Choice, Voice and Control

NSW Nurses and Midwives' Experiences and Aspirations in Hours, Rostering and Flexibility at Work

THE UNIVERSITY OF SYDNEY

The Australian Centre for Gender Equality and Inclusion @ Work
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We recognise and pay respect to the Elders – past and present – of the lands on which the University of Sydney's campuses stand. For thousands of years, they have shared and exchanged knowledges across innumerable generations for the benefit of all.

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About the Australian Centre for Gender Equality and Inclusion @ Work

The Australian Centre for Gender Equality and Inclusion at Work at the University of Sydney is a multidisciplinary research centre with a program of work centred on the question: What can governments, businesses, unions and civil society organisations do to make work more gender equitable? The research is organised under four pillars:

1. Designing gender equality into the future of work
2. Breaking gendered segregations across occupations and industries
3. Building alignment in work and care to meet the needs of women, men and workplaces
4. Motivating respectful and inclusive workplace cultures where all workers can thrive.

These important themes are explored through innovative, tested, mixed-methods research that foregrounds women's voices to understand their experiences and aspirations for their future of work. This has enabled the Centre to develop innovative new workplace datasets, to design new tools to help stakeholders understand challenges in delivering gender equality at work, and to advise on targeted and effective interventions to help build workplace gender equality.

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Executive summary

This report presents the results of a study on New South Wales (NSW) nurses and midwives' experiences and aspirations about their hours, rostering and flexibility at work. The methods included a rapid research review, a survey of over 2,000 nurses and midwives, 15 focus groups, and 13 one-on-one interviews. This report outlines what NSW nurses and midwives want from their hours, roster and shifts; the barriers and enablers that exist between them and their aspirations; and the consequences and risks when nurses and midwives do not properly have the choice, control and flexibility they want and need.

What nurses and midwives want

NSW nurses and midwives have 5 major aspirations for their working time:

1. Greater flexibility and control over their rosters, shifts and hours of work
2. More manageable workloads and improved staffing
3. Increased support from managers
4. Work that accommodates life outside of work
5. Better wages to support retention and ease workloads

These five aspirations align closely with elements of 'good flex' (Cooper et al. 2024), which are working arrangements that provide clear benefits to employees by offering predictability, support, and genuine scope for voice, choice and control – while also meeting organisational needs. This good form of flexibility improves work–life balance, retention and wellbeing, and contributes to productivity and quality of service without imposing career penalties on workers.

Barriers and enablers

Most nurses and midwives have limited access to good flex as a result of multiple overlapping **barriers**, including: the local context of their work (such as the organisational and geographical location they work in, and the specific role they perform); a lack of support for flexibility from local managers; the complex and labour-intensive nature of rostering work; and chronic understaffing of nurses and midwives throughout the state.

Some nurses and midwives experience access to good flex due to the following **enablers**: the local context of the work; strong personal boundaries around when they are willing to work;

formal flexibility arrangements (when supported by managers and teams); and managerial and team support for flexibility.

Consequences and risks

The under-provision of good flex to NSW nurses and midwives has significant consequences and risks at the individual, organisational and structural levels.

At the **individual level**, a lack of good flex contributes to fatigue, emotional exhaustion and burnout; career disadvantages and moves to part-time or casual contracts; and diminished job satisfaction.

At the **organisational level**, participants expressed strong concerns about the impact of their current working conditions on the perceived quality of the care that they can provide to patients.

At the **structural level**, participants reported that these conditions were driving many nurses and midwives (particularly experienced, senior staff) to leave their jobs, with significant and worrying implications for the sustainability of the healthcare sector.

The poor job quality cycle

The barriers and risks facing NSW nurses and midwives combine to create what we call a cycle of poor job quality, with three major elements that simultaneously generate and worsen one another: the endemic **understaffing of nurses and midwives**; chronically busy, heavy and **overwhelming workloads**; and an overall **under-provision of good flex to the entire workforce**. This cycle demonstrates that the issues nurses and midwives are facing are **fundamentally structural in nature:** individual employees, teams and managers are operating within a structural context of understaffing that shapes their daily experiences of work, and actively constrains attempts to improve choice and flexibility in the workplace. Consequently, we argue that to support the job quality of nurses and midwives, as well as the sustainability of the NSW healthcare sector overall, it is imperative to find and implement measures that help to break this cycle. For these measures to be effective, they will need to explicitly target the structural conditions of nurses and midwives' work, rather than simply focus on individual employees, teams, or managers. The costs of allowing the cycle to continue unchecked are too high, for individual nurses and midwives, for healthcare organisations, and for the NSW public who everyday rely on nurses and midwives' work, commitment and care.

Introduction

Australia's nurses and midwives are experiencing sustained and well-documented pressure due to systemic challenges such as chronic understaffing, growing workloads, and the ongoing gendered undervaluation of their skills and labour (Givan & Krachler 2024; Skinner et al. 2011). These pressures are driving an increase in burnout, absenteeism and turnover, with serious consequences for job satisfaction, patient care, and long-term workforce sustainability (Burmeister et al. 2019; Cho & Scott 2022). A key contributor to these poor outcomes is a lack of employee choice, voice and control, particularly in relation to working hours (Holland et al. 2017; Holland et al. 2013; Wilkinson et al. 2014), with limited control over shifts, poor access to workplace flexibility, and an overall inability to 'have a say' in when and how work is done (Cooper et al. 2024; Hill et al. 2008).

To better understand nurses and midwives' current degree of voice, choice and control over their working time – and to identify how these dimensions can be strengthened – the New South Wales Nurses and Midwives' Association (NSWNMA) commissioned the Australian Centre for Gender Equality and Inclusion @ Work to undertake a mixed-method, 3-phase study. The study included a large survey of NSWNMA members, as well as focus groups and interviews, to examine nurses and midwives' experiences, attitudes and aspirations regarding their hours of work, shiftwork, rostering and flexibility. We report what nurses and midwives want from their rosters, shifts and hours of work; the factors that act as barriers to – or enablers of – their ability to meet these aspirations; and the consequences and risks of not giving nurses and midwives voice, choice and control over their rosters, shifts and hours at work.

Methodology

This study used a mixed-methods research design with 3 phases of data collection.

Phase 1: Scoping and design development

First, we undertook a rapid review of existing research on rostering, flexibility and control. We established a project Research Advisory Board (RAB), which provided ongoing guidance throughout the study. The focus question was: *What issues related to rostering and working time matter most to nurses and midwives, and what existing evidence should shape the study design?* We conducted 8 one-on-one interviews with key informants from the NSWNMA and held a workshop with the NSWNMA Council to refine priorities and confirm the project's direction.

Phase 2: Statewide NSWNMA public sector member survey

To capture representative data on nurses and midwives' current experiences of rostering, flexibility and control over their working hours, we designed and conducted an online survey of NSWNMA members employed in the public sector. The guiding question was: *What are the current patterns, challenges and aspirations in relation to rosters, shifts and hours of work among nurses and midwives across the NSW public sector?* The survey was developed with input from the Research Advisory Board, NSWNMA Industrial Officers and a focus group of NSWNMA Council members. The survey ran from 4 June to 7 July 2025 via Qualtrics, and was promoted through member mailing lists, posters in workplaces and SMS reminders. There were 2,183 completed responses. When presenting survey findings, we refer to 'respondents'.

Phase 3: Qualitative deep dive

To develop richer insights into nurses and midwives' experiences and aspirations, we conducted 15 focus groups and 5 in-depth individual interviews with NSWNMA members. We spoke to 80 participants. The guiding question was: *How do nurses and midwives describe their experiences of rostering, flexibility and control, and what changes do they believe would improve their working lives?* Participants were recruited through survey opt-ins (from Phase 2, above), and NSWNMA promotion via social media, mailing lists and a presentation at the NSWNMA annual conference in August 2025. Participants were invited to share further reflections following their session, and we received and analysed 6 follow-up emails. Table 1 summarises the focus group participants. When presenting focus group and interview findings, we refer to 'participants'.

Table 1 – Description of focus groups

Focus group (FG) number	Description of cohort	Number of participants
1	Individuals who write or have written rosters, and who may or may not hold formal management positions.	9
2	Nurses and midwives with up to 5 years' experience.	3
3	Nurses and midwives with up to 5 years' experience.	4
4	Consultants, specialists and others (includes the classifications 'nurse practitioner'; 'clinical nurse/midwifery specialist'; 'nursing/midwifery manager'; 'nurse/midwifery educator'; 'clinical nurse/midwifery consultant'; 'nurse/midwifery academic'; and 'nurse/midwife administrator').	7

5	Nurses and midwives with 20 or more years' experience.	6
6	Nurses and midwives currently employed on a casual contract.	6
7	Nurses and midwives with 15 or more years' experience.[1]	5
8	Nurses and midwives working in rural and regional settings.	5
9	Midwives.	7
10	Nurses and midwives currently holding a Temporary Individual Roster Arrangement (TIRA).	6
11	Nurses and midwives with 20 or more years' experience.	3
12	Nurses and midwives with 5 to 20 years' experience.	5
13	Nurses and midwives currently holding a Temporary Individual Roster Arrangement (TIRA).	3
14	Nurses and midwives with 5 to 20 years' experience.	5
15	Managers with current rostering responsibilities.	6

Structure of this report

This report has 4 parts:

- **Chapter 1** presents a short summary of published research on schedule control and workplace flexibility, focusing on insights for the nursing and midwifery workforce.
- **Chapter 2** outlines what NSW nurses and midwives want in terms of their rosters, shifts and hours – and what they currently have.

[1] It was intended for this to be a focus group with Culturally and Linguistically Diverse (CALD) nurses and midwives. Five participants were recruited, but at the time of participation, only one self-identified as CALD. It was decided at the time to proceed with all five participants rather than to discontinue the discussion

- **Chapter 3** describes the barriers to and enablers of good flex in the NSW nursing and midwifery workforce.
- **Chapter 4** reviews the consequences and risks of nurses and midwives' current working conditions (characterised by an undersupply of good flex).

Chapter 1. Rapid research review

This chapter synthesises findings from 130 peer reviewed research articles on workplace flexibility and schedule control in nursing and midwifery. The rapid review explores which employees are most and least likely to have access to workplace flexibility; what enables or constrains employee access to what we call 'good flex'; and the individual, organisational and system wide consequences of access and absence. Drawing on research from Australia and comparable OECD countries, the review places nursing and midwifery within wider labour market patterns of gender segregation and limited schedule control in frontline, feminised work.

1.1 What is flexible work and why does it matter?

Workplace flexibility refers to the capacity for workers and employers to vary when, where and how work is done (Hill et al. 2008). In theory, flexibility can support better alignment between paid work and other life commitments, while helping organisations respond to changing service demands, staffing needs or client expectations. Yet in practice, flexibility is unevenly distributed and produces different outcomes across occupations, sectors and workforce groups.

