Workforce Report 2023

Results from the 2023 workforce survey of Nurses and Practice Centre Assistants (PCA)

October 2023

Pinnacle Midlands Health Network (MHN) senior project manager
Veronique Gibbons PhD, RN

Part D:
NURSING and PCA

Foreword

Kia ora koutou katoa,

I am pleased to introduce this document to our dedicated nursing workforce within Pinnacle Midlands Health Network. As we navigate the evolving landscape of healthcare, it is of utmost importance to pause, reflect, and listen to the voices that form the very foundation of our network. This document is a testament to this commitment.

In the document, you will find a comprehensive summary of the responses from our recent workforce survey, a powerful expression of the hopes, challenges and aspirations of our nurses and practice centre assistants. Your voices have spoken loudly and clearly, and we are here to listen, to understand, and to act upon your collective wisdom.

The resounding message that echoes throughout is that feeling valued is not just a desire; it is a fundamental need for our nursing workforce. You have emphasised that pay parity is of prime importance, and we hear your desire for us to advocate strongly for that.

The theme of feeling valued also relates to your work in primary care. Your dedication during the challenging times of the COVID-19 pandemic has not gone unnoticed. Your sacrifices have been immeasurable, and we extend our heartfelt acknowledgment and gratitude.

Your calls for proper resourcing and access to training reflect your commitment to delivering exceptional patient care, and we acknowledge the unmet need in these areas. We also take to heart your voices calling for a reduction in administrative work, as we recognise that wish for your primary focus to be on the wellbeing of patients and whānau.

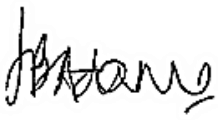
Staff retention is paramount, and we understand that it is intrinsically linked to improving work conditions. Your responses have underscored the importance of gaining a better understanding of funding arrangements, and we are committed to providing information and education to provide further clarity in this regard.

Better communication has been identified as a pivotal area for improvement, and we are fully committed to enhancing our communication channels and practices. As a professional group, you have highlighted the need for more resources to enhance patient care and promote patient self-care, and we are dedicated to exploring ways that, as a network, we can contribute towards collectively meeting this need.

We are in the process of developing a comprehensive workplan that will be directly informed by your feedback and voices from the survey. Your professionalism, specialist knowledge, experience and vision are the driving force behind our nursing strategy and how we strive to deliver exceptional clinical leadership, excellence in primary care nursing, and learning and development opportunities. We will lead new initiatives, undertake research, and contribute to the body of knowledge in the health care sector, all while keeping your needs and aspirations at the forefront of our endeavours.

I extend my deepest gratitude to each and every one of you for your contributions that inform future direction for nursing and PCAs within the network.

Ngā mihi nui,



Jan Adams,
General Manager Midlands Health Network / Nursing Director
Pinnacle Midlands Health Network

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PRACTICE NURSING

SECTION D1: Demographic characteristics

The 2023 workforce survey was sent to all nurses who work for general practices that are members of the Midlands Health Network (MHN) PHO (the 'network') as well as nurses employed by Midlands Health Network who are in clinical (client/patient-facing) roles. For this practice nursing section, data were filtered by those who identified as a 'registered nurse' (one of three choices from the NZ Nursing Council register) and whose workplace was described as 'general practice'. Due to small numbers, urgent care practices and Iwi Māori providers are included in this section.

197 nurses met our criteria for 'practice nurse' (PN) out of the 246 responses received. The following is based on these nurses, although there are times where not all questions were answered. As much as possible, but in keeping with data privacy, raw numbers will be shown where it provides context to the results.

Location of practice (rural/urban)

The location of the practice, defined as 'Rural' and 'Urban', where the 197 PNs in the network work, is shown in Table B1. A practice is categorised as rural based on the rural ranking scale of the GP(s) working in the practice.

Analysis in this section is based on data from 193 survey respondents who provided the name of their workplace which allowed for attribution of the location of practice into urban or rural categories.

Table 1: PNs working in rural and urban practice locations by region

Region	Rural	Urban	Total
Lakes	4	15	19
Tairāwhiti	1	13	14
Taranaki	20	37	57
Waikato	43	60	103
Network (May 2023)	**68** 35%	**125** 65%	**193**
Network (May 2009)	36%	64%	
Network (Aug 2006)	37%	63%	
Enrolled population, May 2023	31%	69%	

Nursing provision in rural general practice remains at roughly one-third of the total nursing workforce in the network.

Key Findings (Table 1):

- Categorised based on the rural ranking scale for GP practices, a little over one-third (35%) of PNs across the network work in rural locations and this proportion is similar to that found during previous surveys completed in 2006 and 2009.
- Approximately 31% of the enrolled population across the network live in areas categorised as rural; in comparison, a slightly higher proportion (35%) of the network PNs works rurally.
- Access to health services is a barrier for rural populations, including factors such as socioeconomic deprivation, geographical barriers and distance, transport, telecommunications, the cost of accessing services, and service acceptability[1], along with previous devolution of some hospital-based services to the community setting. This is where PNs play an important role in the solution.

Gender

Table 2 below gives the gender distribution of PNs in each of the regions and in the network. Analysis in this section is based on data from 196 respondents who answered this question. The gender of one PN was not provided. Comparisons have been made with the network PN workforce in 2006 and 2009, as well as two of the most recent articles looking at the PN workforce in New Zealand[2] and Australia[3].

Table 2: Gender of nurses in practice by region

Region	Female	Male	Total
Lakes	19	0	19
Tairāwhiti	15	0	15
Taranaki	58	0	58
Waikato	102	2	104
Network (May 2023)	**194** 99.0%	**2** 1%	**196**
Network (May 2009)	99.2%	0.8%	

[1] National Health Committee (2010) Rural Health. Challenges of Distance, Opportunities for Innovation https://www.moh.govt.nz/notebook/nbbooks.nsf/0/a06b332fa631554bcc2576c00008ce96/$FILE/rural-health-challenges-opportunities.pdf

[2] Hewitt S et al (2021) Understanding the general practice nursing workforce in New Zealand: an overview of characteristics 2015–2019. AJPH, 2021, 27, 22–29

[3] Heywood T and Laurence C (2018) An overview of the general practice nurse workforce in Australia, 2012–2015. AJPH, 2018, 24, 227–232.

Network (Aug 2006)	99.7%	0.3%	
NZ APPN workforce (2019)	98.2%	1.8%	
Australian National PN workforce (2015)	96.8%	3.2%	

Key Findings (Table 2):

- The PN workforce in the network is predominantly female. Two PNs who responded to the survey identified as being male.
- There is a slightly lower proportion of male PNs in the network compared to the NZ and Australian national PN workforce.
- The network results for male practice nurses are lower than the NZ APPN workforce identified through the study of NZ Nursing Council data[4].

The proportion of nurses who will reach retirement age in the next 10 years or are already at retirement age has increased by 38% since 2009.

Age distribution

The months and years of birth of PNs were collected through the survey and the ages were calculated as a midpoint of 1 June 2023 which were grouped into functional age bands. Analysis in this section is based on data from 190 respondents who answered this question. The ages of seven PNs were not provided.

Figure 1 shows the age distribution and average age of the network PN workforce in 2023 (solid bars) compared with the 2009 workforce survey (dotted line) to see how the age profile has changed during this time.

Some comparisons have been made in the key findings with the NZ and Australian national PN workforces.

Please refer to Appendix Figure 1 for the average age of PNs in each region and by urban and rural location across the network.

[4] APPN—nurses who nominated their area of practice on the NZ Nursing Council register as 'practice nursing' in Hewitt, 2021.

Figure 1: Age distribution and average age of nurses in practice, 2009 and 2023

Key Findings (Figure 1 and Appendix Figure 1):

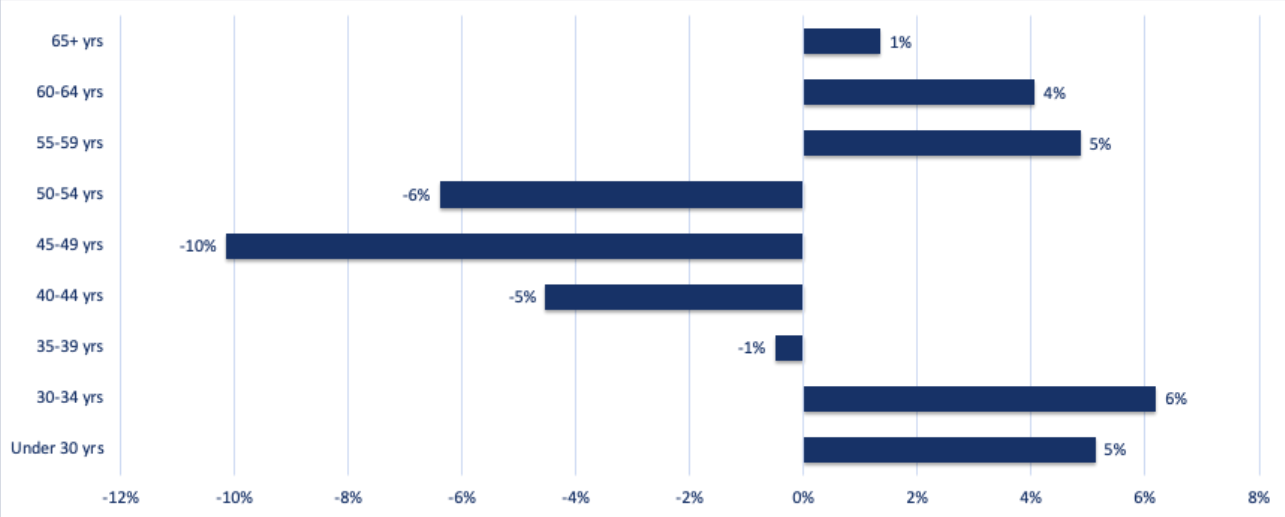
- The average age of PNs across the network is closer to 47 years and has gone down slightly from the average age of nearly 48 years found in 2009. From the bell curve shown by the 2009 age distribution there is the expected numerical ageing of PNs aged 45–54 years up to the 55–64-year age bracket, however this increasing trend for PNs aged 30–45 years into the 40–54-year age brackets have not continued in the same way.
- The age profile of the PN workforce in 2023 is getting younger, with nearly 22% of PNs aged less than 35 years compared to 10% of PNs in 2009 (a 120% increase). At the other end, the proportion of PNs in the 55+ age brackets have increased by 38% from nearly 26% in 2009 to 36% in 2023.
- The average age of PNs varies slightly across the regions, ranging from 43.6 years in Lakes to 49.2 years in Taranaki.
- Comparison with NZ APPN workforce (2019): About 13% of the NZ APPN workforce is aged less than 35 years, compared to 22% for our network. Nurses over 55 years were 46% of the APPN cohort; higher than our network of 36% in this age group. In the 65+ ages, the NZ APPN workforce was 12% compared with our 5%.
- Comparison with Australian PN workforce (at 2015): About 21% of the Australian PN workforce is aged less than 35 years, similar to that found in our network. However, our network has a higher proportion of nurses in older age groups: 36% aged 55 years or more compared to 29% in the Australian PN workforce, and of these, we have 5% of PNs aged 65 years or more compared to 4% in the Australian PN workforce.

Comparison with the network GP workforce

- The average age of PNs (47.3 years) is slightly lower than the GP network workforce; 49.4 years for all GPs, however, it is slightly higher when compared with the average age of female GPs (46.5 years) in the network.

Figure 2 shows the percentage change in the proportion of PNs in each age group across the network. There has been a reduction in PN numbers between 35–54 years of age. This is unlikely a result of structural ageing. With the time between surveys, it is difficult to surmise when this change may have started, whether this is a more recent phenomenon as a result of COVID-19 or if it is merely a result of non-response bias. This is unable to be answered by this survey.

Figure 2: Percentage change in the proportion of PNs in each age group across the network, 2009–2023



'Baby boomers, retiring over the last decade, are being replaced with younger, successively smaller cohorts, creating a vacuum [in the 40–55-year groups] in an already tight labour market'.

Key Findings (Figure 2):

- The age distribution of the network PNs has changed since 2009. There has been an increase in the proportion of PNs less than 35 years of age, but this is significantly offset by the large decrease in the proportion of PNs from 35–54 years of age.
- There have been increases in the proportion of PNs in the three older age groups and this may be a natural projection from the large number of PNs who were aged 40–49 years in 2009.
- It is possible that this reduction through the middle is what is referred to as an hour-glass structure, which may be a symptom of baby boomers who started retiring over the last decade replaced by cohorts in the 20–29 age group, thus leaving a gap as the cohorts move north in the age structure,

'creating a vacuum that will reinforce an already demographically tight labour market', with baby boomers replaced by a successively smaller cohort (Jackson, 2011[5]).

Figure 3 shows the age distribution by location of practice (urban/rural) in the network and compares this to the age distribution from the workforce survey done in May 2009. Please refer to Appendix Figure 1 for the average age of the PNs by location of practice.

Figure 3: Comparison of PNs by practice location in the network, 2009 and 2023

Key Findings (Figure 3 and Appendix Figure 1):

- The age profile of urban and rural workforces has changed since 2009 with more significant ageing seen amongst the urban PN workforce.
- In 2009, nearly 70% of the rural PN workforce was aged less than 55 years which has reduced to 66% in 2023.
- This is more marked in the proportion of the urban PN workforce aged less than 55 years, which has reduced from 77% in 2009 to 63% in 2023.
- The average age of urban PNs (47.3 years) is similar to that for rural PNs (average age: 47.4 years).

[5] Jackson N (2011) The demographic forces shaping New Zealand's future. What population ageing [really] means. NIDEA working papers. https://www.waikato.ac.nz/__data/assets/pdf_file/0011/94619/2011-Demog-Forces-Revised2.pdf

- About 22% of the urban PN workforce is aged less than 35 years compared with 20% amongst rural PNs.

Ethnicity

PNs were asked for all ethnic groups they identified with. We used an approach called 'prioritised ethnicity'. 'Prioritised ethnicity' means that we allocated people to a single ethnic group in an order of priority, even if they identified with more than one ethnicity. For example, if someone identified as Māori and Tongan, they were reported as Māori only. This method is used by all government departments and health entities for ethnicity data analysis. In addition, nurses identified with an Iwi or rohe were invited to provide this information. These have been listed.

Table 3 shows the ethnic group of the network PNs categorised as Māori, Pacific and 'Other'. Analysis in this section is based on data from 196 respondents. The ethnic identity of one respondent was not provided.

Table 3: Ethnic priority groups by PNs by region

Region	Māori	Pacific	Other
Lakes	4	3	12
Tairāwhiti	6	1	8
Taranaki	5	0	52
Waikato	11	2	91
Network (May 2023)	**26** 13.3%	**6** 3.1%	**164** 83.6%
Network (May 2009)	4%	1%	95%
Network (Aug 2006)	4%	0%	96%
NZ APPN workforce (2019)	7.3%	4.5%	88.2%
Network enrolled, Q2 2023	32.5%	2.1%	65.4%
NZ Population, Census 2022 (est.)	17%	7%	76%

The increase in the number of nurses identifying as Māori/Pasifika may be reflective of the increase in the number of these students in nursing programmes.

Over our rohe/districts we have several PNs who whakapapa and affiliate to many Iwi and hapū across the motu. It is excellent to see that many of our practice nurses can identify where they are from and their

Tūrangawaewae; their place of standing. Understanding their connections is important when it comes to building relationships with whānau, Iwi and hapū. Our practice nurses should feel proud of their whakapapa and who they are. Our PNs whakapapa to the following Iwi and hapū:

Kāti Māmoe, Ngā Rauru, Ngāi Taamanuhiri, Ngāi Tahu/Kāi Tahu, Ngāpuhi, Ngaruahinerangi, Ngāti Awa, Ngāti Huri, Ngāti Kahungunu, Ngāti Maniapoto, Ngāti Oneone, Ngāti Porou, Ngāti Raukawa ki te Tonga (Ōtaki), Ngāti Ruahine, Ngāti Ruanui, Ngāti Whātua, Rangatāne, Rongowhakaata, Tainui, Te Aitanga-a-Hauiti, Te Aitanga-a-Mate, Te Atiawa, Te Rarawa (Kaitaia), Te Tai Raawhiti, Te Tai Tokerau, and Te Whānau a Hinerupe.

Key Findings (Table 3):

- The ethnicity of PNs in the workforce has changed since 2009. There is a three-fold increase in both Māori and Pacific practice nurse numbers with their proportion going up from 4% and 1% in 2009 to 13.3% and 3.1% in 2023, respectively. The majority of PNs remain non-Māori and non-Pacific at 83.6%, down from 95% in 2009.
- Māori and Pacific are greatly underrepresented in the network PN workforce compared not only to the NZ population (25.5%), but also to the network population, where Māori and Pacific peoples make up 34.6% of the enrolled population.
- Our PN workforce identifying as Māori (13.3%) is nearly twice that of the NZ APPN workforce (7.3%) identified on the NZ Nursing Council database.

Comparison with the network GP workforce

- Although Māori and Pacific peoples are under-represented in the PN workforce, their numbers are higher than those found in the GP workforce (32 PNs reported their ethnic group as Māori/Pacific compared to approximately 15 GPs). The proportions are also higher in the PN workforce: 16.4% to <5%.

Years since registration

The average time since first nursing registration for PNs was 21 years (median 19 years). Nearly 60% of PNs (117/196) were first registered greater than 16 years ago.

Table 4: Years since first nursing registration

	<4 years	4–7 years	8–11 years	12–15 years	16+ years
Count of PNs	14	25	26	14	117
Percentage	7.1%	12.8%	13.3%	7.1%	59.7%

Place of initial nursing qualifications

Practice nurses who received their initial nursing qualifications in New Zealand are referred to as 'NZ-trained' while those who obtained these qualifications from countries other than NZ are referred to as 'Internationally qualified' (International).

An internationally qualified nurse is defined as a nurse who completed the qualification that led to them joining the New Zealand Register of Nurses anywhere other than Aotearoa NZ.

Analysis in this section is based on data from 196 PNs.

Table 5: Number of NZ and internationally qualified nurses in each region and by practice location

Region	NZ-trained	International	Total
Lakes	16	3	19
Tairāwhiti	15	0	15
Taranaki	55	3	58
Waikato	98	6	104
Network (May 2023)	**184** 93.9%	**12** 6.1%	**196**
Network (May 2009)	92%	8%	
NZ APPN workforce (2019)	84.8%	15.2%	
Rural PNs (May 2023)	91.2%	8.8%	
Rural PNs (May 2009)	91%	9%	
Urban PNs (May 2023)	96.8%	3.2%	
Urban PNs (May 2009)	93%	7%	
NZ population, Census 2018 born overseas		27.4%	

The percentage of NZ-trained PNs in our network has increased since 2009. In urban practices there has been a 4% increase in NZ-trained PNs while the proportion in rural practices have remained steady.

Key Findings (Table 5):

- The PN workforce across the network is predominantly New Zealand-trained with 1 in 16 PNs having been trained internationally. This has reduced from 1 in 10 PNs in 2009.
- The majority of the 12 internationally qualified PNs who responded to the survey obtained their initial nursing qualifications in the UK or Ireland (1 in 3 of internationally qualified PNs) followed by Australia (1 in 6).
- There is little change in the proportion of rural PN workforce for NZ and internationally qualified nurses between 2023 and 2009, however, the urban PN workforce has seen a drop from 7% in 2009 to 3.2% on internationally qualified nurses in 2023. Four PNs did not provide their workplace, therefore urban/rural could not be attributed nor counted. With small numbers of internationally qualified respondents this can have a larger effect on percentage change than is true (non-response bias).
- In relation to the NZ Census 2018 population, PN numbers are not reflective of the percent of the population who identify with being born overseas.

Comparison with the network GP workforce

- While the PN workforce is mainly dependent on nurses trained in NZ, the opposite holds true for the GP workforce with the majority (51%) trained overseas.

SECTION D2: Current work situation

Years working in primary health care

PNs identified how long they had been working outside of secondary care, which was used as a proxy for working in primary health care, including general practice.

This question has not been asked in previous surveys. The analysis is based on data from 196 PNs by region and 193 PNs by location of practice.

Figure 4: Years working in primary health care

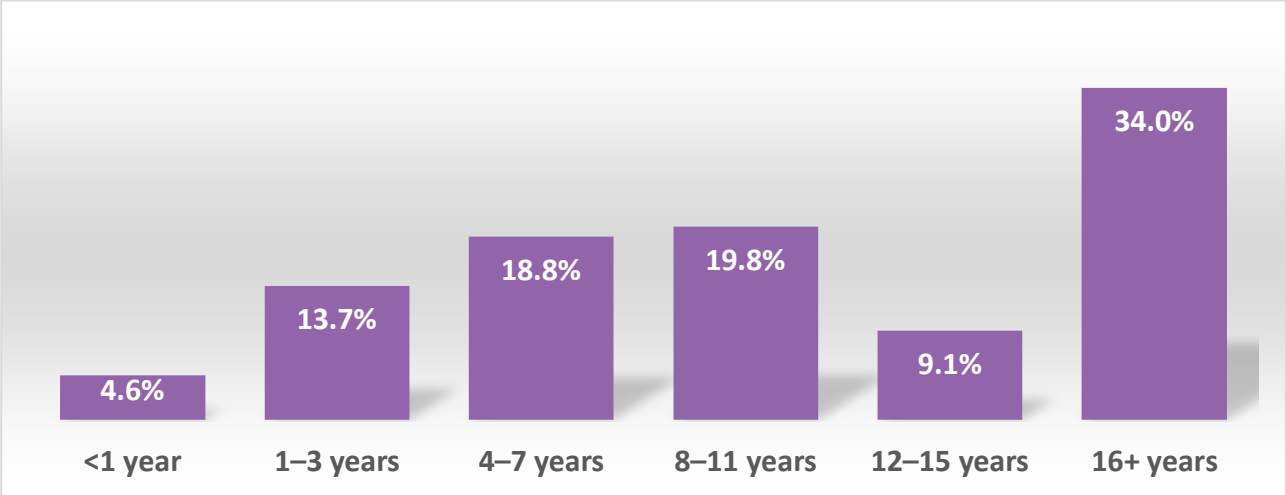


Table 6: Years working in primary health care by region and practice location

Region	<1 year	1–3 years	4–7 years	8–11 years	12–15 years	16+ years	Total	Av. in primary care (in yrs)
Lakes	3	2	7	3	1	3	19	8.4
Tairāwhiti	1	1	3	4	1	5	15	12.7
Taranaki	2	5	10	11	7	23	58	14.7
Waikato	3	19	17	21	8	36	104	12.3
Network (May 2023)	**9** 4.6%	**27** 13.8%	**37** 18.9%	**39** 19.9%	**17** 8.7%	**67** 34.2%	**196**	**12.6**
Rural	4.41%	20.59%	13.24%	26.47%	8.82%	26.47%		11.6
Urban	4.00%	10.40%	22.40%	16.00%	8.80%	38.40%		13.3

Key Findings (Figure 4 and Table 6):

- In the network, PN workforce has a lot of experience with over one-third having worked in primary health care for longer than 16 years. The time in primary health care ranged from very new to nearly all their nursing career.
- The rural experience shows nearly 1 in 4 PNs working in rural locations have worked in primary health care for less than 5 years, compared with 1 in 5 PNs working in urban locations. Conversely, over 2 in 5 nurses in urban practices have worked in primary health care for greater than 16 years compared with just over 1 in 4 nurses in rural practices. The average length of experience in primary care is less in rural locations than urban locations, however, both are greater than 10 years of experience.
- Taranaki region has the longest average length of years working in primary care (14.7%) compared with Lakes at 8.4%. The network average is 12.6% and this is similar to that found in Tairāwhiti and Waikato.

Length of stay in current practice

Practice nurses were asked the start date in their current practice. The length of stay presented in years, calculated as of 1 June 2023, gives an indication of the degree of turnover of nurses in general practice.

The analysis in this section is based on data from 189 PNs by region and 186 PNs by location of practice. The month and year of starting in their most recent practice is unknown for 8 PNs who elected not to answer this question.

Table 6 shows the length of stay in current practice (in years) for PNs in the network categorised by region and location of practice (rural and urban).

Table 7: Length of stay in current practice by region and practice location

Region	<1 year	1–3 years	4–7 years	8–11 years	12–15 years	16+ years	Total	Av. length of stay (in yrs)
Lakes	1	10	6		1	1	19	5.2
Tairāwhiti	1	5	1	5		3	15	10.3
Taranaki	3	18	15	5	7	8	56	8.4
Waikato	4	43	20	14	5	13	99	7.1
Network (May 2023)	**9** 4.8%	**76** 40.2%	**42** 22.2%	**24** 12.7%	**13** 6.9%	**25** 13.2%	**189**	**7.5**
Network (May 2009)	15.4%	26.6%	26.3%	12.9%	7.4%	11.4%		7.0
Rural (May 2023)	3.0%	43.9%	18.2%	15.2%	10.6%	9.1%		7.3
Rural (May 2009)	12.1%	26.6%	23.4%	10.5%	10.5%	16.9%		8.0

Urban (May 2023)	5.0%	38.3%	25.0%	11.7%	4.2%	15.8%		7.7
Urban (May 2009)	17.3%	26.5%	27.9%	14.2%	5.8%	8.4%		6.5

Key Findings (Table 7):

- Across the network, 20% of PNs have been with their current practice for 12 years or more and this proportion has gone up from 18% in 2009. Conversely, 45% of the PNs have been with their current practice for 3 years or less. Some PNs identified having left to raise their family and subsequently returned, and this question only reflects 'this time'.
- The average length of stay in the current practice across the network is around 7.5 years and this is slightly higher than that found in 2009 (7 years). Tairāwhiti was longest at 10.3 years compared with Lakes at 5.2 years.
- The average length of stay in current practice for rural PNs at around 7.3 years is shorter than that for urban nurses (7.7 years). A higher proportion of PNs working at rural locations have been with their current practice for less than 4 years: 47.9% compared with 43.3% for urban PNs. A similar proportion of PNs in rural and urban practices have been with their current practice for 12 years or more (around 20%) but this has dropped from 27% in rural practices in 2009, but an increase in urban practices from 14.2%.

SECTION D3: Nurse prescribing and additional specialist qualifications

Nurse prescribing

Nurses seeking to become registered nurse prescribers require qualifications, training, assessment, and continuing competence assessments to be eligible to be registered with Te Kaunihera Tapuhi o Aotearoa/NZ Nursing Council (NZNC) as **registered nurses with prescribing rights**. They are entered onto the register in one of three nurse prescriber categories[6]. This is the first time we have reported on nurse prescribers in the network.

