service sustainability. Services will also need to accommodate the changing work and lifestyle expectations of health workers and to manage increased demand for key health practitioner groups.

#### **4. Future Nursing Workforce**

*Future Workforce* calls for 'a vital, innovative and responsive health and disability health sector able to deliver New Zealand's desired population health outcomes'. To achieve this vision *Future Workforce* describes broad goals across the health workforce including:

- Appropriate professional, technical, interpersonal, relationship and cultural competencies
- An ethnic and cultural mix that reflects NZ communities
- A consumer focussed, team oriented delivery culture able to work in partnership with an informed and engaged public
- A balance of specialist and generalist skill mixes
- The mix of competencies required to deliver to population health including health promotion competencies and a wellness approach
- Job roles including new roles that recognise the shared and specialised competencies of individual team members
- Accountability structures that support team working.

Service change will present new challenges and opportunities for nursing. The generalist nature of the nursing workforce will continue to be a core strength, enabling flexible deployment of nurses within and across care settings. Many will work in more decentralised teams with higher numbers working autonomously.

The future registered nursing workforce will include a mix of generalist registered nurses, specialist nursing roles and Nurse Practitioners. While most will practice at registered nurse level there will be more specialist nurse roles and a relatively smaller group of Nurse Practitioners. Some nurses will also work in expanded roles with significant aspects of their practice overlapping with the roles of other health practitioner groups. Registered nurses are likely to be supported by a changing mix of second level regulated and non-regulated health workers to maintain workforce and service sustainability.

These changes will require development of strengthened interdisciplinary and team competencies working in partnership with patients/clients to deliver services across settings. Leadership competencies will be important to enable full participation of nurses and to address the supervision needs of non-regulated workers. Services will also continue to rely on nurses for their clinical skills and for increased health promotion and health education competencies as the demand for population health based approaches grows.

## 5. Recommended Priority Actions for Nursing Workforce Development

The Nursing and Midwifery Workforce Strategy Group recognizes the workforce initiatives currently being led by the nursing profession, the Ministry and by DHBs. This paper builds on earlier sector work and provides an overview of the development issues facing the nursing workforce. There is a need now to engage all key stakeholders in a national approach which links initiatives together in a planned and systematic way to progress nursing workforce development.

Due to the size and coverage of the nursing workforce across health and disability services it is not possible to address all areas of nursing workforce development at once. The Nursing and Midwifery Workforce Strategy Group recommend the following actions as priorities and as a base for ongoing development:

## 6. Develop the nursing workforce in primary health, rural and community based services

	<b><i>ACTION</i></b>	<b><i>RATIONALE</i></b>	<b><i>FOCUS</i></b>
(i)	Implement the Nurse Practitioner Facilitation project with a view to increase the number of Nurse Practitioners in the workforce, in particular in Primary Health, Health of Older People and Mental Health Services	The major focus of Nurse Practitioner (NP) development should be on broad NP roles in a range of settings. Initiatives may include support and evaluation of existing NP roles. Includes building on existing successful models and integration of the work completed by the Nurse Practitioner Employment and Development Working Group.	DHB
(ii)	Extend the Nursing Entry to Practice programme (NETP) to include community based settings in primary health and other community settings	Support new graduates to commence practice in community settings by seeking Clinical Training Agency (CTA) funding for an extension of NETP to include primary health and other placements for new graduates	National/ DHB
(iii)	Promote development of clear accessible and integrated nursing leadership in primary health. In the first instance this will be through a stock-take and sharing of current leadership models	A clearly identified primary health care nursing leadership infrastructure is needed at a DHB district level to provide professional leadership, to facilitate change and the development of new roles and models of practice	DHB
(iv)	Work with PHO's, other major employers and the Primary Health Care Nurses Council of New Zealand Nurses Organisation (NZNO) to implement Professional Development and Recognition Programmes (PDRPs) in primary health	Poor development of PDRPs in primary health and community settings limits career pathways for nurses in the priority development areas of the health and disability sector.	National/ DHB

## 7. Support development and retention of the nursing workforce

	<b><i>ACTION</i></b>	<b><i>RATIONALE</i></b>	<b><i>FOCUS</i></b>
(i)	Increase the momentum for DHB employed nurses to complete assessment on PDRPs	PDRPs provide a strong basis for development for individual nurses and a competency framework supporting organisational and service development	DHB
(ii)	Use results of national PDRP picture to identify continuing education priorities for the DHB employed nursing workforce	Health Workforce Information programme (HWIP) in Year 2 to build database on national PDRP information as evidence base of current workforce competency mix	National /DHB
(iii)	Work with the CTA to increase DHBs responsibility for nursing post-entry clinical education	A sector driven education model will strengthen alignment of programmes to service need	National
(iv)	Develop a unified national framework for nursing post-graduate education	Improved targeting, coordination and access to post-graduate education will support the development of the registered nurse workforce. Link with the planned cancer nursing framework as a potential model that can be applied to other areas of post-graduate education	National
(v)	Implement recommendations of the Safe Staffing and Healthy Workplaces Committee of Inquiry report as endorsed by CEOs	Initial set up of capacity to deliver safe staffing / Healthy Workplaces initiative for DHBs as agreed and funded	DHB/National

## 8. Increase the ethnic diversity of the nursing workforce

	<b><i>ACTION</i></b>	<b><i>RATIONALE</i></b>	<b><i>FOCUS</i></b>
(i)	Via DHBs' Health Workforce Information Programme (HWIP), identify target percentages for Maori, Pacific and Asian nurses and work with education institutions nationally and locally to increase programme uptake	A more representative workforce is a key strategy to meet future service needs. Key link to <i>Future Workforce's</i> NZ health sector brand and education sector engagement initiatives	National/ DHB
(ii)	Work with Schools of Nursing to provide support and clinical placement experiences that support Maori and Pacific students to complete undergraduate courses	There is evidence that Maori and Pacific students have a higher attrition rate than other students	DHB
(iii)	Support for secondary students to choose subjects, for example, science to minimise barriers to health as a career choice	Many DHBs have a range of initiatives supporting the choice of health careers by secondary students. There is a need to look at ways of encouraging uptake of appropriate subjects by secondary students at a national level. This relates to the education sector engagement initiative project and to the branding project being undertaken by the DHB/DHBNZ Workforce Group.	DHB/National

## 9. Progress development of a coordinated sector-wide nursing workforce strategy

	<b><i>ACTION</i></b>	<b><i>RATIONALE</i></b>	<b><i>FOCUS</i></b>
(i)	Develop a Position Paper for discussion with other key stakeholders on a second level regulated role to support registered nurses in their practice together with a non-regulated workforce	Agreement with key stakeholders on the shape of a second tier workforce supporting registered nurses is central to best use of nursing expertise and sustainable health services. This should include options for career pathways and stair casing to nursing careers	National
(ii)	Agree the future structure of the registered nursing workforce across service settings and in relation to other health practitioner roles	Includes consideration of changing Registered Nurse, Clinical Nurse Specialist and Nurse Practitioner roles related to other health practitioner roles	National
(iii)	Progress sector wide development of accurate nursing workforce information via Year 2 HWIP work programme	Current data is insufficiently robust to provide an adequate status assessment of the nursing workforce or a baseline for predicting future workforce needs	National
(iv)	Identify the sector's top service development priorities to inform decisions on where to focus development priorities for the nursing workforce	Increased clarity via the DHB/DHBNZ Service Improvement Group on the sector's priorities for service development will enable targeting of professional development programmes and other workforce initiatives	National
(v)	Evaluate the structure, curricula and delivery of current undergraduate nursing programmes to ensure appropriateness to future health sector needs on an ongoing basis	Work with the Nursing Council, the education sector and other stakeholders to ensure that workforce competencies are matched to population and sector needs, including team and interdisciplinary practice models. Work with sector (employers of nurses) to promote quality clinical placements	National
(vi)	Match student intakes into nursing undergraduate programmes with predicted future workforce requirements	Recruit into undergraduate nursing programmes based on future workforce needs. Use workforce [5.3.4 (ii) above] and service planning information to predict workforce supply requirements.	National

# NURSING WORKFORCE STRATEGY

## 1. PURPOSE

This discussion document provides an overview of New Zealand's nursing workforce in the light of New Zealand's changing population health needs and changing health services. The purpose of the discussion paper is to identify the action priorities for nursing workforce development that DHBs will seek to progress working with the nursing profession and other key stakeholders. Predicting nursing workforce needs is dependant on an understanding of both the nature and make-up of the current nursing workforce and the predicted needs of future health and disability service consumers and service delivery models.

## 2. CONTEXT

In October 2005 District Health Board Chief Executives signed off on *Future Workforce* a 5 year collaborative strategic plan for health and disability workforce development. *Future Workforce* builds on earlier collaborative DHB workforce activity (Workforce Action Plan May 2003) and wider sector frameworks including Ministry of Health service strategies and the work of the Health Workforce Advisory Committee.

District Health Boards (DHB) have an important role in health workforce development due to their statutory responsibility for the health of their populations and as funders of health services. As providers of health and disability services DHBs are major employers and also have an important role in clinical training.

A key initiative in *Future Workforce* is the establishment of six Workforce Strategy Groups including one for the nursing and midwifery workforces. The role of the Workforce Strategy Groups is to provide a focus for the development of key health and disability workforces within the overall *Future Workforce* framework.

The strategic framework outlined in *Future Workforce 2005 – 2010* (DHBNZ, 2005) calls for 'a vital, innovative and responsive health and disability health sector able to deliver New Zealand's desired population health outcomes' (2005 p9).

To achieve this vision, *Future Workforce* describes broad goals across the health workforce including:

- Appropriate professional, technical, interpersonal, relationship and cultural competencies
- An ethnic and cultural mix that reflects NZ communities
- A consumer focussed, team oriented delivery culture able to work in partnership with an informed and engaged public
- A balance of specialist and generalist skill mixes
- The mix of competencies required to deliver to population health including health promotion competencies and a wellness approach
- Flexible job roles including new roles that recognise the shared and specialised competencies of individual team members
- Accountability structures that support team working.

The Nursing and Midwifery Workforce Strategy Group has been set up to consider nursing and midwifery workforce development in the context of the *Future Workforce* vision and to identify key priority actions for both workforces within the DHB environment over the next 5-10 years. This paper reflects the Strategy Group's considerations on nursing only.

### **Approach**

Development of the initial discussion document was being led by the District Health Boards' Nursing and Midwifery Workforce Strategy Group, which includes representation from a cross-section of sector service and professional experts (see Appendix 1). The discussion document also drew on previous research and policy work by the nursing profession and central agencies.

The discussion document was distributed widely to key professional and wider sector networks. There were 63 submissions received from organisations that include District Health Boards (DHBs), the education sector, professional groups, non-government organisations and individuals. The feedback has been considered by the Nursing and Midwifery Strategy Group and this document has been updated to reflect that feedback (A summary of feedback received is attached as Appendix 2). Final recommendations will be considered by DHBs' National Chief Executives Group.

### **Structure of this Document**

Predicting nursing workforce needs is dependant on an understanding of both the nature and make-up of the current nursing workforce and the predicted needs of future service consumers.

The first part of this document (3.0) considers predicted population and other changes impacting on demand for health services. The second part of the paper (4.0) profiles the current nursing workforce. The next section (5.0) of the document explores gaps between the current nursing workforce profile and future nursing workforce needs over the next decade. This provides a basis for proposed nursing workforce development priorities which are outlined in the final section.