There are 3 main dimensions of flexible working (Bessa & Tomlinson 2017). **Temporal** flexibility refers to working hours or shift patterns, such as flexitime, compressed working weeks or shift swapping (Cooper et al. 2024). **Spatial** flexibility refers to the location of work, including remote or hybrid arrangements (Cooper et al. 2024). **Contractual** flexibility refers to variation from the standard, permanent full-time employment model, including casual, temporary and part-time work (Cooper et al. 2024). These dimensions intersect with occupational status and job quality in ways that can reinforce labour market inequalities (Foley & Cooper 2021). The experience of flexibility thus diverges sharply between those able to choose when and where they work and those whose hours, locations and conditions are dictated by organisational needs.

'Good Flex' and 'Bad Flex'?

Recent scholarship has a more nuanced approach to understanding flexibility as a continuum of experiences and practices. For example, Cooper et al. (2024) reframe flexibility beyond a set of working arrangements to include questions of interests, power and purpose: who controls flexibility, who benefits, and under what conditions (Cooper et al. 2024; see also Kelly & Moen 2007; Tomlinson et al. 2017). The framework distinguishes between 'bad flex' and 'good flex'.

Bad flex describes employer-driven flexibility designed primarily for operational efficiency and delivery. It includes practices such as fluctuating rosters, last-minute shift changes and insecure contracts that provide employers with agility but transfer the costs of unpredictability and insecurity to employees. Employees experiencing bad flex may face unstable hours, reduced income and limited access to training, promotion and leave entitlements. This pattern is common in feminised and frontline industries such as retail, hospitality, aged care and health (Cooper et al. 2024).

Good flex, by contrast, shows how flexibility can operate with mutual gain for employees and employers. It captures arrangements that are employee-initiated, predictable and supportive of employees' needs, while still meeting organisational goals. Examples include self-rostering, secure part-time work, stable shifts, or flexible start and finish times. An important additional dimension of good flex is that these arrangements do not have a career penalty. Good flex improves work–life balance, strengthens retention and employee wellbeing, and supports productivity, career progression and quality of service. This evolving concept challenges the long-standing assumption that flexibility is inherently beneficial. Instead, it reframes flexibility as a quality of work that depends on fairness, voice and shared benefit.

Enabling 'good flex'

Research consistently shows that achieving good flexibility depends on 3 interlocking conditions operating at the team, organisational and institutional levels. These conditions determine whether flexibility genuinely serves the needs of employees and employers, or whether it reproduces inequalities and insecurity. At the team level, the key drivers are *managerial capability and workplace culture*. Flexibility functions well when it is embedded as a normal part of working life rather than treated as an exception. This requires trust, clarity of expectations and consistency in application. Studies show that even where policies exist, their effectiveness depends on how local managers interpret and apply them (Chung 2020; Cooper & Baird 2015).

Building managerial capability is not only about training leaders in rostering, scheduling or remote work practices, but also about shifting organisational attitudes that link flexibility to lower commitment or performance. Evidence shows that where flexibility depends on managerial discretion, it often produces inequities and perceptions of favouritism (e.g., Davey et al. 2005; Harris et al. 2010; Skinner et al. 2011, 2018). At the organisational level, the *design of systems and processes* is equally important. Studies highlight that transparency about who can access flexible options, and how decisions are made, reduces mistrust and strengthens accountability (Drake 2014a; Kelly & Moen 2007). Conversely, ad hoc or opaque practices

undermine fairness and can create tensions among staff (Harris et al. 2010). Flexibility works best when organisational systems balance individual choice with operational requirements and are regularly reviewed to ensure equity and effectiveness.

Beyond the workplace, *institutional settings* shape what is possible. Statutory rights, collective bargaining and regulatory frameworks create the foundation for fairness and consistency. Comparative evidence shows that where working-time rights are well established, flexibility is more likely to be employee-centred and sustainable (Berg et al. 2014; Chapman 2018). In settings where regulation is weak, access to flexibility often relies on managerial goodwill or individual negotiation, reinforcing inequalities across gender, occupation and income.

Taken together, these team, organisational and institutional dimensions form the conditions under which flexibility can support both productivity and employee wellbeing. Good flex emerges when trust, transparency and regulation work together to ensure that flexibility enhances, rather than undermines, job quality and equity.

1.2 Flexibility in feminised and frontline work

The distinction between good and bad flex is particularly useful for understanding flexibility in feminised and frontline occupations. In nursing and midwifery, operational demands, gendered norms and chronic understaffing combine to make good flex difficult to achieve. Although these jobs are often assumed to be ‘family friendly’, research shows that they more often entail bad flex in the form of irregular or split shifts, insecure contracts and limited control over working time (Chung 2019; Magnusson 2021). Structural features of feminised industries, including low pay, high part-time employment rates and weak bargaining power, further constrain employees’ ability to negotiate flexibility (Adler 1993; Williams et al. 2013). Rostering in health and care settings is typically designed for efficiency rather than equity, with little attention given to how schedules affect employees’ lives. Cortis et al.’s (2024) research on retail work describes this as ‘care theft’: the erosion of employees’ control over their own time through employer-driven rostering practices.

Flexibility is also unevenly distributed across the labour market. Employees in essential, on-site roles such as nursing and midwifery must be physically present to deliver services and therefore have limited capacity to determine when or where they work (Kossek & Kelliher 2023; Warren 2015). They rarely have the option to adjust start and finish times, compress hours or work remotely. Consequently, flexibility in these contexts tends to meet organisational requirements rather than employees’ needs (Swanberg et al. 2005; van der Lippe et al. 2024).

Access and preferences on flexibility in nursing and midwifery

Despite these constraints, nurses and midwives have strong and consistent demand for greater schedule control. They widely view flexibility as essential to wellbeing, retention and career longevity. Younger staff and parents seek temporal flexibility to align work with childcare and school hours (Skinner et al. 2011), while older nurses prioritise predictability and reduced hours to manage the physical and emotional demands of shift work (Moseley et al. 2008; Warburton et al. 2014). Yet flexibility remains unevenly distributed. Senior and permanent staff often secure preferred rosters, while junior or casual employees get the less desirable shifts (Harris et al. 2010). Many report having difficulty accessing annual or school holiday leave, reinforcing inequity (Dawson et al. 2014). Overall, flexibility in these professions remains largely employer-driven, shaped by 24-hour service demands and staffing pressures (Baumgartner et al. 2024; Zeytinoglu et al. 2011).

1.3 Barriers to good flex in nursing and midwifery

The published research identifies several barriers to achieving good flex in healthcare settings, which operate at the team, organisational, or structural and institutional levels.

Key barriers at the team and organisational levels are managerial discretion, the gap between organisational policy and local practice, and the tensions that can occur within teams when some employees are perceived to have more access to flexibility than others.

At the structural and institutional level, a key barrier is the operational reality of continuous service delivery. Round-the-clock staffing requirements and operational demands limit opportunities for employee-led flexibility and reinforce top-down scheduling (Batch et al. 2009; Skinner et al. 2011; Zeytinoglu et al. 2011).

Another structural and institutional barrier is professional and cultural norms that valorise self-sacrifice. The ‘ideal worker’ or ‘ideal nurse’ is often imagined as endlessly available and intrinsically motivated by care (Granberg 2015; Strachan 1997). Such ideals discourage employees from seeking flexible arrangements and help justify low pay, long hours and limited voice (Gilbert et al. 2021; Henttonen et al. 2013).

1.4 Enablers of good flex in nursing and midwifery

While these barriers are deeply entrenched, there is a substantial body of research on the organisational and institutional conditions that enable good flex. At the institutional level,

strong working-time rights form the foundation. Comparative studies show that where regulation provides enforceable rights to request flexibility or restrict unsocial hours, employees report greater autonomy and better work–life balance (Berg et al. 2014; Tomlinson et al. 2017). In Australia, emerging provisions such as the right to disconnect have the potential to strengthen these foundations, although their application in healthcare remains limited (Chapman 2018; Josserand & Boersma 2024).

At the organisational level, flexibility works best when it is employee-centred and predictable. Employee-focused scheduling models, such as self-rostering or team-based roster negotiation, have been found to improve satisfaction, wellbeing and retention (Golden et al. 2014; Kelly & Moen 2007). High quality part-time work with predictable hours and equal pay also supports retention and job quality (Zeytinoglu et al. 2011). Allowing employees to choose between shift lengths or patterns can improve both morale and performance (Skinner et al. 2011; Stimpfel et al. 2025). For these systems to work, rostering must be recognised as skilled labour requiring dedicated time, training and organisational support (Booker et al. 2024; Drake 2014a).

Organisational commitment and transparency are also critical. Clear communication about eligibility, decision-making and review processes helps build trust and ensure consistent application across teams (Harris et al. 2010; Kelly & Moen 2007). Regular reviews of policies and monitoring of outcomes enhance accountability (Stimpfel et al. 2025). Managers need both guidance and resourcing to apply flexibility policies fairly (Drake 2014a).

Finally, employee voice underpins fair and effective flexibility. When employees are involved in designing and reviewing rostering systems, trust and morale improve and turnover declines (Cooper et al. 2021; Donnelly et al. 2012; Holland et al. 2017; Wilkinson et al. 2024). Consultation is most effective when management genuinely responds to employee feedback and ensures that voice mechanisms lead to visible change (Tzafrir et al. 2004).

1.5 Consequences of limited flexibility

The consequences of limited flexibility are well documented and extend from poor individual wellbeing to reduced organisational performance and system sustainability. At the individual level, inflexible schedules contribute to fatigue, burnout and psychological distress (Hurtado et al. 2015; Pisarski & Barbour 2014). Irregular hours disrupt sleep and circadian rhythms, increasing health and safety risks (Geiger-Brown et al. 2011). Fatigue negatively impacts both nurses' wellbeing and patient safety (Cho & Steege 2021). Research shows that low schedule control, high workloads and insecure employment conditions are associated with increased

levels of emotional exhaustion – which is a core component of job burnout, defined as feeling 'emotionally overextended and exhausted by one's work' (Kowalski et al. 2010; Moen et al. 2015; Sexton et al. 2022; Wright & Cropanzano 1998, p. 486). Like job burnout more broadly, emotional exhaustion negatively impacts work performance and contributes to employee turnover, absenteeism, and poorer quality patient care in nursing (Halbesleben et al. 2008; Leiter & Maslach 2009; Wright & Cropanzano 1998).

Conversely, predictable scheduling and self-rostering improve sleep quality, reduce stress and enhance wellbeing (Lovejoy et al. 2021; Wynendaele et al. 2021). Employees who use flexible arrangements may also face flexibility stigma, where those seeking balance are perceived as less committed or capable (Chung 2020; Ferdous et al. 2022). In healthcare, stigma can manifest as resentment from colleagues who must cover the less desirable shifts, creating division and resentment within teams (Harris et al. 2010; Prowse & Prowse 2015).

At the organisational level, rigid or unpredictable rosters drive attrition and over-reliance on casual or agency staff, increasing costs and undermining continuity of care (Roche et al. 2015; Skinner et al. 2011; Stimpfel et al. 2025). At the system level, inflexibility contributes to chronic labour shortages and the loss of experienced staff, particularly in regional and remote areas (Leineweber et al. 2016; Villamin et al. 2023). When senior and mid-career nurses leave, the profession loses both clinical expertise and mentoring capacity, weakening workforce capability and sustainability.