Registered nurses who prescribe in community health (RNPCH) have completed an approved education programme. They can prescribe pharmacy-only and general sale items, and a limited number of medicines for minor ailments and illnesses. These medicines may only be prescribed for 'normally healthy' people who do not have significant health problems.

Registered nurses who prescribe in primary health and specialty teams are experienced nurses that have completed a postgraduate prescribing qualification, and work in collaborative teams. They can prescribe pharmacy-only and general sale items, and from a list of medicines for common and long-term conditions.

Registered nurses who prescribe in diabetes health can prescribe pharmacy-only and general sale items, and a limited set of diabetes-specific medicines. The pathway to this type of prescribing was closed in 2017, as it has been superseded by other types of prescribing.

A total of 43 PNs identified that they had nurse prescriber qualifications of 194 respondents (22.2%). 40 nurses provided which category they were registered under with NZNC. Three PNs did not provide their category or answer other questions related to nurse prescribing and were excluded from the analysis in this section. The data are compared to the NZNC numbers for all registered nurses with an annual practicing certificate (APC) at the end of the last quarter (January to March 2023) (see footnote 6).

Table 8: PNs by registered nurse prescriber categories as set by the NZ Nursing Council

NZNC categories	Prescribers by category	Pinnacle MHN	NZ Nursing Council
Registered nurse prescribing in community health (RNPCH)	23	57.5%	53.5%

[6] Te Kaunihera Tapuhi o Aotearoa/Nursing Council of New Zealand. Nursing Council Quarterly Data Report. March 2023 Report. https://www.nursingcouncil.org.nz/Public/News_Media/Publications/Workforce_Statistics/NCNZ/publications-section/Workforce_statistics.aspx?hkey=3f3f39c4-c909-4d1d-b87f-e6270b531145

Registered nurse prescribing in primary health and specialty teams	16	40%	45.9%
Registered nurse prescribing in diabetes health	1	2.5%	0.6%
TOTAL	**40**	**8.5% of PNs***	**4% of PNs****

* Approx 470 PNs in Pinnacle MHN. Results based on respondents who identified as nurse prescribers.

**These data are gathered when a nurse applies to renew their Annual Practising Certificate and is based on the annual 'snapshot' of the Register of Practising Nurses as of the 31st March 2023. Nurses can select two 'main' practice areas. The figure used is representative of nurses that selected 'Practice Nursing' as at least one of their 'main' practice areas. It is not compulsory for nurses to provide NZNC with this information, and some nurses have chosen not to provide a response. (Total =157/3,875)

Key Findings (Table 8):

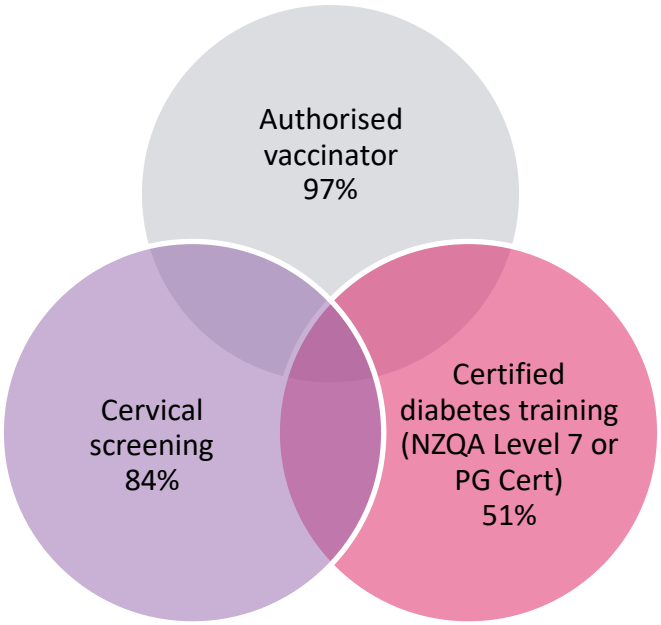
- Most nurse prescribers are in the community health category (RNPCH) (57.5%) followed by nurse prescribers in primary health and specialty teams (40%). In comparison to NZNC, the network has a slightly higher proportion of PNs with RNPCH registration (57.5% c.f. 53.5%).
- The majority of PN prescribers indicated they are using their nurse prescribing expertise often (95%), however for 5% it was used seldomly. Barriers to this were identified as other staff and time.
- In comparison to the NZNC overall figure, our network PNs with nurse prescribing registration appears quite healthy. Comparing with NZNC registered nurses who identify 'practice nursing' as their area of practice, shows Midlands Health Network has twice the proportion of nurse prescribers.

Additional specialist qualifications

PNs acquire an array of skills relevant to their practice. Nurses were asked if they had any additional qualifications in specialty areas of nursing. Reported here are those additional skills which come with a formal qualification—diabetes, vaccinator training and cervical screening.

Analysis in this section is based on the responses from 194 of the 197 PNs. 3 PNs did not complete the remainder of the survey and were excluded from these data.

Figure 5: PNs with additional qualifications in three specialty areas of nursing



Key Findings (Figure 5):

- The high proportion of PNs in the network are authorised vaccinators. This is a core skill and has been an important requirement over the past 2 years since the COVID-19 vaccination roll-out. The proportion of authorised vaccinators has increased to 97% in 2023 from 94% in 2009.
- Cervical screening and diabetes are also key qualifications that support patients in practice. Having PNs trained in key areas supports patients firstly, but also the quality plan for general practice. PNs with cervical screening qualifications have increased to 84% from 63% in 2009.
- Diabetes training has reduced to 51% from 54% in 2009. However, there are other diabetes study days and courses outside of Level 7 and postgraduate training developed in-house or by local clinicians that PNs have been attending, which have given PNs directly relatable practical skills and the training has been available free of charge (anecdotal: Kathy Knight, Diabetes Clinical Specialist).
- Other identified courses include wound care (65%), B4 school checks (54%), and sexual health (39%).
- Newer roles identified by PNs include ECG interpretation (20%), Fitness to Drive medicals (19%), long-term conditions management (17%) and immigration medicals (17%).

SECTION D4: Work hours and work types

Work hours

The working week for practice nurses is best defined by the hours worked. As in the 2009 survey, PNs were asked the *actual* number of hours they worked in an average week (Figure 6) and by region compared with the APPN workforce. There were 193 responses to this question.

Figure 6: PNs employed or contracted hours

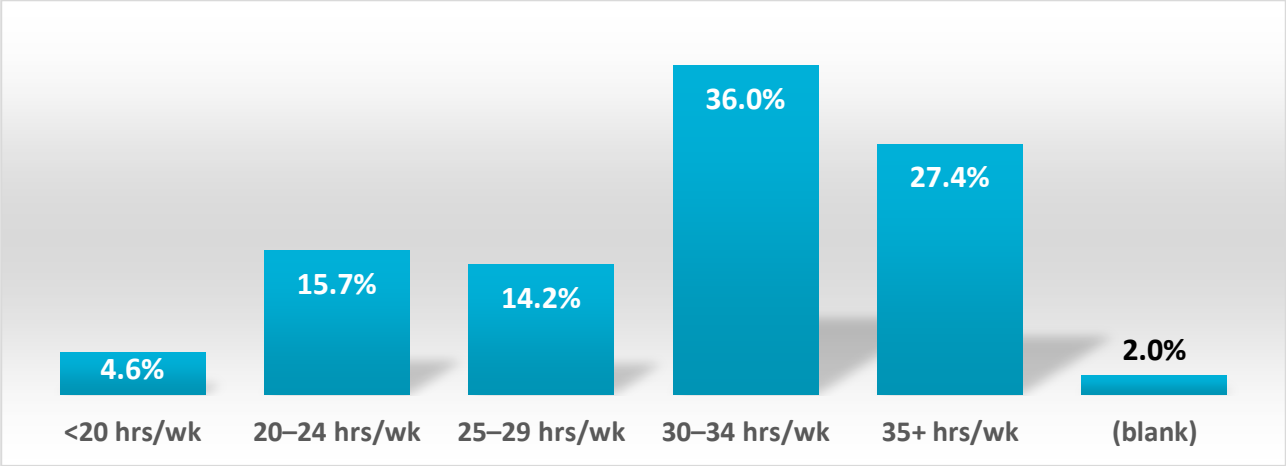


Table 9: PNs employed or contracted hours by region and practice location, compared with NZ APPN data

Region	<20 hrs/wk	20–24 hrs/wk	25–29 hrs/wk	30–34 hrs/wk	35+ hrs/wk	Total	Av. hrs/wk
Lakes	2	5	3	4	5	19	28.8
Tairāwhiti	1	1	1	6	6	15	32.6
Taranaki	1	9	7	18	21	56	32.1
Waikato	4	16	17	43	22	102	31.0
Network (May 2023)	**8** 4.2%	**31** 16.1%	**28** 14.6%	**71** 37%	**54** 28.1%	**192**	**31.2**
NZ APPN workforce (2019)	<35 hrs/wk 74.1%				25.9%		
Network FTE eqv. (2023)	4.2%	approx. 30.7%		approx. 65.1%			
Network (May 2009)	0.5 FTE=29%	0.3–0.5 FTE = 34%		0.8+ FTE = 37%			
Rural (May 2023)	5.97%	13.43%	11.94%	41.79%	26.87%		31.6
Urban (May 2023)	2.46%	18.03%	16.39%	35.25%	27.87%		31.0

Key Findings (Figure 6 and Table 9):

- Contracted work hours ranged from 8–40 hours per week with an average of 31.1 hours.
- 1 in 4 PNs work full time (>35 hours per week, hrs/wk) which is similar to the NZ APPN workforce results at 25.1%. Over one-third of PNs worked 30–34 hours per week.
- In analysing the results using full time equivalents (FTE) at 0.1 FTE per 4 hours work, there is a huge decrease in the number of nurses working 20 hours or less (0.5 FTE), since the 2009 workforce survey. Only 4.2% of PNs identified working less than 20 hours per week compared with 29% in May 2009. This could be a result of non-response bias in our survey. Nurses working approximately 0.8 FTE increased from 37% in 2009 to approximately 65% in 2023.
- The average number of hours of work per week was similar for rural and urban practices at around 31 hours. Slightly more rural PNs worked 30+ hours per week than urban PNs (68.7% c.f. 63.1%).

Work patterns

Client/patient consultations

Nurses were asked about the number of hours they spend working in client/patient-facing work and the time spent completing non-client/patient-facing work. Client/patient-facing work has changed considerably since 2009 and now incorporates increasing usage of telehealth.

The categories of client/patient-facing work were:

- In-person in the work setting: Hours of clinical work which involves consultation with patients kanohi-ki-te-kanohi/face-to-face in the general practice.
- In-person-home visit: Hours of clinical work which involves consultation with patients kanohi-ki-te-kanohi/face-to-face in a private residence or their usual place of residence, e.g. rest-home.
- In person-other venue: Hours of clinical work which involves consultation with patients kanohi-ki-te-kanohi/face-to-face at a venue other than the general practice, e.g. marae, school or one that is not a usual clinical setting.
- Virtual consult (e.g. video or telephone): Hours of clinical work which involves consultation with patients kanohi-ki-te-kanohi/face-to-face over video or telephone.
- Phone triage: Hours of clinical work which involves patient triage, as opposed to a proper consultation.
- Non-client/patient-facing (e.g. patient portal, emails): work related to the client/patient but not with the person present.

Table 10: PNs identification of hours by work type (not adjusted by individual hours of work)

Work type	0 hrs	>0–4 hrs/wk	5–9 hrs/wk	10–14 hrs/wk	15–19 hrs/wk	20–24 hrs/wk	25+ hrs/wk	Grand Total
In-person in the work setting	0	1	15	25	28	32	94	195
In-person—home visit	108	9	2	1	2	0	0	122
In-person—other venue	100	13	1	1	0	1	2	118
Virtual consult	39	50	21	13	8	2	2	135
Phone triage	7	60	53	14	18	4	8	164
Non-client/patient-facing	3	47	66	30	23	8	7	184

Key Findings (

Table 10):

- All PNs identified having kanohi-ki-te-kanohi/face-to-face consultations in the general practice. A small number of PNs did home visits (14/122, 11.5%) or worked at other venues (18/118, 15.3%).
- Up to half of PNs (96/197) continue to consult with patients using some form of telehealth. 39/135 (28.9%) identified not doing any. (See more in the section below.)
- Phone triage was common for PNs: 61% spent up to 10 hours while an additional 29% spend up to 20 hours a week doing phone triage.
- Non-client/patient-facing work was considerable for PNs, with the majority spending up to 10 hours per week on client/patient related work.

Virtual consults

Virtual consults have continued to be part of services being provided to clients/patients since it was encouraged as an emergency response tool during the COVID-19 pandemic to provide health care while minimising the potential spread of infection. Telehealth consultations were reported elsewhere as being most successful where there was a pre-existing relationship between health care provider and patient[7]

[7] Wilson et al (2021) Empty waiting rooms: the New Zealand general practice experience with telehealth during the COVID19 pandemic. NZMJ: 134, 1538, p89–101 https://journal.nzma.org.nz/journal-articles/empty-waiting-rooms-the-new-zealand-general-practice-experience-with-telehealth-during-the-covid-19-pandemic-open-access

Figure 7: Percentage of PNs indicating hours they do virtual consults per week

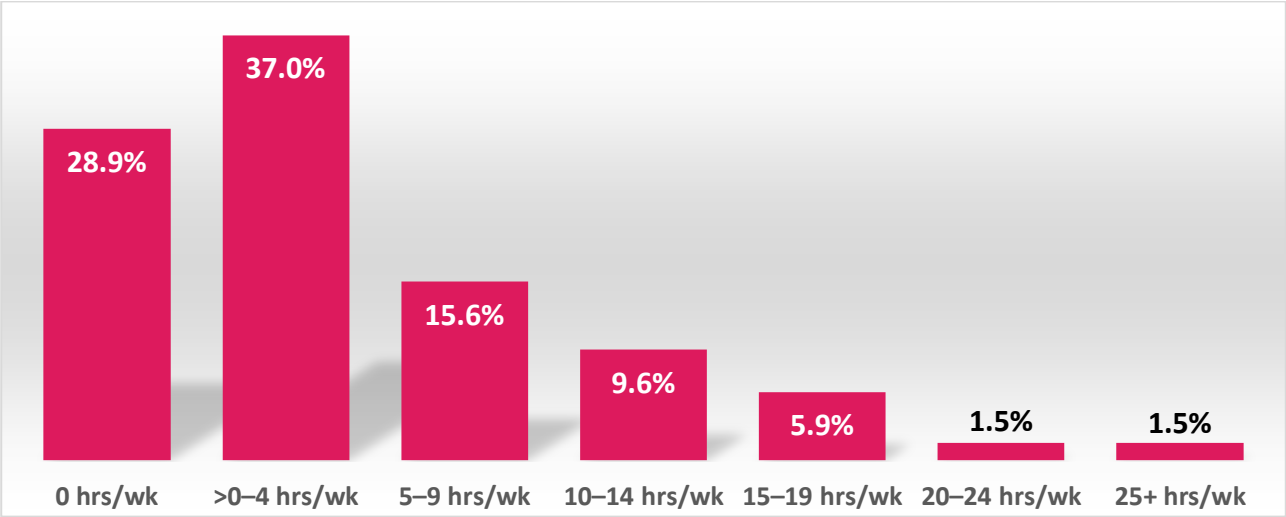


Table 11: PNs using virtual consult by region (n=134) and practice location (n=131)

Virtual Consults	0 hrs/wk	>0–4 hrs/wk	5–9 hrs/wk	10–14 hrs/wk	15–19 hrs/wk	20–24 hrs/wk	25+ hrs/wk	Count
Lakes	21.4%	50.0%	14.3%	14.3%	0.0%	0.0%	0.0%	14
Tairāwhiti	16.7%	33.3%	25.0%	0.0%	16.7%	8.3%	0.0%	12
Taranaki	29.5%	31.8%	18.2%	13.6%	6.8%	0.0%	0.0%	44
Waikato	32.8%	37.5%	12.5%	7.8%	4.7%	1.6%	3.1%	64
Total	**29.1%**	**36.6%**	**15.7%**	**9.7%**	**6.0%**	**1.5%**	**1.5%**	**134**
Rural	36.2%	29.8%	10.6%	8.5%	10.6%	0.0%	4.3%	47
Urban	26.2%	39.3%	17.9%	10.7%	3.6%	2.4%	0.0%	84
Total	**29.8%**	**35.9%**	**15.3%**	**9.9%**	**6.1%**	**1.5%**	**1.5%**	**131**

Key findings (

Figure 7 and Table 11):

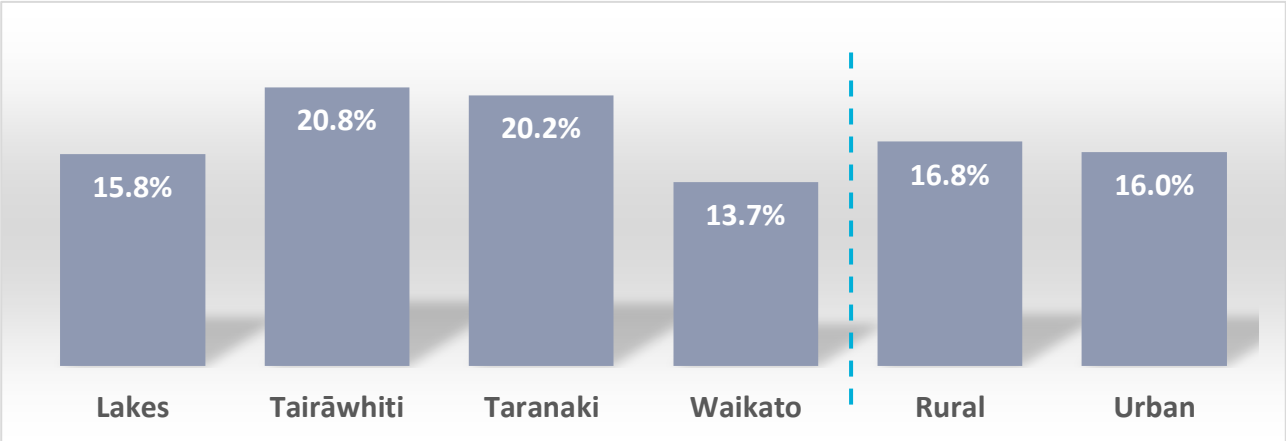
- 28.9% of PNs did no virtual consults, however 37% of PNs indicated a minimum of >0–4 hours per week on telehealth consultations. Excluding those who did none, this equates to 52% of PNs who do virtual consults do >0–4 hours per week.
- While the vast majority of PNs continue face-to-face consultations, having the ability in a practice to do telehealth consultations allows more flexibility (Wilson et al, 2021. Footnote 7).
- PN use of telehealth differed across the region. 2 in 3 PNs used telehealth in the Waikato region, while this was as much as 5 in 6 in the Tairāwhiti region.
- There is no clear pattern to indicate whether there were urban and rural differences in telehealth use.
- A number of enablers were put in place during the initial COVID-19 response. How these are used by PNs and the barriers to telehealth use in the network would benefit from further exploration.

Non-client-related work

Figure 8 below shows the proportion of the total work hours PNs spent doing non-client-related work. This includes sterilising equipment, managing clinical waste and sharps, cleaning beds/equipment, stock ordering and restocking, setting up/cleaning up after clinics/sessions, moving equipment, and recalls.

Analysis in this section is averaged on data from 196 PNs by region and 193 PNs by location of practice as a percentage of total working hours. 12 PNs did not respond to this question or their employed hours for this to be calculated.

Figure 8: Average percentage of total working hours spent doing non-client/patient-facing administrative and other non-clinical work by region and practice location



Key Findings (Figure 8):

- On average, practice nurses across the network spend one-sixth (16.4%) of their work time on non-client/patient-facing work. This has reduced from one-third (32%) in 2009.

- The amount of non-client/patient-facing work was similar between urban and rural areas.
- Comments for PNs included spending a lot of time on recalls, while others praised the role of practice centre assistants (PCAs) who took much of this workload from them.
- This is an opportunity to consider the business model for where an additional person, such as a practice centre assistant, or an external service, such as Patient Access Centre, may be cost-effective to the practice, to free up PN time to utilise their nursing expertise more effectively.

SECTION D5: Responsiveness to Māori

The foundations of our new health system, outlined in the Pae Ora (Healthy Futures) legislation, are:

- Health equity matters for everyone
- Embedding a Tiriti-dynamic health system
- Implementing a population health approach
- Ensuring a sustainable health service delivery system

The workforce survey was an opportunity to establish a baseline for how health professionals were working with clients/patients in a manner that sought to uplift the mana of all patients with a particular focus on responsiveness that supports Māori aspirations. These questions were developed to identify strengths and weaknesses in our network where support can be provided further.

Table 12: PN responses to day-to-day practices focused on Māori responsiveness

Day-to-day practices	%
Checking back (teach-back technique)	89%
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	78%
Enquiring about whānau and their health needs	72%
Recalls focused on increasing Māori engagement/participation in screening or health initiatives	68%
Reaching consensus with Māori clients/patients about their management/treatment plans (goals, options, length)	64%
Greetings using te reo Māori	59%
Partnership with Māori organisations/groups in service provision or community initiatives, i.e. working alongside to improve outcomes for client/patient where specific skills are needed	48%
Working to a Māori health plan developed within the workplace that sets out broad direction to address inequity	39%
Karakia in meetings/consultations	27%

Key findings (Table 12):

- Nearly 90% of PNs use teach-back technique—a way of checking understanding by asking clients/patients to state in their own words what they need to know or do about their health or follow-up. This is a clear health literacy tool that benefits all patients and their whānau.

- 4 out of 5 PNs have completed Te Tiriti o Waitangi and/or cultural competency training and are working with this knowledge; providing a solid platform for understanding the challenges faced and how collectively PNs can make a difference.
- Nearly half of PNs identify partnership with Māori organisations/groups in service provision, supporting the premise that general practice work alongside community providers and those in extended roles of practice to support our population.
- Māori health plans are part of the Foundation Standards of which 39% of PNs identifying working with one in their workplace. However, further analysis is required with nurses within the same practices not working to one in their workplace suggesting they are unfamiliar with its existence or it may not be underpinning their day-to-day work.
- There was a single response stating that these questions were racist and were therefore not answered. Responses such as this demand a reply. We recognise that as nurses we believe we are treating all our clients/patients the same. However, you will appreciate we are not all the same. When you look at our health statistics, Māori are less likely to get tests and investigations, less likely to get medications, less likely to get referred; for the same conditions as Europeans[8]. Therefore, while we personally do our best, the health statistics show a different story. When considering, 'treating everyone the same' we need to think what our underlying assumptions are when doing so. If we do this based on 'how we wish to be treated', it is a closed mindset to assume we know how everyone else wishes to be treated. Without having an open mind and a conversation that ensures we are on the same page, it is difficult to see how our unconscious biases are not having an impact on how we work. I urge readers to consider what they can do to better understand the role they have as individuals to improve equity.

[8] Hauora: Māori Standards of Health IV, Chapter 1: https://www.otago.ac.nz/wellington/otago067740.pdf

Figure 9: Te Whare Tapa Whā pictorial view (not discussed here)

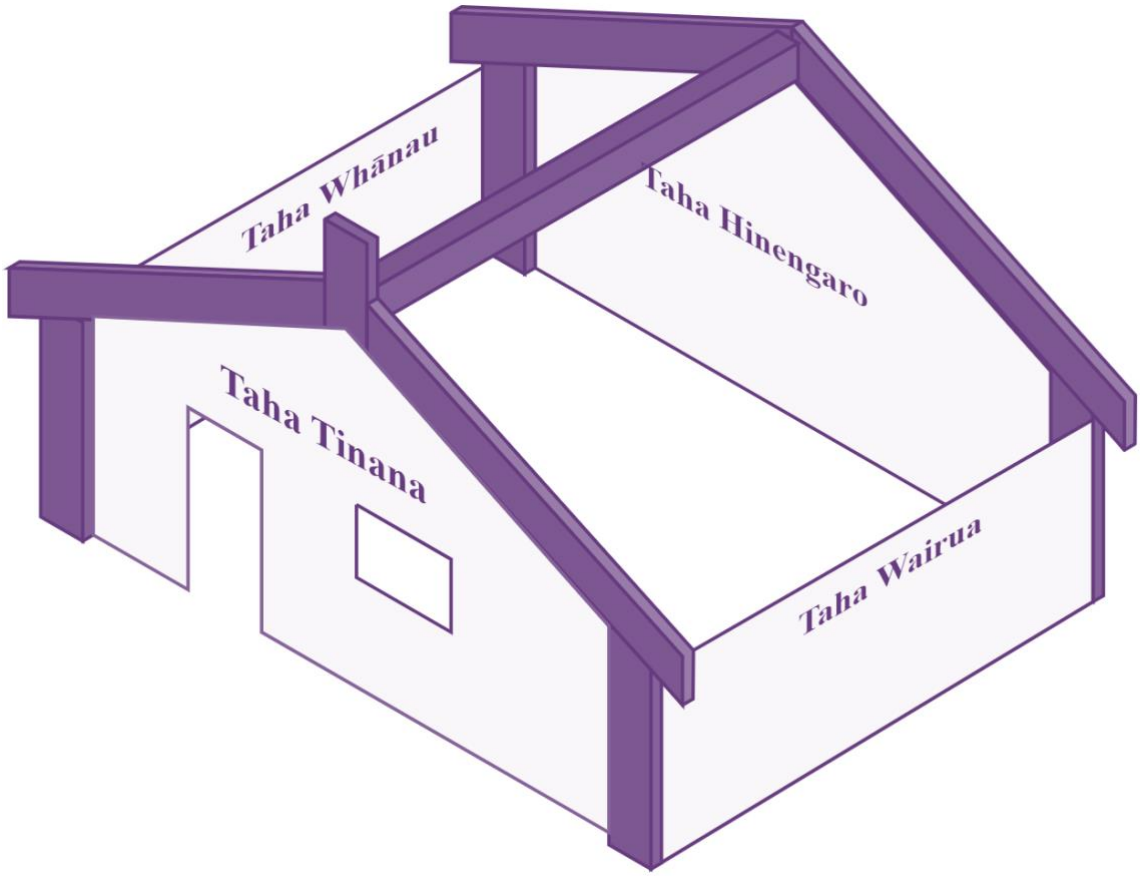


Image from:
https://en.wikipedia.org/wiki/Hauora#/media/File:Hauora.svg

SECTION D6: Nurse leadership and supervision of clinical skills

Nurse leadership

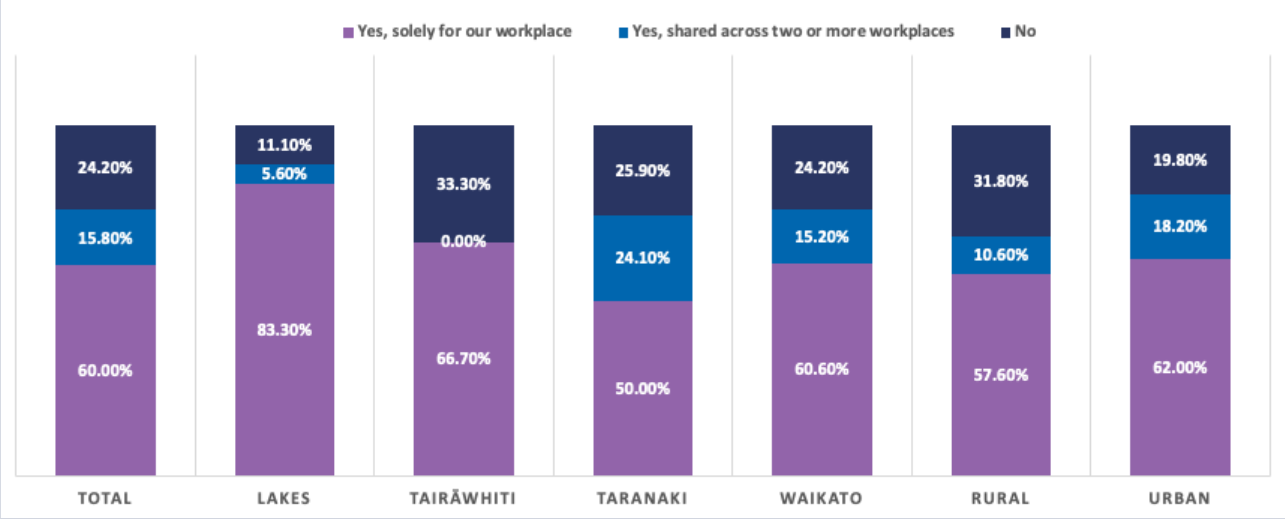
Leaders within nursing have a positive effect that can improve the quality of services and therefore, to grasp these opportunities, it is important to invest in the development of leaders.