***A summary of feedback received from submissions on the discussion document is included as Appendix 2. The feedback reflects a variety of sector perspectives and is included to illustrate the range of views. Where appropriate, changes have been made to the text of the document based on the feedback received.***

#### **Note**

The intent of this document is to provide a snapshot of the service development context and of the current nursing workforce in New Zealand as a basis for identifying nurse workforce development needs. The document does not aim to be a detailed review of the literature related to the nursing workforce but to pick up the key development themes for the nursing workforce going forward.

## 3. FUTURE POPULATION HEALTH NEEDS

### 3.1. Introduction

The changing structure of New Zealand's population is expected to have significant impact on demand for health and disability services within the next 5 to 10 years. Understanding more about New Zealand's changing population will enable DHBs to work proactively with nurses and other stakeholders to shape the nursing workforce to meet future population and health service needs.

### 3.2. Population Drivers

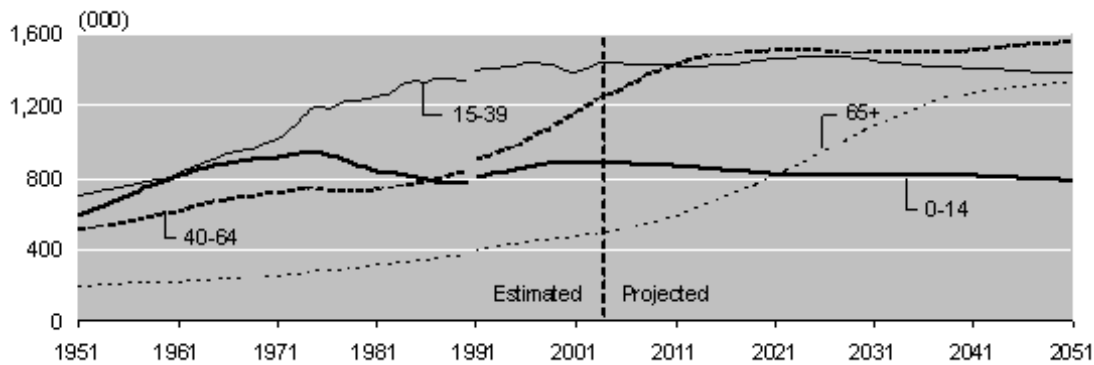
The under 14 and over 65 age groups are considered to be 'dependent' age groups, requiring higher levels of health care. This group is projected to increase from 33.6% in 2007 to 34.4% by 2016 (Source: Stats NZ, 2006). All of this growth comes from an expected 3% increase in the over 65 age group. The proportion of children in the population as a whole is projected to decrease by 2.1% over the next 10 years.

The main population and other drivers shaping future services and the health workforce are discussed below. They include:

- An ageing population
- Increasing complexity of need
- Changing ethnic mix and health disparities
- Other population factors, such as rural populations and children
- Lifestyle choices
- Increased consumer expectations
- Technological development.

**3.2.1 An ageing population:** The number of people aged 65 years and over has doubled since 1970 to 490,000 in 2004. By 2021, this portion of the population is expected to grow to 792,000 people (Figure 1 below). In 2021, those over 65 will make up over 25% of New Zealand's population, compared with 12% in 2004. There will also be a significant increase in the number of people over age 85 years.

Figure 1: Predicted change in population aged 65+ years



**3.2.2 The Need for Care is Increasing:** Per capita health expenditure is currently estimated to be three to five times greater for older people than the 15 – 64 age group (NZIER, 2004). Many of those over 65 have multiple health problems. Due to advances in health care and technology those with a chronic illness are likely to survive longer. As this population grows, the complexity of need of both community based and hospital inpatients will increase. Hospitalisation statistics indicate those over 65 years (12% of the current population) make up 53% of inpatient days and just over half of acute medical, surgical, AT& R and palliative care discharges. Patient complexity is also increasing due to technological advances. Those injured or disabled are more likely to survive and live longer with complex health problems.

**3.2.3 Changing ethnic mix and health disparities:** New Zealand’s changing population structure includes a significant change in ethnic mix as shown in Figure 2 below. This along with the drive to reduce disparities means services will need to respond and adapt.

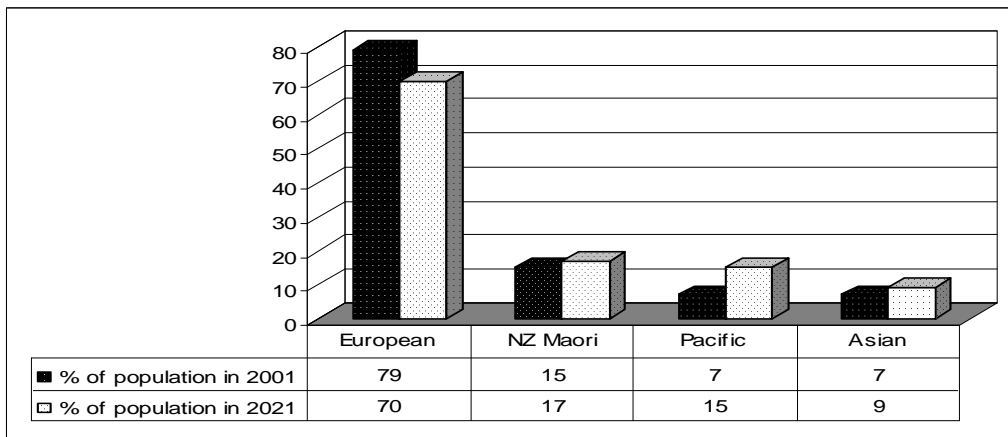


Figure 2: Ethnic diversity of the NZ population in 2001 compared with predictions for 2021.

Source: Statistics NZ, 2006.

Maori and Pacific people have a different pattern of health needs than the rest of the population and are more likely to experience ill health than other population groups (NZIER, 2003). This is reflected in a greater

incidence of chronic illness. By 2011, only 5% of Maori are anticipated to be in the 65+ age group compared with 23.9% of Europeans, with the proportion of hospitalisations for Maori expected to increase from 13% to 17% and for Pacific People, from 6% to 8%. This compares with a fall during the same period from 78% to 64% for those identifying as 'European'.

**3.2.4 Other population factors:** Whilst the ageing population and New Zealand's changing ethnic mix will be major drivers for health service development, services for other population groups will continue to be important particularly those for rural populations and children and young people.

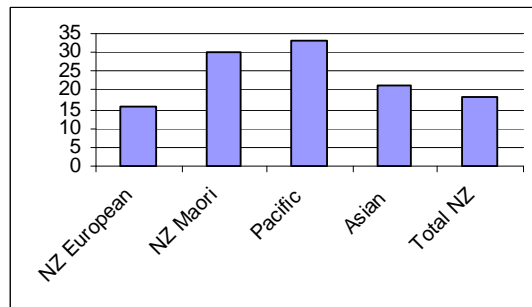
Rurality: New Zealand's geographically dispersed population will continue to be a development theme for future health services. One in four New Zealanders currently live in rural areas or small towns. Rurality is a recognised barrier to health service access. Typically rural New Zealand has small isolated populations, high levels of deprivation, more transient and seasonal populations and a higher proportion of Maori. Challenges for rural service development include sustainability, coverage and appropriateness and from a user perspective, physical accessibility and affordability.

**Children**

Currently, children (0 – 14 years of age) make up 23% of the New Zealand population. By 2021, this proportion is expected to reduce to 18%.

However, as shown in Figure 2, some ethnic groups will have a population profile with a significantly higher proportion of children.

Figure 3. NZ population: Predicted proportion (%) of 0 – 14 year olds by ethnicity by 2021



Source: Statistics NZ, 2006.

**3.2.5 Lifestyles:** Less healthy lifestyles significantly contribute to the rising incidence of chronic illness. The 2002/03 New Zealand Health Survey, (MOH, 2003) which included a sample of just over 12,000 people, identified lifestyle factors as a concern for the health and well being of this and the next generation. Only half of those surveyed met recommended levels of daily exercise and one third had diets lacking in fruit and vegetables. In adults over 45 years of age:

One in five are obese,

One in five smoke,

One in six had hazardous drinking habits.

Health promotion will become a priority for future services. The impact of lifestyle on health will energise a focus on healthy living from an early age. Diet and exercise focused health promotion activities will be based on the notion that healthy living starts early (UK DOH, 2006).

**3.2.6 Increased consumer expectations:** Consumers are more knowledgeable than ever before on health matters due to access to health information resources through the media, advertising and the internet. Health service delivery is expected to fit more with people's changing lifestyles, new expectations and opportunities (National Health Service (NHS), 2006). In response the NHS is currently preparing for a much more consumer driven approach to health service development. Choice and informed and collaborative decision-making underpin health development strategies.

In New Zealand, upcoming 'aged consumers' will be better educated and more 'rights conscious' (NZIER, 2004). These consumers are more likely to expect a 'patient centred' model of care. The principles of continuity of care across the continuum -from keeping people healthy, to living well with chronic illness, including individualised care for those with highly complex needs- now guide health and disability service development. Consumers will increasingly seek care in their own home for longer. Health workers will need to be responsive to and manage the expectations of future consumers.

**3.2.7 Technological development:** Medical science, assistive technology and pharmaceutical advances can improve people's lives, but the organization of health services needs to reflect the speed of this technological change (NHS, 2006). Increased demand means that more health care will take place in the community. To meet this challenge, health workers will need to be supported to deliver services in the home, where they will work with technology and therapies more autonomously than in the 'protective' hospital environment. Increasingly new information technology will be used to support new models of care and integration of services.

### **3.3. Impact of Changes in Demand for Health Services**

The main response to changing population health needs has been the development of a more strategic approach to health service provision. The New Zealand Health Strategy (MOH, 2000) focuses primarily on achieving health and wellness maintenance, while increasing access to health services for those who need it. Acknowledgement of the implications of an aging population has placed emphasis on the need to maintain wellness throughout the lifespan. A range of other key Government strategies will also focus the range of services and responses to population need. These include outcomes such as *Ageing in Place*, a greater emphasis on primary care, reducing disparities and a population health focus.

The changing picture of population demand also demonstrates the need to plan strategically to ensure the availability of a skilled and responsive workforce. Nurses are a key workforce for the future of New Zealand's health and disability services. We need to move now to develop the ongoing contribution of nursing to a sustainable future health sector.

**Source:** Statistics NZ, 2006.

## 4. THE CURRENT NURSING WORKFORCE

### 4.1. Introduction

Nursing is the health sector's largest qualified professional workforce. Nurses practice in virtually all areas of health and disability services across diverse delivery settings. Nursing includes both generalist and specialist practitioners providing wellness and illness services for people at all life stages.

The scope and broad range of present day nursing practice shows the versatility and adaptability of the nursing workforce. However the size and breadth of this workforce also present a development challenge for the profession and for the health sector as services respond to changing patterns of health need. A planned approach to nursing workforce development is essential to ensuring an ongoing fit between nursing workforce capability and health sector needs.

This section provides an overview of New Zealand's current nursing workforce and highlights issues for development.

### 4.2. Defining the Nursing Workforce

New scopes of practice for nurses have been gazetted under the Health Practitioner Competence Assurance Act (2003).

**4.2.1 Registered Nurses:** The Nursing Council of New Zealand has gazetted two scopes of practice under the title Registered Nurse: Registered Nurse and Nurse Practitioner. Previous nursing registrations have been unified under the new legal title of Registered Nurse.