1.6 Conclusion

Across the labour market, access to good flex remains unequally distributed. Nurses and midwives, who deliver essential care in 24-hour environments, face distinctive barriers that limit their ability to control when and how they work. These include the operational demands of continuous care, enduring cultural expectations of self-sacrifice, inconsistent managerial discretion and flexibility stigma. The effects are far-reaching: stress and burnout for individuals, turnover and instability for organisations, and persistent skill shortages across the health system.

Yet the research evidence also points clearly to solutions. Strengthening working-time rights, embedding employee-centred rostering, enhancing managerial capability and transparency, and enabling genuine employee voice can deliver good flex that benefits employees, employers and patients alike. Recognising the skilled labour of rostering should be a priority for workforce and policy reform. Building good flex in nursing and midwifery is therefore not a

question of innovation but of fairness, sustainability and gender equality. Good flex is fundamental to the long-term resilience of Australia's health workforce.

Chapter 2. What do nurses and midwives want?

This chapter reports nurses and midwives' aspirations for their hours, rosters and flexibility at work. We group the responses into 5 main aspirations that were articulated forcefully and repeatedly:

1. **Greater flexibility and control over rosters, shifts and hours of work**
2. **More manageable workloads and improved staffing**
3. **Increased support from managers**
4. **Work that accommodates life outside of work**
5. **Better wages to support retention and ease workloads**

These 5 key aspirations are not entirely separate concerns; they overlap and reinforce each other. For example, participants felt that higher wages would strengthen retention and thereby enable more manageable workloads. Further, all 5 aspirations can be conceptualised as elements of good flex, which the research literature identifies as working arrangements that give employees predictability, support, and genuine choice, voice and control (see Chapter 1). These aspirations, if met, would provide mutual benefit across workforce and health systems to simultaneously meet employee and system needs.

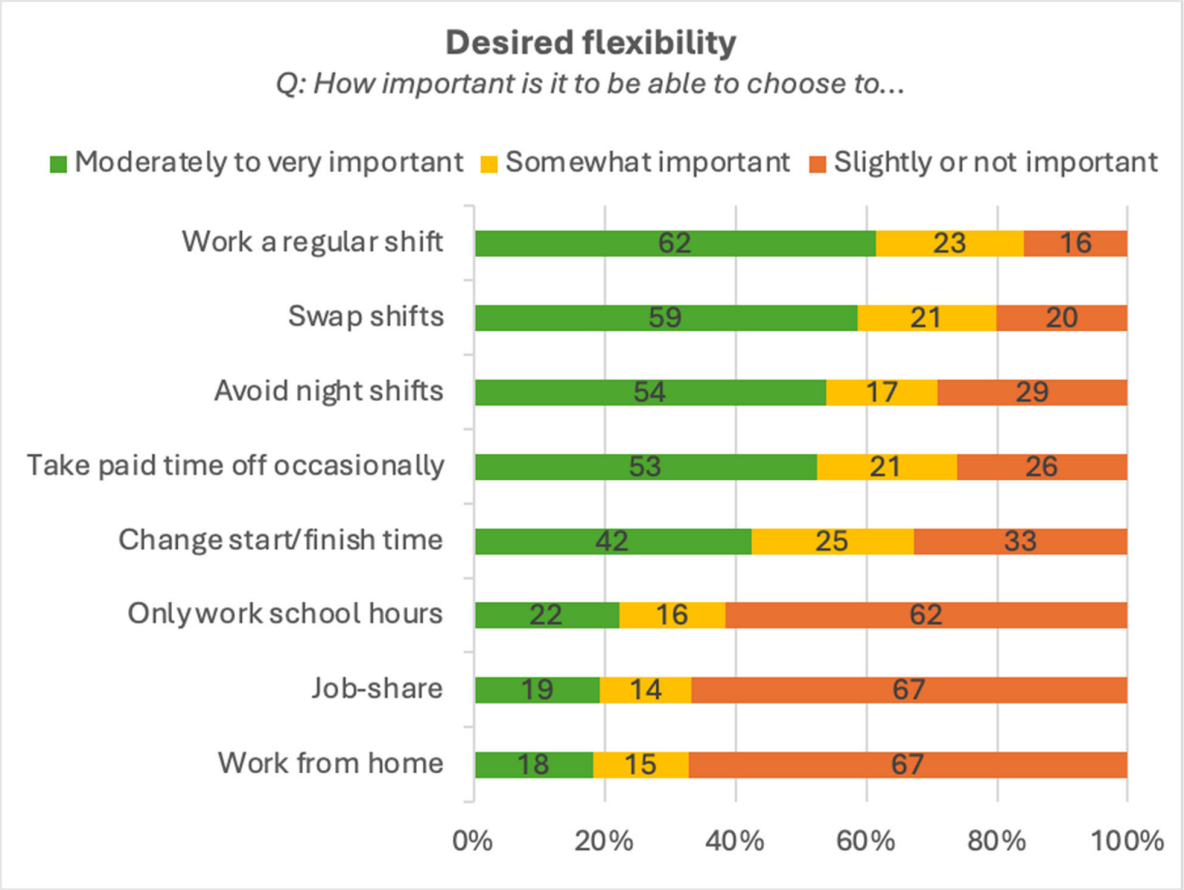
2.1 Greater flexibility and control over rosters, shifts and hours of work

Nurses and midwives reported a lack of access to flexible working arrangements, and limited control and choice over their own working time. Consequently, they wanted greater access to flexible working arrangements and better alignment between their preferred working patterns and their rostered shifts.

The survey asked respondents how strongly they want to access 8 different forms of workplace flexibility, and the extent to which they are already able to access these different forms. Figure 1 shows 4 types of flexibility that are most highly sought-after (i.e., identified as moderately or very important to respondents): the ability to work a regular shift (62%); swap shifts (59%); avoid night shifts (54%); and take paid time off to attend occasional appointments

(53%). There was lower, but still substantial, desire for the ability to change start and/or finish times (43%).

Figure 1 – Desired flexibility



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'In your current job, how important is it for you to **be able to choose** to do each of the following things?' The 8 question items were: 'Work a regular shift (e.g., start and finish at the same time every shift)' / 'Swap your shifts' / 'Avoid night shifts' / 'Take paid time off to attend occasional appointments' / 'Change your start and/or finish time' / 'Work only during school hours' / 'Job-share (this is where two people share a single job title)' / 'Work from home'. For each question, the response options were: 'Not at all'; 'Slightly'; 'Somewhat'; 'Moderately'; 'Very'.

These results show that nurses and midwives want more predictability and control over their work hours and shifts, including the ability to change their hours and shifts when needed.

Comparing what respondents *want* to what they *have*, there is generally an alignment in the **forms** of flexibility available. That is, the forms of flexibility that are most highly desired, such as working a regular shift or swapping shifts, are also the most widely available (see Table 2). Note that this does not mean that *most* respondents are able to work a regular shift, but that

working a regular shift is the most widely available form of flexibility of the 8 items we asked about.

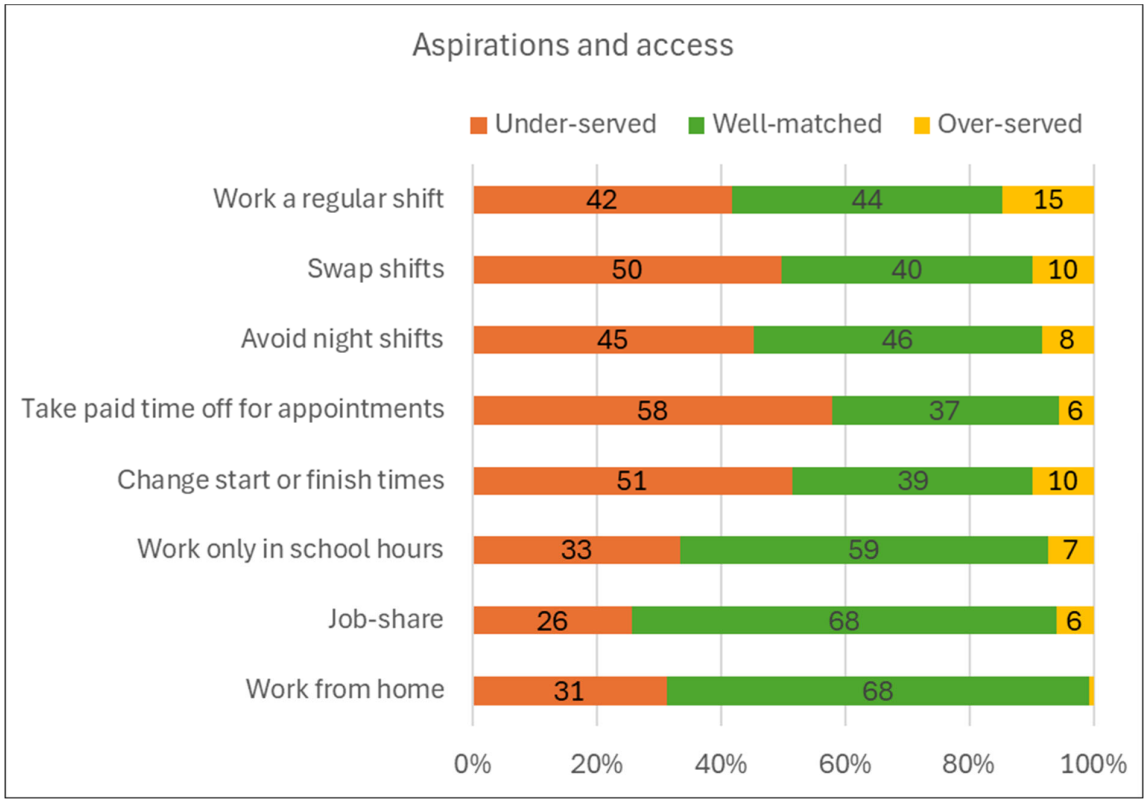
Table 2 – Comparing the order of flexibilities preferred with what is available

Type of flexibility	Ranking: Desired	Ranking: Available
Work a regular shift	1	1
Swap your shifts	2	2
Avoid night shifts	3	3
Take paid time off for occasional appointments	4	5
Change your start/finish time	5	4
Work only during school hours	6	7
Job-share	7	6
Work from home	8	8

Source: Survey of NSWNMA public sector members.
Note: In addition to the question detail below Figure 1, respondents were also asked: 'In your current job, to what extent can you **already choose** to do each of the following things?' The 8 question items were identical to those in Figure 1. The response options were: 'All the time'; 'Most of the time'; 'Some of the time'; 'Rarely'; 'Never'.

However, there are substantial gaps in the **extent** of availability for these 8 forms of flexibility. Figure 2 shows that respondents have markedly less access than they want to the most sought-after flexible work arrangements. For instance, 42% are under-served in working a regular shift, meaning that their aspirations exceed current availability. Many respondents (40–50%) have less access than they want to the 3 most sought-after forms of flexibility: working a regular shift, swapping shifts, and avoiding night shifts. Even higher proportions (50–60%) want to be more able to take paid time off for occasional appointments and to change their start or finish times at work. These 'shortfalls', where less flexibility is available than is wanted, indicate important areas where employee choice and control is currently lacking.