Nursing leads within the PN workforce are available to many practices, either at an individual practice level or shared across several practices, but this is not yet available to all.

Table 13: Access to a nurse lead for the workplace

Nurse leadership in place	Total	Lakes	Tairāwhiti	Taranaki	Waikato	Rural	Urban
Yes, solely for our workplace	115	15	10	29	60	38	75
Yes, shared across two or more workplaces	30	1	0	14	15	7	22
No	46	2	5	15	24	21	24
Total	**191**	**18**	**15**	**58**	**99**	**66**	**121**
		n=190				**n=187**	

Figure 10: Access to a nurse lead for the workplace, by region and practice location



Key findings (Table 13 and Figure 10):

- 76% of PNs had access to a nurse lead with 60% identifying a nurse lead solely for their workplace and nearly 16% shared across two or more workplaces.
- Access to nurse leads is variable across the region with the highest proportion of nurses supported in Lakes region (89%) and lead in Tairāwhiti (67%).
- More nurse leads are shared across practices in urban practices than rural practices.
- 46 respondents from 29 practices did not have access to a nurse lead. These were fairly evenly distributed between urban and rural practices.

Nurse leads

32 PNs (22%) identified themselves as a nurse lead. This included 20 PNs who were nurse lead solely for their workplace and 12 PNs who were nurse lead across two or more workplaces.

The average time in the nurse leadership role was 5.5 years and ranged from 'months' to greater than 20 years.

The average time allocated per week for the nurse lead role was 8.1 hours and this ranged from nearly full time as a nursing lead to no time allocation. Some PNs had time set aside which incorporated their leadership role alongside other non-clinical work. Nurse leads identified that ring-fenced time allocated to this role becomes flexible when there are workforce pressures.

Half the PNs identified that the time spent in nurse leadership was often less than what was allocated or sometimes no time was allocated at all, most often due to staff shortages. A few PNs described it as always being 'on call' for the staff, while others were unable to state how much time they spent specifically on nurse leadership as it was often tied into other work.

83% of PNs (24/29) identified being remunerated for their nurse leadership role. However, 5 stated 'it's hardly worth it'. Where an amount was given, this was $1 or less added to their hourly rate.

Over half of nurse leads (15/28, 53.6%) identified no formal training. 5 PNs mentioned leadership training provided by Pinnacle, others had completed management and leadership courses in previous employment. Some PNs identified preceptorship training and professional supervision training as their leadership training.

Nurse leads being part of the decision-making workplace management leadership team occurred for 69% (20/29). 6 nurse leads identified their input into decision-making as: 'to provide a nursing perspective' x3, '50% of the time' x2, 'sometimes' x1.

Supervision of clinical skills

Supervision of clinical skills requires more than just the interaction of two people observing a process. Understanding the evidence-based practice of safe and effective patient care through training, establishing

and maintaining an environment for learning, teaching and facilitating the learning, supporting educational progress, guiding personal and professional development, and continuing professional development as an educator are all important facets.

Supervision of clinical skills is an added component of the workload for PNs, which may take on several forms such as formal professional supervision (clinical supervision), mentorship, preceptorship, or less formal supervisory functions.

Supervision of clinical skills is a function of practice nursing in 3 out of 5 PNs (116/189, 61.4%). This is provided to a variety of health professionals, non-clinical colleagues and students.

Table 14: Recipients of supervision of clinical skills by PNs

Supervision of clinical skills	%
Student nurse	47.6%
Practice centre assistant	43.4%
Registered nurse completing specialty training	29.1%
Enrolled nurse	6.3%
Nurse practitioner	0.5%

Key findings (Table 14):

- Supervision of clinical skills is most often provided to student nurses and practice centre assistants. Support for registered nurses completing specialty training is also common.
- New graduate nurses (NETP), registered nurses new to general practice, student doctors, and clinical support to the wider health care team, including GP registrars and house officers, dentists, dieticians and physio students were also identified.
- The type of training received was varied and reported as follows:
    - 45/116 PNs (38.8%) received formal training through an education programme to support supervision of clinical skills
    - 35/116 PNs (30.2%) identified on the job training
    - 26/116 PNs (22.4%) received no training
    - 10/116 PNs (8.6%) identified having received training ‘a long time ago’ x2 and ‘would really love a refresher’ x1, through a hospital-based or previous workplace preceptor course x4, ‘undergoing a course at the moment’ x1, having had a previous teaching qualification outside of nursing x1 and one PN was just ‘unsure’.
- Having an environment that supports education and training is vital in nurturing our future general practice health professionals, especially those who are there for a short while, such as students (plant the seed).

SECTION D7: Postgraduate study and professional development

Current and intentions for postgraduate study

Postgraduate qualifications (often in the form of postgraduate certificates and diplomas) are often required for registered nurses working in expanded or specialist practice roles. A master's degree is required to become a mātanga tapuhi nurse practitioner (NP) to meet Nursing Council of New Zealand competencies. Commonly, PNs participate in postgraduate study while working and anecdotally this is often self-funded and/or completed out of work time.

Table 15: PNs position on postgraduate study

Position	Count	Percentage
Yes, currently doing postgraduate study	26	13.4%
Yes, thinking about doing postgraduate study in future	76	39.2%
No, not doing or thinking about postgraduate study	92	47.4%
Total	194	

Table 16: Interest in mātanga tapuhi nurse practitioner pathway

Interest	Count	%
I am currently on the NP pathway	7	6.8%
Yes, I would like to, but I am not on the NP pathway yet	40	38.8%
No, I am not considering become an NP	56	54.4%
Total	103	

Key findings (Table 15 and Table 16):

- 1 in 7 PNs are currently undertaking postgraduate study (13.4%) with a further 40% considering postgraduate study in the future.
- 7 PNs identified that they are currently on the mātanga tapuhi nurse practitioner pathway. Nearly 40% are considering this pathway at some point in the future.

- A large proportion of PNs are not considering postgraduate study or becoming a mātanga tapuhi nurse practitioner.

Literature identified nurses as often experiencing challenges in committing to postgraduate study through juggling their study/work/family obligations often while sacrificing time with friends and family, and foregoing annual leave when study leave is not forthcoming[9].

A call to action is for nurse educators, nurse employers, and policy developers to engage with nurses to improve the postgraduate study experience for registered nurses.

Postgraduate achievements

Over one-third of the workforce identified having a postgraduate (PG) qualification (73/194, 37.6%) – 60 respondents provided details as follows:

- 8 PNs (4.1%) had master's degrees
- 27 PNs (13.9%) had PG diplomas
- 25 had PG certificates (12.9%).

Many of these were in nursing science, advanced nursing, primary health care, health science, orthopaedics, gerontology, and child and family health, indicating a highly educated workforce.

Some PNs who identified a postgraduate qualification did not stipulate the level attained and are not counted in the PG summary above. Others included non-nursing but relatable qualifications, for example, diploma in teaching and diploma in strategic leadership.

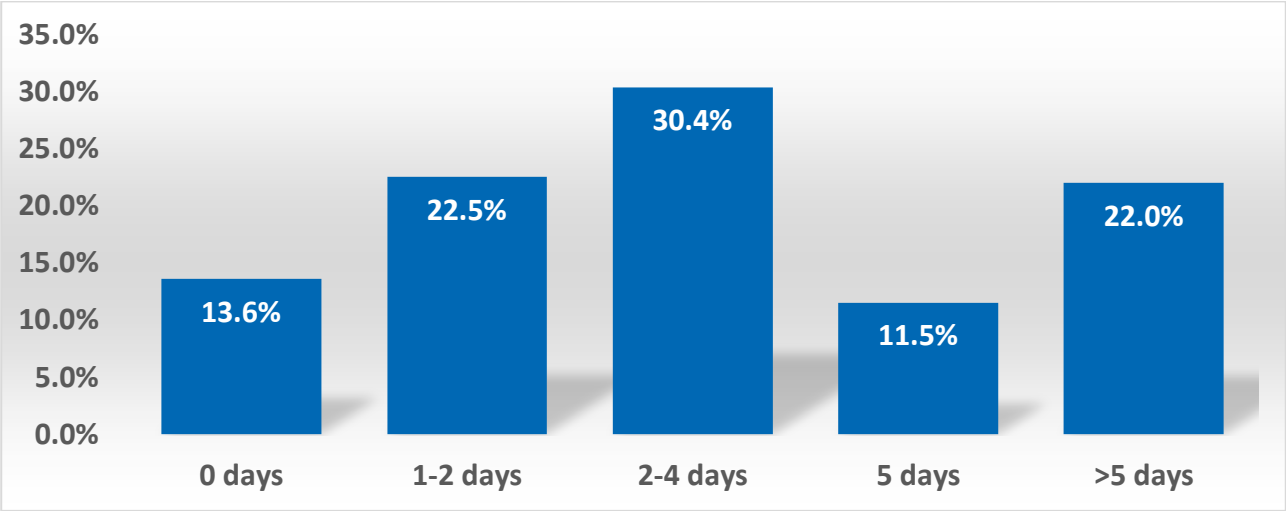
Professional development/study leave

Access to professional development supports PNs to keep up to date with the latest evidence in their chosen topic. This has been challenging in the past few years due to COVID restrictions, with plans being made and then cancelled. Many organisations have expanded the provisions of teaching with many providing online courses as an adjunct, some have become more permanent as an alternative for face-to-face educational opportunities.

Nurses were asked how many professional development/study leave days they had in the past 12 months (Figure 11)

[9] Groube, J (2017) Postgraduate Study: The Journey of Registered Nurses. MHSc thesis. University of Canterbury. https://ir.canterbury.ac.nz/bitstream/handle/10092/15114/JANICE%20GROUBE%20THESIS%20pdf.pdf?sequence=3

Figure 11: Professional development days in past 12 months (n=191)



Key findings (Figure 11):

- Most of the professional development was for 2–4 days in the past 12 months. However, one-eighth of PNs did not receive any external professional development in the past year.
- Nearly 60% of PNs (114/194) felt the amount of professional development over the past year was adequate. For the remainder who felt the amount was inadequate—from all groups—barriers included being too busy at work (53 responses), the cost wasn't covered by their employer (23 responses), it was not offered or encouraged (18 responses), nothing of interest was on offer (8 responses) or the event was cancelled (8 responses).
- Other comments included: cost and time involved, COVID and Cyclone Gabrielle put training on hold, work/life balance—often done in own time, several identified not enough clinical staff to cover—mentioned several times, preference for face-to-face rather than online learning—PHO used to do lots of in-service training.
- For those whose inability to attend professional development due to reasons outside of the PNs control, e.g. staffing or natural events, this must be recognised and rectified as soon as possible to support connectedness to the wider health community and the importance of keeping current outside of the pressures of day-to-day work.
- PNs whose 'cost and time involved' suggests personal cost and time, require a different model that supports their ability to upskill or to spend time on efforts that are more meaningful to them and to have the value-add of these efforts recognised in doing so.

SECTION D8: Work pressures

Burnout

All nurses were asked to identify their level of burnout using their own definition based on a validated one-question scale. Where symptoms of burnout were identified, support structures such as EAP offered by Pinnacle to practice staff and available elsewhere (e.g. 1737 line) were provided as well as online tools.

Table 17: PN burnout measure

Measure	Count	Percentage
Burned out—average score (1–5)	**2.4**	
(1) I enjoy my work. I have no symptoms of burnout.	27	14.4%
(2) Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	87	46.5%
(3) I am definitely burning out, and have one or more symptoms of burnout, such as physical or emotional exhaustion.	48	25.7%
(4) The symptoms of burnout I am experiencing won't go away. I think about the frustrations at work a lot.	16	8.6%
(5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	9	4.8%
Total	**187**	

Key Findings (Table 17):

- 60.9% of PNs either have no symptoms of burnout or feel under stress with less energy but not feeling burned out.
- Nearly 40% of PNs have symptoms of burnout with 13.4% recognising that their symptoms are not going away.

SECTION D9: Looking ahead

One suggestion for primary care to thrive

PNs were asked to make one suggestion that would help primary care to thrive. The analysis in this section is based on comments from 172 of the 197 responding PNs, that is, 87% of the respondents. 208 separate suggestions were recorded.

Being valued through pay parity

Value has wider connotations of being financially valued as well as feeling valued for the role they play.

Overseas media headlines such as 'Two-thirds of practice nurses considering quitting in the next year'[10], and 'Expertise underestimated and poorly articulated, report finds'[11] are a frightening reality for PNs. Our workforce survey found similar sentiment in reference to workload pressures currently faced by general practice, exacerbated by the pandemic.

Overwhelmingly, pay, particularly pay parity with secondary care nurses, was forefront as the number one issue facing PNs.

> *'Resource and pay for primary care workers — It is chronically underpaid and undervalued, for the amount of skills and qualifications required.'*
>
> *'Equal pay parity to our DHB colleagues would be fair for practice nurses…I may retire and still not earn what I believe I am worth...there are young nurse graduates out there earning more than me, a practice nurse, this is shocking given that the DHB push a lot of their work out to primary care e.g. IV cellulitis treatments, iron infusions, and expect nurses to meet Ministry of Health targets too, whereas our priorities are to keep people well from COVID and influenza and keep them out of hospital. Hence the reason I do not want to do anymore study FOR WHAT, my energy is exhausted fighting pointlessly for pay parity when we treat older NZ nurses like they are already being put out to pasture. It's tiring people.*
>
> *'Pay equity. Recognising that what we do matters and makes a difference. We are experienced nurses being paid like second-class citizens. It's insulting especially after all the work we did looking after the community during COVID. Who looked after the majority of COVID + pts??? The community did. But we don't… undervalued and underpaid.'*
>
> *'Increase funding/pay rates for primary care to match the DHB and other community providers…Currently many of my colleagues and myself are feeling unseen, unrecognised, and are becoming burnt out due to staffing issues and underpaying.'*

[10] https://www.nursinginpractice.com/latest-news/exclusive-two-thirds-of-practice-nurses-considering-quitting-in-next-year/
[11] https://www.nursinginpractice.com/latest-news/gpn-expertise-underestimated-and-poorly-articulated-report-finds/

'Enable better pay to attract nurses to primary care. It is hard to keep staff now with the attraction now of DHB pay. I have had two nurses leave due to this, one of whom was offered over $10 more [per hour] and one who might be unable to return from maternity leave in August due to increase in cost of living and attraction of better pay in DHB. I have another two thinking of leaving for the same reason, but love being primary care nurses and our team here, so are torn and holding out hope we get better pay to reflect our skills. I have advertised repeatedly but pay lets primary care down. Last advertisement only gained one applicant.'

Being valued for knowledge and specialism

Pay was closely related to feeling valued as practice nurses, feeling recognised as skilled health professionals, and being acknowledged for the work primary care does, particularly during COVID. PNs felt that they were not recognised for the unique skills of practice nursing. This was particularly evident with the issue of pay parity with secondary care, that PNs were seen as being of less value (financially) and subsequently, less valued as nurses.

'I feel that primary nurses need to be recognised for their unique skills and autonomy in their workplace. Especially as we have nurse-led clinics, often working without a doctor present. Our financial remuneration I feel doesn't match our skill set especially when our hospital-based colleagues with the same experience are paid more.'

'Reaching out to our communities and sharing how amazing primary health care nurses are, what our scope includes, and just how dynamic and skilled PHC nurses are.'

'Primary care is under-recognised as a key player in the health system.'

'Primary health care won't thrive until its importance and value is acknowledged within the health system. Primary health care is vital but hugely undervalued and not understood.'

'Primary care doesn't seem to get the recognition it deserves, the hospitals are always the focus, however it is the work that we do and provide that keeps patients out of hospital.'

Staff retention

Pay was also closely linked with retaining staff, especially experienced staff, and the need to future-proof the sector.

'Better pay and retention is required to attract more workers, retain staff and future-proof the sector.'

'Improved pay to retain better experienced staff.'

'Ensure practice nurses supported and paid well to keep them from leaving the sector, pay equity, retaining GPs.'

'Incentives to attract and retain staff in primary care.'

Being valued by being properly resourced

There was a call for more staff in general—GPs, more nurses, more NPs, more enrolled nurses, more HCAs and more HIPs—to meet the demands placed on primary care. A lack of resource meant not being able to meet demand which affected the ability for patients/clients to get same day or next day appointments and to receive timely care. In addition, there was acknowledgement that many GPs are ageing and near retirement.

> *'I acknowledge this is a business, but to maintain the loyal staff that this practice has had for many years I feel the organisation needs to be careful not to streamline the staff numbers so much that you do burn out your staff. We tend to be a stoic group of people and just keep going and taking on more work covering others' loads when needed. At some point that will create burnout or people resigning and that would be a real shame when we have such a fantastic, supportive culture in this practice.'*

> *'Competitive pay rates are needed to attract more nursing staff into the role and reduce staffing concerns.'*

> *'Recruiting younger GP and nurses as most of our local GP's are ageing and near retirement.'*

> *'Invest more into employing and educating more nurses and HCAs.'*

> *'Recognition of the huge requirements on general practices and a focus on recruiting GPs (in one way or another).'*

> *'More funding for the GP and nurse to be able to do their job, admin and paperwork etc. can take up a lot of time which does not generate any income and some of the patients are demanding and sometimes a phone call can take the nurses away from other work as the patients need help or advice which is not able to be charged for advice.'*

> *'More resources from government—a realisation that PC is vital for the health of our nation and current stresses health system is having are mainly because of inadequate PC funding and coverage. So much money would be saved, and social inequities be prevented if PC was acknowledged and resourced adequately.'*

> *'Fund GP and nurse time adequately for complex consultations, because they almost always are, and you need the time to address the whole picture. There are very few simple and straightforward consultations anymore.'*

> *'Pay equity and recognition across the whole of GP practice, money and staff to allow us to really help out patients, as at present we are losing ground!'*

> *'More funding put into paying health care professionals and training of new ones.'*

> *'More MONEY! Govt needs to invest more in primary care initiatives to reduce burden on secondary care.'*

> *'Strengthened social supports for our communities.'*

Better understanding of funding arrangements

Some of the comments related to the way in which primary care is funded and tensions between how the business side appeared at odds with providing health care. In addition, increased funding would enable PNs to continue to support the wider health system.

> *'The government funding primary health appropriately. Working in a VLCA [Very Low Cost Access scheme] practice is rewarding but is hard work and being constantly hounded and things not being in the budget is tiring and is not helping the people it needs to. We can't offer a service if we are not funded appropriately.'*

> *'FUNDING!!! The ability for those that make the financial decisions to actually know how general practice runs. Stop making care "paid per consultation" i.e. anti-viral funding. It takes away from what they are there for and puts the emphasis on making money.'*

> *'Listen to the nurses when they tell you what they need. The patient's health needs need to come first; not be controlled by dollar units.'*

> *'Primary care is crucial more than ever in reducing pressure on our overloaded and unsafe acute care/hospital settings, for our people of Aotearoa. We need more funding and support to enable us to reduce ED presentation and hospitalisation NOW.'*

> *'More funding needed so patients have better access to health care and not having to wait so long for appointments.'*

> *'More funding for time to work proactively with patients rather than reactively. It's talked about all the time but not funded.'*

> *'Subsidy for nurses' wages to allow nurses and nurse practitioners to be paid what they are worth. This will help with our rural doctor shortage.'*

> *'If Pinnacle can amend/increase the patient's fees, GP may be able to increase nurses' wages.*

Improving work conditions

PNs identified the need to have resources available that supported nurses to be able to work safely, to know they were not putting additional pressure on their colleagues if they were sick or on study leave or if they had a young family.

> *'Have a pool of RNs that can be called upon when staff members are sick or away.'*

> *'More flexibility for part-time working mums.'*

> *'To have staff numbers that provide a safe working environment and safety for all patients attending clinic appointments.'*

> *'Improved conditions e.g. pay scale, more nurses, more doctors, safer environment, team players.'*

> *'Additional leave would also encourage nurses to primary health.'*

Being valued by having access to training

PNs are required to upskill as part of the specialist training that they do. They need more support to do this, with suggestions for a greater focus on nurse prescribing—including time to study within work hours to complete the training, external funding for training programmes, and support for PNs wishing to become NPs.

> *'Better support for primary care in upskilling to meet the growing demands of secondary care pushing back to primary. This would be arranged by primary health care organisations to support us better. Especially new to primary care staff with fracture management, updated wound care education, triage training and support, being more visible, hearing other stories, feeling part of a wider team of primary care nurses.'*
>
> *'Emphasis on education for non-clinical staff as well to ensure good patient flow and management.'*
>
> *'A bigger focus on nurse prescribing. Soooo underutilised.'*
>
> *'Training programmes funded so that new practice nurses are competent when they start.'*
>
> *'HCA workforce trained elsewhere/less supervision required.'*
>
> *'All practice nurses should be actively gaining qualifications to enable diagnosis and prescribing.'*

Being acknowledged for carrying the load during COVID-19

PNs identified the lack of appreciation for what they do for the wider health sector. The primary sector and particularly PNs were the first line of support for patients requiring health services during the pandemic (most were involved with testing and triage) and were known to have felt less prepared and supported than their colleagues in public hospitals[12].

> *'Better support and appreciation from leaders and MOH. Totally underappreciated.'*
>
> *'… reflect the work that primary care is doing to support the DHB. Especially in COVID-19.'*
>
> *'Recognition of the hard work done.'*
>
> *'…very disappointed that as a whole we are not recognised to be as valuable as other nurses who work in the public settings, particularly as we carried so much of the load over the COVID-19 lockdowns.'*
>
> *'Acknowledgment for our mahi.'*

[12] Report reveals frontline nurses' struggles during COVID-19 pandemic (May 2020) https://www.nzdoctor.co.nz/article/undoctored/report-reveals-frontline-nurses-struggles-during-covid-19-pandemic

'If you want to keep nurses in primary health, pay them what they are worth. We were there through the pandemic at the front of client care. We take all the work that the hospital doesn't do any more e.g. dressings, IV medications, complicated diabetes care.'

Better communication

There was a call for better communication, which is often a challenge. Nurses did not always have their own work email address and did not necessarily receive the communications that were sent out or in a way that was best for them. With the many changes occurring in general practice (and the busy workloads), better ways of sharing information are needed.

'Communication, beyond emails. More support about new changes.'

'Co-ordination/collaboration and communication with other health services.'

'It is hard to keep up with new updates coming thick and fast. Especially with vaccination changes and coming up cervical screening changes.'

Feeling valued by doing less administrative work

There was a call for PNs to do less administrative work with recalls and quality work identified or at least to have these centrally managed. In addition, the administrative work was not always factored into work time and this meant trying to make extra time in a work day (or using their own time). In some practices HCAs were doing this work, which did free up PNs to do more clinical work. Pinnacle also has the Patient Access Centre where recalls are part of this remit. It would need to be for business managers to identify what the best options are for their practices.

'Recalls for screening/vaccinations and meeting health care needs being centrally managed to allow more staff on the floor seeing patients. The demands increase on nursing every few months and it feels overwhelming to meet quality goals.'

'Allocate specific jobs to HCAs to free up nurses' time, employ admin people who can do the recalls to free up nurses' time, too much admin and not enough clinical hours.'

'There are so many monotonous repetitive tasks like preparing prescriptions, phoning to give test results etc. that can surely be reduced or made easier somehow. Manage My Health app is a good attempt at this but is not widely used and creates its own unique problems.'

'The need for less red tape paperwork such as CQI [continuous quality improvement, older term for quality measures] assessments, etc. A lot of time is spent on proving that we are attempting to meet targets, etc. rather than serving our patient.'

'More time for administration jobs—taskbar, inbox, patient follow up via phone. All important parts of the job but I find the time it takes in a nurse's or doctor's day is not acknowledged and often you are either coming to work early, working through breaks, staying late or working from home to keep on top of it.'

'Stop putting red tape and administrative tasks on nurses.'

Resources to improve patient care and patient self-care

The call for more funding continues but in ways that could support patient outcomes, as well as ways to encourage people to take better care of their own health. What these responses continue to show is the place of PNs within the wider health system, working alongside patients to prevent hospitalisation and working with other agencies to provide care in the community.

'More funding for easier access to patient care.'

'Accessibility—funding for nurses to provide free diabetic health care.'

'For patients to access services such as mental health support.'

'Podiatry care for ALL our diabetic patients etc.'

'Low-cost access for health care for those with LTC. I feel at times we are a bit of an island, more by being semi-rural.'

'Free primary care for people with low incomes and long-term conditions.'