- Registered nurses include Registered Comprehensive Nurses (R CompN) and those who qualified under earlier apprenticeship training programmes including Registered General Nurses (RGN); Registered General and Obstetric Nurses (RGON); Registered Psychiatric, Registered Psychopaedic and Registered Obstetric Nurses.
- Nurses registered under apprenticeship schemes have conditions placed on practice unless they have subsequently qualified as comprehensive nurses. For example, the previous 'obstetric nurse' must work under the direction of a doctor or midwife<sup>1</sup>. As 'single registration' nurses retire, there will be fewer scope of practice restrictions in the nursing workforce.
- The broad Registered Comprehensive Nurse scope of practice provides a more generic qualification for registered nurses on entry to the workforce. On registration nurses are now more able to be flexibly deployed across the health and disability sector, with specialization being introduced post- registration
- A growing area of expanded registered nurse practice is the development of the Clinical Nurse Specialist Role. This is essentially a registered nurse who has developed advanced practice knowledge and skills within a defined area of speciality practice. The majority of these nurses have post graduate education

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<sup>1</sup> Midwives are no longer considered as part of the nursing workforce. The HPCA (2003) established the Midwifery Council of New Zealand (MCNZ) in September 2004. From this point on all midwives and nurses with midwifery qualifications applying for midwifery registration and/or midwifery annual practicing certificates (APCs) apply to the Midwifery Council.

to underpin their area of practice and clinical speciality. This is an area that has developed over recent years. Initially areas such as Diabetes Nurse Specialists were developed and since then a number of specialist roles have emerged in other areas such as respiratory, chronic care/disease management, wound care and continence etc. Another role is the neonatal nurse specialists who work in a highly specialised tertiary care setting. To date, a large number of clinical specialist's roles have evolved within the hospital sector. Going forward and to benefit wider population groups, it is anticipated that clinical specialist roles will extend further into primary, community and aged settings. Further development of these advanced practice roles will support the work of other registered nurses including Nurse Practitioners as well as other health professionals.

**4.2.2 Nurse Practitioners:** Nurse Practitioner is a new scope of practice first introduced in 2003.

- Nurse Practitioners must be qualified at Masters level and endorsed by the Nursing Council. Nurse Practitioners are experienced registered nurses who work at an advanced level of practice and are eligible to apply for prescribing rights.
- Currently there are 26 Nurse Practitioners on the Nursing Council register. Of these 16 are employed in Nurse Practitioner positions. Nurse Practitioners represent a key opportunity for the sector to harness advanced nursing practice to support achievement of service goals. A Nurse Practitioner Employment and Development Working Party is currently exploring ways to promote the implementation of Nurse Practitioners in the sector.

**4.2.3 Second level nurses:** The Nursing Council provides a scope of practice for a second level nurse with the title Nurse Assistant (or Enrolled Nurse for those who graduated before 2000).

- There are now three Schools of Nursing that have Nurse Assistant programmes. The Nursing Council is currently seeking feedback on a new scope of practice for this group. The earlier Enrolled Nurse programme was discontinued in 1993.
- Enrolled nurses and nurse assistants are regulated by Nursing Council to 'perform delegated interventions from the nursing care plan' (NCZN website, 2006). They are required to work under the direction of a Registered Nurse or Registered Midwife.
- The role of the second level nurse intersects the registered nurse and unregulated health worker interface.

**4.2.4 Pre-registration nursing education:** Pre-registration nursing education is now standardised to a three year degree based course. In the mid 1970s nursing education in New Zealand transitioned from a hospital based apprenticeship model to a three-year course conducted by a tertiary education facility.

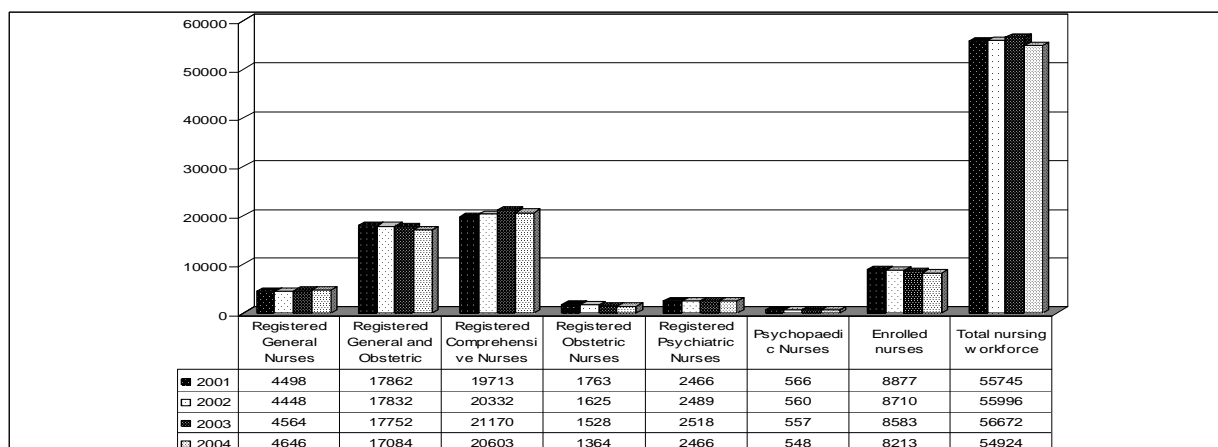
- Currently there are 16 polytechnics and universities providing undergraduate nursing programmes at an estimated 51 sites throughout the country. Programmes are required to meet Nursing Council guidelines and standards.
- The cost to the Crown (through the Tertiary Education Commission (TEC)) and the student for completion of a pre-registration nursing course was estimated to be \$39,000 /student in 2003, one fifth the cost of a medical pre-registration course (MOH, TEC,2004).

- Curricula are regulated and audited by the Nursing Council and require the student to undertake a specified programme of study including clinical practice experience to achieve required competencies. On completion of the degree programme, the graduate must pass a national examination set by the Nursing Council to become registered.
- All new graduate nurses now register as a Registered Comprehensive Nurse. The expectation is that nursing curricula provide an integrated programme to enable students to demonstrate broad nursing competencies at beginning practitioner level<sup>2</sup>.

### 4.3. Nursing Workforce Profile

This section outlines the qualification base, distribution and key demographics of the nursing workforce.

**4.3.1 Size of the Nursing Workforce:** The current nursing workforce (NCNZ, 2004) includes 54924 registered nurses, enrolled nurses and nurse assistants who have current practicing certificates. It is estimated that nurses make up 52% of the qualified health practitioner workforce (Health Workforce Advisory Committee, 2002; MOH/TEC, 2004). Figure 3, below, gives a breakdown of volume by qualification of nurses with Annual Practising Certificates (APC) for the years 2001-2004 and shows the significant proportion of the workforce who hold a single registration.



**Figure 4: Number of Nurses Obtaining Annual Practising Certificates from 2001 to 2004**

**Source:** Nursing Council of New Zealand (2006)

Over the past 5 years the registered nurse workforce has grown by 5.7%. When viewed by registration type, the majority of nurses are still either RGON or single registration nurses. Comprehensive nursing became the end qualification for pre-registration nursing programmes in the early 1980s and by 1987, all new graduate

<sup>2</sup> A list of the competencies for Registered Nurses is available on the Nursing Council website: [www.nursingcouncil.org.nz](http://www.nursingcouncil.org.nz).

nurses registered as comprehensive nurses. The overall proportion of comprehensive nurses in the nursing population has grown very slowly.

As shown in Table 1 below, approximately 26,000 (56%) of today's nursing workforce received their initial nursing registration more than 20 years ago under the earlier apprenticeship system. This proportion is potentially significant in terms of the professional development needs of the workforce given the changing context of health care.

**Table 1: Type of Pre-registration Nursing Education 2001 – 2004.**

<b>Nursing Annual Practising Certificate.</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Single registration and/or RGON with APCs	27,155	26,954	26,919	26,108
Registered comprehensive nurses with APCs	19,713	20,332	21,170	20,603
<b>Total Registered Nurses with current APCs</b>	<b>46,868</b>	<b>47,286</b>	<b>48,089</b>	<b>46,711</b>
<b>Percentage of comprehensive nurse APC holders</b>	42%	43%	44%	44%

Source: Nursing Council of New Zealand.

**4.3.2 Geographic distribution:** Nurse workforce supply is unevenly distributed. As shown in Table 2, geographic differences in the distribution of nurses include below national average ratios of nurses to population in the Auckland region, Central North Island and Southland. There are higher than average national ratios of nurses per population in Canterbury, West Coast, Otago and Wellington.

**Table 2: Rates of Nurses per 100,000 Population by Geographic Region, 2004.**

<b>Rates <i>above</i> national average of 853.5</b>		<b>Rates <i>below</i> national average of 853.5</b>	
<b>Regions*</b>	<b>Rate per 100,000 people</b>	<b>Regions</b>	<b>Rate per 100,000 people</b>
Waikato	858.8	Northland	852.0
Bay of Plenty	858.0	Hawkes Bay	844.2
Nelson/Marlborough	880.1	Tairāwhiti	844.1
Wellington	932.8	Taranaki	835.4
Otago	940.7	Invercargill	835.5
Canterbury	977.8	Manawatu/Wanganui	800.9
West Coast	1013.4	Auckland	771.7

\*These are geographic regions, not DHB regions.

Source: NZHIS, 2006

The Auckland region is predicted to account for two thirds of New Zealand's future population growth through to 2026. This equates to a 46% increase in the regional population. It is of concern that the nurse per population rate is currently the lowest in this region. Canterbury, Waikato and Bay of Plenty are expected to have the next highest population growth over the same period. Currently the nurse to population ratio is higher in these regions. Southland and Taranaki regions are expected to have the greatest decline in population through to 2026 (Statistics NZ 2006).

**4.3.3 Work type distribution:** The distribution of nurses by work type (Table 3) indicates that at least 57.1% of nurses work in health institutions. Most nurses are employed by District Health Boards. In 2004 less than 1 in 5 nurses worked in primary health care. The primary health care nursing workforce includes 'registered nurses providing care in the community and outside the hospital' (MOH, Expert Advisory Group, 2003).

**Table 3: Distribution of Nurses by Work Type, 2004.**

Nursing work type	Primary Health	Aged care/ATR	Mental health	Secondary & Tertiary	Admin Education	Other	Total
Percentage	16.7	13.6	8.8	43.5	7.5	9.9	100.0

Source: NZHIS, 2005

Although only 16.7% of nurses currently work in primary health, this is the sector where most growth is expected in the future. The move to care in primary health and other community settings will impact on nursing expanding the range of roles and complexity of service delivery within roles.

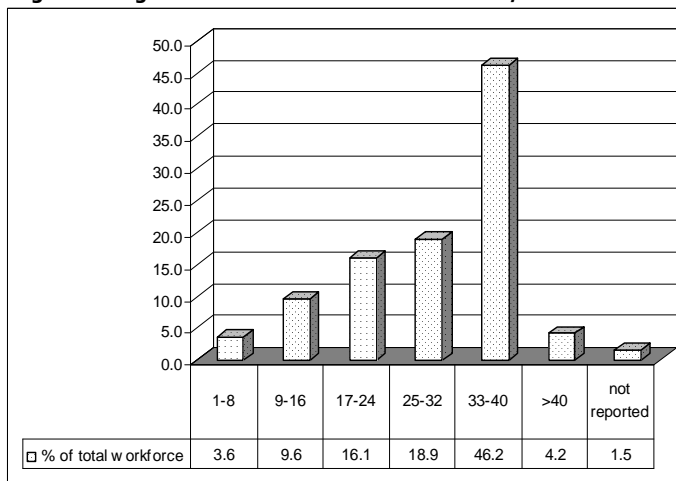
Because of the relatively few nurses working in the primary health sector, opportunities for nursing students to gain experience in this area is also limited. There are also barriers to placing new graduates in the community as a first option due to lack of infrastructure.