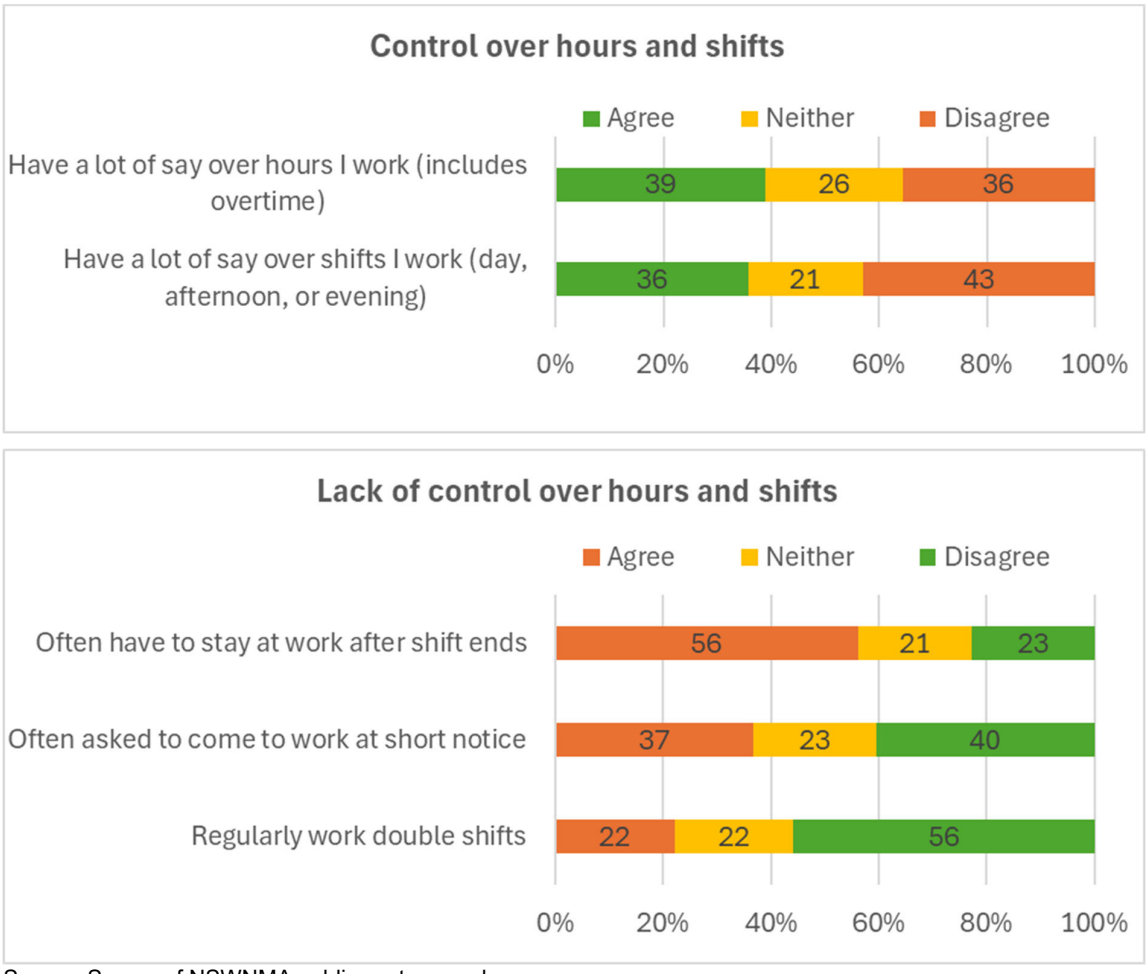
Figure 2 – Aspirations and access: Current workplace flexibility provision falls short



Source: Survey of NSWNMA public sector members.
Note: This Figure combines the results from Figure 1 and Table 2. For each form of flexibility, responses were first classified as High, Medium or Low on desirability (High = Moderately or Very; Medium = Somewhat; Low = Not at all or Slightly) and also as High, Medium or Low on availability (High = All or Most of the time; Medium = Some of the time; Low = Rarely or Never). We compared desirability and availability across the whole sample. Respondents who want more of a given form of flexibility than they have available at present are 'Under-served'. 'Well-matched' means respondents have as much of a flexibility as they want. 'Over-served' respondents have more access than they currently want or need.

Given the large extent to which current access to flexible work fails to match the aspirations of nurses and midwives, many respondents also expressed having a low degree of control over their working time (see Figure 3). When asked whether they 'have a lot of say about which shifts [they] work', about one-third (36%) of respondents agreed, and a larger proportion *dis*agreed (43%). When asked whether they 'have a lot of say about how many hours [they] want to work per week', only 39% agreed. Further, more than half of survey respondents (56%) agreed that they 'often have to stay at work after [their] shift has ended'. While issues of workload and overtime (discussed further below) are somewhat distinct from issues of flexibility and control over hours, rosters, and shifts, we argue that this indicates the extent to which nurses and midwives feel that they *lack control* of their working time overall.

Figure 3 – (Lack of) Control over hours and shifts



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'I have a lot of say about how many hours I want to work per week, including doing overtime' / 'I have a lot of say about which shifts I work (day, afternoon or evening)' / 'I often have to stay at work after my shift has ended' / 'I am often asked to come to work at short notice' / 'I regularly work double shifts'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

In line with the survey findings, many focus group and interview participants described having limited flexibility and control over their shifts. They also expressed frustration at what was perceived as undue rigidity in how shifts and rosters are organised. Many spoke about their dislike for rotating rosters (which preclude a regular schedule and can require working a certain number of night shifts per roster); being allocated to shifts that are too long or too short; and being unable to change shift start and finish times. For instance, one Enrolled Nurse and single mother described her frustration at not being able to move her workday forward by 30 minutes to accommodate school drop-off:

> '... it's that just that little bit of extra if... I could start at 7:30, I could do everything on my own [rather than rely on paid assistance and extended family] ... But I I'm not allowed to do that. They won't let me stay out a little bit late... It's – and I've tried to ask because it would just make my family life so much... more balanced and less stressful...' (Enrolled Nurse, Woman, FG2)

Due to their current lack of choice and control over hours and shifts, many participants wanted more of a say over their hours and shifts – and to feel that their voice is being listened to. One Clinical Nurse/Midwifery Specialist articulated this as an aspiration to '*be heard*':

> 'You would think that the volume of nurses that there are in any ward or any hospital, if we all were able to put forward our preferences and then be heard. You would think things would balance out pretty much.' (Clinical Nurse/Midwifery Specialist, Woman, FG7)

Overall, both survey respondents and interview participants reported significant gaps between the degree of choice, control and flexibility that they currently possess at work, and the degree of choice, control and flexibility to which they aspire. Allowing nurses and midwives to exert greater influence over their own working time is one way to improve their work experiences.

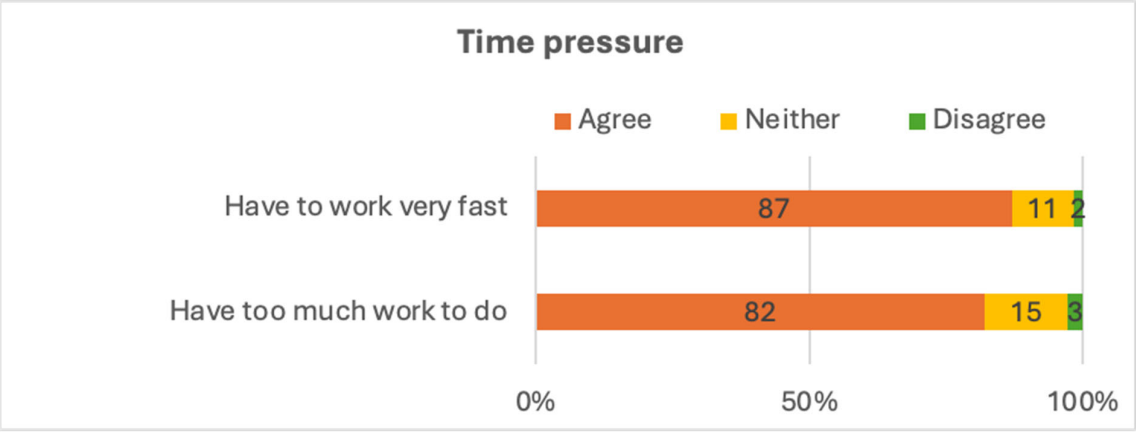
2.2 More manageable workloads and improved staffing

Heavy workloads are endemic in nursing and midwifery. As a result, nurses and midwives reported wanting more manageable workloads, aided by improved staffing.

Focus group and interview participants described experiencing chronically busy, overwhelming and stressful workloads: 'We're still waiting for safe staffing, [we're] constantly short staffed' (Registered Nurse, Woman, FG13); 'Way too many hats and not enough clarity around how much we should be doing' (Registered Nurse, Woman, FG14); 'I miss my lunch break every single day of the week, I guarantee you' (Enrolled Nurse, Woman, FG2).

The prevalence of overwhelming, frequently unmanageable workloads was also strong in the survey. As Figure 4 shows, more than 4 out of 5 respondents (82%) agreed 'I have too much work to do' and even more (87%) agreed 'I have to work very fast'. Together, these results clearly indicate a workforce under severe and unsustainable workload pressure.

Figure 4 – Time pressure



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'I have to work very fast' / 'I have too much work to do'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

Participants reported that overwhelming workloads were both a cause and a consequence of insufficient staffing. Time pressure and exhaustion push staff away from nursing and midwifery and, when experienced staff cannot easily be replaced, overwhelming workloads intensify, perpetuating the cycle.

Significantly, focus group and interview participants reported that the time pressure they feel at work often spills over into non-work hours, in the form of regular overtime. Participants saw direct links between insufficient staffing, overwhelming workloads, and overtime. A Clinical Nurse/Midwifery Consultant with 14 years' experience noted those already working a shift often feel compelled to stay back after their own shift has technically ended, to cover for gaps in the roster caused by insufficient staffing:

> 'We have deficits in the FTE [Full-Time Equivalent] ... the regular staff members are often called on to do overtime and it's not just one overtime shift a fortnight. In some units it's a couple a week... you feel like you're letting down your team if you say no, there's often a lot of pressure or a lot of guilt leaving your team members understaffed, walking out on a shift where you know there's a deficit for the following shift.' (Clinical Nurse/Midwifery Consultant, Woman, FG14)

Survey results also revealed how much *unpaid* overtime nurses and midwives are doing. Respondents' median shift length was 8 hours, and 30 minutes of this shift was typically unpaid. For some respondents, the effective time penalty was even larger: 1 in 10 (11%) reported working more than an hour of unpaid overtime per shift. This extra labour is

organisationally and socially useful, but it brings no financial benefit to employees and robs them of time outside of work.