'Free smears, cervical screening is the only screening that isn't funded!'

'Increase funding to lower access and increase wages.'

'More creative thinking around mental health provision.'

'More funding for time to work proactively with patients rather than reactively. It's talked about all the time but not funded.'

'More funding needed so patients have better access to health care and not having to wait so long for appointments.'

'More funding to provide cheaper services to patients.'

'More funding to provide services rather than all going to secondary care.'

'Patients with long-term conditions gaining free access to allied health providers throughout Aotearoa.'

'Put more money into prevention of conditions rather than trying to fix them later.'

'Patient education, more media input re self-monitoring and regular checks.'

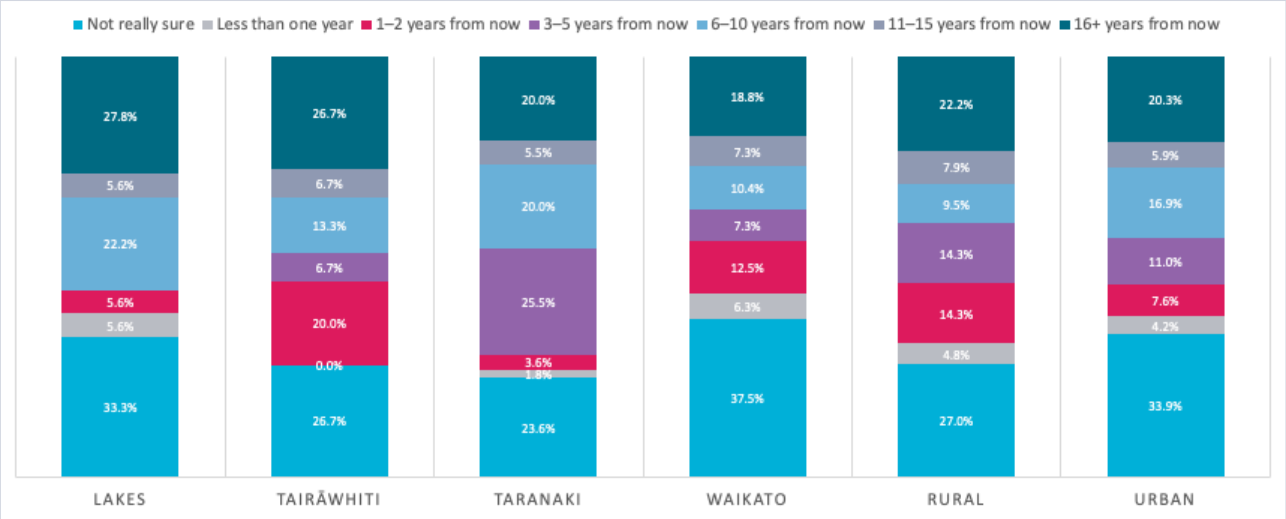
Retirement plans

185 PNs responded with their retirement intentions, although 59 PNs (31.9%) identified that they were not really sure, leaving 125 PNs (68.1%). A further 12 PNs left this question blank. In addition, those that were

unsure when they intended to retire accounted for 6 from Lakes (33.3%), 4 from Tairāwhiti (26.6%), 13 from Taranaki (23.6%) and (37.5%).

Figure 12 is based on 125 PNs. Note: the denominator for each category varies, which may have a large effect with small numbers.

Figure 12: PN retirement intentions by region and practice location



Key findings (Figure 12):

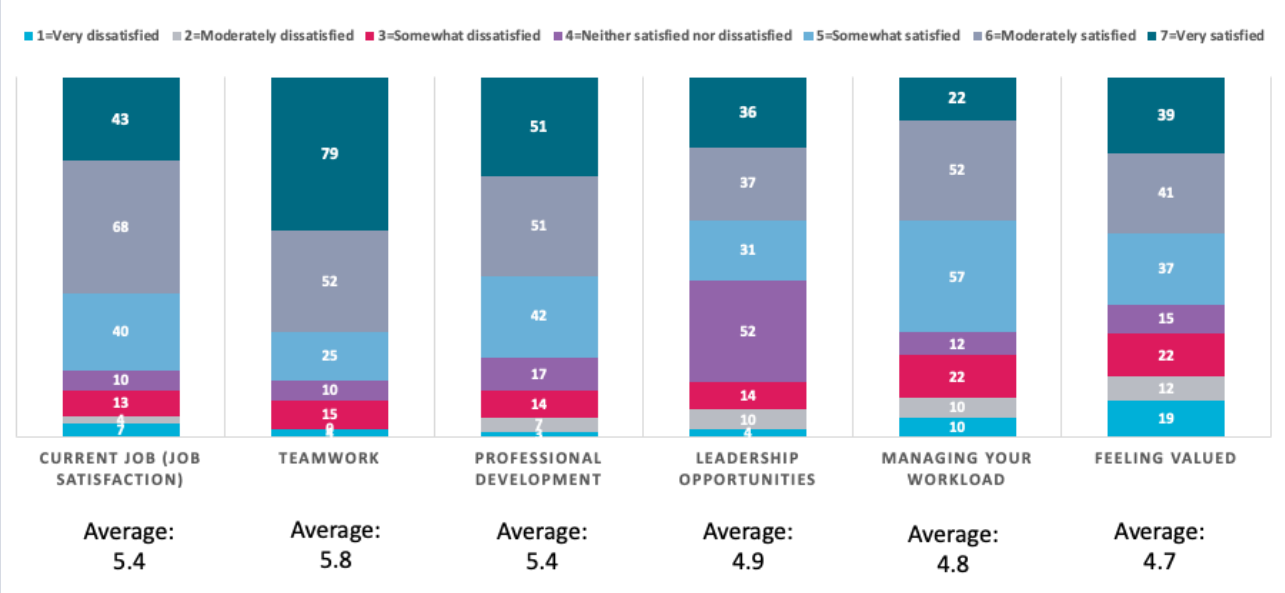
- PN retirement intentions vary across the regions with Tairāwhiti having the greatest movement (20.0%) in the next two years (orange and grey colours), followed by Waikato (27.3%). Lakes and Taranaki have smaller shifts at 11.1% and 5.5% respectively.
- Nearly one-fifth (19.0%) of the rural workforce have indicated their intentions to retire in the next two years compared with nearly 12% in urban practices.
- By 2028 (intentions in five years' time—orange, grey and yellow combined), over one-quarter of PNs from Tairāwhiti (26.7%) and Waikato (26.0%) are looking to be retired, with a massive 30.1% in Taranaki. There is no additional change identified in Lakes region.
- The differences show between urban and rural practices in five years' time with one-third of PNs in rural practices intending to be retired compared with 23% of PNs from urban practices.
- In 10-years' time (orange, grey, yellow and cornflower blue combined), retirement intentions compound, with Taranaki at 50.9%, Tairāwhiti at 40%, Waikato at 36.5% and Lakes at 33.3%.
- Rural differences are much closer with 42.9% of PNs in rural practices intending to be retired within the next 10 years compared to 39.8% from urban practices.

- A NZ study[13] looking at retirement intentions of nurses aged 50+ identified access to flexible or decreased hours is required, along with less physically demanding work options and roles that recognise and utilise the knowledge, skills and experience of older nurses, are key factors in reducing attrition. It suggests these measures have the potential to enable older nurses to continue to contribute for longer to the workforce, albeit on a more part-time basis.

Final overall topics

A final matrix was provided for PNs to rate topics from very dissatisfied to very satisfied based on their current job (job satisfaction), teamwork, professional development opportunities, leadership opportunities, managing your workload and feeling valued. Each result is introduced, displayed on a graph and has some key findings featured. Each response was scored with 1=very dissatisfied to 7=very satisfied. The average is reported without a standard unit. The number towards 7 indicates greater satisfaction and vice-versa, the lower the average, indicates greater dissatisfaction.

Figure 13: PN ratings on a range of topics



Key findings (Figure 13):

- Each of these topics are given in more detail on the following pages.
- PNs showed a high degree of job satisfaction although there are pockets of nurses who are dissatisfied with their current job.

[13] Walker L and Clendon J (2013). Ageing in Place: Retirement intentions of New Zealand nurses aged 50+. Labour, Employment and Work in New Zealand. https://ojs.victoria.ac.nz/LEW/article/view/1972/1796

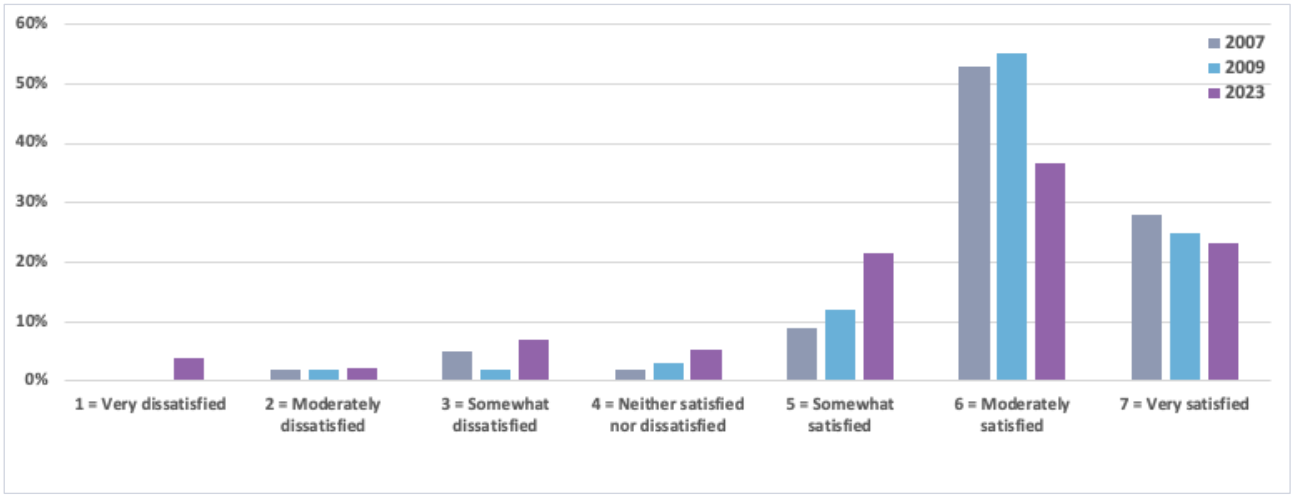
- PNs were on average moderately satisfied with teamwork and this was rated highest of the topics.
- Professional development opportunities appeared satisfactory with equal numbers across the moderate and very satisfied categories and an average 5.4. Some PNs indicated dissatisfaction in this area.
- Leadership opportunities were less strongly conveyed (average 4.9), with a large proportion being neither dissatisfied nor satisfied.
- PNs identified being predominantly satisfied with managing their workload although a large number of dissatisfied in this area.
- While many nurses felt satisfied with how valued they felt, this category had the highest number of dissatisfied PNs, particularly those identifying as very dissatisfied.

Job satisfaction

The PNs were asked to rank their overall degree of satisfaction with their current role as a practice nurse on a seven-point Likert type scale where 1 is equal to very dissatisfied and 7 is equal to very satisfied. The analysis in this section is based on responses from 189 PNs in the network.

Comparisons have been made to the job satisfaction ratings recorded during the 2007 and 2009 surveys of the network PNs (question on job satisfaction was not included in the 2006 survey). Please refer to Appendix Table 4 for the job satisfaction ratings by region and categorised by location of practice (rural/urban).

Figure 14: Levels of satisfaction with current PN job, network 2007, 2009 & 2023



Key findings (Figure 14, Appendix Table 1, Appendix Figure 3):

- The average satisfaction rating by practice nurses across the network is 5.4, which is less than that found in the 2007 and 2009 surveys, meaning there is an increase in job dissatisfaction. The proportion

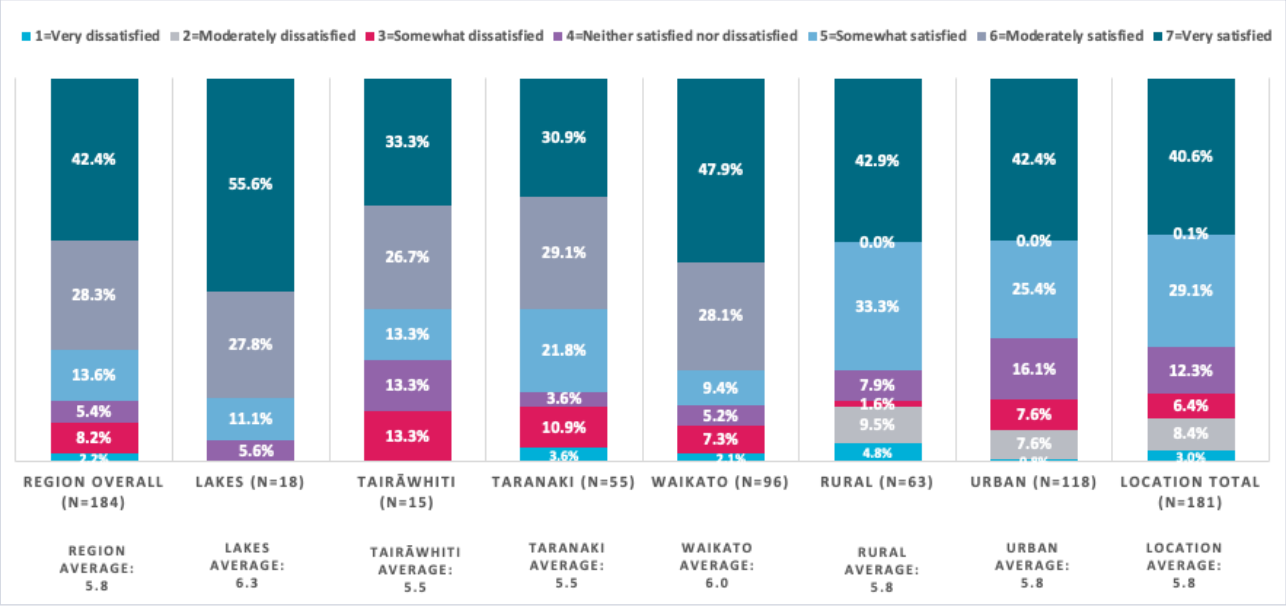
of nurses who reported varying degrees of dissatisfaction with their current role varied from 7% in 2007 to 4% in 2009 up to 13% currently (2023).

- There are small differences between rural and urban practice nurses with rural reporting an average job satisfaction rating of 5.7 compared with urban at 5.3. However, this hides the greater dissatisfaction in urban PNs, with 14.4% reporting varying degrees of dissatisfaction with their current role compared to 8.8% amongst PNs at rural practices. About 94% of the urban practice nurses reported being slightly to very satisfied compared to 90% amongst their rural counterparts.
- One-fifth of PNs from Taranaki and Tairāwhiti regions have identified varying degrees of dissatisfaction with their jobs.

Teamwork

It is recognised that since the 2009 workforce survey there have been changes in the range of health professionals that now make up the wider primary health care workforce. Being able to work collaboratively with colleagues is a key part of any functioning workplace.

Figure 15: Self-reported rating of teamwork by region and practice location



Key findings (Figure 15 and Appendix Table 2):

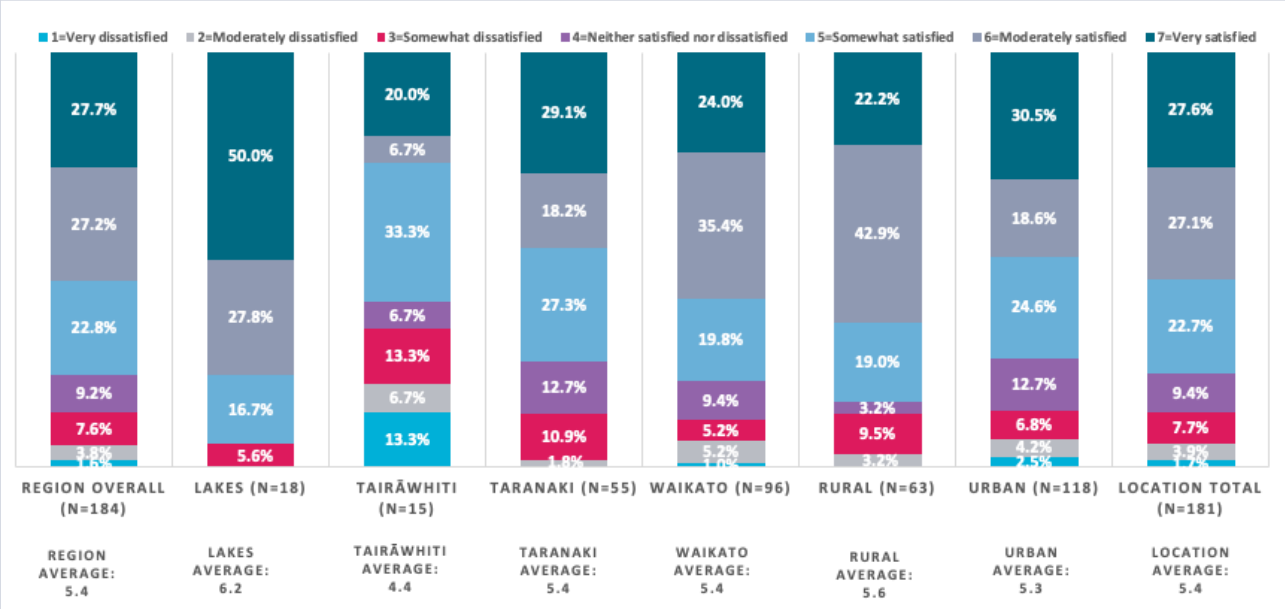
- On average, respondents were 'moderately satisfied' with teamwork (average 5.8) by region and practice location.
- By region, levels of satisfaction for teamwork were greatest in Lakes (average 6.3), with moderately and very satisfied categories accounting for 15/18 responders.

- By practice location, the average rate for teamwork was the same for both rural and urban locations at 5.8, however, this masks the dissatisfaction rate, which was higher in rural practice locations in the moderate to very dissatisfied categories (14.3% vs 8.4%).

Professional development opportunities

Professional development is a commitment for keeping PNs updated, to ensure minimum standards are met for supporting patients with long-term conditions and for meeting quality indicators such as cervical screening, immunisations, and diabetes reviews.

Figure 16: Self-reported rating of professional development opportunities by region and practice location



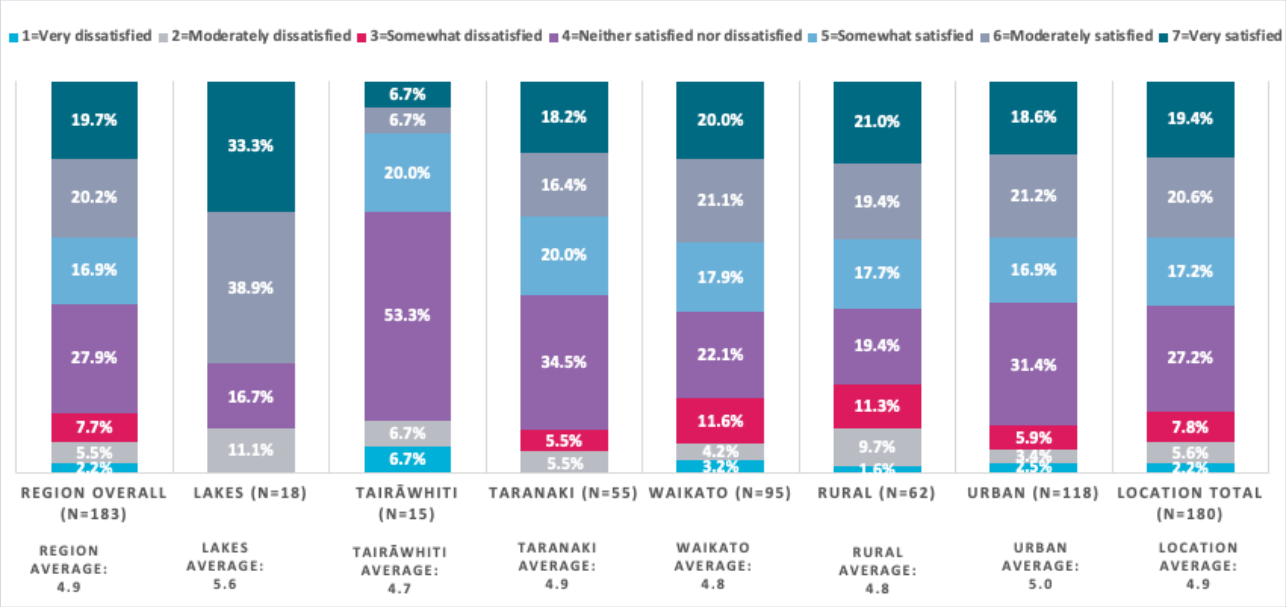
Key findings (Figure 16 and Appendix Table 3):

- On average, respondents were 'moderately satisfied' with professional development opportunities (average 5.4) by region and practice location.
- By region, levels of satisfaction for professional development opportunities were greatest (moderately and very satisfied) in Lakes (average 6.2) accounting for 17/18 responders. Levels of dissatisfaction were greatest (moderately and very dissatisfied) in Tairāwhiti (average 4.4) accounting for one-third of responders (4/15). On the back of COVID and weather events, opportunities may have been impacted.
- By practice location, the average rate for professional development opportunities were both within the 'moderately satisfied' range. Rural location had an average score of 5.6 compared with urban location at 5.3. The lower average for urban locations reflects percentages in the moderate to very dissatisfied categories (6.7%).

Leadership opportunities

Given the high levels of self-direction in the way PNs work, having strong leadership helps to maximise efforts towards a common purpose. The opportunities for leadership may indicate where PNs may wish to have influence.

Figure 17: Self-reported rating of leadership opportunities by region and practice location



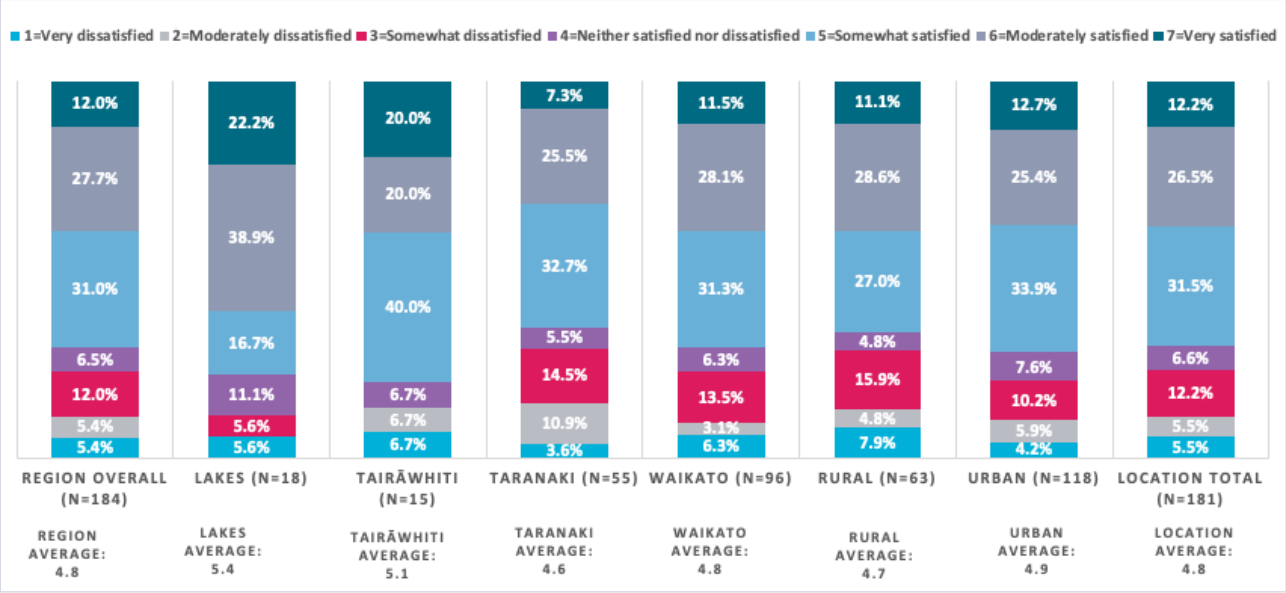
Key findings (Figure 17 and Appendix Table 4):

- PNs rated leadership opportunities in the 'somewhat satisfied' range at 4.9 overall.
- By region, this was greatest for Lakes with an average of 5.6, compared with Tairāwhiti at 4.7.
- By practice location, numbers were similar for rural and urban practices at 4.8 and 5.0 respectively.

Managing your workload

Globally, the demand for primary health care has risen on the back of an ageing population living with more complex health needs, along with a shortage of GPs and nursing staff. In addition, primary care faced further pressure from the COVID-19 pandemic with PNs at the frontline of testing and vaccinating. It was important to understand how the pressure on primary care transferred to self-reported workload management of PNs.

Figure 18: Self-reported rating of managing workload by region and practice location



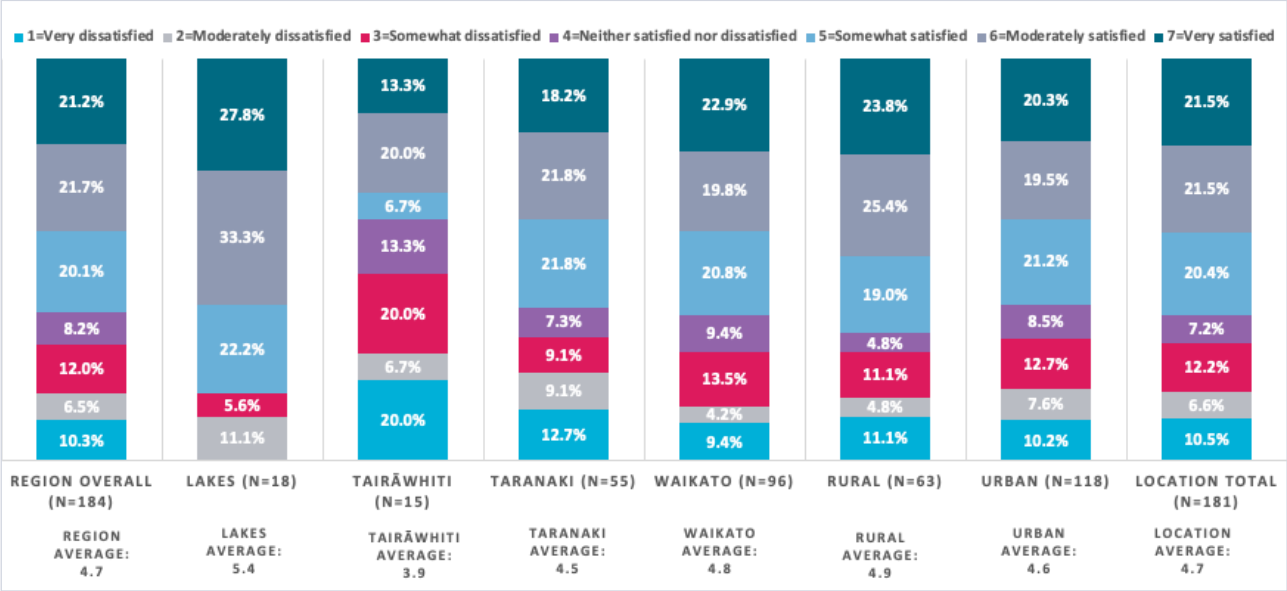
Key findings (Figure 18 and Appendix Table 5)

- Overall, PNs were 'somewhat satisfied' with how well they were managing their workloads.
- By region, this ranged from highest in Lakes at 5.4 compared with Taranaki at 4.6, with 29% of Taranaki region respondents identifying dissatisfaction (somewhat, moderately and very dissatisfied).
- The average for workload management by practice location was 4.8, rural was slightly less at 4.7 compared with urban location at 4.9. In particular, 13.7% of rural location PNs identified dissatisfaction (moderately and very dissatisfied) with workload management increasing to 28.6% when including those who are somewhat dissatisfied. In comparison, 23.2% of PNs in urban locations identified dissatisfaction of some description.