In recognition of the priority of nursing workforce development in primary health, a number of DHBs have introduced initiatives using differing approaches to assist new graduate entry into primary health settings. These initiatives at Capital and Coast, Hutt, Counties Manukau, Canterbury and MidCentral DHBs provide a base for further development.

**4.3.4 Hours of work :** In 2004 while 51.4% of registered nurses worked 4 or more days per week, just under one third of all nurses active in the workforce worked 3 days per week or less.

The nursing workforce, being predominantly female (93%) has a significant proportion of part-time workers (Figure 5).

**Figure 5: Registered Nurse hours of work in 2003/04.**

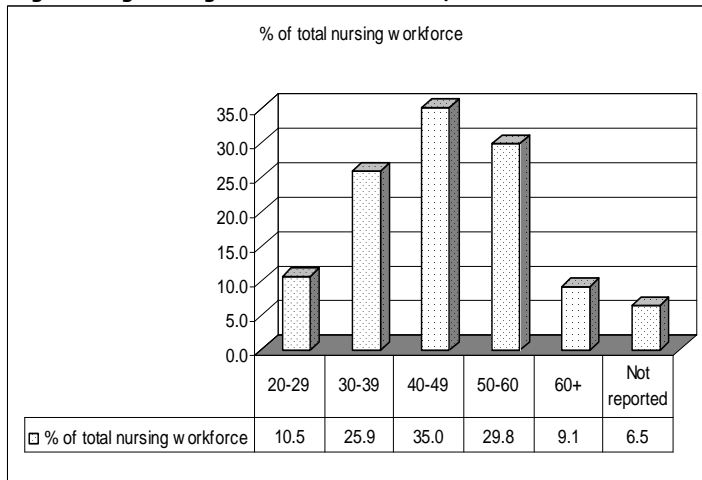


Source: NZHIS, 2005

**4.3.5 Age Structure:** Nursing is an ageing workforce. Almost two thirds of the active nursing workforce is over 40 years of age and 38.8% is aged 50 years or older. The average age of nurses in the workforce is 47 years.

The significant ageing pattern of the nursing workforce presents a retention challenge to the sector, which will need to explore flexible employment options to retain the expertise of this group.

**Figure 6. Age of Registered Nurses in 2003/04**



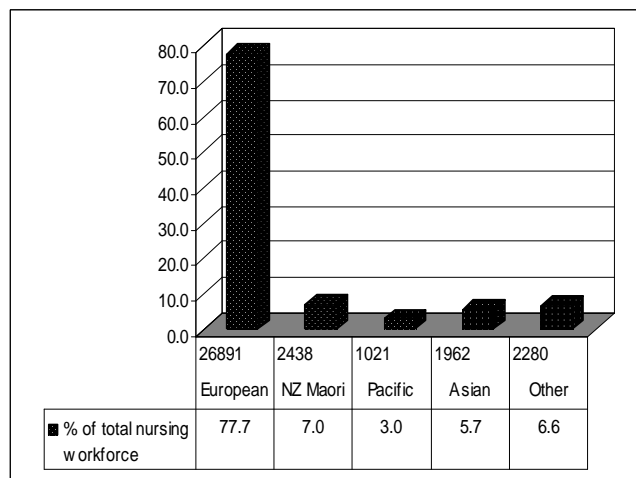
Source: NZHIS, 2005

**4.3.6 Ethnicity:** The majority of active nurses in New Zealand identify as NZ European. 7% identify as Maori. Only 3% identify as Pacific People.

This ethnic make-up is not representative of the community as a whole. In 2001, Maori made up 14% of the total New Zealand population and Pacific People, 6%. Predictions of the ethnic diversity of the future New Zealand population indicate that the Maori, Pacific and Asian populations will increase at a greater rate than the European population. By 2021 Maori are expected to make up 17% of the total population and there will be a significant increase in the proportion of Pacific peoples to 15% of the overall population.

Achieving a nursing workforce that is more reflective of New Zealand's population structure is a key challenge for the future. This will require increased recognition of the barriers experienced by Maori and Pacific people in successfully undertaking undergraduate nursing programmes. For example a 2003 national survey of Pacific nurses highlighted language, academic content, student support issues and personal factors such as family health and financial problems as key barriers for Pacific nursing students.

**Figure 7. Ethnicity of Registered Nurses in 2004.**



Source: NZHIS, 2005

#### 4.4. Recruitment & Retention

Understanding nursing workforce supply, recruitment and retention issues is complex given the size, demographics and wide distribution of the nursing workforce and the lack of robust workforce data. Based on current data it is possible to give only a broad overview of workforce trends and flows and to highlight issues and questions for further investigation.

**4.4.1 Workforce Supply:** New graduates and overseas nurses registering in New Zealand provide the main avenues for recruitment into the nursing workforce. The number of nurses re-entering the workforce is more difficult to gauge.

Table 4 demonstrates that there were 158 (12%) more nurses graduating from New Zealand pre-registration programmes in 2005 than 5 years previously. There were 21 Nurse Practitioners with Nursing Council APCs in 2005.

**Table 4: Number of new graduate nurses for years 2001 – 2005**

<b>Number of new graduate registered nurses</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>	<b>2005</b>
Nurse practitioners					21
Registered Nurses	1146	1100	1262	1245	1304
Nurse Assistants	-	-	30	78	41

Source: Nursing Council of New Zealand, 2006.

A Department of Labour analysis suggests that the training rate for nurses in New Zealand is adequate compared to growth in employment (DOL, November 2005). Similarly, findings of the Qualification Supply Analysis undertaken by TEC in 2004 suggest that the number of graduates produced by the tertiary education sector is sufficient assuming a 35 year workforce replacement cycle. However, these analyses do not take into account differences in workforce participation for predominantly female workforces which may influence the numbers of student places required. The extent to which student numbers may need to grow based on expected increased service demand should also now be considered.

**Table 5: Summary of all new APCs issued to nurses in New Zealand 2001 - 2004**

<b>Number of new Annual Practising Certificates issued by Nursing Council</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>	<b>2004</b>
Number of new graduate nurses (all scopes)	1147	1105	1296	1325
New APCs to overseas nurses (all scopes)	888	1394	1504	1163
<b>Total new APCs (all scopes)</b>	<b>2035</b>	<b>2499</b>	<b>2800</b>	<b>2488</b>

Source: Nursing Council of New Zealand, 2006.

As shown in Table 5, the total number of new graduate nurses grew by 15.5% between 2001 and 2004. The number of overseas nurses taking out a New Zealand APC grew by 30% from 2001 baseline during the same period. It is important to note that while overseas qualified nurses represent a significant supply source now, New Zealand will increasingly face competition for the international pool of nurses.

**4.4.2 Health / Education Planning Gap:** Pre-registration nursing education is funded via the education sector, effectively placing responsibility for recruitment to the profession with educational facilities, rather than to match workforce needs. This inhibits health sector involvement in the numbers of students entering nursing programmes. For example, the uneven distribution of registered nurses throughout the country does not appear to influence recruitment activities by educational institutions.

There is no coordinated process between the health and education sectors to guide and advise on the numbers of nurses required or the nature of the education programmes that should be delivered. For example, there is no direct mechanism for the health sector to influence development of the new competency sets that may be needed by future health services.

**4.4.3 Retention:** A lack of strategic workforce planning over the past 15 years, has resulted in nursing recruitment activities being focused mainly on vacancy filling and matching nursing volumes to acute demand. This 'just in time' nursing workforce planning has helped to shape the current New Zealand nursing workforce.

Until recently there has been little systematic focus on retention. The Department of Labour 2005 analysis of a registered nurse skill shortage noted above cited occupational detachment (i.e., qualified nurses working in non-nursing roles) as one of the key reasons for the reported shortage of actively practising registered nurses within the health sector. While the figures quoted in the study are now rather dated (in 1998 40% loss to the active nursing workforce in the first 3 years of practice) they portray a significant attrition rate in the early years of entry into the nursing profession. Initiatives such as transition to practice programmes (for example the Nursing Entry to Practice Programme) may have mitigated this loss of new practitioners. The as yet unknown impact of the Nursing Council competence to practice requirements introduced under the HPCAA may be a future contributor to occupational detachment.

Overall, a range of factors have been identified as influencing retention of the nursing workforce including:

Support for new graduates in the transition to practice

The impact of gender roles on a predominantly female workforce

Employment conditions, including workplace conditions e.g. access to childcare

Access to recognized career pathways and career development opportunities

Migration and overseas travel

Ageing workforce.

The relative importance of each of the above factors and indeed the existence of a current retention issue for the nursing workforce is difficult to quantify based on available data.

However, increased demand for health workers in the future requires a focus on retention and improved information on workforce flows to enable better workforce planning. A systematic approach and creative solutions at all levels of the sector will be needed to retain nursing expertise

## 4.5. Competency Maintenance and Career Development

A range of education programmes are available to nurses to maintain and develop their competence to practice and to further their professional qualifications. Access to ongoing training and education is an important component of workforce development and a significant challenge for a large workforce such as nursing.

**4.5.1 New graduate programmes:** DHBs have been providing new graduate nursing programmes for some years to provide supported orientation to the workplace and to practice. A CTA funded new graduate programme in mental health has been running for over 10 years and has anecdotally had a significant impact on the capacity and capability of the Mental Health nursing workforce. In 2005 the Minister of Health provided funding for a 10 - 12 month Nursing Entry to Practice (NETP) programme for new graduate nurses who enter employment with District Health Boards. The new funding has resulted in a joint initiative between the Clinical Training Agency, DHBs and the Nursing Council to implement a nationally consistent approach to transition to practice for new graduates.

New graduate programmes have been introduced due to concerns around the work readiness of new graduate nurses and to retain new graduates in the health sector. One view is that the need for new graduate programmes demonstrates a disconnect between nursing education and practice. Another view is that the complexity of the current clinical practice environment requires a more intensive orientation for new graduate nurses who are prepared to a beginning practice level. These different views signal the need for ongoing dialogue between health, education and the profession to ensure a smooth transition to practice for registered nurses and an optimum beginning competency level for the sector.

**4.5.2 Competency maintenance:** The HPCA Act places responsibility for competency maintenance on the individual health professional. However, the need for health practitioners to have the opportunity to demonstrate competency maintenance within their work environment has resulted in a significant role for employers. Nursing competency maintenance activities have placed more pressure on employers to provide programmes that enable practitioners to demonstrate their competence. These processes also provide opportunities for employers to enable nurses to respond to the health needs of the population they serve and up-skill, refresh and/or redevelop their skills, thus developing a more flexible clinically sound nursing workforce.

One example of how organisations are realising the benefits of supporting competency development is the MidCentral DHB Nursing Practice Development Programme. MDHB has developed a Nursing Practice Development Programme (NPDP) framework for the development of speciality nursing competencies across the continuum of health and wellbeing for DHB high priority areas such as diabetes, cardiovascular, and respiratory services. The NPDP is a framework around which structured support and learning facilitate development of expertise in professional nursing practice. A system of 'levels' (fundamental, competent, proficient or expert) facilitates nurses learning across the DHB (provider arm and non-provider) in a systematic and targeted fashion.

