HCHA Nursing Survey 2018 Report

Summary

The survey was undertaken over the first two weeks in August 2018, using Survey Gizmo. 22 providers responded – an 80% return. Based on HCHA's knowledge of 'market share', we think this represents 95% of service volume under HCSS and closely related community contracts (noting there may be other contracts engaging community nurses that are outside of this count). A list of the providers that participated is included in this report. Whilst providers were asked to provide FTE counts per DHB and services, they were given assurances that no provider would be specifically identified, and so data is aggregated.

The survey asked for an FTE count recognizing that community nurses are likely to work across contracts. Providers were asked to give best estimates of the FTE pertaining to specific services. There was some variation in the recoding of casuals, which was not asked for in the survey questions. A number of nurses are employed on a casual basis – similar to the broader health sector. This may distort the FTE numbers, but not to a significant extent. A few providers were not able to separate FTE into different funder categories, but this was not significant.

The survey asked providers to comment on whether they had increased or reduced the number of employed nurses over the last three years. This was asked based on the sector perception of increased complexity/need, and sustainability pressure. More followup is needed to establish the reasons for increases and decreases. The survey also asked about nursing workforce challenges and general comments.

Salary levels were not counted because on initial inquiry there was not enough clarity on salary ranges in 'grades' to be able to gather accurate information at short notice.

Results

Numbers and distribution

The total FTE count of nurses reported by respondents is 794 (Registered Nurses 683, Enrolled Nurses 96, Casuals 16). 644 of the counted nurses (FTE) are employed in DHB HCSS Services. Of those 128 are District Nurses employed by HCSS providers holding District Nursing contracts. There are 139 FTEs undertaking ACC nursing and 11 FTEs in MoH DSS services.

We asked a separate question on total numbers of nursing staff employed, but this was not answered by all providers, possibly because they had already answered it in the first question.

The distribution per provider across DHBs and providers is too broad to make any assumptions around averaging or service model.

Employment trends

We asked for providers to comment on whether they had increased or decreased the number of nurses they employed over the last three years. This was answered by 21 providers. 47.3% said they had increased the number of nurses they employed. 38% were much the same and 14.3% had reduced the number of nurses employed (by provider, not weighted).

COUNTING THE NURSES

Service	FTE Count	FTE RN	FTE EN	FTE Cas
Total HOP HCSS Nurses	487	415	72	1
District Nurses	128	109	19	
MoH DSS	11	9	2	
ACC General HCSS services	38	37	0.5	
ACC Nursing	102	102	0	
Multi Casual RN (not FTE)	15	0	0	15
Support worker co-ordinator	4	2	2	
Clinical Management	9	8	0	
	794	**682**	**96**	**16**

Total number RN (FTE)	682
Total Number Ens (FTE)	96
Casuals (RNs) not FTE	16
Total	**794**

DHB nurses and others (FTEs)

HCSS HOP Nurses	487	
Casuals (across services)	15	
Support worker coordinator	4	
Clinical management	9	
District Nurses	128	**644**
ACC Community Nursing and ACC HCSS Nursing related	139	
Ministry of Health DSS	11	
	794	

Notes:
HOP HCSS nurses include care coordination staff.
40 of the District Nurses were identified as casual (36 RN, 4 EN). They are included in the District Nursing count rather than in the Casual (across services count)

Main Challenges with the community nursing workforce

We have summarized the top challenges reported by respondents under recruitment and retention and quality issues. All of the comments are provided at the end of the report:

1. **Recruitment and retention due to:**
    - Inability to compete with DHB pay rates (this was the most frequently reported problem)
    - Pay equity now bringing enrolled nurses under top SW rate.
    - Geographical isolation, ability to travel daily, finding Maori nurses
    - More complex client needs
    - Fragmented sector and manual processes
    - Immigration challenges and barriers; international workforce shortages
    - Ageing workforce (leaving, reducing hours)

2. **Quality Issues**
    - Institutionalisation of recruits, loss of critical thinking from working in hospital settings
    - Staff enjoy their roles and stay for the duration of their career making it difficult to employ new people into the sector. Also means experienced staff paid on high wage, which is costly and not recognized by funder.
    - Level of expertise required for specialised services and these not always being available. (e.g. Complex Burns)
    - Most health professionals have had very little exposure to this sector. This means: - limited perception around the proficiency a health professional needs for their role due (wide client scope) - longer learning curve as they become familiar with their role.
    - Many nurses straddle more than one contract requiring them to understand different funder service specifications again lengthens their learning curve.
    - Maintaining and improving clinical skills
    - Lack of sector specific and appropriate in-service training programs

3. **Other comments**

    Providers were invited to make other comments about nursing workforce. The key theme was funding including the impact of pay equity and DHB nurse pay settlements. There was also a strong theme of a lack of health sector appreciation of the role undertaken by community nurses, and repetition of comments on insufficient structured training or professional development opportunities.