Feeling valued

There are variations for PNs in terms of employment conditions, expectations and opportunities. Feeling valued was a theme PNs identified for helping primary care to thrive. In addition, the feeling of being valued has been prominent in the discussion around pay parity with secondary care nurses.

Figure 19: Self-reported rating of feeling valued by region and practice location



Key findings (Figure 19 and Appendix Table 6)

- Overall, PNs were 'somewhat satisfied' with feeling valued (4.7).
- Feeling valued was greater in Lakes region (5.4 moderately satisfied) compared with Tairāwhiti region (3.9 neither satisfied nor dissatisfied). 20% of PNs in Tairāwhiti were very dissatisfied with feeling valued and this increased to 46.7% for any dissatisfaction category.
- By practice location, the average for PNs in rural practices (4.9) was greater than the satisfaction at urban practices (4.6). Dissatisfaction (moderately to very dissatisfied) was higher in rural practice PNs than urban practice PNs, respectively (15.9% vs 17.8%).

Final comments

This final section provided more opportunity for comments relating to the sector: pay inequity/parity, being under pressure, practice nursing not feeling valued, being tired, being bullied, workload along with responsibility and expectations are doubling, burnout, needing investment in wellbeing, under mountains of paperwork, personal time spent to study, working longer than paid hours, and recognition of the practice nursing profession, and the feeling that no-one is listening.

These were small glimmers of hope: '*Don't forget to celebrate the little things', 'Love my job!'* but unfortunately these types of comments were not common enough.

MĀTANGA TAPUHI
NURSE PRACTITIONERS

The analysis in this section is based on 9 nurses who identified they were on the New Zealand Nursing Council scope as a mātanga tapuhi nurse practitioner (NP). All bar one worked in the general practice setting. Due to the small numbers, these have **not** been broken down by region or practice location. Where there is a likelihood of identification, the majority response will be described.

The roles of NPs [and nurse prescribers] are integral to the future of health care, with ongoing health reforms and an ageing workforce among the many challenges facing the sector, says Jan Adams, general manager MHN/nursing director in executive.

There are an increasing number of nurses in the network who are either on the pathway to becoming a mātanga tapuhi nurse practitioner or are thinking of going along that path.

Mātanga tapuhi nurse practitioners have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a registered nurse.

In order to be registered as an NP in New Zealand, applicants must meet the following criteria prescribed by the Nursing Council of New Zealand:

- Registration with the Nursing Council of New Zealand in the registered nurse scope of practice; and
- A minimum of four years of experience in a specific area of practice; and
- Successful completion of a clinically focused master's degree programme approved by the Nursing Council of New Zealand, or equivalent qualification; and
- A pass in a Nursing Council of New Zealand assessment of nurse practitioner competencies and criteria.

NPs seeking registration with prescribing rights are required to have an additional qualification:

- Successful completion of an approved prescribing component of the clinically focused master's programme relevant to their specific area of practice.

SECTION D10: Demographic characteristics

All NP respondents were female and ranged in age from their 40s to 60s, with an average age of 51.3 years.

Nearly 80% of respondents identified with European ethnicity.

NPs first received their registered nurse registration on average 27.7 years ago, and nearly 90% gained their first nursing registration in New Zealand.

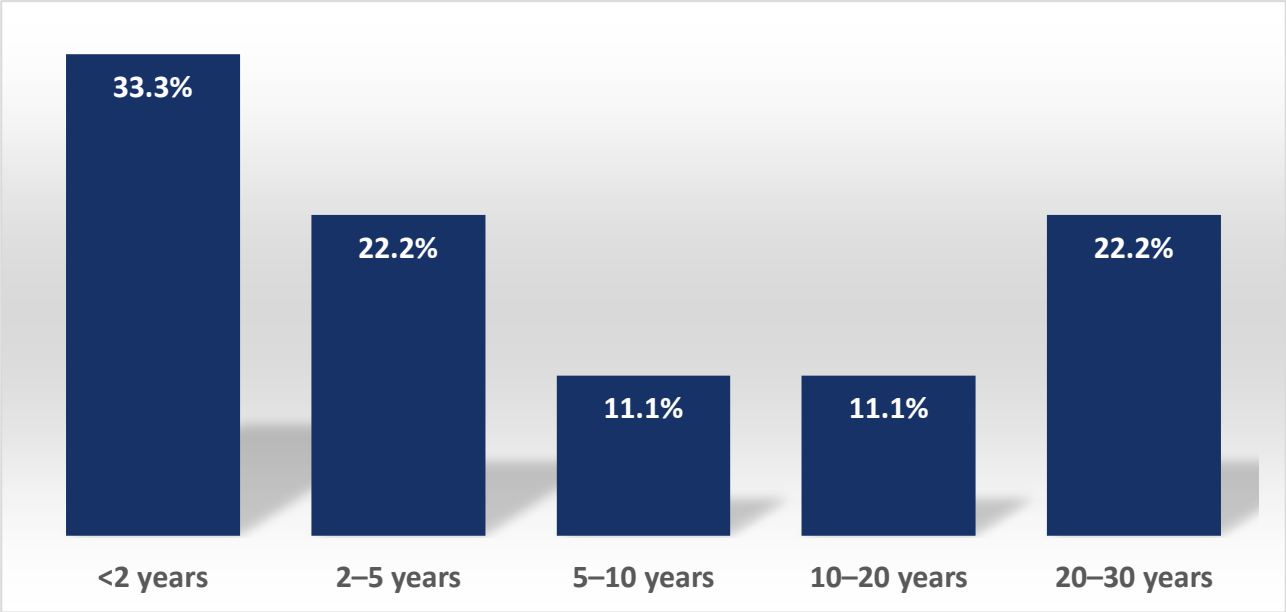
Overall, NPs have been employed either part-time or full-time as a nurse for an average of 25 years (ranging from 12–30+ years), with an average of 16 years outside of the hospital setting.

SECTION D11: Current work situation

NPs have identified many years of practice and may have commenced working in their current setting as registered nurses before continuing onto education and training to achieve NP status. This was not differentiated, and the responses relate to the questions as they were presented.

NPs were asked how long they had been employed in their current work setting. Wording considered that not all nurses work within a general practice setting.

Figure 20: NPs time in current work setting



Key findings (Figure 20)

- NPs have worked in their current work setting for an average of 8.9 years, ranging from less than 1 year to 20+ years. Greater than 50% have been in their workplace for less than 5 years. Due to small numbers, no inference can be made from this.

All NPs identified that they work greater than 35 hours per week. Table 18 provides a breakdown of the type of work NPs do within a week. Note: not all options had responses.

Table 18: NP work type per week

Work type	0 hrs	>0–4 hrs/wk	5–9 hrs/wk	10–14 hrs/wk	15–19 hrs/wk	20–24 hrs/wk	25+ hrs/wk	Grand Total
In-person in the work setting						3	4	7
In-person—home visit	4		1				1	6
In-person—other venue	1	3					1	5

Virtual consult		5	2		1			8
Phone triage		1		1	1			3
Non-client/patient-facing		4	2	2	1			9
Non-client hours	6	2	1					

Key findings (Table 18)

- The majority of NP work is face-to-face work in a work setting, although one NP spent much of their time home visiting and another at a venue separate to their usual work setting.
- Virtual consults were continuing but the majority did less than 5 hours per week, although one NP spent up to 20 hours providing consultations virtually.

Non-client hours for NPs were few, compared to the amount of non-client work (including administration) that PNs do (

Table 10).

The content of work NPs perform in their professional practice was informed from an online survey of the NZ NP workforce conducted in mid-2019[14] and our results have been compared with this paper. The questions reflected NP contribution to leadership and management, policy development, locum work and research.

Table 19: NP professional practice domains showing frequency for each type of work

	Regular work	Occasional work
NP in clinical practice	9	
Management/leadership position in workplace	1	1
Professional nursing leadership (e.g. NPNZ, NZNO)		2
Policy development	1	1
Tertiary education teaching	1	1
Other		1

Key findings (Table 19)

- NPs are engaged in a range of work in addition to their clinical practice. Due to the small number of respondents, it does not reflect the contribution that network NPs make to leadership and management and to policy development.
- None of our network NPs identified locum work or research as being a part of their workload, unlike the Adams paper, which identified 13% and 15% of NPs, respectively.
- Leadership of clinical/practice development at regional or national level was not identified in the network NPs, whereas this is as high as 36% in the Adams paper.

NPs identified factors that contributed to their job satisfaction. NPs display autonomy in clinical decision-making and it is interesting to see what additional factors support job fulfilment.

Table 20: Factors that contribute to NP job satisfaction

Factors that contribute to job satisfaction	Count
Working in my particular specialty/interest area	9
Interprofessional relationships	6

[14] Adams et al (2020) A survey of the NP workforce in primary healthcare settings in NZ. NZMJ, 133:1523, p29–40.

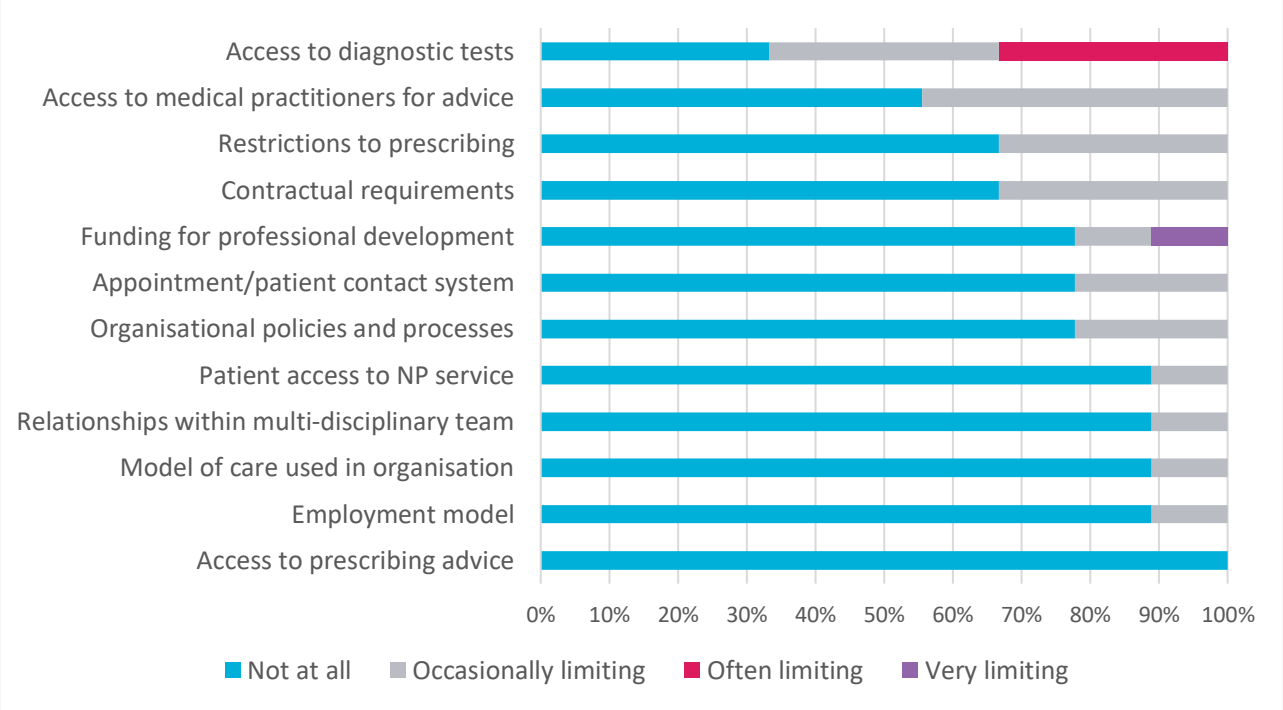
Belonging to a mātanga tapuhi nurse practitioner professional group	4
Scheduling appointments	3
Flexibility of hours	3

Key findings (Table 20)

- NPs identified that their job satisfaction comes from working in their particular specialty/interest area. This affirms the ability of NPs to meet changing health needs safely and appropriately within their area of influence.
- To a lesser degree interprofessional relationships and belonging to a professional group were key factors in job satisfaction.
- Flexible working arrangements were low on the list (as were scheduling appointments) and this could be due to most NPs working more than 35 hours per week (in which flexibility is not an issue).

The survey asked NPs about aspects that may limit their ability to work to their full scope of practice. This was taken from and compared with the Adams paper (see footnote to previous page).

Figure 21: Factors that limit NPs' full scope of practice



Key findings (Figure 21)

- Access to prescribing advice appeared the least limiting of all factors, however, diagnostic tests appeared the most limiting aspect of practice along with access to medical practitioners for advice.

- Restrictions to prescribing was cited by one-third of respondents and a comment in relation to Section 29 of the Medicines Act was made.
- Funding for professional development was not a limitation for most NPs but for one it was very limiting and another, occasionally limiting. Adams et al identified 45% of their respondents identified a lack of funding with over half of this group identifying that no funding was available to them for professional development.
- Another comment related to a lack of understanding of the scope of their roles. NP training and legislative changes have enabled NPs access to funding, which provides another means of service provision for patients/clients to receive expert care. NPs can also independently generate a viable income in general practice.

SECTION D12: Responsiveness to Māori

The workforce survey was an opportunity to establish a baseline for how health professionals were working with clients/patients in a manner that sought to uplift the mana of all patients with a particular focus on responsiveness that supports Māori aspirations. These questions were developed to identify strengths and weaknesses in our network where support can be provided further.

Table 21: NP responses to day-to-day practices focused on Māori responsiveness

Day-to-day practices	%
Reaching consensus with Māori clients/patients about their management/treatment plans (goals, options, length)	100%
Checking back (teach-back technique)	88.9%
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	88.9%
Enquiring about whānau and their health needs	88.9%
Greetings using te reo Māori	88.9%
Karakia in meetings/consultations	55.6%
Recalls focused on increasing Māori engagement/participation in screening or health initiatives	44.4%
Partnership with Māori organisations/groups in service provision or community initiatives, i.e. working alongside to improve outcomes for client/patient where specific skills are needed.	33.3%
Working to a Māori health plan developed within the workplace that sets out broad direction to address inequity	22.2%

Key findings (Table 21)

- 100% of NPs identified reaching consensus with Māori clients/patients about their management/treatment plans. This is a testament to the way in which NPs work with clients.
- Nearly 90% of PNs use teach-back technique—a way of checking understanding by asking clients/patients to state in their own words what they need to know or do about their health or follow-up. This is a clear health literacy tool that benefits all patients and their whānau.
- Nearly 90% of NPs have used knowledge gained from Te Tiriti o Waitangi and/or cultural competency training; providing a solid platform for understanding the challenges faced and how collectively NPs can make a difference.
- Nearly 90% of NPs enquire about whānau and their health needs as part of their day-to-day practices.
- It is excellent to see that greetings using te reo Māori are also at 90%. In comparison, PNs reported 59% use.

- Partnership with Māori organisations/groups in service provision was uncommon with 3/9 NPs identifying a relationship. This statement established the premise that general practice works alongside community providers and those in extended roles of practice to support our population. How NPs work with external support services, particularly for Māori clients, is not established.
- Working to a Māori health plan, which are part of the Foundation Standards, was less common for NPs with 2/9 identifying that they do. This is in comparison with 39% of PNs identifying working to one.

SECTION D13: Nurse leadership and supervision of clinical skills

Nurse leadership

NPs often work autonomously and can benefit from being part of a clinical team. Having nurse leadership in place supports wider connectedness, links to strategic planning and direction, and is known to improve quality of services to patients.

Two-thirds of NPs had access to a nurse leader solely in their workplace or shared across two or more workplaces. The majority of NPs had a nurse lead solely in their workplace (5/9).

None of the NPs identified themselves in the role of nurse lead for their workplace or group. As a member of a wider team, opportunities for better use of delegation to others in the workforce may recognise that this role does not sit with NPs.

It is recommended that nursing services should be led by nurses working within a professional practice model of leadership (i.e. line accountability for nursing)[15].

Supervision of clinical skills

Supervision of clinical skills was a feature of 8/9 NPs and covered several roles within the practice team.

Table 22: Recipients of supervision of clinical skills by NPs

Supervision of clinical skills	%
Student nurse	25.0%
Practice centre assistant	25.0%
Registered nurse completing specialty training	75.0%
Enrolled nurse	0%
Nurse practitioner	25.0%
Nurse practitioner on NP pathway	12.5%

[15] Manatū Hauora (2018) Primary Health Care Nursing Leadership https://www.health.govt.nz/our-work/nursing/nursing-leadership/primary-health-care-nursing-leadership

Key findings (Table 22)

- The majority of supervision is provided to registered nurses completing specialty training.
- In comparison to RNs, NPs provide more supervision to other NPs and NPs in training.
- RNs completing specialty training are supported by 75% of NPs, compared with 29% of RNs, however the small number of NP respondents may account for this difference, as well as size of practice (staff composition).
- The NP role is less likely to support supervision of student nurses and practice centre assistants, who are more often under the delegation of RNs; these groups are supported by over 40% of PNs who provide supervision of clinical skills.

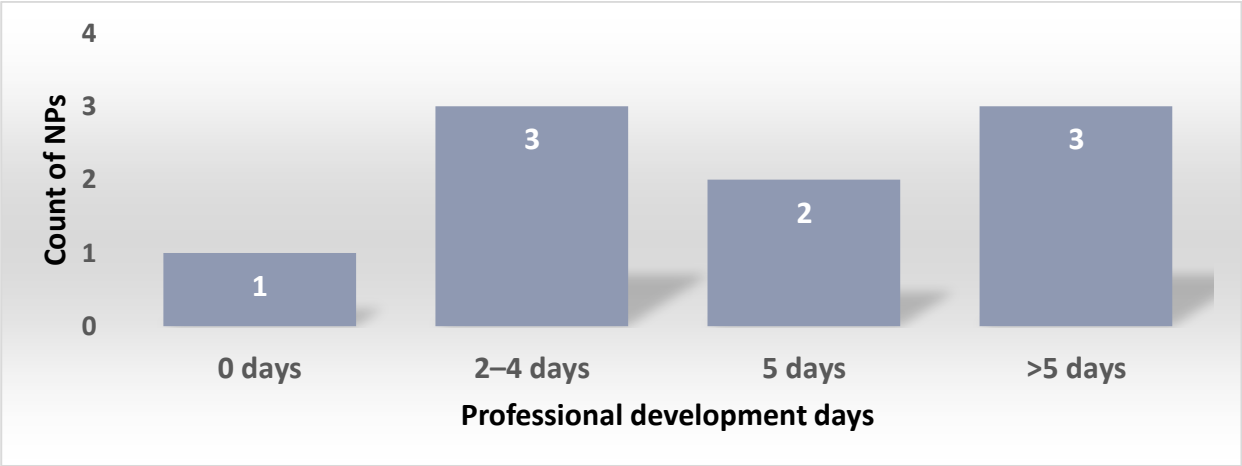
Supervision training in clinical skills was identified by 6/8 NPs with half having learnt on the job and half having completed an education programme.

SECTION D14: Postgraduate study and professional development

All our respondent NPs identified that they were not undertaking further post-graduate study. We did not ask their reasons for this. The NP qualification is a mandatory master's-level postgraduate programme and there are ongoing re-certification processes with NZNC. Interest in other formal postgraduate qualifications may not be a priority.

NPs are required to undertake 40 hours per year of professional development and ongoing peer review of their prescribing practice to maintain registration. The amount of professional development received in the last year was identified.

Figure 22: NP Professional development in the past year



Key findings (Figure 22)

- Over half of NP respondents received five or more days of professional development, which meets one part of their NZNC requirements.
- A NZ study highlighted that NPs do not always receive equitable support for continuing education or maintaining annual requirements for clinical competence[16]; however, the majority of nurses did not consider funding for professional development limited their scope of practice (Figure 21).

For two-thirds of NPs (6/9), access to professional development in the past 12 months was adequate.

Reasons given for not accessing more were identified as: too busy at work x2, cost not covered by employer x1, and lack of subsidised or supported CNE funding for NPs x1.

[16] Harvey C, Papps E, Roberts J (2015) Obstacles that prevent nurse practitioners in New Zealand fulfilling their roles. Primary Health Care. Vol 25:5,24–29.

SECTION D15: Work pressures

Burnout

All nurses were asked to identify their level of burnout using their own definition based on a validated one-question scale[17]. Where symptoms of burnout were identified, support structures such as EAP offered by Pinnacle to practice staff and available elsewhere (e.g. 1737 line) were provided as well as online tools. One NP did not answer this question.

Table 23: Measuring burnout in NPs

Measure	Count	Percentage
Burned out—average score (1–5)	1.9	
(1) I enjoy my work. I have no symptoms of burnout.	2	25.0%
(2) Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	5	62.5%
(3) I am definitely burning out, and have one or more symptoms of burnout, such as physical or emotional exhaustion.	1	12.5%
(4) The symptoms of burnout I am experiencing won't go away. I think about the frustrations at work a lot.	0	
(5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	0	
Total	**8**	

Key findings (Table 23)

- Most NPs were not feeling burned out (score 1 or 2). One respondent recognised that they have one or two symptoms of burnout, such as physical or emotional exhaustion.
- In comparison, NPs average score of 1.9 is less than the burnout score for PNs average at 2.4.

[17] Rohland B, Kruse G and Rohrer J (2004) Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. Stress and Health. 20: 75–79.

SECTION D16: Looking ahead

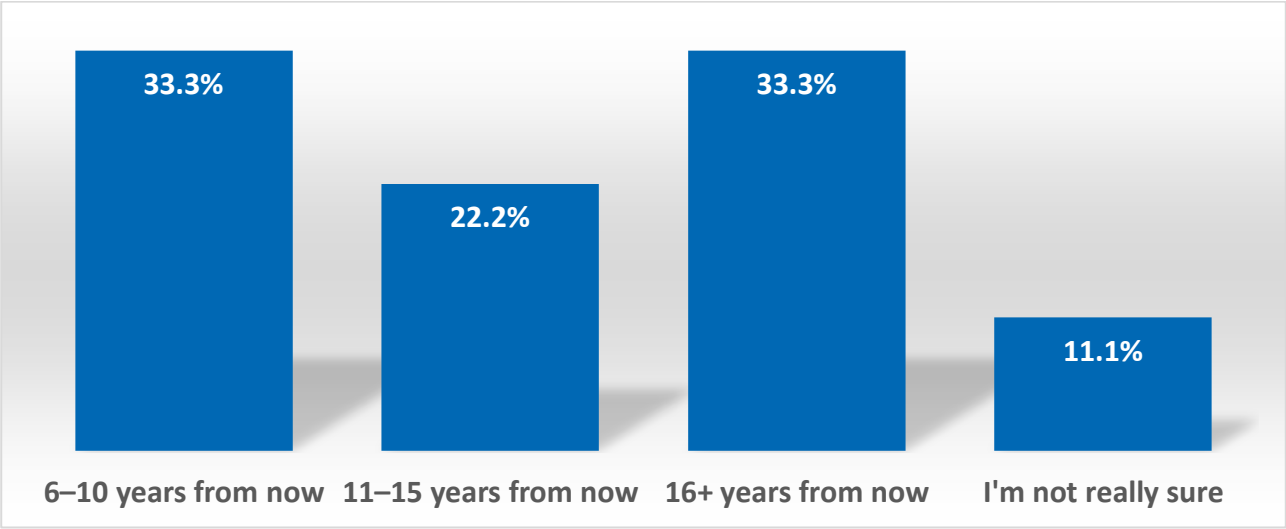
One suggestion for primary care to thrive

Particular comments related to: pay parity (equaling Te Whatu Ora senior nurse pay scale), attraction and retention, more funding for education, salaries and support, increasing funding and access for everyone, development and implementation of social policy, and the importance of professional development as a necessity.

Retirement plans

Organisations need to be cognisant of their workforce demographics and determine workforce plans for retirement. Particularly with NPs, their roles uniquely support primary care and, in some cases, fill in spaces created from gaps elsewhere in the workforce.