**4.5.3 Professional Development and Recognition Programmes:** In the past 10-15 years there has been increased emphasis on the development of clinical career paths for nurses. Both DHBs and Nursing are now engaged in the development of Professional Development and Recognition Pathways (PDRPs) which provide nurses with workplace based opportunities to demonstrate their increasing experience and expertise as a nurse. For employers PDRPs provide a way of understanding and developing the competency mix of their nursing workforce. Nursing Council accreditation of DHB PDRP programmes now provides a mechanism to assist nurses to meet Nursing Council competence requirements.

There has been more limited development of PDRP in primary health and other community settings. A PDRP developed by the Primary Health Care Nurses Council (NZNO) has now been agreed for nurses in primary health. This PDRP framework recognises that a nurses' role encompasses clinical practice, education and research. The PDRP is seen as catalyst for change and for maximising nursing's contribution to the health outcomes of individuals, families, whanau, and population groups in line with the Primary Health Care Strategy.

More now needs to be done to encourage implementation of PDRPs and their take up by nurses in both DHB provider arms and in other settings to support professional development and maintenance of professional competence requirements.

**4.5.4 Return to nursing programmes:** Under the HPCA Act, nurses returning to practice after more than a five year break from clinical practice must demonstrate that they meet nursing competencies for practice. Return to nursing programmes has now been formalized into 'Competency Assessment Programmes' requiring Nursing Council approval. To date, four DHBs and nine nursing education providers have been approved to run programmes (NCNZ website, 2006). Numbers of actual courses or of those attending are not available from any one reliable source, as they tend to be run on an 'as needed' basis to boost the workforce in times of acute need. A more organized approach to Return to Nursing Programmes is now needed. As noted above, difficulties for nurses in accessing return to nursing programmes may contribute to occupational detachment

**4.5.5 Post-Registration Education programmes:** A range of post-registration education programmes are available to nurses to maintain and develop their practice throughout their professional careers. However access to education is unevenly distributed between individual nurses and across different service areas.

Nursing specialty and advanced nursing education programmes: The Nursing Council has approved 16 providers of post-registration programmes which provide a recognized post registration nursing qualification. The Nursing Council approves both the provider and the programme, which is required to meet the specifications of:

Specialty Nursing Practice or

Advanced Nursing Practice, which includes preparation for the Nurse Practitioner role and nurse prescribing.

Among providers of these programmes are three District Health Boards and 13 educational institutions. Most courses have been developed in conjunction with local health sector representatives, because of the specific clinical practice experience required by the nurse undertaking the programme. DHB providers of approved post-registration nursing programmes offer the only courses in Specialty Nursing Practice. There are 53 approved courses, 20 in specialty nursing, which are generally shorter courses and 33 in Advanced Nursing Practice. The latter are generally longer and more complex courses and are also a prerequisite for nurse prescribing.

Postgraduate academic nursing education: There are six providers of nursing programmes that lead to academic qualifications such as Masters and PhDs (many offer their courses in conjunction with other Schools of Nursing to increase access for students). All Nurse Practitioner programmes complete at Masters level. There are also a number of Masters level (and beyond) programmes focusing on the academic study of nursing. Many nurses undertaking these programmes are self-funded, many planning to transition into nursing education and research.

Access, range of programmes and funding: Access to post-registration and postgraduate education is important across the sector and there is a need for flexibility in regard to distance learning, access to not only clinical focused programmes but also to nursing education, leadership, management and research programmes.

There is a need for more interdisciplinary post graduate education especially in areas where there are strong interdisciplinary models of care and therefore the need for these to be recognised towards nursing postgraduate qualifications.

Education programmes should recognise prior learning and expertise so that nurses do not have to complete another qualification if they change speciality area of practice. This would also enhance flexibility of post graduate qualifications and the nursing workforce from the sector's perspective.

Currently, whilst there is local input from service providers into the development of post graduate nursing programmes there is little coordination at national level and this leads to duplication of programmes in some areas and gaps in other areas.

There is also little direct DHB input into funding of post-entry nursing education. DHBs have the responsibility to assess the health need of their populations. It is logical therefore that DHBs have a role in identifying the priority areas for development of the workforce to best meet their population health needs. This then implies that for nursing workforce development there should be a stronger focus on linking the needs of the population to nursing education priorities.

#### **4.6. Key Issues**

The current profile of the nursing workforce highlights key gaps and issues to be addressed to ensure that the future New Zealand health workforce includes the right number, distribution and mix of nurses, and with the competency sets needed by New Zealand communities. This will require a planned and coordinated approach to nurse workforce initiatives by all stakeholders.

Also highlighted is the lack of up to date workforce information which compromises an accurate understanding of the current nursing workforce. Development of robust workforce data to enable more informed decisions and workforce planning is already a priority in DHBs' collaborative workforce programme through the Health Workforce Information Programme (HWIP). HWIP data will soon begin to support improved nurse workforce planning.

Identified key issues for development are discussed in the next section of this paper in the context of a vision for the future nursing workforce. Recommendations are made on priority actions to address identified issues.

## 5. TRANSITION TO THE FUTURE

### 5.1. A Future Vision

This discussion document has highlighted the significant population changes that are already shaping future services and the new models of care that will drive future nursing workforce needs.

**5.1.1 Future Services:** Sustainability and quality will be twin development themes for models of care in the face of increased service demand. The future vision in the NZ Health and Disability Strategy is for services provided flexibly across the continuum of care. Health workers will increasingly work across service settings to provide patient/consumer centred care. Services are more likely to be 'wrapped around' the patient with less focus on delivery settings. There will be an increased emphasis on delivery in primary health care and community settings including people's homes and the complexity of care in these settings will increase. To make best use of workforce skills and to deliver services tailored to patient/consumer need, services will be provided increasingly by interdisciplinary teams relying on both regulated and non-regulated health workers. Future services will be responsive to new technologies and will also be responsive to the higher expectations of more informed and engaged consumers. Population based approaches will be an important service emphasis.

Future service development priorities include primary care, mental health, chronic care management, and intellectual disability.

**5.1.2 Future Workforce:** Both the health workforce and services will be more flexible to ensure sustainable services for New Zealanders, and to align the health workforce to the needs of the population. On the one hand, services will need new competency sets from the health workforce and health workers will work in new ways. On the other, future services will be more flexible to accommodate the changing work and lifestyle expectations of health workers and to manage increased demand for key health practitioner groups.

**5.1.3 The Future Nursing Workforce:** Nursing will continue to be a key workforce to the future of New Zealand's health and disability services, as the sector responds to a range of population and social drivers. Service change will present new challenges and opportunities for nursing. The generalist nature of the nursing workforce will continue to be a core strength, enabling flexible deployment of nurses within and across care settings. Many will work in more decentralised teams with a higher number working autonomously responding to local community need. There are likely to be changes in the skills and structures of the workforce to accommodate predicted shifts in the consumer/patient population and in health needs.

The future registered nursing workforce will include a mix of generalist registered nurses, specialist nursing roles and Nurse Practitioners. While most will practice as registered nurses, there will be more specialist

nurse roles and a relatively smaller group of Nurse Practitioners. Some Nurses will expand their practice within the role of the RN, whilst others will expand their breadth of practice as a progression to that of a Nurse Specialist role. The expansion of nursing roles in this way is consistent with the development of a flexible workforce. Some nurses will also work in expanded practice roles and develop specific competencies shared with other health practitioner groups. Registered nurses are likely to be supported by a changing mix of nurse assistant, regulated and non-regulated health workers to maintain workforce and service sustainability. Development of regulated and unregulated support roles will also provide alternative access to health careers for future health workers.

Future registered nurses will have new and expanded competencies to meet the more complex health needs of future patients. These will include expanded assessment skills and other clinical competencies including working with new technologies; competencies in population health and community development; cultural competency; relationship management and leadership; interdisciplinary practice and team work; competencies in working in partnership with patients; research, quality and managing ethical issues.

## 5.2. Transitioning the Workforce to Meet Future Needs

The vision for future services highlights the need for new and expanded workforce competencies to meet the challenge of future service and population trends. This paper has identified issues for the nursing workforce that the sector must address to ensure a sustainable nursing workforce into the future. Initiatives need to build on existing sector work in a coordinated approach across all stakeholders involved in nursing workforce development. Key development themes include:

- Workforce structure and numbers
- Workforce distribution
- Leadership
- Skill mix
- Competency development and maintenance
- Undergraduate nursing education
- Recruitment and retention of nurses
- Workforce planning.

5.2.1 Workforce structure and numbers: The demographic structure of the nursing workforce presents some key development themes for the future:

- a) Workforce numbers:** Due to a lack of accurate, comparable and up to date workforce data, it is not clear whether there is a current issue with New Zealand's present nursing workforce numbers. However this analysis has highlighted questions around supply and retention issues that need further investigation. Available evidence suggests that current workforce supply is adequate to sector need but will not be adequate in the face of increased service demand and anticipated increased global competition for health workers. It is likely that demand will also be increased due

to a combination of diminishing numbers or growth not keeping pace with demand in some other professional groups. An appropriate response needs to be developed as a collaborative effort with other professional groups.

- b) Ethnic diversity:** There is a need for the nursing workforce to become more representative of the ethnic diversity of the population as a whole. More Maori, Pacific and Asian nurses are required to support provision of culturally appropriate services. This will require increased recruitment into undergraduate nursing programmes and ensuring that programmes are structured to support students to complete and qualify, as well as ensuring that mentoring at both the under-graduate and graduate level is available. It will also be important to work with schools to support uptake of subjects that will lead to a future health career. For example, science and promoting health as a good career choice should begin early.
- c) Gender Balance:** There is a need for the nursing workforce to become more representative of the population and this includes promoting nursing as a career choice for men, and addressing the barriers that contribute to this choice.
- d) An ageing workforce:** Increasing focus will need to be placed on retaining the expertise of older nurses who, within 10 years, are anticipated to form the bulk of the nursing workforce. A range of strategies will need to be considered including:
  - Enabling transition into more flexible range of roles,
  - Providing opportunities for part time and flexi-work arrangements
  - Access to wellness and health maintenance programmes
  - Mentoring roles for new graduates and other learners.

**5.2.2 Workforce Distribution:** Currently the nursing workforce is unevenly distributed geographically and across different levels of the health sector.

Geographical distribution: There is a need to ensure that services in all regions have access to adequate supplies of new graduates. This will require the health and education sectors to work together at both national and local level to structure programmes to support access by local populations to undergraduate nursing programmes and to ensure that intake numbers are geared to workforce needs.

Primary health and community settings: Development of primary health and community based services is a key development thrust for the health sector, yet the vast majority of nurses still work in institutional settings. Over the next few years the sector must progressively support the transition of nurses to work in primary health and community settings. There is a need to build on existing initiatives to create a sufficient momentum for change and a nursing workforce that is able to fully contribute to an interdisciplinary model of care within a vital primary health and community sector. Key change drivers to be considered include: Support for employment of new graduates in primary health and community settings

- Development of primary health nurse leadership roles to support change
- Development opportunities for nurses already working in primary health
- Support and education programmes enabling experienced secondary /tertiary sector nurses including those who trained in earlier apprenticeship programmes to move into primary care settings
- Expanded nursing roles including nurse practitioners
- New nursing team structures potentially including new roles for second tier regulated and non-regulated health workers
- Reviewing funding streams and service agreements to promote employment models for primary health nurses that maximise the contribution of nursing to service delivery
- Development of deployment models enabling nursing to work across primary, secondary and tertiary sectors
- Continuing to support Mental Health Workforce Development<sup>3</sup>, including advanced practice and leadership roles. Recognising that CTA funding for first year of practice for mental health nurses is essential to developing and maintaining a Mental Health Nursing workforce
- Raising the focus on the nursing contribution to the Health of Older People through promoting the potential contribution that advanced nursing roles can make. This is likely to be a trade-off between adding value, meeting quality standards and providing cost effective care, whilst maintaining the fundamental principles of positive ageing.