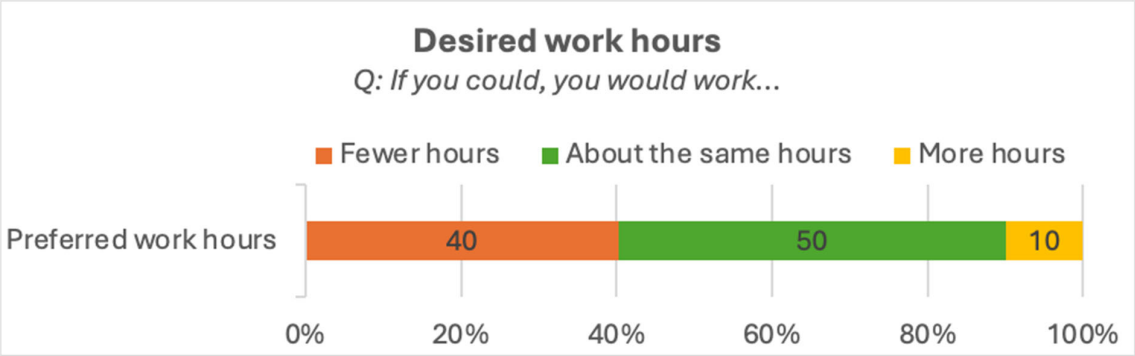
Consequently, many participants reported a key aspiration to address this problem through adequate staffing: '[I wish] there was, you know, an extra 20 of us in the job' (Clinical Nurse Educator, Man, FG12). As a Registered Nurse with rostering experience indicated, adequate staffing would enable good flex by improving workloads, ensuring coverage for busy periods, and giving managers the ability to construct better rosters for their teams:

> '… if they were to increase the number of FTE on every [small unit], it would give the manager more flexibility with rostering, and there would be staff to cover for busy periods as well...' (Registered Nurse, Woman, FG1)

A related aspiration for a sizeable minority of survey respondents was to work fewer hours. When asked about the number of hours they would work each week if they were free to choose, and allowing for how it would affect their income, only 50% of respondents wanted to work about the same hours as they do now. The remaining 40% wanted to work fewer hours, while 10% wanted to work more hours each week. Concerningly, 51% of respondents in permanent full-time roles want to work fewer hours, 43% are happy with their hours, and 6% would like to work more hours. Among those in permanent part-time roles, most (58%) are happy with their current hours, but 30% would like to work fewer hours, and only 13% would like to work more hours, suggesting there is little interest in longer hours even among part-time workers.

Compared to respondents who are satisfied with their current working hours, those who want to work fewer hours reported having less say over their hours and shifts and being more likely to stay back after their shift ends or regularly work double shifts. Notably, the desire to reduce working hours was also linked to experiencing more time pressure, more emotional exhaustion, less effective recovery between shifts, and stronger turnover intentions.

Figure 5 – Desired work hours



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'If you could choose the number of hours you work each week, and taking into account how that would affect your income, would you prefer to work…' And the response options were: 'Fewer hours than you do now?'; 'About the same hours as you do now?'; 'More hours than you do now?'.

Taken together, these results suggest that many nurses and midwives are responding to the significant time pressure and overtime demands they experience at work by cutting down on (or considering cutting down on) their hours, despite the negative impact this would have on their income (see also discussion of career disadvantages in Chapter 4). This underlines the real time pressure nurses and midwives experience and supports their appeals for improved staffing and more manageable workloads.

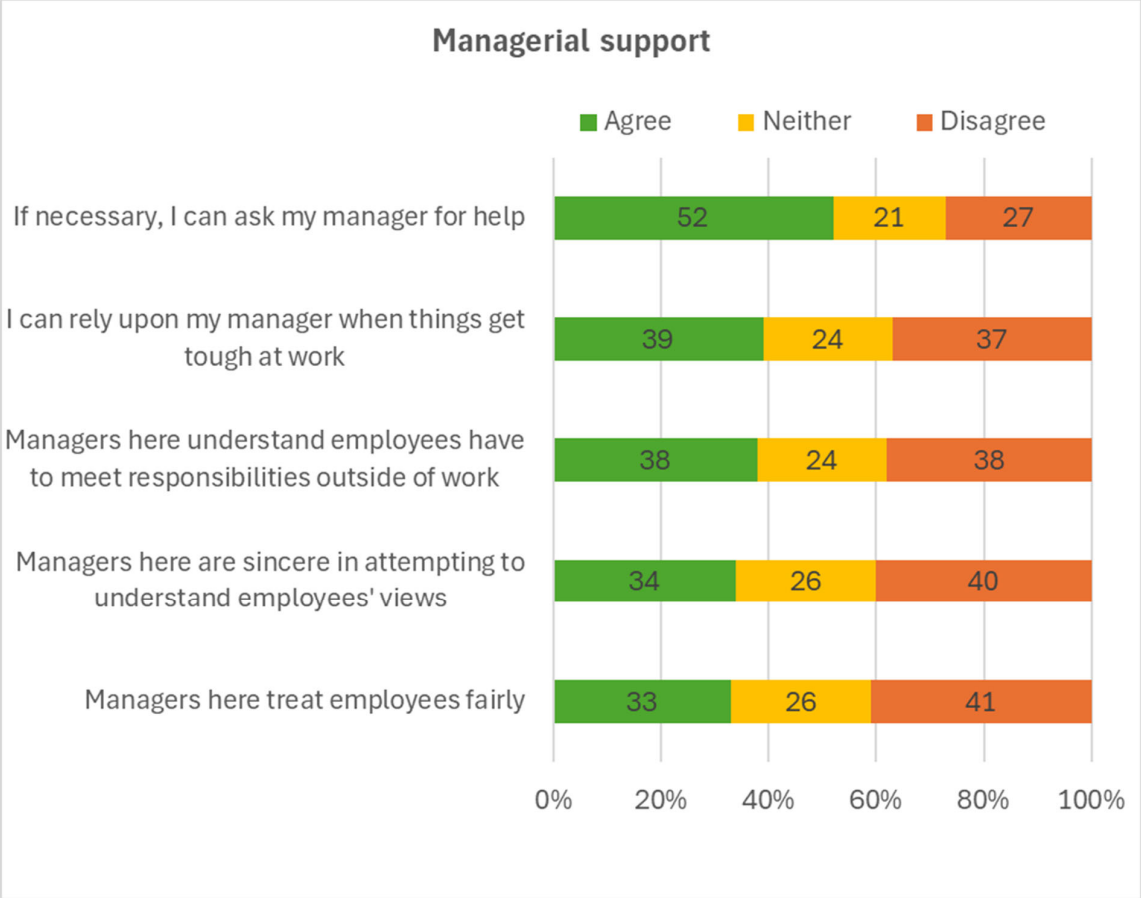
2.3 Increased support from managers

Nurses and midwives reported dissatisfaction with what they perceive as shortcomings and inconsistencies in managerial practice in relation to working hours and scheduling. As a result, participants wanted more and better support from their managers, including greater fairness and equity in rostering; clearer communication with employees; and a more sincere desire to understand employees' needs and wants in relation to workloads, rosters and hours.

The survey results showed moderate to high levels of dissatisfaction with managerial practice. Figure 6 shows that a third to a half of survey respondents agreed that they could approach their managers for help and 'count on them' to assist in difficult work situations. On the other hand, more than 1 in 4 respondents felt the opposite: that their manager was not approachable or dependable in tough times. Of perhaps greater concern is that only 1 in 3 respondents felt their manager treats employees fairly in their workplace. The level of *dis*agreement with this question (41%) was noticeably higher than the level of agreement (33%). Finally, there was a pervasive feeling among respondents that their managers do not understand – or give enough weight to – employees' views and personal circumstances. About 40% disagreed that managers are 'sincere in attempting to understand employees' views', while 38% disagreed

that managers ‘understand employees have to meet responsibilities outside of work’; for both questions, the percentage of respondents with unfavourable views was greater than or equal to the percentage with favourable views.

Figure 6 – Managerial support



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: ‘To what extent do you agree or disagree with the following statements about your current job?’ The question items were: ‘If necessary, I can ask my manager for help’ / ‘I can rely upon my manager when things get tough at work’ / ‘Managers here understand employees have to meet responsibilities outside of work’ / ‘Managers here are sincere in attempting understand employees’ views’ / ‘Managers here treat employees fairly’. For each question, the response options were: ‘Strongly agree’; ‘Agree’; ‘Neither’; ‘Disagree’; ‘Strongly disagree’.

Dissatisfaction with managerial practice was echoed in the focus groups and interviews. Participants discussed favouritism as a common practice throughout the profession, using terms like ‘cliques’ (Clinical Nurse/Midwifery Consultant, Woman, FG14) and ‘nepo [nepotism] babies’ (Registered Nurse, Woman, FG7) to refer to the lucky nurses and midwives who found themselves in a manager’s ‘in-group’. A Registered Nurse with almost 30 years’ experience argued such favouritism is perceived regularly across workplaces:

> ‘Nepotism, I suppose, really is what it is. Yeah. But I've seen that play out so many times where, you know that your roster isn't being treated as fairly, you know, or it's not fair across the board, or you see someone else's roster get damaged...’ (Registered Nurse, Woman, Interview 1)

Many focus group and interview participants also reported that their managers did not express empathy, or an understanding of employees’ specific life circumstances, when constructing rosters. Participants expressed frustration with managers who did not seem open to understanding and accounting for employees’ personal caring responsibilities or health issues, as a Registered Nurse and Midwife with 27 years’ experience demonstrates:

> ‘My daughter was seriously ill and I was going to have to have time off work. So my manager wasn't able to hold that position for me. She said “you can go casual and find some work whenever you can”. So it wasn't a very understanding manager's attitude...’ (Registered Nurse and Midwife, Woman, FG11)

As a result of these widespread perceptions of ineffective managerial practice, many focus group and interview participants wanted more and better support from managers. Several said they wanted managers to be more proactive in communicating with employees, and to demonstrate a more sincere desire to understand employees’ needs and wants in relation to workloads, rosters and hours. An Enrolled Nurse with 4 years’ experience noted this improved support could take the form of direct, structured conversations between managers and employees about employees’ specific rostering wants and needs:

> ‘What I think needs to happen is when a new grad starts, I think that whoever does the rostering or whoever is in charge of that person needs to sit down and have an understanding of that person.’ (Enrolled Nurse, Woman, FG3)

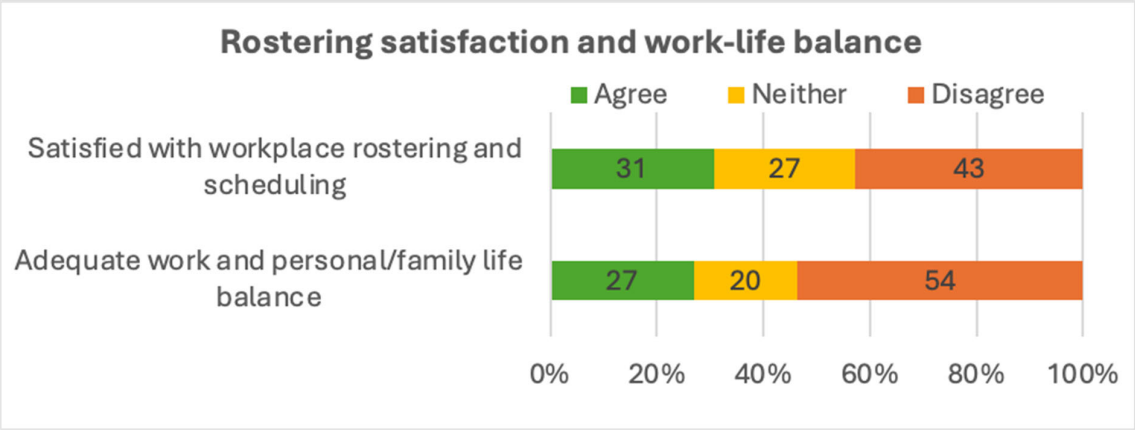
2.4 Work that accommodates life outside of work

Nurses and midwives reported that their time at work currently intrudes on their broader lives, robbing them of time they would otherwise devote to family, hobbies and other personal commitments. Consequently, the fourth major aspiration reported by participants was for their work to better accommodate their lives outside of work.