Figure 23: NP retirement intentions



Key findings (Figure 23)

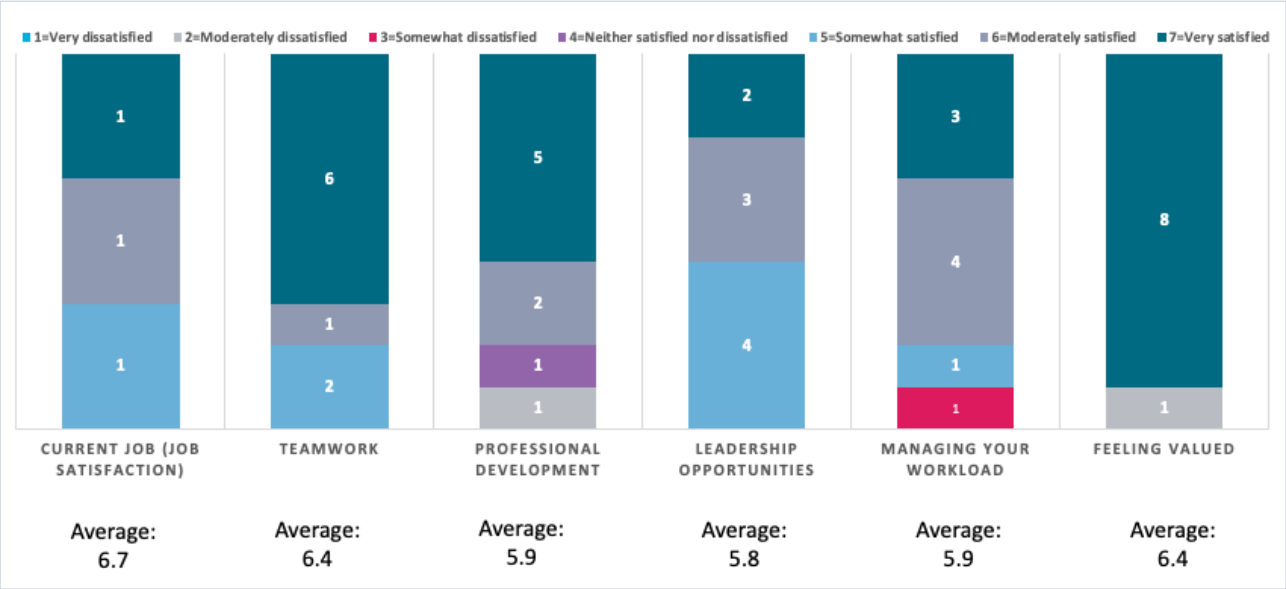
- 8/9 respondents are intending to stay for at least a further 6–10 years (with the majority indicating over 10 years) suggesting a stable workforce for this group of NPs. 1 NP was unsure of their retirement intentions.
- In comparison, Adams et al[18] identified 60% intending to stay for at least three years.

[18] Adams S, Boyd M, Carryer J, Bareham C, Tebensel T (2020) A survey of the NP workforce in primary healthcare settings in New Zealand. NSMJ Vol 133: 1523, 29–40.

Final overall topics

A final matrix was provided to rate topics relating to current job (job satisfaction), teamwork, professional development opportunities, leadership opportunities, managing your workload and feeling valued. Each response was scored with 1=very dissatisfied to 7=very satisfied which were then grouped into dissatisfied and satisfied. The average is reported without a standard unit. The number towards 7 indicates greater satisfaction.

Figure 24: NP ratings on a range of topics



Key findings (Figure 24)

- NPs show a high degree of job satisfaction with none identifying being dissatisfied with their current job.
- NPs were mostly very satisfied with teamwork (6/9), compared with moderately satisfied (1) and somewhat satisfied (2).
- Professional development opportunities were less strongly conveyed (average 5.9), with some NPs indicating that they were moderately dissatisfied (1) or neither satisfied nor dissatisfied (1) although the majority were moderately satisfied (2) or very satisfied (5).
- Leadership opportunities were less strongly conveyed (average 5.8), with some NPs indicating that they were somewhat satisfied (4) versus moderately satisfied (3) and very satisfied (2).
- Managing your workload was less strongly conveyed (average 5.9), with some NPs indicating that they were somewhat dissatisfied (1) and somewhat satisfied (1) although most were moderately satisfied (4) or very satisfied (3).
- NPs felt valued (8/9), although one NP felt moderately dissatisfied with feeling valued.

- On further analysis of the dissatisfied choices made, all came from one NP who had also indicated higher than average levels of burnout. It shows how burnout can become all-consuming and affect other aspects of work enjoyment, collegiality and satisfaction. Opportunities for receiving support were identified within the survey.

Final comments

One NP recognised her privilege in having an amazing role where they are valued, supported and encouraged to work at the top of their scope but recognising it is not the case for all. Another pointed to nurse leadership in practice being poorly paid, poorly carried out and poorly supported but indicated that clinically NPs were well supported. There was a plea for organisational support of general practice staff to campaign for better wages, education and support. In particular, the comparison to pay parity with hospital nurses, the tireless work during COVID and the current nursing workforce crisis were common threads. Many of these comments mirror those of nurses in general practice and urgent care.

COMMUNITY-BASED NURSING

Community-based nurses work in various nursing roles outside of a structured clinic environment. This includes nurses who are part of the extended care team (ECT), an interdisciplinary approach of clinical and non-clinical employees working together with general practice to provide support and education based on an individual's circumstances and needs, and other community-based nurses working in care in the community, in child health and immunisation, in mobile services, and with patients with long-term conditions.

Seventeen respondents identified themselves as working in a 'community/outreach/extended care team' role. Just over half of workplaces were identified and due to small numbers analysis will not be categorised further.

SECTION D17: Demographic characteristics

All community-based nurses identified as female and ranged in age from their 30s to 60s, with an average age of 46.9 years.

82% of respondents identified with New Zealand European ethnicity with 18% of Māori ethnicity. Nurses who identified with Māori ethnicity acknowledged whakapapa to: Ngāti Porou, Ngā Ariki Kaipūtahi, Ngāi Tahu, Te Aitanga-a-Māhaki, Ngāti Te Roro-o-te-Rangi and Ngāti Uenukukopako.

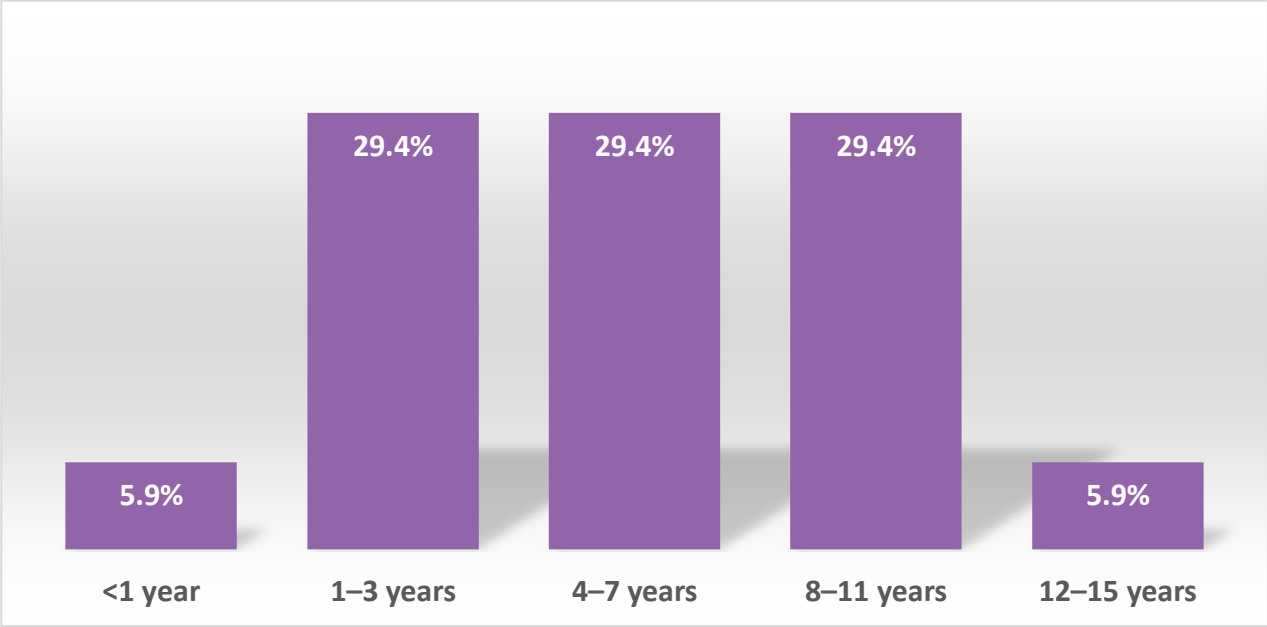
Community-based nurses first received their registered nurse registration from 7–30+ years ago, averaging 18.9 years, with over 90% of respondents gaining their first nursing registration in New Zealand.

The average length of time working outside of a hospital setting for community nursing is 12.3 years, ranging from 1.5–16+ years.

SECTION D18: Current work situation

Community nurses have worked in their current workplace for an average of 6 years, ranging from <1 year to up to 15 years. Hours vary: 38% work full time (40 hours) but on average community nurses work 33.2 hours per week.

Figure 25: Community nurses time in current work setting



Key findings (Figure 25)

- A small proportion of community nurses have been in their current workplace for less than 1 year and greater than 12 years, but in general the community nursing workforce is stable (with an average of 6 years).

Work types for community nursing are variable depending on their employment contracts. As expected, community nursing involves more work outside of a clinic setting than would be expected from a nurse in general practice.

Table 24: Community nursing identification of hours by work type (not adjusted by work hours)

Work type	0 hrs	>0–4 hrs/wk	5–9 hrs/wk	10–14 hrs/wk	15–19 hrs/wk	20–24 hrs/wk	25+ hrs/wk	Grand Total
In-person in the work setting	1	1	3	6	2		1	14
In-person—home visit	0	3		6	2	3	1	15
In-person—other venue	0	6	4	0	0	1	0	11

Virtual consult	1	6	2	2	0	0	0	17
Phone triage	2	7	1	0	0	0	0	10
Non-client/patient-facing	0	6	6	3	1	0	0	16
Non-client related work	1	8	5	1	0	0	0	16

Key findings (Table 24)

- On average, nurses spend more time home visiting than working from a work setting and this is supported by more hours spent on non-client/patient facing work, possibly to complete clinical records and any follow-ups or referrals that are required.
- Virtual consults and phone triage are a smaller part of the community nursing workload.
- Community nurses do some but much less non-client related work up to 5 hours per week than has been identified in a general practice setting (up to 10 hours per week).

SECTION D19: Responsiveness to Māori

The workforce survey was an opportunity to establish a baseline for how health professionals were working with clients/patients in a manner that sought to uplift the mana of all patients with a particular focus on responsiveness that supports Māori aspirations. These questions were developed to identify strengths and weaknesses in our network where support can be provided further.

Table 25: Community nurse responses to day-to-day practices focused on responsiveness to Māori

Day-to-day practices	%
Greetings using te reo Māori	94.1%
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	82.4%
Enquiring about whānau and their health needs	82.4%
Reaching consensus with Māori clients/patients about their management/treatment plans (goals, options, length)	76.5%
Karakia in meetings/consultations	76.5%
Partnership with Māori organisations/groups in service provision or community initiatives, i.e. working alongside to improve outcomes for client/patient where specific skills are needed	76.5%
Checking back (teach-back technique)	70.6%
Recalls focused on increasing Māori engagement/participation in screening or health initiatives	58.8%
Working to a Māori health plan developed within the workplace that sets out broad direction to address inequity	47.1%

Key findings (Table 25)

- It is excellent to see that greetings using te reo Māori are at 94%. In comparison, PNs reported 59% use.
- Over 80% of community nurses enquire about whānau and their health needs as part of their day-to-day practices.
- Over 80% of community nurses have used knowledge gained from Te Tiriti o Waitangi and/or cultural competency training; providing a solid platform for understanding the challenges faced and how collectively community nurses can make a difference.
- Just over three-quarters of community nurses identified reaching consensus with Māori clients/patients about their management/treatment plans, using karakia in meetings/consultations, and partnering with Māori organisations and groups to improve outcomes for client/patient.

- 70% of community nurses identified using teach-back technique—a way of checking understanding by asking clients/patients to state in their own words what they need to know or do about their health or follow-up.
- Focused recalls, recognising the extra emphasis on Māori engagement and participation in health initiatives, were identified in nearly 60% of the cohort.
- Working to a Māori health plan, which is part of the Foundation Standards, was less than 50% at 47.1%, although, in comparison, 39% of PNs identifying working to one.

SECTION D20: Nurse prescribing and additional specialist qualifications

Nurse prescribing

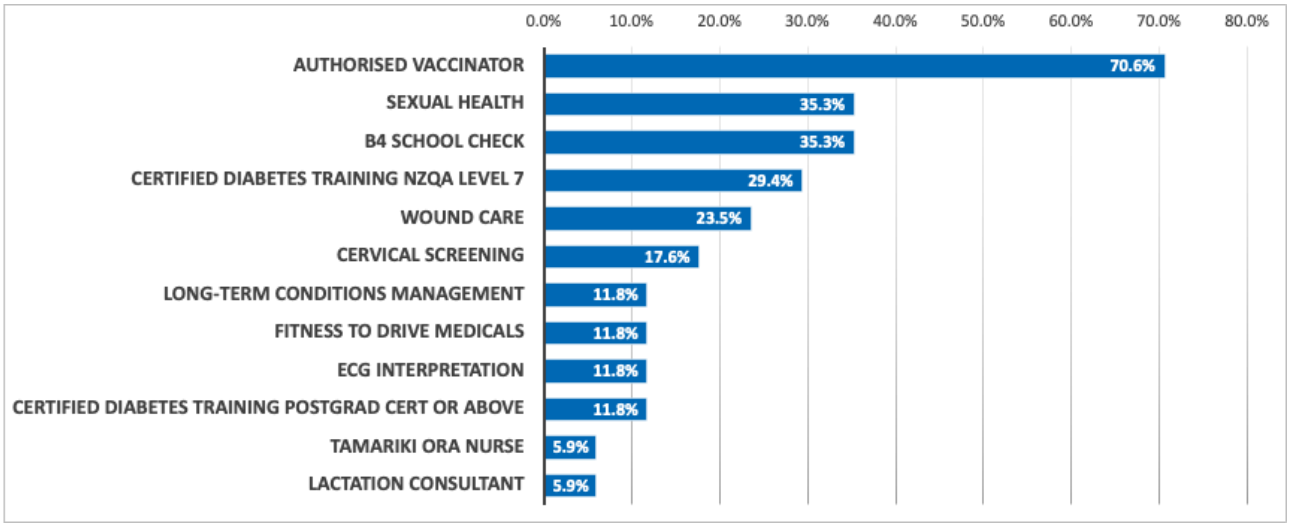
30% of community nurses identified that they were nurse prescribers, with the majority in the registered nurse prescribing in community health (RNPCH), category. A further two community nurses were working towards their nurse prescriber registration.

80% of nurse prescribers used their nurse prescriber skills often although the opportunity was greatest in seeing people with acute conditions rather than long-term conditions.

Additional specialist qualifications

Community nurses hold a variety of qualifications which may or may not be related to the current roles they have within their work areas.

Figure 26: Community nurse specialist qualifications and expertise



Key findings (Figure 26)

- Over 70% of community nurses have authorised vaccinator status.
- Sexual health and B4 school checks are held by one-third of respondents.
- Some qualifications may have been gained from previous employment and may not be required in current roles.

SECTION D21: Nurse leadership and supervision of clinical skills

Nurse leadership

Community nurses often work in an autonomous manner. Nurse leadership is available to support nurses in their mahi.

87.5% of community nurses had access to a nurse lead, with 62.5% solely for their practice and 25% shared across two or more practices. A further 12.5% did not have access to a nurse lead.

A small percentage of respondents identified their role as nurse leads, suggesting many more community nurses who did not complete the survey may fulfil this role. A good amount of time was spent in the nurse leadership role for which they were remunerated for it. While training has been ad hoc it was clear that any training or recommendations given would be gratefully received.

The nurse leads felt part of the workplace management decision-making processes.

Supervision of clinical skills

Supervision of clinical skills related to the oversight of clinical practice but less holistic than the process of clinical supervision, per se. For our purposes, supervision of clinical skills was similar to 'bedside teaching' which occurred on the job and was often opportunistic in the course of business as usual.

Nearly 50% of community nurses identified themselves as being involved in the supervision of clinical skills.

Table 26: Community nurses providing supervision of clinical skills

Supervision of clinical skills	%
Student nurse	87.5%
Practice centre assistant	50.0%
Registered nurse completing specialty training	50.0%
Kaiawhina	12.5%

For the community nurses who provided supervision, one respondent had formal training in the form of a Certificate in Adult Teaching, while three had on the job training. The other half of the cohort had not identified training to supervise clinical skills.

SECTION D22: Postgraduate study and professional development

Postgraduate study

Nearly 60% of community nurses have postgraduate qualifications at certificate and diploma level.

Three community nurses are interested in becoming mātanga tapuhi nurse practitioners but are not yet on the pathway, while one community nurse indicated moving towards a leadership/management path.

Professional development

16 community nurses identified the amount of professional development leave they had within the past 12 months. This ranged from zero days to greater than 5 days of leave. 10 community nurses had less than 5 days professional development leave with nearly 30% indicating this was not adequate.

The most common barriers to professional development leave were being too busy at work (3) and a lack of subsidised or supported CNE funding (1).

SECTION D23: Work pressures

Burnout

All nurses were asked to identify their level of burnout using their own definition based on a validated one-question scale[19]. Where symptoms of burnout were identified, support structures such as EAP offered by Pinnacle to practice staff and available elsewhere (e.g. 1737 line) were provided as well as online tools. One community nurse did not answer this question.

Table 27: Measuring burnout in community nurses

Measure	Count	Percentage
Burned out—average score (1–5)	2.0	
(1) I enjoy my work. I have no symptoms of burnout.	3	18.8%
(2) Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	10	62.5%
(3) I am definitely burning out, and have one or more symptoms of burnout, such as physical or emotional exhaustion.	3	18.8%
(4) The symptoms of burnout I am experiencing won't go away. I think about the frustrations at work a lot.	0	
(5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	0	
Total	16	

Key findings (Table 27)

- The majority of community nurses recognised that they were occasionally under stress but did not feel burned out.
- A few (3) recognised that they had symptoms of burning out.
- Community nurses, in comparing averages, sat between NPs (1.9) and PNs (2.4).

[19] Rohland B, Kruse G and Rohrer J (2004) Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. Stress and Health. 20: 75–79.

SECTION D24: Looking ahead

One suggestion for primary care to thrive

A seamless patient record accessible by all those who provide health care services was suggested as a way to bring together authentic relationships between providers.

Community connectedness, in sharing health messages and being involved and excited about health outcomes, was considered imperative. *Knowledge is power!*

Pay parity and pay equity was mentioned often and considered vital for staff retention, not only in primary care but in New Zealand.

Funding to address staffing shortages including increasing extended care members to enhance our communities.

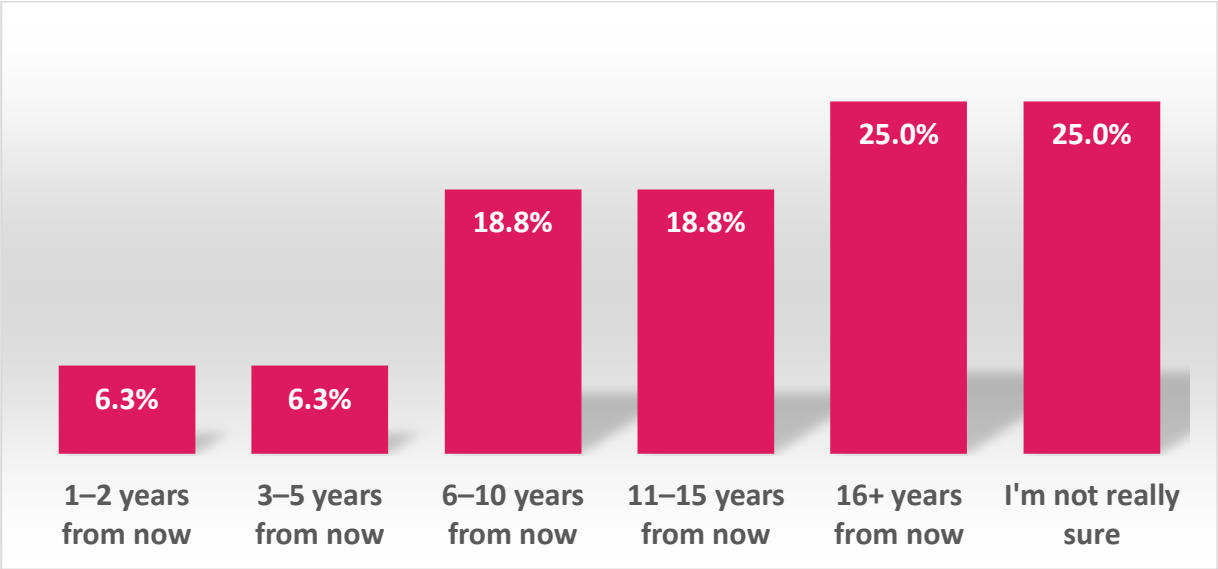
Taking services to the people was one way to increase access to health services and reduce barriers caused by upstream effects.

> *We need to help people's social circumstances to make the most impact to their health. Finance, housing, access to nutrition, isolation within whānau and communities remain barriers. There is no time in primary care to get to know people anymore, so it is hard for people to develop trusting relationships with their health providers.*

Retirement plans

The community nursing workforce appears stable with the majority not planning to retire for the next 10+ years.

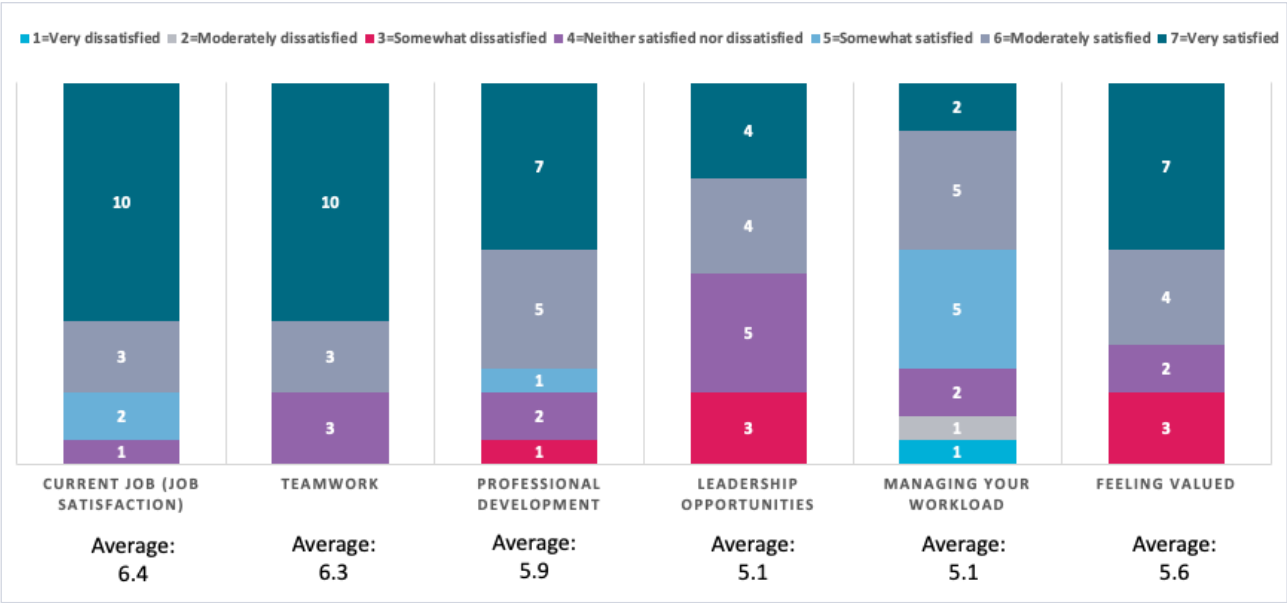
Figure 27: Community nursing retirement intentions



Final overall topics

A final matrix was provided to rate topics relating to current job (job satisfaction), teamwork, professional development opportunities, leadership opportunities, managing your workload and feeling valued. Each response was scored with 1=very dissatisfied to 7=very satisfied which were then grouped into dissatisfied and satisfied. The average is reported without a standard unit. The number towards 7 indicates greater satisfaction.

Figure 28: Community nursing ratings on a range of topics



Key findings (Figure 28)

- Job satisfaction and teamwork are high with community nurses.
- As with practice nursing, leadership opportunities and managing your workload scored lower than others.
- Community nursing averaged 5.6 for feeling valued, which sat between NPs (6.4) and PNs (4.7).

Final comments

Community nurses commented about satisfaction relating to the difference they make in someone's life through their roles as well as having a better work-life balance. While community teams are recognised as an important support for a stretched health system, acceptance (referrals) from some general practices are not always forthcoming. Having a linked health records system enables a more seamless service, which is currently not available.

SCHOOL-BASED NURSING

School-based nurses are funded by Midlands Health Network to cover 37 sites across the Waikato region from Te Kauwhata to Taumarunui including the Coromandel. They are funded to cover nurse-led clinics in decile 1–5 high schools, wharekura, alternative education facilities and teen parent units.

The aim of the school health service is to reduce poor health outcomes for youth and their families who traditionally face access barriers by making themselves readily available in their day-to-day education setting at no cost.

A total of 10 school nurses responded to the workforce survey.

SECTION D25: Demographic characteristics and current work environment

School nurses ranged in age from 35–59 years of age with an average age of 47.7 years, similar to that of practice nurses.

All school nurses identified as female and 50% identified as European and the remaining were Māori, Asian and Pacific ethnic identity. For Māori kaimahi, affiliations were to Tainui, Ngāti Koroki Kahukura and Ngāi Tahu.

School nurses identified first registration ranging from 12–35 years ago, with an average of 24 years passed. 80% of nurses first registered in New Zealand. Nurse employment has averaged 21 years and time working as a nurse outside of a hospital setting averaged 12.8 years.

School nurses have worked in their current roles on average 4.2 years and are contracted for nearly 30 hours per week.

Table 28: School nursing identification of hours by worktype (not compared with work hours)

Work type	0 hrs	>0–4 hrs/wk	5–9 hrs/wk	10–14 hrs/wk	15–19 hrs/wk	20–24 hrs/wk	25+ hrs/wk	Grand Total
In-person in the work setting			2		3		5	10
In-person—home visit	3	1						4
In-person—other venue	4		1					5
Virtual consult	2	4						6
Phone triage	1			1				2
Non-client/patient-facing		6	2	1				9
Non-client related work		5	4	1				10

Key findings (Table 28)

- School nurses spend most of their time seeing students face-to-face in their educational setting.
- One school nurse did home visits or in person at another venue.
- Virtual consults were minimal (>0–4 hours per week) for 40% of nurses.
- Non-client/patient-facing work related to students was common for 90% of school nurses but for the majority the time spend was less than 4 hours per week.
- Non-client/patient-facing work unrelated to students was less than 5 hours per week for half of the school nurses and up to 10 hours per week for 40% of nurses.

SECTION D26: Responsiveness to Māori

Māori responsiveness recognises the need to increase health equity for Māori through focused ways of working that uplift the health and mana of students and their families resulting in equitable [or greater] health outcomes.