**5.2.3 Leadership:** Investing in nursing leadership development provides an opportunity for the sector to strengthen nurse workforce and service development. Clinical governance has become more developed in the hospital sector over the last few years. There is a need to extend this across the sector and in particular into primary care and PHOs. As noted above nursing leadership roles are needed in primary health to lead change alongside other disciplines, to participate in governance of primary health care organisations and for clinical governance- promoting development of nursing service delivery and quality in primary health services and community settings. Healthy workplace initiatives including the implementation of Magnet principles (see Appendix four) in some settings and the Safe Staffing Unit initiative support nursing participation in decision-making.

**5.2.4 Models of Care and Skill Mix:** As the largest professional health workforce, nurses represent a significant social investment. Ensuring future services are sustainable from workforce supply, quality and cost perspectives will include ensuring an appropriate mix of nursing roles to provide services geared to differing levels of patient complexity and different care settings.

This will require discussion between the nursing profession and the health and education sectors on the roles and preparation of second tier regulated and non-regulated health workers supporting the nursing workforce. Currently there is variable access across the sector to a second tier workforce supporting nurses to deliver nursing care. Nevertheless, it is clear that in the future there will need to be some form of second

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<sup>3</sup> Add reference to the Mental Health Workforce Development Programme

tier workforce across all service settings, including acute service settings, due to expected continuing pressure on nurse workforce supply and the need to make best use of available registered nurse expertise. Feedback on this discussion document suggests that there is a place for a second tier regulated as well as non-regulated roles supporting registered nurses across care settings.

Although generalist nurses will continue to be a core strength, the health sector will also need to work with nursing in consultation with other health professional groups to develop more specialist nurses and advanced nursing roles including Nurse Practitioners. As noted above the development of clinical specialist roles will complement those of the generalist registered nurses and a relatively smaller number of Nurse Practitioners. Some new roles may include a component of overlap as nurses develop specialist competencies shared with other health practitioners.

**5.2.5 Competency Development and Continuing Professional Development:** The pace of change and technological development is already placing new demands on health practitioners related to competency maintenance and development. Legislative change with the introduction of the HPCA Act now requires all nurses to demonstrate ongoing competency for APC maintenance. Changes in models of care will also require new and expanded competencies of the nursing workforce including strengthened team competencies to work in partnership with other health professionals and patients/clients to deliver services across settings. Leadership competencies will be important to enable full participation of nurses in service development and to address the supervision needs of non-regulated workers. Services will also continue to rely on nurses for their technical skills and for increased health promotion and health education competencies as the demand for population based approaches grows.

Over the next few years the sector and nurses will need to work together to support competency development across the nursing workforce, in all parts of the health sector, building on existing initiatives such as the Nursing Entry to Practice Programme and Professional Development Recognition Programmes.

More comprehensive and health service responsive post registration/postgraduate programmes will need to be developed in order to develop and promote retention of the nursing workforce. Nurses will need:

Transition to practice support

More opportunities to take part in post registration specialist training and post-graduate education programmes

Support for competency maintenance

Proactive development of career planning/pathways

Access to career development programmes, including in leadership and management

Improved access to return to nursing programmes.

The sector would benefit from a more coordinated framework for post-graduate nursing education developed in a collaborative manner with the education sector. This could lead to the emergence of centres of excellence for specific post-graduate education programmes and a sensible number and distribution of

programmes. A high level of access to programmes is a key measure of success. In the primary and aged care sectors programmes that support working as an inter-disciplinary team will be important.

**5.2.6 Undergraduate Preparation:** More discussion is needed between the health and education sectors and the Nursing Council to ensure that undergraduate programmes equip nursing students with the competencies needed by the future health sector. As noted above, access to nursing undergraduate programmes is viewed as a key factor in recruitment to local services and should be considered as part of a review of nursing education to ensure:

Programme quality and competency development with greater responsiveness to health sector needs

Better access to a broader range of clinical practice experience possibly through an extension of the academic year

Flexible and transportable programme location.

**5.2.7 Recruitment and Retention:** A more deliberate and planned approach needs to be taken to recruitment and retention of nurses to ensure that the health sector is able to attract and retain its nursing workforce. A range of strategies will be needed including:

- Collaboration with the education sector to develop joint health / education sector student recruitment strategies and processes
- National promotion of nursing as a career option
- Building on current health workplace and employment strategies to create attractive and flexible work environments for nurses across the sector
- Development of career pathways and PDRPs
- Improved access to post-entry clinical training and postgraduate education
- Strategies to retain registered nurses in New Zealand and to encourage those practising overseas to return to the New Zealand health sector.

**5.2.8 Workforce Planning:** There has been little systematic planning for the nursing workforce in recent years. As noted above, the lack of adequate workforce data limits our ability to understand the current status of the nursing workforce. The dearth of consistent and reliable information available to construct a current New Zealand nursing workforce profile has highlighted the need to develop and maintain a national overview of the nursing workforce. This would provide benchmarks against which nursing workforce strategies could be measured. For example, current information does not allow an up to date understanding of workforce flows and whether current supply through the education sector and immigration is adequate to present or future workforce needs. A strategic and planned approach to nurse workforce development in partnership with nursing and other stakeholders is now needed to ensure that nurse workforce development strategies can be appropriately targeted to meet health sector needs as services respond to changing population demand. The Health Workforce Information Programme (HWIP) work stream will assist with an improved range and accuracy of information available to inform future planning.

### 5.3. Recommended Priority Actions

The Nursing and Midwifery Workforce Strategy Group recognizes the workforce initiatives currently being led by the nursing profession, the Ministry and by DHBs. This discussion paper builds on earlier sector work and provides an overview of the development issues facing the nursing workforce. There is a need now to engage all key stakeholders in a national approach which links initiatives together in a planned and systematic way to progress nursing workforce development.

Due to the size and coverage of the nursing workforce across health and disability services it is not possible to address all areas of nursing workforce development at once. The Nursing and Midwifery Workforce Strategy Group recommend the following actions as priorities and as a base for ongoing development:

#### 5.3.1 Develop the nursing workforce in primary health, rural and community based services

	<b>ACTION</b>	<b>RATIONALE</b>	<b>FOCUS</b>
(i)	Implement the Nurse Practitioner Facilitation project with a view to increasing the number of Nurse Practitioners in the workforce, in particular in Primary Health, Health of Older People and Mental Health Services	The major focus of NP development should be on broad NP roles in a range of settings. Initiatives may include supporting and evaluation of existing NP roles. Includes building on existing successful models and integration of the work completed by the Nurse Practitioner Employment and Development Working Group.	DHB
(ii)	Extend the Nursing Entry to Practice programme (NETP) to include community based settings in primary health and other community settings	Support new graduates to commence practice in community settings by seeking Clinical Training Agency (CTA) funding for an extension of NETP to include primary health and other placements for new graduates	National/ DHB
(iii)	Promote development of clear accessible and integrated nursing leadership in primary health. In the first instance this will be through a stock-take and sharing of current leadership models	A clearly identified primary health care nursing leadership infrastructure is needed at a DHB district level to provide professional leadership, to facilitate change and the development of new roles and models of practice	DHB
(iv)	Work with PHOs, other major employers and the Primary Health Care Nurses Council of NZNO to implement PDRPs in primary health	Poor development of PDRPs in primary health and community settings limits career pathways for nurses in priority development areas of the health and disability sector.	National/ DHB

#### 5.3.2. Support development and retention of the nursing workforce

	<b>ACTION</b>	<b>RATIONALE</b>	<b>FOCUS</b>
(i)	Increase the momentum for DHB employed nurses to complete assessment for Professional Development & Recognition Programmes (PDRP)	PDRPs provide a strong basis for development for individual nurses and a competency framework supporting organisational & service development	DHB
(ii)	Use results of national PDRP picture to identify continuing education priorities for the DHB employed nursing workforce	Health Workforce Information programme (HWIP) in Year 2 to build database on national PDRP information as evidence base of current workforce competency mix	National /DHB
(iii)	Work with the CTA to increase DHBs' responsibility for nursing post-entry clinical education	A sector driven education model will strengthen alignment of programmes to service need	National
(iv)	Develop a unified national framework for nursing post-graduate education	Improved targeting, coordination and access to post-graduate education will support the development of the registered nurse workforce. Link with the planned cancer nursing framework as a potential model that can be applied to other areas of post-graduate education	National
(v)	Implement recommendations of the Safe Staffing and Healthy Workplaces Committee of Inquiry Report as endorsed by CEOs	Initial set up of capacity to deliver safe staffing initiative for DHBs as agreed and funded.	DHB/National

### 5.3.3 Increase the ethnic diversity of the nursing workforce

	<b>ACTION</b>	<b>RATIONALE</b>	<b>FOCUS</b>
(i)	Via DHBs' Health Workforce Information Programme (HWIP), identify target percentages for Maori, Pacific and Asian nurses and work with education institutions nationally and locally to increase programme uptake	A more representative workforce is a key strategy to meet future service needs. Key link to Future Workforce's NZ health sector brand and education sector engagement initiatives	National/ DHB
(ii)	Work with Schools of Nursing to provide support and clinical placement experiences that support Maori and Pacific students to complete undergraduate courses.	There is evidence that Maori and Pacific students have a higher attrition rate than other students.	DHB
(iii)	Support for secondary students to choose subjects, for example, science to minimise barriers to health as a career choice.	Many DHBs have a range of initiatives supporting the choice of health careers by secondary students. There is a need to look at ways of encouraging uptake of appropriate subjects by secondary students at a national level. This relates to the education sector engagement initiative project and to the branding project being undertaken by the DHB/DHBNZ Workforce Group.	DHB/National

### 5.3.4 Progress development of a coordinated sector-wide nursing workforce strategy

	<b>ACTION</b>	<b>RATIONALE</b>	<b>FOCUS</b>
(i)	Develop a Position Paper for discussion with other key stakeholders on a second level regulated role to support registered nurses in their practice together with a non-regulated workforce.	Agreement with key stakeholders on the shape of a second tier workforce supporting registered nurses is central to best use of nursing expertise and sustainable health services. This should include options for career pathways and stair casing to nursing careers.	National
(ii)	Agree the future structure of the registered nursing workforce across service settings and in relation to other health practitioner roles	Includes consideration of changing Registered Nurse, Clinical Nurse Specialist and Nurse Practitioner roles related to other health practitioner roles	National
(iii)	Progress sector wide development of accurate nursing workforce information via Year 2 HWIP work programme	Current data is insufficiently robust to provide an adequate status assessment of the nursing workforce or a baseline for predicting future workforce needs	National
(iv)	Identify the sector's top service development priorities to inform decisions on where to focus development priorities for the nursing workforce	Increased clarity via the DHB/DHBNZ Service Improvement Group on the sector's priorities for service development will enable targeting of professional development programmes and other workforce initiatives	National
(v)	Evaluate the structure, curricula and delivery of current undergraduate nursing programmes to ensure appropriateness to future health sector needs on an ongoing basis	Work with the Nursing Council, the education sector and other stakeholders to ensure that workforce competencies are matched to population and sector needs, including team & interdisciplinary practice models	National
(vi)	Match student intakes into nursing undergraduate programmes with predicted future workforce requirements	Recruit into undergraduate nursing programmes based on future workforce needs. Use workforce [5.3.4(ii) above] and service planning information to predict workforce supply requirements	National

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# APPENDIX ONE

## NURSING SUBGROUP

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Helen Pocknall	Director of Nursing	Wairarapa DHB
Mary Gordon	Director of Nursing	Canterbury DHB
Chris Fleming	Chief Operating Officer	Counties Manukau DHB
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Heather Casey	Mental Health Nurse Leader	Otago DHB
Rosemary Minto	Chair NZCPN	NZNO
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## NURSING AND MIDWIFERY WORKFORCE STRATEGY GROUP

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Rosemary Minto	Chair NZCPN	NZNO
Judy Bruce	Midwife	West Coast DHB
Ann Yates	ADHB Midwifery Leader	Auckland DHB
Sue Bree	Midwife	College of Midwives (Advisor)
Cath Jackson	ER Specialist	DHBNZ
Marilyn Rimmer	Portfolio Manager	DHBNZ
Chris Hendry	Contractor	DHBNZ

# APPENDIX TWO

## SUMMARY OF SUBMISSIONS

***A summary of feedback received from submissions on the discussion document is included below. The feedback reflects a variety of sector perspectives and is included to illustrate the range of views. Where appropriate, changes have been made to the text of the document based on the feedback received.***

There were 63 responses from organizations that include District Health Boards (DHBs) (16 of 22), education sector, professional groups, non-government organizations and individuals. A full list is included as Appendix 3.