    - Access to the DHB Clinical Professional Development is much appreciated.
    - Clients more complex with physical and intellectual needs – more professional development needed.
    - Nursing needing to become more aligned to primary care
    - Community nursing requires a broad range of skills

- RNs are very passionate about HCSS but looking for opportunities in the DHB/Hospital – higher salaries.
- Nurses have very high client nurse ratio, huge responsibility = needs more recognition.
- Nurses view use of company vehicle as requirement of the job and don't equate the financial benefit to their earnings.
- Retention would be improved if nurses were able to fully work within their scope in the community. If they are restricted due to contracts or service specifications which then do not pay accordingly for that skill, then they need to do part time or volunteer elsewhere so they maintain competency for licensing.
- Highly valuable workforce, and nurses who work in the community require a specific skill set and competencies, that don't appear to be acknowledged across the sector, nor the differences to hospital nurses don't appear to be well understood.
- Homecare nursing is a very specialised practice requiring proficient nurses who can juggle a comprehensive spread of client groups. This requires a nurse to be a "generalist expert". The day in the life of our nurses is varied from ensuring the right services are set up and continue to meet the needs of a client (case management), through to ensuring support workers have the right skills and undertaking client risk investigations. All of this is undertaken in a person's home or community within a multi-disciplinary team which adds further complexity… Our nurses undertake case management to support NASC assessors. The contribution this group makes to community health services is often hidden and so under-estimated/undervalued.
- Some clients are becoming increasingly complex, with combinations of physical and mental health issues and sometimes substance abuse as well, which requires appropriate in-service training for nursing staff (and support workers).
- Pay equity legislation for support workers means that in less than a year they will be on pay rates very close to those of the nurse coordinators

---

Further research needed on this workforce

The comments made in by respondents point to a need for further structured research and data gathering, on matters such as:

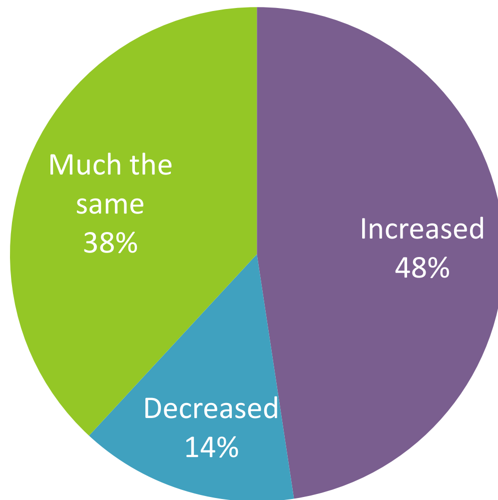
- Salary ranges and salary caps, other benefits
- Nurse to client and nurse to CSW ratio
- The breadth of work undertaken by nurses
- The types of roles undertaken in community services
- The level of accountability and direction in the role/s
- Professional development and access to peer support
- Age, gender, ethnicity
- Adequacy of training programmes
- The nature of the work – flexible, self-directed, responsive, dynamic
- The costs of employing and upskilling nurses
- Numbers of allied and other professional staff employed in home support

Nursing Survey 2018: Data

Participant providers

Disabilities Resource Centre Trust
Lifewise
Te Korowai Hauora o Hauraki
The Florence Nightingale Agency (Marlborough) Ltd
Royal District Nursing Service New Zealand (RDNS NZ)
Te Kohao Health
Presbyterian Support South Canterbury
Geneva Healthcare
Presbyterian Support East Coast
Home Support North Charitable Trust
Nurse Maude Association
Healthvision (NZ) Ltd
Counties Manukau Homecare Trust
Lavender Blue Nursing and Home Care Agency Ltd
Waiheke Health Trust
Drake New Zealand
Access Community Health
Healthcare NZ
Whaiora
Presbyterian Support Northern
Healthcare of NZ
Visionwest

3.Have you increased or decreased the number of registered/enrolled nurses you employ over the past three years under government funded contracts?



Value	Percent	Count
Increased	47.6%	10
Decreased	14.3%	3
Much the same	38.1%	8
	Totals	21

NURSING SURVEY, COMMENTS

What are the main challenges in regards to your nursing workforce? eg recruitment, retention, quality, aging, or something else?

Recruitment and geographical location. We struggle to compete financially and to encourage Nurses to work in a Community Organisation.
Recruitment. Age
Recruitment
aging workforce, more complex needs
Keeping their clinical skills up to date with current practice. To date our retention has been good. We have 1 specific ACC Client who requires 24/7 RN care and in relation to this client - retention has been an issue.
Recruitment, retention, qualifications, Maori nurses (preference to)
No challenges. We don't have any problems recruiting or retaining and quality and age is fine.
Finding experienced RN's in the sector, ability to travel daily. We have also found the fragmented sector and manual processes to be quite difficult to manage in the community - difficult to retain staff. However lately we have found salaries to be a drawback as HCSS are not able to meet the expectations and is not aligned with DHB salaries. A lot of nurses are also "institutionalized" and not able to work independently and autonomously without the direct oversight of Ward Senior. Almost like they lost their ability to do critical thinking without direct oversight.
Recruitment - finding nurses with the relevant experience. The pay discrepancy between DHB and the sector is a challenge.
retention - being paid for their qualification. this needs to be higher than the current Level 4 pay Equity rates a SW receives. A SW who has LoS rate ($24.50) and NO Qual should jot be receiving more than a RN or EN who has competently achieved their license over 18mths or 3 years
overall we do not have issues with recruitment or retention. The reason for leaving are usually moving our of area or career progression
We have an aging workforce. Staff tend to enjoy their roles and stay for the duration of their career making it difficult to employ new people into the sector. This also means that we have very experienced staff providing a quality service but paid on a high wage which is costly for the organisation and not recognised by the funder.
Recruitment is a key challenge: Immigration challenges and barriers; international workforce shortages; level of expertise required for specialised services and these not always being available. It can take up to 2 years to find the right specialist nurse for specific territories. (e.g. for Complex Burns) The new nursing contract will create an interestng change, and may create salary pressures. Pay Equity: This has created disparity between ENs and L4 carers (L4 carers are paid more than ENs). From