Table 29: School nurses day-to-day practices focused on responsiveness to Māori

Day-to-day practices	%
Greetings using te reo Māori	90.0%
Enquiring about whānau and their health needs	80.0%
Checking back (teach-back technique)	80.0%
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	70.0%
Karakia in meetings/consultations	60.0%
Reaching consensus with Māori clients/patients about their management/treatment plans (goals, options, length)	50.0%
Partnership with Māori organisations/groups in service provision or community initiatives, i.e. working alongside to improve outcomes for client/patient where specific skills are needed	50.0%
Recalls focused on increasing Māori engagement/participation in screening or health initiatives	40.0%
Working to a Māori health plan developed within the workplace that sets out broad direction to address inequity	10.0%

Key findings (Table 29)

- School nurses were confident using te reo Māori greetings.
- Enquiry about whānau reflects the way in which school nurses support students and their families in reducing barriers to improved health outcomes.
- Increasing health literacy by using the teach-back technique of checking understanding is done routinely with students.
- School nurses have benefited from Te Tiriti or cultural safety training that support their mahi.

SECTION D27: Nurse prescribing and additional specialist qualifications

Nurse prescribing

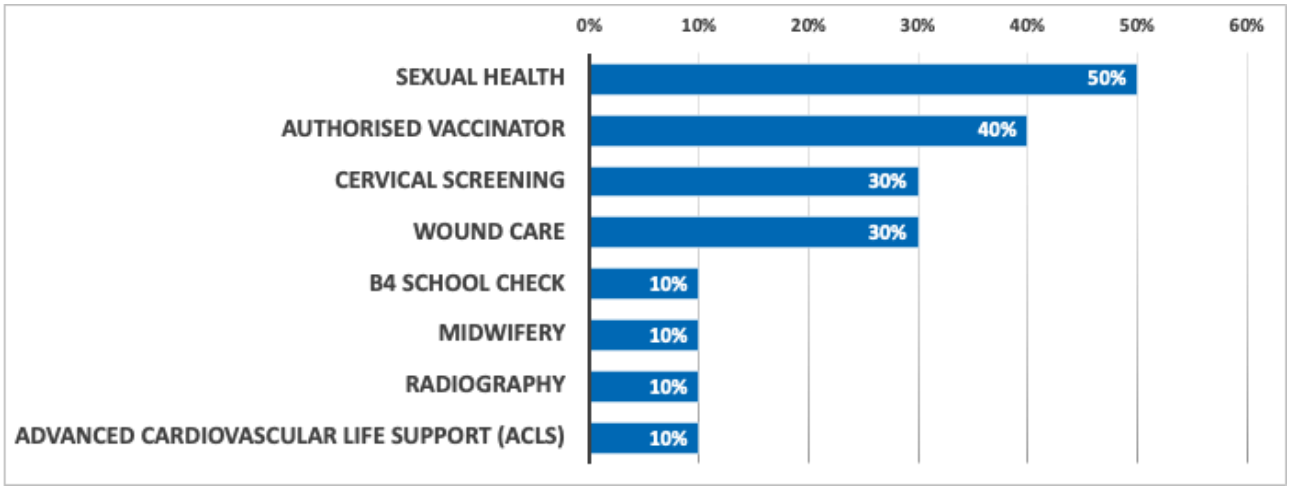
40% of school nurses identified themselves as nurse prescribers, all with registered nurse prescribing in community health (RNPCH) training. All of these nurses were able to put their training to good use.

Additional specialist qualifications

Minimum training requirements for employees include HEEADSSS[20], smoking cessation, resuscitation level 4 and certificates in child protection and family planning.

In addition, school nurses identified the following specialist qualifications.

Figure 29: School nursing specialist qualifications and expertise



Key findings (Figure 29)

- Apart from minimum training requirements, school nurses are knowledgeable in sexual health and are authorised to vaccinate.
- Some of the training identified are likely to have been enabled from previous roles and may add to the strengths of current school-based nursing positions.

[20] HEEADSSS: A Psychosocial Interview Format for Adolescents. Stands for Home, Education/Employment, Eating, Activities, Drugs, Sexuality, Suicide/Depression, and Safety.

SECTION D28: Nurse leadership and supervision of clinical skills

Nurse leadership

Nurse leadership was evident in school nursing with 90% of school nurses indicating access to a nurse leader, of which seven were solely for their workplace and two respondents identified that their nurse leaders were shared across two or more practices.

None of the school nurse respondents identified themselves as the nurse lead.

Supervision of clinical skills

One school nurse identified that they provide supervision of clinical skills to a registered nurse completing specialty training. In addition, supervision training was provided on the job.

SECTION D29: Postgraduate study and professional development

Postgraduate study

One school nurse was currently studying towards a postgraduate qualification, four were considering it for the future, while a further two were not doing or thinking about postgraduate study. One school nurse was considering studying towards a mātanga tapuhi nurse practitioner qualification but was not yet on the NP pathway.

Four nurses identified postgraduate study qualifications including health science, midwifery, a Master of Health Science and a PGCert in Advanced Nursing.

Professional development

70% of school nurses identified >5 days for professional development in the past 12 months, however, one school nurse felt this was not enough.

The most common barriers to professional development leave were that nothing of interest was on offer or they were too busy at work.

SECTION D30: Work pressures

Burnout

All nurses were asked to identify their level of burnout using their own definition based on a validated one-question scale[21]. Where symptoms of burnout were identified, support structures such as EAP offered by Pinnacle to practice staff and available elsewhere (e.g. 1737 line) were provided as well as online tools.

Table 30: Measuring burnout in school nurses

Measure	Count	Percentage
Burned out—average score (1–5)	1.3	
(1) I enjoy my work. I have no symptoms of burnout.	60	60%
(2) Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	30	30%
(3) I am definitely burning out, and have one or more symptoms of burnout, such as physical or emotional exhaustion.	0	
(4) The symptoms of burnout I am experiencing won't go away. I think about the frustrations at work a lot.	0	
(5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	0	
Total		

Key findings (Table 30)

- School nurses did not identify signs of burnout although recognised they were occasionally under stress.

[21] Rohland B, Kruse G and Rohrer J (2004) Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. Stress and Health. 20: 75–79.

SECTION D31: Looking ahead

One suggestion for primary care to thrive

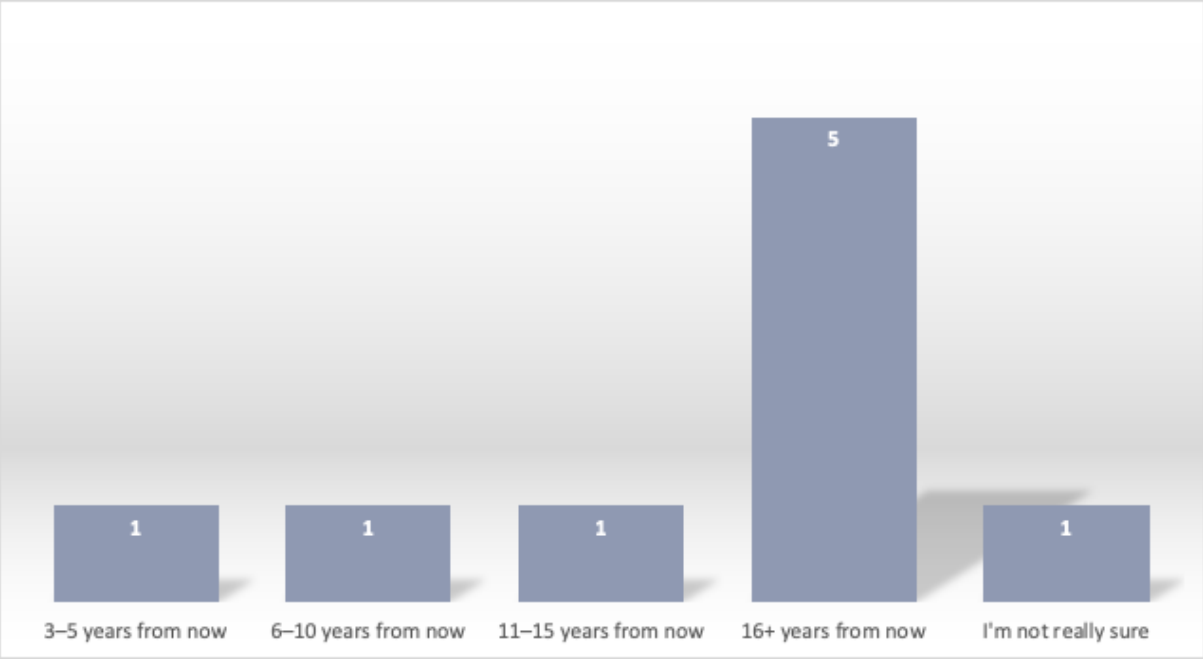
Respondents made suggestions relating to pay parity with Te Whatu Ora nurses, greater access to services such as mental health, access to requesting x-rays and for taking blood — with the ability for school nurses to perform these, encouraging young people to seek routine checkups without waiting on parents to decide and to look after frontline staff better.

> *'Value the importance of professional development. It needs to be seen as a necessity, not a nice to have. Nurses need to be encouraged and supported to pursue learning opportunities within primary care including post-graduate education. Attraction and retention are also fundamental. Pay equity is essential to ensure that we develop a strong and effective workforce.'*

Retirement plans

Retirement plans were a long way off with over 65% identifying that it would be 16+ years away or they were not really sure at this stage, indicating a stable cohort of nurses.

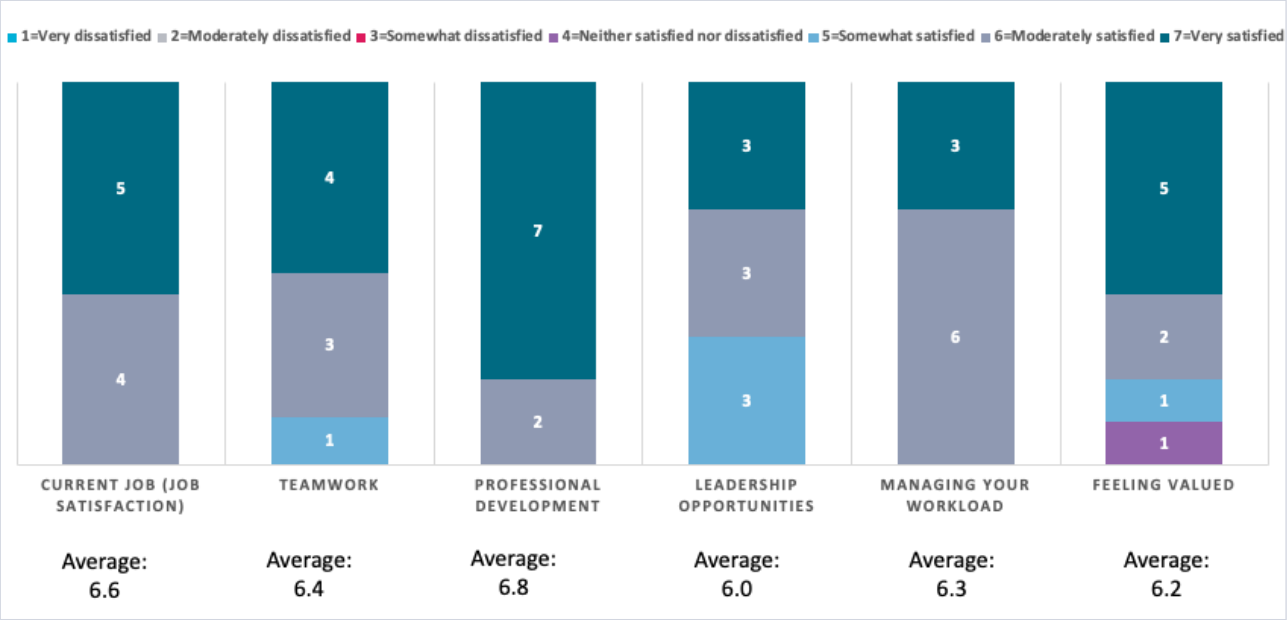
Figure 30: School nurse retirement intentions



Final overall topics

A final matrix was provided to rate topics relating to current job (job satisfaction), teamwork, professional development opportunities, leadership opportunities, managing your workload and feeling valued. Each response was scored with 1=very dissatisfied to 7=very satisfied which were then grouped into dissatisfied and satisfied. The average is reported without a standard unit. The number towards 7 indicates greater satisfaction.

Figure 31: School nurse ratings on a range of topics



Key findings (Figure 31)

- School nurses had the highest average ratings of the nursing groups, however as a small cohort this is not necessarily the true picture.
- The majority of nurses had greater than 5 days professional development leave which might contribute to the high average for this category.
- The picture appears rosy for school nurses even though their workload and their client group can be challenging at times.
- There were high levels of job satisfaction by school nurses.

PRACTICE CENTRE ASSISTANTS

The practice centre assistant (PCA) is an unregulated health worker role that has been developed as part of the extended general practice team in response to changing health workforce needs. The original roles were as key enablers to support the implementation of the core components of the Health Care Home model of care.

The valuable role provides administrative and clinical support to the general practice team, freeing up clinician time to allow more quality time to interact with clients/patients. PCAs work under the direction and delegation of regulated health professionals.

Practice centre assistants cover similar job titles such as medical centre assistant, primary care assistant, patient care assistant, health centre assistant, health care assistant and other variations of this role in general practice.

A total of 47 PCAs responded to the workforce survey.

SECTION D32: Demographics and current work situation

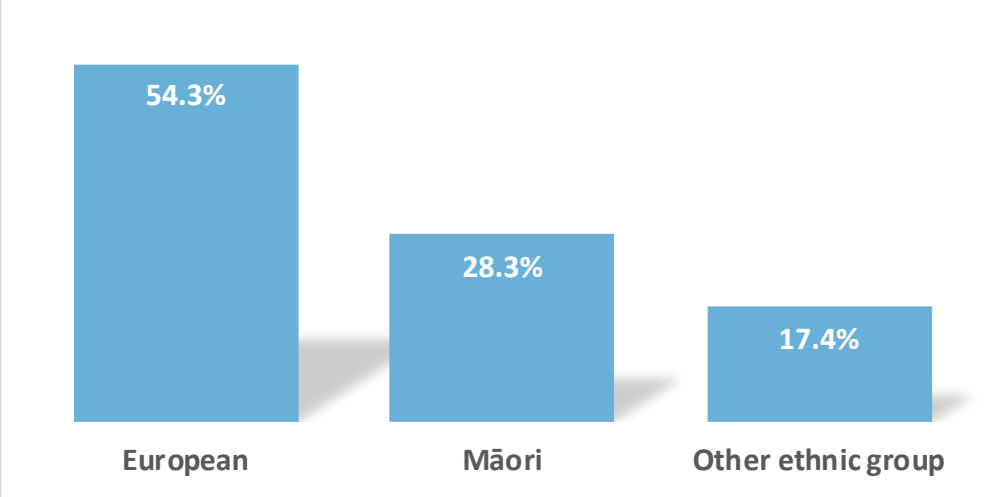
Age distribution

PCAs ranged in age from 22–64 years of age with an average age of 46.6 years, similar to that of practice nurses.

Ethnicity

All PCAs, bar one, identified as female and over 54.3% identified as European and the remaining were Māori (28.3%), or identified as another ethnicity. Due to small numbers the remaining groups are not shown.

Figure 32: PCA prioritised ethnicity



Key findings (Figure 32)

- Māori kaimahi affiliated to Ngā Puhi, Ngāriki Kaiputahi, Ngāti Pikiao, Ngāti Porou, Ngāti Tuwharetoa, Raukawa, Raukawa ki Wharepuhunga, Rongowhakaata (Tairāwhiti), Tainui, Te Aitanga-O-Hauiti, Te Arawa, Te Atiawa (Taranaki) and Tūranga nui-a-kiwa.
- Most PCA respondents worked in Waikato (61.7%) followed by Taranaki (19.1%), Lakes (14.9%) and Tairāwhiti (4.3%).

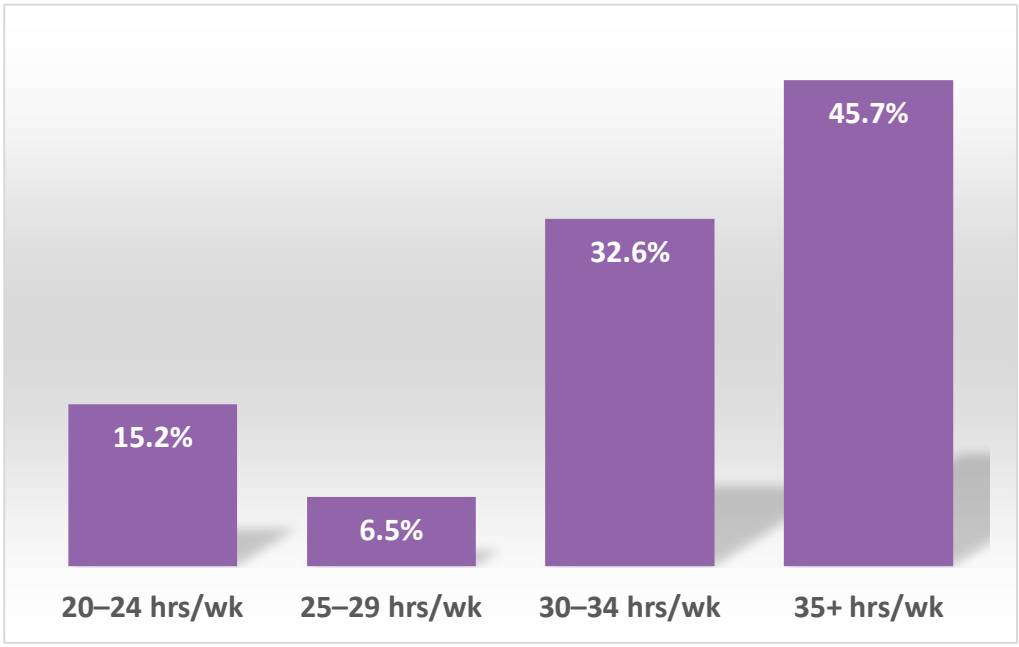
Practice location

Based on practice location, 61.7% of PCAs worked in urban areas and the remainder worked in rural areas.

Hours of work

PCAs worked for an average of 34 hours per week, with a large proportion (45.7%) working greater than 35 hours per week.

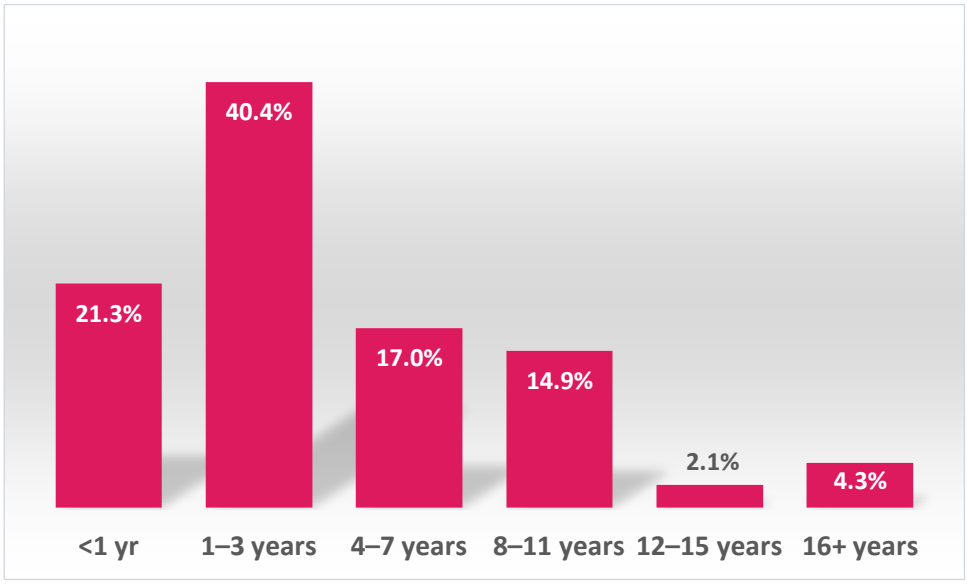
Figure 33: PCA hours of work



Year working as a PCA

The average number of years working as a PCA was 4 years with a range from 1 month to 23 years.

Figure 34: Years working as a PCA



Working elsewhere

Nearly 24% of PCAs identified that they also work elsewhere.

Table 31: PCA self-identification of working elsewhere

Work elsewhere	Count
Yes	11
No	35
Grand Total	46

Work type

PCAs were tasked with identifying their work type based on a similar question to nurses. The majority of PCAs work with clients/patients in a clinic setting. This was followed by virtual consults. Non-face-to-face was common for PCAs.

Table 32: PCAs identification of hours by work type (not adjusted by individual hours of work)

	0 hrs/wk	>0–4 hrs/wk	5–9 hrs/wk	10–14 hrs/wk	15–19 hrs/wk	20–24 hrs/wk	25+ hrs/wk	Total
In-person—work setting		1	5	3	3	4	29	45
In-person—home visit	29	5						33
In-person—other venue	25	7	2					34
Virtual	7	14	4	4		4		33
Non-face-to-face	3	12	7	4	5	6		37

Work practices

PCAs were asked to identify what work they did based on those identified in the PCA handbook. PCA work varies across practices.

Table 33: PCA work practices

	n=46
Collecting baseline data—height, weight, BP, etc	93.5%
Decontaminating and sterilising equipment	93.5%

Stock ordering, restocking, monthly stock checking	93.5%
Urine testing	91.3%
Cleaning beds/equipment	91.3%
Routine ECGs	87.0%
Set up/clean-up for minor surgery	87.0%
Patient recalls	82.6%
Managing clinical waste and sharps	82.6%
Stop smoking support	76.1%
Visual acuity (eyesight) checks	71.7%
Tasks for medicals	67.4%
Updating visual display board in workplace	58.7%
Liaising with patients re results/follow-up	47.8%
Registering patients on the patient portal	43.5%
Spirometry	23.9%
Phlebotomy	23.9%
Audiometry	19.6%
Collation of insurance medical reports	13.0%
None of the above	8.7%
Other	
assisting with minor surgery	
chaperone	
reception cover	
CBAC, COVID swabs	

Key findings (Table 33)

- Collecting baseline data, cleaning surgical equipment and stock control were a key part of the PCA remit (93.5%).

- Urine testing and cleaning beds and other equipment was also high on the workload.
- Patient recalls were completed by 4 in every 5 PCAs.
- More clinical-type work such as spirometry, phlebotomy and audiometry were completed by less than 1 in 4 PCAs.

SECTION D33: Responsiveness to Māori

All workforce surveys included questions about Māori responsiveness to provide a baseline and to enable targeting of health messaging focused on equitable health outcomes for Māori.

Table 34: PCA day-to-day responsiveness to Māori

Day-to-day practices	%
Working with knowledge gained from Te Tiriti o Waitangi and/or cultural competency training	76.1%
Recalls focused on increasing Māori engagement/participation in screening or health initiatives	60.9%
Checking back (teach-back technique)	58.7%
Greetings using te reo Māori	58.7%
Enquiring about whānau and their health needs	45.7%
Working to a Māori health plan developed within the workplace that sets out broad direction to address inequity	45.7%
Reaching consensus with Māori clients/patients about their management/treatment plans (goals, options, length)	30.4%
Karakia in meetings/consultations	28.3%
Partnership with Māori organisations/groups in service provision or community initiatives, i.e. working alongside to improve outcomes for client/patient where specific skills are needed.	26.1%

Key findings (Table 34)

- Three-quarters of PCAs are utilising knowledge from Te Tiriti or cultural safety training in their day-to-day work with clients/patients.
- 60% indicated consideration for Māori engagement/participation in recalls. As this is often a key part of the PCA role, this is a factor that could be addressed.
- Less than half of PCAs work to (or may be aware of) a Māori health plan within their practice.

SECTION D34: Education

Formal training

A NZ Certificate in Health and Wellbeing (Primary Care Practice Assistance course, NZQA Level 4 accredited) or equivalent is the standard for PCAs.

Over 63% of PCAs have completed specific PCA training with a further 6.5% currently on the course. The remainder had not started training.

Table 35: Receipt of formal training by PCAs

NZ Certificate, NZQA Level 4 or equiv.	Count
Yes	29
No, but currently completing a PCA course	3
No, never started	14
Grand Total	46

Barriers to completing PCA education include being very new, hoping to start next year, time to complete, lack of funding and some identified other commitments outside of work.

Over half of PCAs (51%) indicated courses they have attended.

Table 36: Training identified by PCAs

Annual stop smoking practitioner practicing certificate
COVID swabbing, throat swabbing, PCA tests
CPR
Cultural competency
Diabetes education
EMA H&S rep level 3
First aid
Health and safety representative training stage 2
Health ABC
Infection, prevention and control
Mental health first aid

Mini ace cognitive exams
N95 fit testing training
Privacy Act 2020 certificate
Privacy breach reporting certificate
Spirometry training course
Sterilisation/autoclave
Understanding bias in health care
Vaccinator course
Venepuncture training
Workplace drug testing
Wound care

One PCA stated that they are an unregistered enrolled nurse and did not indicate additional training as a PCA.

Informal training

Informal training was identified also, which is defined here as 'on the job' training. This included: how to do ECGs, blood pressures, vital signs, recalls, assisting with minor surgery, stock taking and ordering, emergency bag stocking, driver licence training, CVD risk assessment e-learning, fit testing, Lean methodology, nutrition advice for patients, and suicide prevention/postvention. One PCA wrote 'too many to name, sorry' [which is excellent].

SECTION D35: Mentorship/Supervision

PCAs are required to work under delegation. Nearly all PCAs (98%) have access to a workplace mentor/supervisor. Supervisors are commonly accessed daily or a few times a week, with one-third 'only as needed'. From the nursing survey, less than half of supervisors have received formal training and it would be useful in future to understand what that supervision looks like—informal check-in versus more structured supervision techniques.

Table 37: PCA reported supervisor access

Frequency of supervision	Count
Every day	11
A few times a week	8
About once a week	2
A few times a month	4
Once a month	4
Less than once a month	1
Only as needed	15
Grand Total	45

Many PCAs reported being in a supportive team and having regular debriefing. Unfortunately, one respondent said meetings kept getting cancelled as everyone was too busy.

SECTION D36: Authorised vaccinators

PCAs can complete training to become authorised vaccinators. One-fifth of PCAs received vaccinator training with all, bar one, completing authorised Vaccinating Health Worker (VHW) Stage 1 and the other completing Stage 2.

Vaccinations offered by those who had completed Stage 1 training were stated as: COVID-19 incl. paediatric dose, MMR, influenza, Boosterix (DTaP) and HPV, although VHW1 authorisation does not include administering paediatric vaccinations. This might be an error by the respondent where they may be VHW2.

Half of the trained PCAs indicated support by a clinical supervisor who is an authorised vaccinator. The other half indicated 'not at the moment' or did not complete the training.