### **Key Themes**

Overall there is clear support from respondents for the broad vision that was outlined in the strategy document, the key development themes and the action priorities.

### **Future Service Development**

There was clear feedback from a large number of respondents that the priority areas for future development are in the primary care sector, for the care of the increasing elderly population and those people with complex needs. In particular; caring for these people at home or in their own communities.

Nurses will increasingly require skills across the spectrum of population health including health promotion, public health and primary health care principles, and are likely to provide services in a variety of locations e.g. marae, community settings.

### **Nursing Roles**

The majority of respondents believe that the current scopes of nursing practice do support a flexible nursing workforce, and there was a high level of support for the continued development of Nurse Practitioners, Nurse Specialists and support worker roles.

Feedback strongly suggests that the future mix of nursing skills is likely to require a range of nursing roles to meet service requirements. There was also comment on the need for 24/7 support from a range of other healthcare workers, including allied health staff, clerical and housekeeping staff.

The range of nursing roles required included;

- **Nurse Practitioners**

The Nurse Practitioner role was well supported by the respondents with many commenting on the need to increase the numbers and broaden the scope of Nurse Practitioners, in particular in the primary care and rural settings and for specific ethnic groups e.g. Maori and Pacific Island communities.

- **Nurse Specialists**

An increasing role was seen for clinical nurse specialists, and a wide range of nurse specialist roles were described. There was a high level of support for nurse specialists with a generalized approach that could provide care across the spectrum, often in primary care and rural settings. Roles suggested include outreach nurse specialists such as critical care nurses, hospital in the home to support complex clients to remain at home, marae based nurses, mental health specialists, Maori and Pacific Island nurses, emergency department nurse specialists and nurse-led pre-admission clinics. The important, ongoing role of nurse specialists within hospitals is also acknowledged.

- **Second Level Health Worker**

There is a large amount of support for a second level health worker role that is regulated rather than unregulated across all service settings. However, there was also comment that this requires further definition, in particular the use of the title 'nurse' for this group. The strongest support is for the expansion of support worker roles into primary and rural settings. Respondents also saw an opportunity to utilize these roles as entry to the nursing workforce, which will require clear progression pathways.

## **Distribution of the Nursing Workforce**

There was a high degree of support for the development of incentives for nurses to work in prioritized geographical or service areas, and into primary care. Access to good clinical placements to support nurses working in these areas is a high priority, as is pay parity between primary care and DHBs. Many respondents suggested that it is important to consult with local communities about ways to attract staff to a specific area.

## **Ethnic and Gender Diversity of the Workforce**

It was highlighted by respondents that there are both gender and ethnic issues related to the current make-up of the nursing workforce. The strategies that were most supported through the feedback to encourage a closer match with the population are; mentoring nursing students and new graduate nurses with good role models, offering financial support and promoting health as an excellent career choice.

## **Recruitment and Retention**

The two main strategies for retaining the nursing workforce identified most strongly in the submissions are the implementation of family friendly / flexible work environments that are supportive of staff, and workplace training opportunities.

## **Transition across Service Areas**

Respondents described how successful transition across service areas needs to be supported with recognition of transferable skills, appropriate orientation programmes and good mentoring and support.

### **Support for the Workforce Strategy**

There is clear support for the broad vision that was outlined in the strategy document, the key development themes and the action priorities as outlined.

## **FEEDBACK TO DISCUSSION QUESTIONS**

This section summarises the responses to each question, with an overall summary of the main themes and general comments. Many of the questions had more than one part to them, and many of the respondents included comments as part of the response to another question.

**Section 3.0: Future Population Health Needs:** *Population trends and resulting changes in service demand will impact on nursing practice across the health and disability sector.*

**Question 1:** What are the new and/ or expanded competencies nurses will need as the sector responds to population trends?

The two top priorities were identified as population health needs and care of the elderly. Population health needs includes skills in health promotion and illness/accident/injury prevention. Development themes for Care of the Elderly include the increase in complexity of care in primary settings, recognising the increase in the proportion of elderly, and the continued development of a positive view of ageing. Other important priorities are chronic illness and palliative care, interpersonal and team skills; increased use of clinical and information technology; advanced practice roles; rural and primary mental health; and care co-ordination and management. Advanced practice roles included the role of nurses as autonomous practitioners, the need for strong nursing leaders and participation at a governance level (in particular primary care) and as contributors to innovative models of care.

**Question 2:** Which key service areas should the sector target as priorities for nursing workforce development?

As for question 1 the priorities by a very clear majority were primary care and care of the elderly. Other areas identified were rural health; mental health and addiction; chronic disease (across the continuum); high complexity / acute care; family health (child and youth especially Maori and Pacific Island children); and cultural groups such as Maori and Pacific Island.

**Question 3:** What new nursing roles will be needed to support the sector's response to changing health needs? How can the sector support the development of these roles?

The roles that were most supported by the majority of respondents were Nurse Practitioner e.g. chronic conditions, rural and mental health; nurse specialists, including those with a generalist approach; and more specialized support worker roles, including second level nurses.

The roles that were supported by some of the respondents were community based nurses e.g. child health, elderly; nurse educators and managers for primary care; and no new roles, rather expansion of current roles.

The roles that were supported by a small number of respondents were outreach nurse specialists e.g. critical care; hospital in the home roles – supporting complex clients to remain at home and Case Managers / Care Coordinators.

The sector can support the roles by ensuring there is a robust infrastructure in place, with access to both new graduate and ongoing clinical education.

**Section 4.0: The Current Nursing Workforce:** *The Nursing Council of New Zealand has identified two registered nurse scopes of practice and one scope of practice for enrolled nurses/nurse assistants.*

**Question 4:** How can the sector best use the range of competencies offered by each of these nursing scopes? Please comment on opportunities and /or barriers.

The responses to this question were very varied with the themes not as well established as some other questions

#### **Overall Comments**

The comments that applied to all nursing roles were; improved coordination between hospitals and the primary sector; the overall care delivery models need to be reviewed – not just nurses; strengthening roles across primary (practice and district nursing), family & child services with a broader approach; different service areas require a different mix of nurse practitioner, nurse specialist, registered nurse and nurse assistants; developing national frameworks for all health service personnel to work together; define roles in accordance with competencies and move advanced roles into primary sector.

The barriers to achieving the above were identified as matching the funding to the ideal; the current employment status of Practice Nurses to individual practices ; funding and contract limitations to the employment of independent nurse practitioners and any nurse led service; traditional silos and patch protection; funding (including education); recognition of the positive contribution that nurses make by other health professionals and the public.

The opportunities to support the achievement of the above included increasing flexibility within standardised boundaries; clear career pathway with consistent roles and titles, and targeted training.

#### **Registered Nurses**

For Registered Nurses (RNs) there were a mix of comments including that registered nurse generalist competencies allow for a wide scope which is essential for small and rural areas; the need to differentiate between RN's that work in mental health and generalist RNs; nurse specialists to work

across primary and secondary; the scopes are too restrictive; primary health nurses to complete mental health assessments; RN to include nurse specialist and nurse specialist required to have post-graduate education; Increase the number of Pacific Island specialist nurses; focus on generic core with nurse specialists; RNs with skills to support home based care and career pathway for nurses in primary care.

The only barrier identified in addition to those above was funding for home based care.

### **Nurse Practitioners (NP)**

The Nurse Practitioner scope of practice needs to be broad (is narrow and restricts breadth) across continuum and NPs to drive/lead primary health initiatives.

Barriers include the cost to employ NP; recognition by funders and employers; the time to go through the Nursing Council process to achieve NP status; the lack of collaborative support to develop role; the perceived conflict or usurping of traditional roles by NPs; reluctance of some doctors and some nurses to accept NP roles; and the commitment and time required for completion of education. It was also suggested that the Nursing and Midwifery Workforce Strategy Group consider the Nurse Practitioner Employment & Working Party report.

Opportunities were that the career pathway to NP is established and to increase the number of Maori NPs.

### **Second Level Nurses**

There was a reasonable level of comment about second level nurses including; increase the overall skill level through an increase in second level nurses and decrease in unqualified health carers; there is a need to map competencies through to RN; include second level worker (without nurse title); and expand the role to include mental health and primary care.

Barriers were identified as the narrow Enrolled Nurse (EN) scope of practice (extend scope); the EN title (second level nurses who trained since 2000, title changed to Nurse Assistant) more confusing for the public; second level nurses are at times employed inappropriately and work above scope of practice; that no continuity of competencies creates a barrier between DHB's; there are supervision requirements in primary care; and the perception that ENs do not have the required skills.

Opportunities include; adding more modules to nurse assistant training programmes; competencies for second level nurses in area of expertise, so skills and knowledge are acknowledged and more credentialing of specific skills for second level nurses.

**Question 5:** To what extent do present nursing scopes of practice support a flexible nursing workforce that will meet the needs of future models of care and sustainable health and disability services?

The majority of respondents that answered this question indicated that the present nursing scopes of practice do support a flexible nursing workforce. A lesser number disagreed, and a large number did not indicate agreement or disagreement.

There were some comments relating to the need for there to be greater definition of the scopes, and in particular that there is a big difference between the RN scope (which includes nurse specialists) and the Nurse Practitioner scope. It was also identified that there is a more limited scope for non-RCpN educated nurses, however many of these nurses have completed degree programmes which is not

recognized. This was perceived as a negative feature.

### Section 4.3: Nursing Workforce Profile

**Question 6:** What strategies should the sector adopt to promote a better match between the distribution of the nursing workforce and population/ service need?

The strategies described by the majority of respondents were; incentives to work in prioritised areas (service or geographical areas) and the need to consult with local communities; ensuring availability of good clinical placement (and local access to education) to attract people into nursing; initiatives to support nurses moving into primary care (greater awareness of chronic care models and population health); and pay parity between primary care and DHBs.

A lesser number of respondents mentioned; scholarships to cover the cost of nurse education; workforce planning (use of good data / understanding of why nurses move or leave areas); strengthening the nursing leadership role within DHB planning and funding teams / Primary Health Organisations (PHOs); reduce barriers such as parking problems / child care (family friendly policies); and flexible employment contract arrangements (cover for leave etc across the continuum).