a competency standpoint, this could be considered inappropriateThe new nurse contract negotiation will create further wage pressure for Homecare.
Recruitment and Retention. These RN are employed as Service Coordinators but need to be competitively paid as per a RN.
Remote and Isolated location/s Recruitment - aging workforce Casualisation Pay Equity
Recruitment
Recruitment and retention. Most health professionals have had very little exposure to this sector. This means: - limited perception around the proficiency a health professional needs for their role due (wide client scope) - longer learning curve as they become familiar with their role. - many of our nurses straddle more than one contract requiring them to understand different funder service specifications again lengthens their learning curve. Aging will become an issue in the immediate future as our present workforce retire. High client numbers due to funding restraints.
Aging workforce (average age 60), Lack of government funding means pay rates not competitive so difficult to recruit younger nurses, Lack of sector specific and appropriate in-service training programs
Recruitment and retention Staff in district nursing align more closely to their colleagues in primary and secondary care. Our staff are signalling they are looking for parity with these colleagues. Skill mix is going to be an issue as the present workforce resigns through retirement.
Recruitment, retention and PDRP support
We know that the average age of our nursing workforce is 57 and we have a low number of Maori and male nurses. Nurses need to have a thorough understanding of direction and delegation so they are able to utilise the unregulated workforce as effectively as possible. Nurses in the HCSS need to be able to work autonomously while developing a team approach with the unregulated workforce.

Do you have any other comments regarding your nursing workforce?

We do get access to the DHB Clinical Professional Development for our Nurses and we really appreciate this greatly.
Enrolled nurses are becoming less desirable to hire in view of the changes to the medication guidelines, and inability to do HC assessment sign off.
The clients are becoming more and more complex with physical and intellectual needs; requiring more professional development.
Community nursing requires a broad range of skills that can support other contracts and departments within the organisation.
No other comments regarding the Nurses.

There has been a trend lately where we have struggled to recruit due to: either new grads(no experienced) or too experienced and very institutionalized with no understanding of HCSS. Large number of our RN's are very passionate about HCSS but are looking for opportunities within DHB/hospital where they will most likely be offered higher salaries resulting in a great loss of knowledge and experience in HCSS. They have very high number of client/nurse ratio and a lot of responsibility to ensure clients remain safe in their homes which needs more recognition.
Currently the partial use of a company vehicle is a debatable issue. Nurses view this as a requirement of the job and do not equate the financial benefit to their earnings. Overall we have a great team of nurses but we do face losing them as a result of the wage disparity between sectors.
They could be retained if they were able to fully work within their scope in the community. If they are restricted due to contracts or service specifications which then do not pay accordingly for that skill, then they need to do part time or volunteer elsewhere so they maintain competency for licensing
This is a highly valuable workforce, and nurses who work in the community require a specific skill set and competencies, that don't appear to be acknowledged across the sector, nor the differences between hospital nurses don't appear to be well understood. I would recommend that workforce segmentation occurs in a more granlular way. Equally, the DHB nurses may also perform ACC nursing, so there may need to be caution about double counting. Thanks for the initiative!
No, thank you for this initiative
Homecare nursing is a very specialised practice requiring proficient nurses who can juggle a comprehensive spread of client groups. This requires a nurse to be a "generalist expert". The day in the life of our nurses is varied from ensuring the right services are set up and continue to meet the needs of a client (case management), through to ensuring support workers have the right skills and undertaking client risk investigations. All of this is undertaken in a person's home or community within a multi-disciplinary team which adds further complexity. The efforts of this group helps ensure that clients can be discharged early from hospital, avoids unnecessary hospital and residential care admissions, supports general practice, pharmacy, hospices and allied health professionals. Our nurses undertake case management to support NASC assessors. The contribution this group makes to community health services is often hidden and so under-estimated/undervalued.
Some clients are becoming increasingly complex, with combinations of physical and mental health issues and sometimes substance abuse as well, which requires appropriate in-service training for nursing staff (and support workers). Pay equity legislation for support workers means that in less than a year they will be on pay rates very close to those of the nurse coordinators.
In our organisation we are undergoing a restructure which shall elevate the role of nurses. Nurses orientation is reinforcing that they are part of the Primary Care sector and need to have a close relationship with primary care services