SECTION D37: Work pressures

Burnout

All PCAs were asked to identify their level of burnout using their own definition based on a validated one-question scale[22]. Where symptoms of burnout were identified, support structures such as EAP offered by Pinnacle to practice staff and available elsewhere (e.g. 1737 line) were provided as well as online tools.

Table 38: Measuring burnout in PCAs

Measure	Count	Percentage
Burned out—average score (1–5)	1.9	
(1) I enjoy my work. I have no symptoms of burnout.	12	26.1%
(2) Occasionally I am under stress, and I don't always have as much energy as I once did, but I don't feel burned out.	29	63.0%
(3) I am definitely burning out, and have one or more symptoms of burnout, such as physical or emotional exhaustion.	4	8.7%
(4) The symptoms of burnout I am experiencing won't go away. I think about the frustrations at work a lot.	1	2.2%
(5) I feel completely burned out and often wonder if I can go on. I am at the point where I may need some changes or may need to seek some sort of help.	0	0.0%
Total	46	

Key findings (Table 38)

- Nearly 90% of PCAs had no burnout, although nearly half recognised that they were occasionally under stress.
- 10% of PCAs were having symptoms of burnout, which is likely to affect their interaction with clients/patients and colleagues.

[22] Rohland B, Kruse G and Rohrer J (2004) Validation of a single-item measure of burnout against the Maslach Burnout Inventory among physicians. Stress and Health. 20: 75–79.

SECTION D38: Looking ahead

One suggestion for primary care to thrive

Pay parity was the overarching theme of the PCA comments. Next was a better funded primary care system to cover: long appointments so patients do not have to pay, more staff—GPs, nurses and paediatric doctors, better access to mental health support for patients. Training and education for PCAs was important, requiring a commitment to upskilling employees and to include hands-on work, not just administration.

On the other hand, flexible working was suggested, including working from home which would be helpful for completing administrative tasks if access was available.

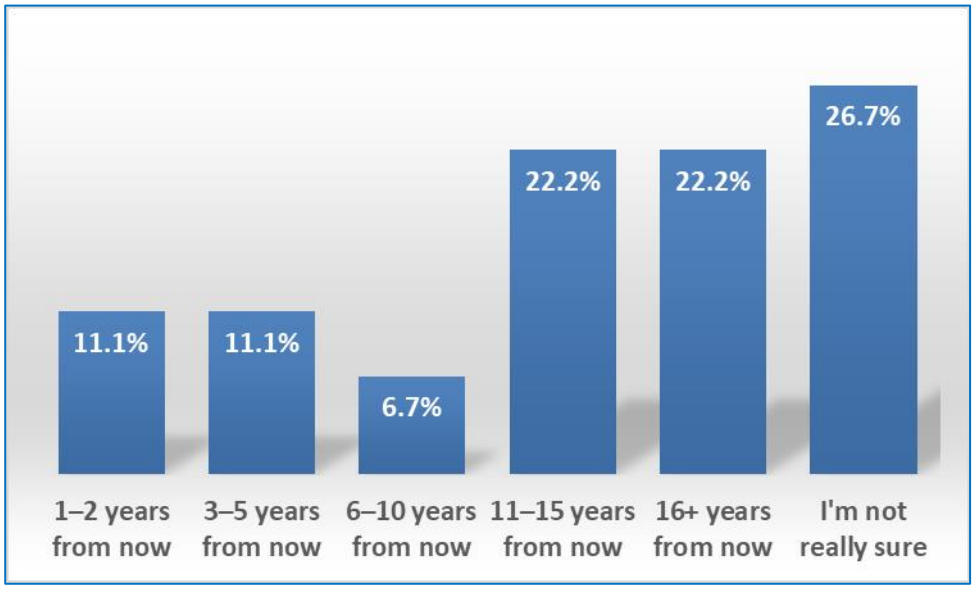
Other suggestions included:

- Making better use of enrolled nurses
- Annual appreciation and recognition in the form of awards that are voted on
- Easy access to accurate and reliable consumer health information
- Working together with Māori health organisations

Retirement plans

20% of the PCA workforce indicated retirement in the next 5 years, although over half were 16+ years from now or not really sure.

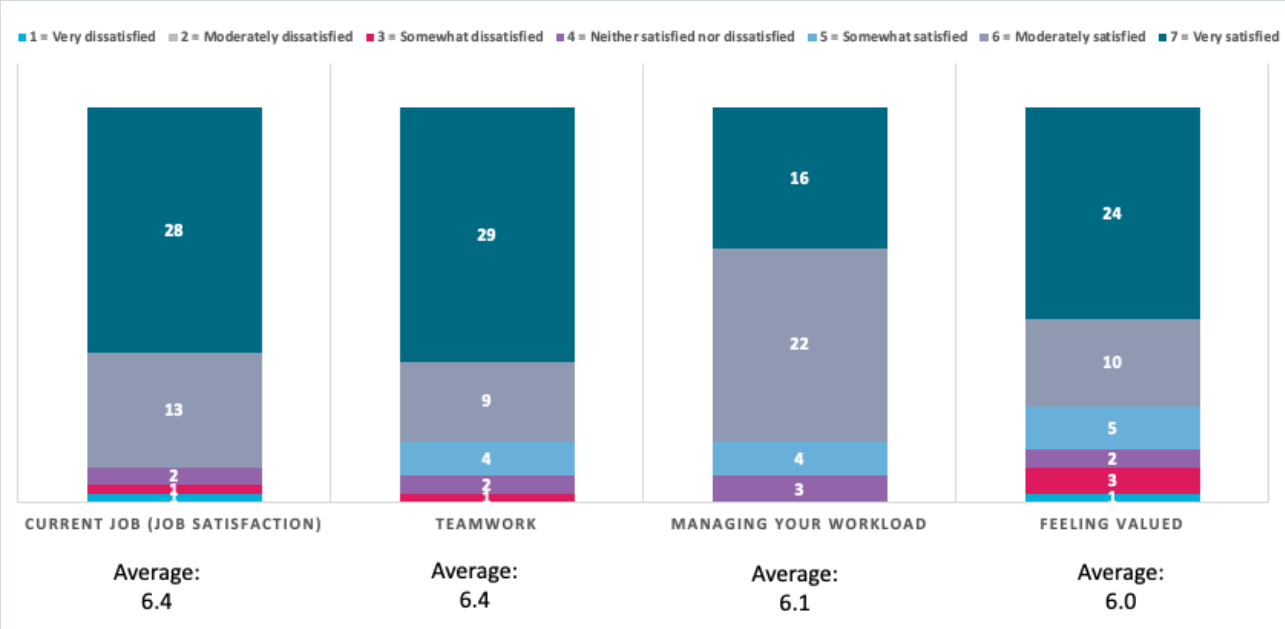
Figure 35: Retirement intentions of PCAs



Final overall topics

A final matrix was provided to rate topics relating to current job (job satisfaction), teamwork, professional development opportunities, leadership opportunities, managing your workload and feeling valued. Each response was scored with 1=very dissatisfied to 7=very satisfied which were then grouped into dissatisfied and satisfied. The average is reported without a standard unit. The number towards 7 indicates greater satisfaction.

Figure 36: PCA ratings on a range of topics



Key findings (Figure 36)

- PCAs indicated satisfaction with their job, teamwork, managing their workload and feeling valued.
- Of the four topics, feeling valued showed the most levels of dissatisfaction. PCAs play important roles in enabling the seamless running of general practice. While teamwork is high, ensuring PCAs are recognised through respect and appreciation is vital towards working in a psychologically safe environment.

Final comments

PCAs were appreciative of the opportunity to have their say through this survey. Most PCAs felt valued and supported, although recognised the pressure general practice was under and the pressure on staff (‘*leaving in droves’)*. A pay rise, which recognised rising costs, and paid training were important, as was not feeling like a number.

QUICK SUMMARIES

Practice Nurse (PN) highlights

Workforce

- **The average age of PNs in the network has decreased.** The age distribution of the network PNs has changed since 2009. There has been an increase in the proportion of PNs less than 35 years of age, but this is significantly offset by the large decrease in the proportion of PNs from 35–54 years of age.
- **Greater numbers of Māori and Pacific PN responders give percentages a boost.** The ethnic profile of the network practice nurse workforce has changed since 2009. The majority of PNs remain non-Māori and non-Pacific at 83.6%, down from 95% in 2009. There is a three-fold increase in both Māori and Pacific practice nurse numbers with their proportion going up from 4% and 1% in 2009 to 13.3% and 3.1% in 2023, respectively. However, they still remain underrepresented against the network population and NZ population.

Workload

- **The roles of practice nurses have expanded since our last survey** in 2009, some, more recently, because of the COVID-19 pandemic, while others were due to changes in legislation, particularly the change to the Medicines Act which allowed nurses to prescribe to a fuller formulary.
- **One-fifth of PNs (22.2%) are registered nurse prescribers.** This is the first workforce survey to ask about nurse prescribing. The majority are registered with the NZ Nursing Council as registered nurse prescribing in community health (RNPCH) (57.5%) followed by registered nurse prescribing in primary health and specialty teams.
- **A high proportion of PNs are trained vaccinators.** This proportion has increased to 97% from 94% in 2009. The proportion of PNs with specialist qualifications in cervical screening has increased from 63% to 84% during this time and diabetes training has reduced slightly to 51% from 54% in 2009.
- **New areas of PN development.** PNs now include ECG interpretation (20%), fitness to drive medicals (19%), long-term conditions (17%) and immigration medicals (17%) in their repertoire.
- **PNs are experiencing burnout** with 40% having one or more symptoms including 13% recognising that their symptoms are not going away.
- **Job satisfaction rating is reducing overall** at an average of 5.4 (previously 5.9 in 2007 and 2009).
- **Feeling valued came out strongly as an area requiring more attention.** This was mentioned often in relation to both pay parity and being recognised for the professionalism of practice nursing particularly their work during COVID lockdowns.

Mātanga Tapuhi Nurse Practitioner (NP) highlights

Workforce

- The **NP workforce is on average older than PNs**. The average age is 51.3 years compared with PNs at closer to 47 years of age.
- **Most NPs are of European ethnicity**, with 80% of respondents identifying with this.
- **NPs are highly experienced nurses** with an average of 27.7 years since first nursing registration.
- **NPs** had an average of 16 years working outside of the hospital setting.
- **Retirement plans are not in the immediate future for NPs**.

Workload

- **NPs are not often limited in their practice** but are occasionally limited by access to diagnostic tests, access to medical practitioners and restrictions to prescribing (such as some section 29 restrictions).
- **NPs are most often focused on clinical practice**. A small number are involved at a management level, with policy development and tertiary education teaching regularly, while professional nursing leadership through Nurse Practitioner NZ and NZNO, policy development and tertiary teaching are occasional additional work for some.
- **NPs work collaboratively with Māori clients/patients** about their management/treatment plans.
- **NPs feel valued** but identify being limited in leadership opportunities.
- There are **high levels of job satisfaction** amongst NPs

Practice Centre Assistants highlights

Workforce

- Practice centre assistants (PCAs), also called medical centre assistants and primary care assistants, work across the network.
- PCAs are an average of **46.6 years** of age.
- Most PCAs identify as **European** ethnicity followed by **Māori**.
- PCAs average more than 30 hours work per week.
- **A qualified PCA workforce**, with over 60% completing some level of NZQA course.

Workload

- **Their workload is vast** taking the admin tasks and non-clinical work away from PNs and also supporting health professionals in practice.
- PCAs have regular access to nurse supervision.
- Overall, PCAs are **not feeling burned out** and have **high levels of job satisfaction**.

Implications for nursing

Nurses bring clinical knowledge, skills and expertise to the fore when supporting clients/patients to manage their health conditions and to support the functioning of general practice. The scope of nursing has changed considerably since our 2009 survey, in part to meet the complexities of primary health care due to an ageing population and greater prevalence of long-term conditions. Nursing roles continue to evolve; more recently enabling nurse prescribing, as well as skills more often considered the remit of other health professionals. Nurses might work autonomously, strengthened by expert decision-making skills in providing consistently high-quality care. In addition, nurses are leading the way toward a future primary care that extends from general practice into the wider community for practice-registered and non-registered clients/patients alongside GPs, Māori health organisations, pharmacists, physiotherapists, dieticians, and other health professionals.

The past three years have been difficult

Natural events, such as COVID and floods, have impacted practices across the network. The pressure on general practice has been immense and this has shown in the places where commentary was requested. In helping primary care to thrive, pay parity was the largest issue, along with the overwhelming pressure on primary care, the work to strengthen the frontline COVID response with no additional workforce and disruption to life in general (living separately to the family to prevent passing on the virus), the need for more funding to primary care, more staff including allied health, and more recognition for what practice nurses do. Nurses showed that their job satisfaction, teamwork and professional development was somewhat satisfactory, however leadership opportunities, managing workloads and feeling valued rated lower. Burnout levels were higher than previous surveys.

Pay parity for nurses

The government has increased funding for primary and community providers from a pool of $200m to support pay increases for nurses and health care assistants in primary and community settings. On the back of this, however, a further increase was announced soon after for hospital nurses, thus further widening the gap between hospital nurses and practice nurses.

Nurse leadership and supervision of clinical skills

Over two-thirds of nurses have access to a nurse lead. The descriptors of the role of nurse lead that were provided described day-to-day operations and staff management, as opposed to strategic, direction-

setting, vision-aligning leadership. In addition, nurses often supervise clinical skills in practice. Training in leadership and supervision of clinical skills was often provided 'on-the-job' and nurses were keen for more formal training in these areas.

Non-client/patient facing care

Practice nurses identified working up to 10 hours per week on non-client/patient facing work relating to client/patients but without them present. This work might include follow-ups, results filing, and work identified on discharge summaries or community referrals. In addition, non-client/patient-facing work which does not relate directly to client, i.e. recalls, inventory, pre- and post-surgical room preparation, filing, and moving equipment were also consuming up to one-sixth of the workload of practice nurses.

Supporting patients in preventative health and to manage their care

Practice nurses coordinate health care for patients that includes preventing illness through vaccination, screening programmes, and diabetes monitoring. Through this, nurses support GPs to meet their quality targets and contribute to providing care in a coordinated way. Practice nurses will also provide clients/patients with the opportunities to take charge of their own care through education and improving health literacy.

Younger nurses coming through

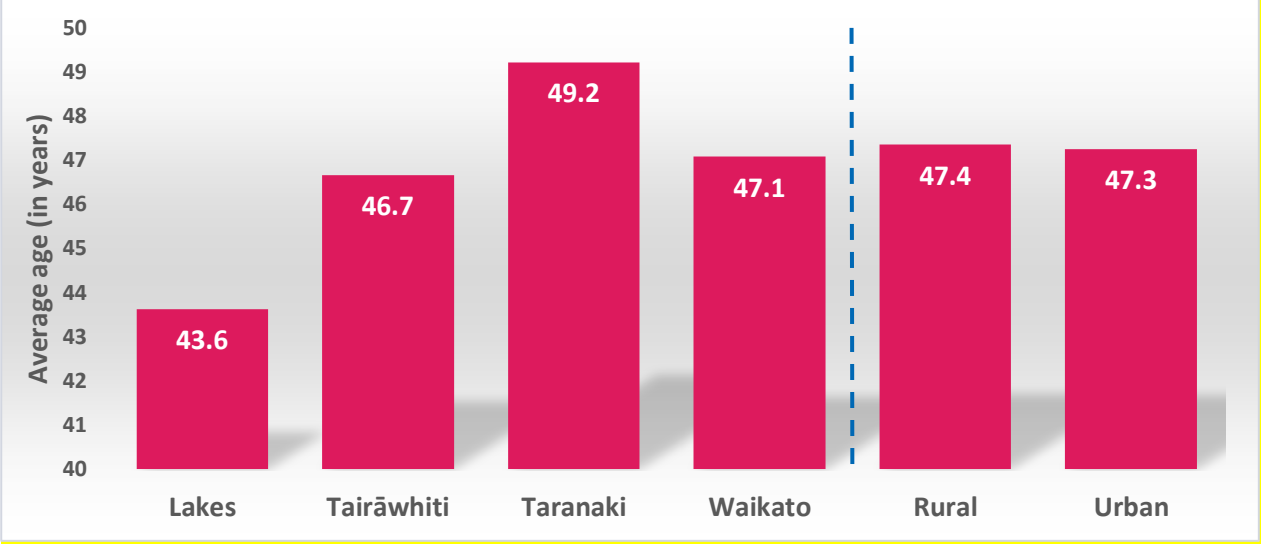
The average age of practice nurses has reduced since the previous survey in 2009. As the 'baby boomer' cohort leaves, a younger cohort is coming in to replace them but there is not enough in this cohort to fill all the gaps. A focus on retention is equally as important as bringing nurses into the profession of primary care into what is currently an ageing profession.

Nurse prescribing

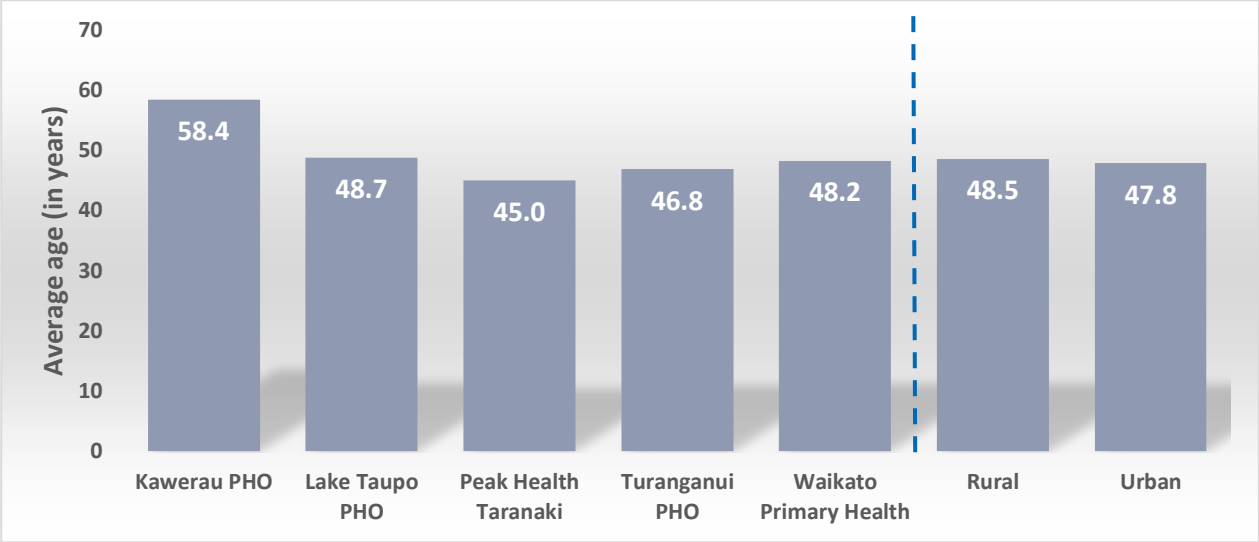
22% of practice nurse respondents had completed nurse prescribing qualifications equating to 8.5% of all nurses in the network. Our network has higher numbers of nurse prescribers compared with the New Zealand Nursing Council practice nurses (4%). These nurses have been able to put their training to good use, adding to the seamlessness of service for patients/clients. Most nurse prescribers have the registered nurse prescribing in community health (RNPCH) qualification; which has a limited formulary and allows prescribing to normally healthy individuals.

APPENDIX

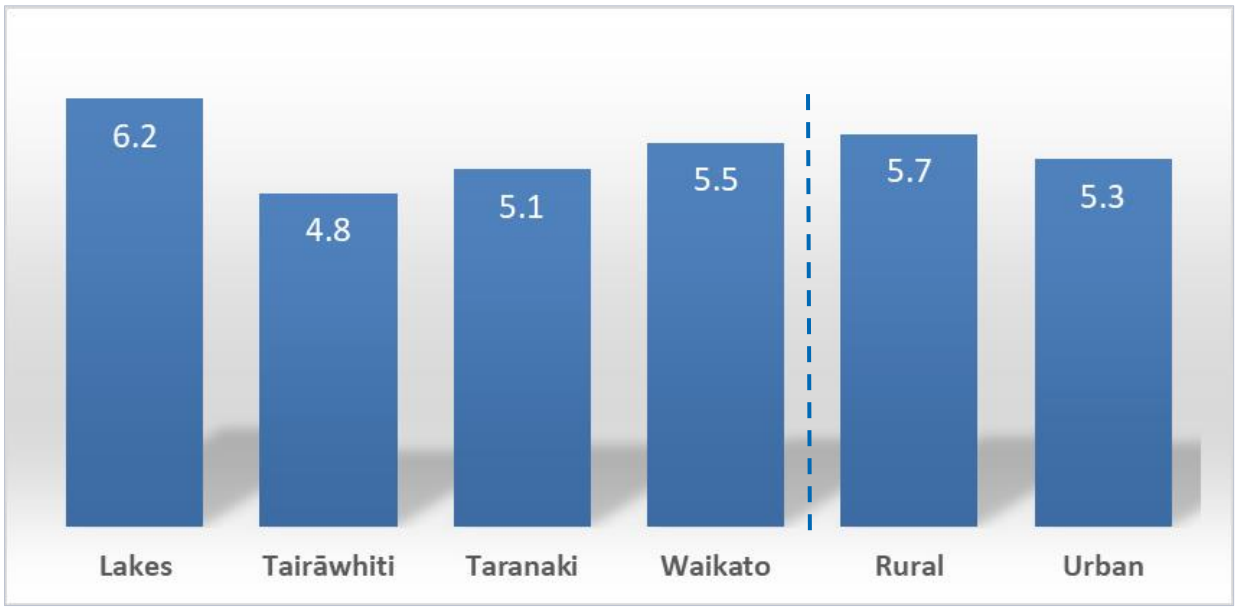
Appendix Figure 1: Average age of the practice nurses in each region and by practice location, 2023



Appendix Figure 2: Average age of the practice nurses in each PHO and by practice location 2009



Appendix Figure 3: Job satisfaction ratings by region and practice location, 2023



Appendix Table 1: Job satisfaction ratings of PNs by region and by practice location

CURRENT WORKLOAD	Very dissatisfied	Moderately dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Moderately satisfied	Very satisfied	Grand Total	Average
Region Overall	**7**	**4**	**13**	**10**	**40**	**67**	**43**	**184**	**5.4**
Lakes	0	0	0	1	2	8	7	18	6.2
Tairāwhiti	2		1	1	5	4	2	15	4.8
Taranaki	3	1	7	2	13	19	10	55	5.1
Waikato	2	3	5	6	20	36	24	96	5.5
Rural	3	1	2	1	13	25	18	63	5.7
Urban	4	3	11	9	26	40	25	118	5.3
Location Total	**7**	**4**	**13**	**10**	**39**	**65**	**43**	**181**	**5.4**

Appendix Table 2: Teamwork ratings of PNs by region and by practice location

TEAMWORK	Very dissatisfied	Moderately dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Moderately satisfied	Very satisfied	Total	Average
Region Overall	**4**	**0**	**15**	**10**	**25**	**52**	**78**	**184**	**5.8**
Lakes	0	0	0	1	2	5	10	18	6.3
Tairāwhiti	0	0	2	2	2	4	5	15	5.5
Taranaki	2	0	6	2	12	16	17	55	5.5
Waikato	2	0	7	5	9	27	46	96	6.0
Rural	3	6	1	5	21	0	27	63	5.8
Urban	1	9	9	19	30	0	50	118	5.8
Location Total	**4**	**0**	**15**	**10**	**24**	**51**	**77**	**181**	**5.8**

Appendix Table 3: Professional development ratings of PNs in each region and by practice location

PROF DEV	Very dissatisfied	Moderately dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Moderately satisfied	Very satisfied	Grand Total	Average
Region Overall	**3**	**7**	**14**	**17**	**42**	**50**	**51**	**184**	**5.4**
Lakes	0	0	1	0	3	5	9	18	6.2
Tairāwhiti	2	1	2	1	5	1	3	15	4.4
Taranaki	0	1	6	7	15	10	16	55	5.4
Waikato	1	5	5	9	19	34	23	96	5.4
Rural	0	2	6	2	12	27	14	63	5.6
Urban	3	5	8	15	29	22	36	118	5.3
Location Total	3	7	14	17	41	49	50	181	5.4

Appendix Table 4: Leadership opportunities ratings of PNs by region and practice location

LEADERSHIP	Very dissatisfied	Moderately dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Moderately satisfied	Very satisfied	Grand Total	Average
Region Overall	**4**	**10**	**14**	**51**	**31**	**37**	**36**	**183**	**4.9**
Lakes	0	2	0	3		7	6	18	5.6
Tairāwhiti	1	1	0	8	3	1	1	15	4.7
Taranaki	0	3	3	19	11	9	10	55	4.9
Waikato	3	4	11	21	17	20	19	95	4.8
Rural	1	6	7	12	11	12	13	62	4.8
Urban	3	4	7	37	20	25	22	118	5.0
Location Total	**4**	**10**	**14**	**49**	**31**	**37**	**35**	**180**	**4.9**

Appendix Table 5: Managing workload rating of PNs by region and practice location

MANAGING WORKLOAD	Very dissatisfied	Moderately dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Moderately satisfied	Very satisfied	Grand Total	Average
Region Overall	**10**	**10**	**22**	**12**	**57**	**51**	**22**	**184**	**4.8**
Lakes	1	0	1	2	3	7	4	18	5.4
Tairāwhiti	1	1	0	1	6	3	3	15	5.1
Taranaki	2	6	8	3	18	14	4	55	4.6
Waikato	6	3	13	6	30	27	11	96	4.8
Rural	5	3	10	3	17	18	7	63	4.7
Urban	5	7	12	9	40	30	15	118	4.9
Location Total	**10**	**10**	**22**	**12**	**57**	**48**	**22**	**181**	**4.8**

Appendix Table 6: Feeling valued rating of PNs by region and practice location

VALUED	Very dissatisfied	Moderately dissatisfied	Somewhat dissatisfied	Neither satisfied nor dissatisfied	Somewhat satisfied	Moderately satisfied	Very satisfied	Grand Total	Average
Region Overall	**19**	**12**	**22**	**15**	**37**	**40**	**39**	**184**	**4.7**
Lakes	0	2	1	0	4	6	5	18	5.4
Tairāwhiti	3	1	3	2	1	3	2	15	3.9
Taranaki	7	5	5	4	12	12	10	55	4.5
Waikato	9	4	13	9	20	19	22	96	4.8
Rural	7	3	7	3	12	16	15	63	4.9
Urban	12	9	15	10	25	23	24	118	4.6
Location Total	**19**	**12**	**22**	**13**	**37**	**39**	**39**	**181**	**4.7**