Figure 7 shows that many nurses and midwives reported experiencing clashes between work and life, with half of the survey respondents (54%) *dis*agreeing that they ‘have an adequate balance between [their] work and personal/family life’. Only 27% agreed with this statement, meaning that those with inadequate work–life balance outnumber those with an adequate balance by 2 to 1. This result further substantiates the conclusion that nurses and midwives

are under unsustainable workload pressure, with many of them feeling that their jobs interfere excessively with their personal and family responsibilities outside the workplace.

Figure 7 – Rostering satisfaction and work–life balance



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'I am satisfied with how the rostering and scheduling is done in my workplace' / 'I feel that I have an adequate balance between my work and personal/family life'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

Consistent with the survey, focus group and interview participants said that a major aspiration was to simply be away from work more often. Participants in different stages of their careers, and with different family structures, all similarly wanted a better, more balanced relationship between work and life. One Registered Nurse and mother, currently in her graduate year, argued that 'We want to be more present for our kids... the bigger problem is, we need to be supported more' (Registered Nurse, Woman, FG2). Similarly, a Registered Nurse with 34 years' experience and caring responsibilities for a grandchild argued that current rostering practices create fatigue and rob nurses and midwives of time for family, domestic responsibilities, and self-care:

> '... when you're running your nurses for 7 days, giving 48 hours off and bringing them back on a morning shift, you're creating fatigue. You're not allowing for family time, you're not allowing for me time. I've actually said to my manager, do you want to come around and do my washing and cook a week's worth of meals because, you know, this roster, I haven't got time.' (Registered Nurse, Woman, FG7)

Other focus group participants discussed wanting more time for hobbies and social activities, as articulated by an Enrolled Nurse, currently in her first year:

> ‘It's like everything is nursing for me... So for example, like I really love [my sport] like that's really annoying because [my sport] and nursing are two things that happen at the same time.’ (Enrolled Nurse, Woman, FG3)

This aspiration can be viewed as an extension of the desire for improved flexibility and control over hours (that is, via greater flexibility and control one can achieve greater balance between work and life). However, some participants argued that it is particularly important to emphasise work–life balance for nurses and midwives because of the heavily feminised nature of this workforce. That is, due to stubbornly engrained gender norms, caring and domestic labour is typically unequally distributed in families, with women doing the bulk of this work (Sayer 2016). For these reasons, one Clinical Nurse/Midwifery Specialist with 37 years’ experience and adult children argued that, unless nursing and midwifery becomes ‘family friendly’, the workforce is at severe, continuing risk of high attrition:

> ‘... you [need to] make nursing family friendly... we are a female dominated workforce still... And it generally tends to be the mother that says, yeah, I'll work and – but you still get to do the household duties, you still get to get the sick calls... So every time they say they're short of nursing I always think you will retain nurses if you make it accessible to people who... have kids and have to work these unsocial hours.’ (Clinical Nurse/Midwifery Specialist, Woman, Interview 2)

Overall, participants revealed that nursing and midwifery is not only unfriendly to workers with families, but to anyone who wants to have a life outside of work.

2.5 Better wages to aid retention and ease workloads

Participants reported dissatisfaction with current workloads and staffing levels. Consequently, the fifth major aspiration was for the work of nurses and midwives to be more highly valued through increased wages, specifically because this was viewed as a useful tool to aid retention and ease workloads for the entire workforce.

While better wages may not seem to relate to hours and flexibility, the focus group and interview participants saw the two as intertwined. Specifically, participants articulated that, without adequate remuneration, nurses and midwives have little incentive to stay in jobs that offer poor control over hours, clash with life commitments and responsibilities, and lead to fatigue, emotional exhaustion and burnout. Thus, for participants, inadequate compensation leads directly to poor retention, which intensifies workloads and reduces choice and control for remaining staff. As the following Registered Nurse with 3 years’ experience argued,

insufficient wages chase nurses and midwives – and particularly skilled, senior nurses and midwives – away from the profession, which negatively affects the sustainability of the entire workforce:

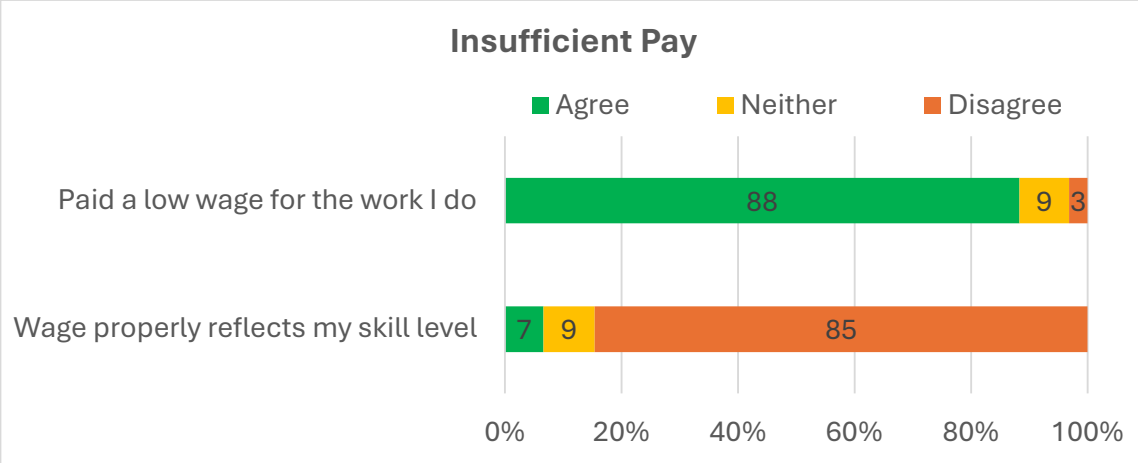
> 'I think honestly, we need to start paying nurses better... we've got to figure out how to retain seniors... The 50-year-old mum of three that has been doing this her whole life needs money to stay.' (Registered Nurse, Woman, Interview 5)

Similarly, a Clinical Nurse/Midwifery Specialist with over 20 years' experience identified a wage increase as a central factor of the 'total transformation' that needs to occur in the profession to keep nurses and midwives in their jobs:

> '... there has to be a total transformation and... nursing really needs to change *big time*... if nursing is interested in actually getting people in to actually become nurses and but not only that, but to actually survive beyond the first 5 years... wage increase is one of those things that needs to happen.' (Clinical Nurse/Midwifery Specialist, Man, FG4)

Important context for this aspiration is that a strikingly high proportion of survey respondents felt undervalued in their work as nurses and midwives (Figure 8). The vast majority (88%) agreed they were 'paid a low wage for the work I do' while two-thirds (68%) *strongly* agreed. Further, 85% of respondents *dis*agreed that 'My wage properly reflects my skill level', and 58% strongly so. There is a pervasive feeling among nurses and midwives that they are low paid relative to their job demands and skills.

Figure 8 – Insufficient pay



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'I am paid a low wage for the work I do' / 'My wage properly reflects my skill level'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

Focus group and interview participants reiterated this point. As argued by a Clinical Nurse/Midwifery Specialist with 9 years' experience, one of the major, systemic issues facing nurses and midwives is that their skills, education and training are fundamentally devalued:

> '... as nurses we're devalued and that's one of the main problems... we need to be able to use our skills that we have that we went to university for, that some of us did [graduate certificates] and diplomas and whatever for, to be able to have a monetary value like a doctor does... we're just so devalued as nurses and... it comes back to pay. But also just to the whole system. The whole system needs to change.' (Clinical Nurse/Midwifery Specialist, Woman, FG8)

Overall, NSW nurses and midwives feel that they are simultaneously overworked and underpaid, particularly considering their skills. Thus, participants argued that better wages would not only help them to feel that their work and skills are properly valued, but would also improve their access to good flex by aiding retention and easing workloads.

Chapter 3. Barriers and enablers to good flex

This chapter outlines the factors that act as barriers to – and enablers of – nurses and midwives accessing good flex. It asks: what factors are preventing nurses and midwives from realising the aspirations detailed in Chapter 2, and what factors are helping them to achieve these aspirations?

The following factors are ***barriers*** to nurses and midwives' ability to access good flex:

- **Local context of work**
- **Lack of managerial support for flexibility**
- **The complex labour of rostering**
- **Understaffing**

And the following factors are ***enablers*** of nurses and midwives' ability to access good flex:

- **Local context of work**
- **Personal boundaries**
- **Formal flexibility arrangements (when supported by managers and teams)**
- **Managerial and team support for flexibility**

3.1 Barriers

Local context of work

Participants in focus groups and interviews said that the local context of work has a significant impact on their ability to access good flex. 'Local context' refers to the organisational and geographical location of work, as well as the specific work role.

Nursing and midwifery operate within highly complex service systems with substantial variation in functions, settings and organisational demands. The profession has multiple classifications and practice domains, and the environments in which nurses and midwives work differ markedly across hospitals, wards, community services and specialised care units. These settings vary in patient acuity and operational hours, as well as in the intensity, unpredictability and coordination required to deliver safe care. Structural, institutional and organisational factors combine to produce a diversity of experiences of flexibility. This diversity

means nurses and midwives find themselves in specific local contexts at specific times, due to their individual life choices and circumstances.

Consequently, participants' access to good flex is often largely determined by their local context of work. Notably, focus group and interview participants argued that rural and regional workplaces are often worse than metropolitan workplaces in terms of staffing and resourcing, which has knock-on effects for workload and work–life balance. For instance, a Registered Nurse from a rural area argued that specific geographical contexts can amplify the staffing and workload issues throughout the profession:

> 'Challenges are still the same, but I find the challenges out here in the rural area a lot harder than certainly city life... We're really on our knees. We've only got about 8 on-call staff for about 96 on-call shifts, so makes the work–life balance pretty difficult.' (Registered Nurse, Man, FG11)

Participants also said that heavier, more complex work contexts can be more difficult to adapt to, more conducive to emotional exhaustion and burnout (see discussion in Chapter 4), and thus more challenging for retaining staff. For example, a Midwifery Unit Manager with 14 years' experience explained the unique stressors of working with high-risk patients:

> 'In a tertiary centre you're working with really high-risk women and... if you haven't got the support and the experience, one or the other, but preferably both, it's incredibly hard work and people do get burnt out very quickly.' (Midwifery Unit Manager, Woman, FG9)

Overall, participants argued that specific work contexts are more prone to the understaffing and workload issues that make good flex more difficult to access.