One or two respondents mentioned initiatives such as; a national recruitment and education campaign; over-extend intake of nurses to increase supply; focus on staff benefits e.g. access to dentist; reduction in the number of DHBs; attract school leavers; tertiary education sector to link more closely with DHBs and service plans; greater sharing of service planning using epidemiological data across DHBs; improved job security; introduction of specialist roles where required; return to practice programmes; safe staff / client ratio; second level nurses and moving services out into the community e.g. district nurses to PHOs.

**Question 7:** With a predominantly 'Eurocentric' nursing workforce a present, what strategies should be implemented to increase the ethnic diversity of this workforce?

A large number of respondents mentioned mentoring both pre and post qualification (good role models & leadership development); financial support and promoting health as career that offers a wide range of work opportunities to encourage all ethnic groups.

A lesser number of respondents mentioned; appropriate consultation and engagement mechanisms with Maori, Pasifika and other ethnicities; Maori, Pasifika and Asian student's school achievement levels should be targeted and improved to enable them to succeed at university level (especially science); explore education environments that encourage diversity of ethnicities (Maori, Pacific Island programmes); provide an increased range of entry points into nursing, with well planned staircasing opportunities; ensuring appropriate support systems are in place; clarity of how the future of nursing will look and encourage students to consider this as a future career; flexible learning options (on-line learning facilities) and supporting the second tier role.

A small number of respondents mentioned; ensuring the work environment is culturally safe for people to work in, removing barriers to overseas trained nurses entering the workforce; opportunities for all nurses to have clinical placement with Maori health teams; that to promote diversity we may need to be more honest about the consequences/implications of cross cultural differences within teams; and strengthen the cultural workers workforce to work alongside nurses.

Both the Whiteria Pacific Nursing Programme and Maori Nursing programmes were mentioned as good example of initiatives already in place.

The Ministry of Health also commented that a report from Health Workforce Advisory Committee (to be released in September) is addressing issues for getting more Maori into the health workforce. Their report "Encouraging Maori to work in Health Professions" may well be useful in assisting to increase the ethnic diversity of the workforce, and that there are good strategies in the Maori and Pacific workforce development plans on the Ministry of Health website.

**Question 8:** Broad undergraduate preparation has implications for supporting transition to practice. What input should the health sector have in determining the competencies needed by new graduates?

An overwhelming majority stated that the health sector should have input into determining the competencies needed by new graduates.

Additional comments included; that the orientation of new graduates is the main issue; there are Advisory Groups in place and that there is also the need to meet the needs of the community.

It was also stated that competencies for practice have been determined by Nursing Council in consultation with the health sector within New Zealand and with due regard for overseas requirements, and that all education providers must consult with health providers regarding their curriculum to achieve Nursing Council accreditation.

Also to maintain credibility of nursing qualifications it is important that an autonomous professional body such as the Nursing Council presides over the process of determining what competencies are required.

**Question 9:** What creative approaches should the health sector be taking to recruitment and retention of nurses to ensure sufficient workforce numbers and mix as service demand increases?

### **Recruitment**

The single largest initiative is the marketing of health and nursing as a worthwhile career, with individual comments such as promotion of new roles i.e. primary sector and stair casing from health assistant roles to RN, and encouraging people with leadership qualities and academic achievements to consider nursing as a career choice;

### **Retention**

There were two approaches identified as the overwhelming themes. Firstly, the implementation of family friendly work environments and staff support systems e.g. Look at physical barriers, parking, facilities such as crèches, good employer health initiatives such as gyms, social clubs, health clinics onsite for

workers, better access and reduced rates. Secondly, workplace training opportunities e.g. funding, clinical educators.

The next largest group of initiatives included implementation and evaluation of quality frameworks that promote and value nursing e.g. Magnet principles; pay equity across roles and availability of superannuation; listen to staff through reviewing exit surveys; return to practice programmes; career pathways and recognition of prior learning and life experience and opportunities for sabbatical leave and rotation to other areas e.g. primary care.

Lesser numbers of respondents suggested education across disciplines to encourage team work and acknowledgment of role differences; more second level nurses; clarify and ensure appropriate use of roles – RN, Nurse Specialist, NP; support for new graduates; ensure that the role of nursing has a clear place within DHB's and PHO's at clinical and corporate levels, with authority to influence policy/ practice and to act as change managers/ leaders; involving nurses in policy development etc; ensure staff are able to work in areas of choice; for a more supportive role to be taken by Nursing Council, Education sector and DHB's so that nurses feel valued and therefore wish to stay in the profession; reduce bullying in the workplace; ensure suitable clinical equipment and resources are available; and joint appointments with tertiary providers should be considered to allow complimentary practice / theory to evolve into a "normal" environment.

#### **Section 4.5: Competency Maintenance and Career Development**

**Question 10:** What new strategies are needed to support transition to practice for nurses across service areas?

Clear themes were the need for recognition of transferable skills, good orientation programmes and mentoring and support to enable a successful transition.

Other comments included, better links between primary and secondary care (secondments); having an infrastructure in primary health care; valuing nursing across the sector - no one area is better and all areas work hard, hence address bullying; add in resiliency training, support strategies to incorporate fun in the workplace; leadership; clinical supervision; promotion of teamwork; promotion of the role of primary care nurses; flexibility in work environment and Nurse Specialists and Case Managers to coordinate care.

**Question 11:** What is the appropriate balance between the role of individual nurses and the health sector in supporting maintenance and development of professional competencies?

There is a clear understanding that there is a partnership between the individual nurse and the employer. Individuals are responsible for the maintenance and development of their skills, and the health sector should support with education opportunities and (financial) support.

**Question 12:** How should the health sector be involved in post entry nursing education?

The majority of respondents suggested through advisory committees or in collaboration with education providers and/or that DHBs (and PHOs) to have a role in identifying priority areas for workforce development.

A lesser number of respondents suggested that it is important to provide clinical experts to the nursing education facilities in a teaching capacity; to support nurses through post-entry education; through joint appointments and in partnership with education providers.

## **Section 5.0: Transition to the Future**

**Question 13:** Do you agree with the broad vision for the future nursing workforce outlined in the discussion document? Are there any gaps?

The majority of respondents agree with the broad vision outlined in the discussion document.

Gaps and/or changes were identified as more emphasis on primary care; greater focus on generalist nurses; more distinction between general and mental health nurses; greater integration of regulated and unregulated workforce groups at both strategic and practical levels; pandemic planning has identified a lack of nurses with infection control skills; lack of agreement with expansion of non-regulated health care workers; greater emphasis on hospital nurses, child health nursing, health of older people, mental health; more future focused; gaps for Maori; and too broad – needs more 'how'.

**Question 14:** Overall do you support the key development themes identified in Section 5.0 to assist the transition of the nursing workforce to meet future health sector needs? Which development themes should be assigned the highest priority? Are there further development themes that should be added?

The majority of respondents do support the key development themes in section 5.0.

The priority themes with the highest at the beginning are;

1. Leadership and leadership development
2. Primary health care
3. Recruitment and retention
4. Post graduate education
5. Workforce distribution/skill mix
6. Undergraduate nurse education
7. Integrated care (including teamwork)
8. Ethnic diversity
9. Workforce development planning and good data on workforce
10. Career pathways
11. Competency development and maintenance
12. Magnet hospital.

**Question 15:** What is the nursing workforce mix that the sector will need for sustainable nursing services in the future? What type of second tier workforce(s) will be needed to support registered nurses? What skill mix will be needed within the registered nurse workforce?

The majority of respondents stated that a mix of roles is required, and comment was made that this is dependent on the type and nature of the service.

Some respondents commented that the second level worker roles needed to be defined further and others that there should be a second level worker rather than health care assistant.

**Question 16:** The sector will not be able to address all aspects of nursing workforce development at once. Overall, do you support the action priorities recommended in the discussion document? Please add your comments.

The majority of respondents do support the action priorities in the documents.

The small number of additional comments included; add development of interdisciplinary skills, change management and chronic illness management, primary mental health and palliative care; the group needs to represent all specialties; and remove focus on Nurse Practitioners.

## APPENDIX THREE

### LIST OF SUBMISSIONS

<p><b>DHBs</b></p> <p>Auckland DHB  Auckland DHB  Auckland DHB  Bay of Plenty DHB  Canterbury DHB  Capital and Coast DHB  Counties-Manukau DHB  Counties-Manukau DHB  Hutt Valley DHB  Lakes DHB  Midcentral DHB  Nelson-Marlborough DHB  Northland DHB  Otago DHB  Otago DHB  South Canterbury DHB  Southland DHB  Taranaki DHB  THD and MH&amp;AS  Wairarapa DHB  Waitemata DHB  Waitemata DHB  Waitemata DHB</p>	<p>Judy Haslemore  Jackie Robinson  4 Anonymous submissions  Christine Payne  Mary Gordon and Nanette Ainge  Kaye Carncross  Keryn Irwin  Kathy Sangster  Michele Halford  Gary Lees  Sue Wood  Denise Hutchins  Pat Hartung  Anne Marshall  Serina Murphy  Alick Gellatly  Leanne Samuel  Kerry-Ann Adlam  Anne Prince and Dianne Irwin  Helen Pocknall  Brian McKenna  Sylvie Dombroski  Anna Daley</p>
<p><b>Education</b></p> <p>Community Support Services ITO  Department of Primary Health Care and General Practice Wellington School of Medicine  Massey University  Nurse Education in the Tertiary Sector  Western Institute of Technology at Taranaki  Western Institute of Technology at Taranaki  Whangarei NorthTec</p>	<p>Nicky Murray  Eileen McKinlay    Jann Fielden  Kathy Holloway  Deb Parry  Deb Parry et al  Kerene Strochnetter</p>
<p><b>Professional Bodies</b></p> <p>Auckland Occupational Health Nurses Association  College of Nurses  General Practice Nursing Alliance  NZ College of Mental Health Nurses  NZ Institute of Rural Health  NZNO  NZNO  NZNO – Womens Health Section</p>	<p>Janice Reigen  Phillipa Cole    Thelma Puckey  Kathy Shaw  Merilyn Beken  Robyn Hewitt</p>

NZNO – Critical Care Nurses Section NZ Public Service Association Nursing Council Hui Nursing Council of New Zealand Nurses for Children and Young People Aotearoa Royal NZ Plunkett Society	Alison Pirret Glenn Barclay Te Miringa Huriwai Marion Clark Denise Kivell Brenda Hynes
<b>Ministry of Health</b> MOH Pacific Nurses	Jenny Prentice Debra Tuifao Kathy Grace
<b>NGOs</b> Age Concern NZ CHMEDS Healthcare Aotearoa St Lukes Community Mental Health Centre Trinity Home and Hospital	Ann Martin Heather Gray Petra van den Munckhof Tom Woods Jill Baker
<b>Unknown Organisations / Individual Submissions</b>	Alice McLeod Anne Marsden 6 Anonymous Submissions

## **APPENDIX FOUR**

### **MAGNET PRINCIPLES**

#### Management and Administration principles of "Magnet" organisations

- Participation and supportive management style
- Well-prepared and qualified senior nurse leaders
- De-centralised organisational structure
- Adequate nursing staff
- Deployment of clinical specialists
- Clinical career opportunities

#### Principles for professional practice and professional development

- Professional practice models of delivery of care
- Professional autonomy and responsibility
- Availability of professional advice
- Emphasis on teaching responsibilities of staff
- Teamwork and collaborative relationships
- Planned orientation of staff
- Emphasis on in-service and continuing education
- Competency-based clinical pathways
- Management development

Magnet NZ website <http://www.moh.govt/moh.nsf/wpg>