Lack of managerial support for flexibility

One of the most widely reported barriers to good flex was a lack of managerial support. In focus groups and interviews, numerous participants emphasised how an employee's ability to access good forms of flexibility and have a degree of control over their hours and shifts, largely depended on whether their manager was 'supportive' or 'unsupportive'.

Nurses and midwives felt widespread dissatisfaction with managerial practice. This included perceptions of favouritism, inequity, and a lack of empathy and understanding by managers when rostering. Managers could also impede employees' ability to access and benefit from formal flexibility arrangements, such as Temporary Individual Roster Arrangements (TIRAs).

In the NSW public health system, a TIRA is a formal agreement for an employee 'to work (or not work) specific shifts or specific days for a specific period' (NSW Ministry of Health 2025, p. 47). Managers are responsible for managing TIRA requests, and for regularly reviewing ongoing TIRAs at a suggested rate of once 'every three months' (NSW Ministry of Health 2025, p. 48). Typically (according to participants), TIRAs are used to accommodate employees with caring responsibilities and/or health issues. However, focus group and interview participants argued that local managers could make TIRAs unduly difficult to obtain or maintain. For instance, some reported that managers would push back against an ongoing TIRA when it was up for review and, relatedly, that the regularity of TIRA reviews varied significantly from manager to manager. A Registered Nurse described how the TIRA review process offered a series of opportunities for her manager to pressure her into operating contra to her agreement, by working days or shifts that did not suit her:

> 'They've made me do it [the TIRA review process] every 3 months for 3 years. And at every meeting is an opportunity for them to try and pressure me into changing days or using different excuses.' (Registered Nurse, Woman, FG10)

Other focus group participants reported that their managers tended to forget or simply ignore the conditions of employees' TIRAs: 'for whatever reason, [our manager] can't seem to remember [employees' arrangements] and makes a mistake every single month' (Clinical Nurse/Midwifery Specialist, Woman, FG14).

Overall, participants argued that relying on the support and discretion of a specific manager – who may or may not be empathetic, understanding, fair, and adherent to formal flexibility practices – was a major and widespread barrier to accessing good flex.

The complex labour of rostering

While many focus group and interview participants pointed to a lack of managerial support as a major barrier to good flex, it is important to acknowledge that constructing and maintaining rosters is difficult. Thus, an additional and significant organisational barrier to good flex in nursing and midwifery is 'the complex labour of rostering'. According to participants who construct rosters (including Nursing Unit Managers and Midwifery Unit Managers) this labour is complex, time-consuming, ongoing, and too often invisible and undervalued.

First, in terms of complexity, participants reported that constructing a workable roster requires deep knowledge of skill mix, seniority, staff needs and preferences, and nurse-to-patient ratios. Managers must also keep fairness and equity considerations in mind when assigning shifts. One Midwifery Unit Manager with 12 years' experience and 8 years' experience rostering referred to the rostering task as a 'puzzle':

> ‘We've got AINs, student midwives, ENs, RNs, midwives. I need to make sure I've got enough midwives on the shift... Making sure that the skills within the midwives is good and I don't have all juniors on or I don't have all seniors on...’ (Midwifery Unit Manager, Woman, Interview 3)

Second, and partly because rostering is so complex, this is an extremely time-consuming task. One Midwifery Unit Manager (Woman, Interview 3) reported that writing a one-month roster takes ‘at least 6 to 7 hours’. Additionally, several participants reported taking the work of rostering home with them when it could not be completed during work hours, arguing that finishing this work outside of the workplace ‘was easier, undisrupted, spread out on the dining room table’ (Nursing/Midwifery Manager, Woman, FG15). This underlines that the chronically heavy workloads discussed in Chapter 2 are experienced workforce-wide, rather than being the private issue of select groups or classifications of nurses and midwives. Managers are not exempt from the overwhelming, stressful workloads that characterise the entire profession.

Third, it is important to note that rostering work does not finish once a roster is written. Rather, rosters require ongoing maintenance, given sick leave, shift swaps, employee requests to change start or finish times, and even resignations. The Midwifery Unit Manager quoted above described how these staffing changes could knock-over a ‘solved or semi-solved' rostering puzzle:

> ‘Especially when we have people resign partway through a roster... and then it leaves all these vacancies... It's like I literally just solved or semi-solved this puzzle and now someone's just kicked the board over... So it’s like starting from scratch multiple times a month sometimes.’ (Midwifery Unit Manager, Woman, Interview 3)

Fourth, and crucially, manager participants argued that the complex, time-consuming and ongoing work of rostering is largely invisible and undervalued by more senior leaders. They argued that few other people (including staff covered by rosters, hospital management, the NSW Department of Health and even the union) had a good understanding of the demanding nature of this work: ‘I think [our staff] think we sit in an ivory tower, to be honest’ (Nurse Unit Manager, Woman, FG15); ‘I think our staff have no idea [about] the stuff that we do or the stuff we take home’ (Midwifery Unit Manager, Woman, FG15).

The complex and labour-intensive nature of rostering means that, even when managers are skilled, knowledgeable and committed to writing fair, equitable rosters in conversation with their employees, ‘good’ effective rosters can still be very challenging to produce. These heavy workloads shed more light on some participants’ perceptions that managers can forget their

employees' individual flexibility arrangements (discussed in the previous section). Thus, the complex workload of managers, specifically their rostering work, is a significant barrier to good flex.

Understaffing

Perhaps the biggest, most widespread barrier to good flex in nursing and midwifery is understaffing. In focus groups and interviews, numerous participants described understaffing as an endemic problem. Participants spoke about 'running on a shoestring' of staffing and the budget allocated to it (Registered Nurse, Woman, FG7) and of working in 'unsafe... pretty dire' conditions characterised by insufficient staff coverage (Registered Nurse, Woman, FG10). For instance, the following Nurse Unit Manager described the significant burden regularly placed on her staff to simply 'make the services run' in the context of chronic understaffing:

> '... the massive staffing shortages across our state have really sort of compounded and added to all the stress that we feel... [staff] are worked to the bone just to make the services run.' (Nurse Unit Manager, Woman, FG15)

Understaffing is a direct barrier to good flex in several ways. Chiefly, as noted above, focus group and interview participants identified understaffing as the major cause of the overwhelming and unsustainable workloads they face on a day-to-day basis. As discussed in Chapter 2, these overwhelming workloads can be associated with doing more overtime (which creates work–life clashes and inhibits the choice and control associated with good flex), as well as employee desires to reduce hours despite the financial costs of this (see Chapter 4).

Some manager participants also reported that understaffing forces them to roster around gaps. This leaves managers with less room to consider individual employee needs and preferences, and adds an additional layer to the complexity of rostering work. As a Midwifery Unit Manager argued, it is simply not possible to write a fair, flexible roster when you do not have the staff to fill it:

> '... if we had the staff to fill the vacancies I could do an amazing roster. It would be fair. I could have staff generally have no more than 4 nights each, but I need those staff.' (Midwifery Unit Manager, Woman, FG15)

In these ways, understaffing operates as a major, workforce-wide barrier to good flex. Additionally, as we return to in the conclusion to this report, this barrier is particularly concerning because it creates a negative cycle of heavy workloads and an undersupply of good flex, which then lead to poor retention of nurses and midwives, ultimately exacerbating the issue of understaffing.

3.2 Enablers

Local context of work

The local context of work can act as a barrier to good flex in nursing and midwifery, but also as an enabler. Many focus group and interview participants noted that they experienced some degree of flexibility and control over their hours and shifts because they worked in roles and contexts that more easily allowed for this. Most often, this occurred when participants held non-clinical roles (i.e., not involving direct care of patients), or when they worked in contexts that did not provide 24/7 service: 'In my non-clinical role... it's very flexible. I can do some work from home, I can change my hours' (Clinical Nurse/Midwifery Specialist, Woman, FG14). For example, a Clinical Nurse/Midwifery Specialist described how the operational context of her work (which does not involve patient care) helps to support access to good flex throughout her team, including options to work from home and change start and finish times, particularly to accommodate caring responsibilities:

> 'I work in the public health unit... So we don't provide any patient care and... we're not a clinical service, so... I guess by the nature of that, we are able to utilise a lot of flexibility. We're really supported to work from home if we want to or work in the office. There's flexible start and finish times for the staff that have children. They're completely supported to work around childcare or, you know, anything like that. I've got pretty much total autonomy over my work and how I plan my work day.' (Clinical Nurse/Midwifery Specialist, Woman, FG4)

Thus, in the same way that some local contexts of work can be more prone to staffing and workload issues (see above), participants argued that other contexts can more easily support flexible work.

Personal boundaries

An individual-level enabler of good flex reported by multiple focus group and interview participants was strong personal boundaries. Several participants argued that it is possible to achieve a degree of good flex by developing and communicating strong personal boundaries around the hours and shifts that they are willing to work. For instance, the following Registered Nurse and single mother argued that clear personal boundaries allowed her to prioritise her parenting responsibilities above anything else:

> 'My priority will always be being a mum, if that makes any sense. So, it's got to do with making very clear priorities and very clear boundaries for me.' (Registered Nurse, Woman, Interview 1)

Some constructed these personal boundaries as a counterpoint to the strong norms of self-sacrifice and care that are common in the nursing and midwifery workforce (see Chapter 1). Several participants noted that younger generations of nurses and midwives are pushing back against these 'outdated' norms, replacing these with a concern for self-care, as articulated by a Clinical Nurse/Midwifery Specialist with 37 years' experience:

> 'The older team will be the ones to put their hands up [to do overtime] and the younger ones don't feel necessarily that pressure, or they're strong enough to resist it and I think that's really good self-care 'cause I know I can't. I think that's excellent self-care because it's good to recognise that you can't and... at some point you have to put yourself first.' (Clinical Nurse/Midwifery Specialist, Woman, Interview 2)

Significantly however, this appears to be a highly contingent enabler of good flex because it is so individualised, and because it contradicts longstanding cultural norms around nurses and midwives' 'duty' to put others first. As one Registered Nurse (who is covered by a TIRA) demonstrates, maintaining personal boundaries involves resisting the significant guilt of saying 'no' when your own needs clash with the needs of your co-workers and patients: 'Sometimes it can be tricky. If someone calls in sick... because we're small, you sort of have that guilt... it's just about balancing all those things' (Registered Nurse, Woman, FG13). Even highly developed personal boundaries can be weakened or dismantled by an uncompromising manager (see earlier discussion). For these reasons, the efficacy of this enabler depends on individual and organisational contexts.

Formal flexibility agreements (when supported by managers and teams)

Focus group and interview participants reported another individual-level enabler of flexibility is the use of formal flexibility agreements, specifically TIRAs. However, this enabler is highly individualised and contingent, and hinges on the support of managers and teams.

According to focus group and interview participants covered by TIRAs, these arrangements can be very helpful for enabling greater work flexibility, particularly in the context of challenging life circumstances. For instance, a TIRA can help somebody to avoid night shifts (particularly when these would be challenging for health or caring reasons) or alter their hours of work (e.g., to accommodate caring responsibilities or healthcare appointments). One Nursing/Midwifery Manager described how her TIRA helped her to manage her rosters while undergoing cancer treatment:

> 'I am also very lucky at the fact that I have quite a flexible workplace, currently going through... cancer treatment, so have been very well supported with rosters from my district, which is great...' (Nursing/Midwifery Manager, Woman, FG10)

However, as discussed above, a lack of managerial support can make TIRAs difficult to obtain, maintain and benefit from overall. Many TIRA-holders reported experiencing hostility from their colleagues due to their TIRA. Across multiple focus groups and interviews, participants with and without TIRAs reported that there was a widespread perception that TIRAs are unfair on other employees (who are overburdened with the unpopular shifts that TIRA-holders are able to avoid): 'sometimes you can't get the shifts that you do want because you've got all the people working on the weekends because… they're on a TIRA' (Registered Nurse, Woman, FG11). There was a widely held view among participants that TIRAs are not a good long-term or universal solution to the issue of inflexibility in nursing and midwifery because they are, by design, *temporary* and *individual*. Some suggested that TIRAs were often used as a 'band-aid' response to inflexibility. For instance, one participant discussed how she applied for a TIRA as a 'compromise' after experiencing 'huge push back' from her manager in response to her request to work from home on certain days (as a Clinical Nurse Consultant, she engages in a lot of research work that could be done from home):

> 'My TIRA was a compromise... there's just such a huge push back against working from home. That compromise from my manager was... could you just switch your hours around? … the TIRA is working OK for me now, but I would have preferred to be allowed to work from home.' (Clinical Nurse Consultant, Woman, FG13)

Another Registered Nurse with a TIRA felt that individual formal flexibility arrangements would not be necessary if good flex was built into nursing and midwifery jobs:

> 'If you give employees that autonomy... there won't be any need for TIRAs or the negative spin associated with TIRAs will slowly die away. Because at the end of the day, flexible working practices are good for everyone.' (Registered Nurse, Woman, FG10)

Consequently, while TIRAs can be an enabler of good flex for some participants in some contexts, they are not a sustainable remedy for the systemic problem of inflexibility in nursing and midwifery.

Managerial and team support for flexibility

Finally, many participants reported that access to good flex could be enabled by the support of individual managers and teams. While many participants reported that managerial discretion was a major barrier to employees accessing good flex (see above), others noted that a supportive manager could make all the difference in allowing for flexibility and control over hours and shifts. In focus groups and interviews, multiple participants spoke positively about managers that had endeavoured to make rostering 'work' for their teams. For example,

one Registered Nurse and Midwife with a TIRA explained that she feels ‘really good... at the moment’ largely because of the effort her ‘amazing manager’ had put into building a positive team culture that supports access to flexibility: ‘We've had an amazing manager and she's worked hard at the culture that we are a really good team’ (Registered Nurse and Midwife, Woman, FG13). Similarly, a Nursing/Midwifery Manager discussed how the support and ‘trust’ provided by her ‘really great manager’ allowed her to work autonomously and flexibly:

> ‘I'm 5 months into this role... I have a really great manager. I have a lot of flexibility in that I can run my own show... I find that working from that place of trust really works for me. And gives me a lot of value, but also a lot of fulfillment and I can then pass that on to the team that I manage as well.’ (Nursing/Midwifery Manager, Woman, FG4)

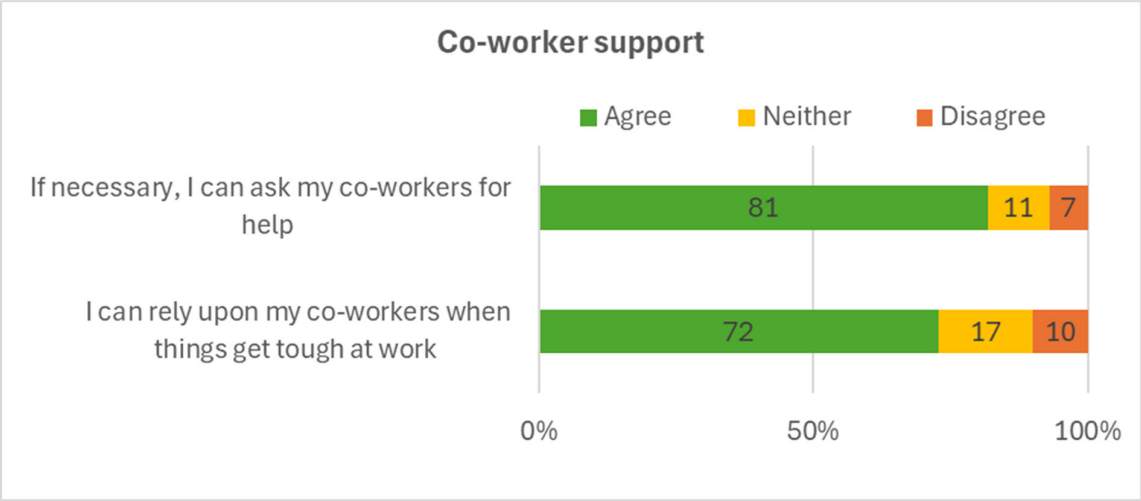
Relatedly, many participants said that support from teams was a significant enabler of good flex. For instance, participants spoke about supportive teams in which individuals would swap shifts (if necessary) and rally around individuals confronting difficult life circumstances, as a Clinical Nurse Educator notes:

> ‘If someone's travelling, I guess like an hour, an hour and a half to work compared to someone who's travelling 15 minutes, the team would usually get around that person if the manager wasn't helping them and kind of swap shifts and whatnot.’ (Clinical Nurse Educator, Man, FG12)

It should be noted that perceptions of co-workers and teams as supportive were not universal. Rather, some focus group and interview participants argued that unfairness, inequity and a lack of understanding from managers trickled down to the team level, creating unsupportive or even hostile peer interactions. For example, a Registered Nurse with 41 years’ experience argued that a lack of support from co-workers and managers can create a ‘dog-eat-dog’ team culture: ‘It becomes that dog eat dog... you're not caring for each other, you're not giving back to each other’ (Registered Nurse, Woman, FG1).

Encouragingly, however, most survey respondents experienced their teams as a source of support: 81% agreed that they can ask co-workers for help, and 72% agreed that they can rely on their co-workers when things get tough at work (Figure 9). This suggests that, while there are clearly exceptions, for the most part co-workers and teams seem to act as an enabler of good flex in nursing and midwifery. When combined with reliable support from managers, this appears to create positive workplaces that are particularly enabling of access to good flex.

Figure 9 – Co-worker support



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'If necessary, I can ask my co-workers for help' / 'I can rely upon my co-workers when things get tough at work'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

Chapter 4. Consequences and risks

This chapter discusses the consequences and risks associated with nurses and midwives' lack of access to good flex. These consequences and risks are felt at multiple levels, and have the potential to impact individual employees, organisations and the entire workforce.

At the ***individual level***, the consequences and risks of a lack of access to good flex include:

- **Fatigue, emotional exhaustion and burnout**
- **Career disadvantages**
- **Middling job satisfaction**

At the ***organisational level***, a lack of access to good flex can have a negative impact on:

- **Quality of care**

And at the ***structural level***, a major and costly consequence and risk of nurses and midwives' current working conditions is:

- **Poor retention and loss of staff, especially senior nurses and midwives**

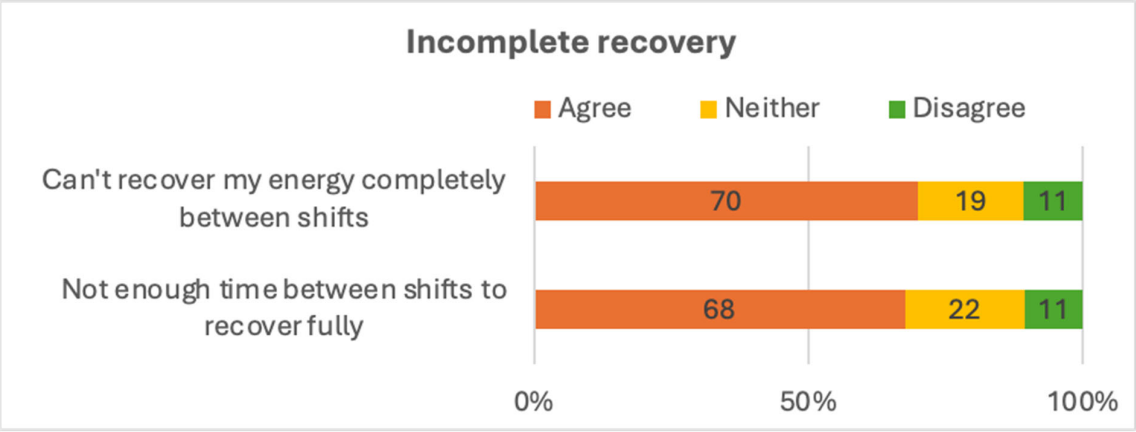
4.1 Individual level

Fatigue, emotional exhaustion and burnout

Long shifts, high work demands, stressful environments, and limited flexibility are widely recognised contributors to fatigue, emotional exhaustion and job burnout among nurses (see Chapter 1). Across our survey, focus groups and interviews, nurses and midwives recounted their ongoing experiences with facing and trying to manage these well-documented challenges of their work and workplaces.

Two-thirds of survey respondents (68%) reported that they do not get enough time between shifts to fully recover, and a similar proportion (70%) reported being unable to completely recover their energy between shifts (Figure 10).

Figure 10 – Incomplete recovery



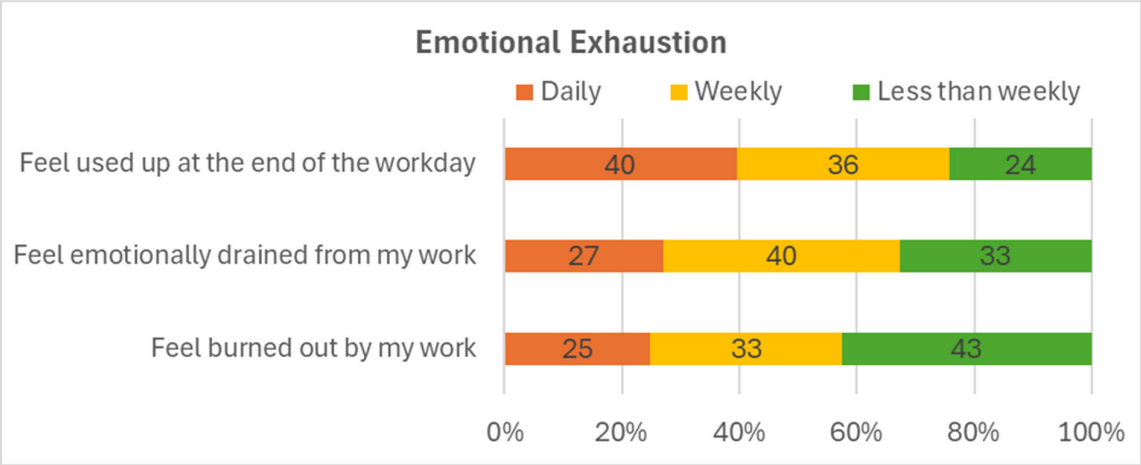
Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'I can't recover my energy completely between shifts' / 'I don't get enough time between shifts to recover my energy fully'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

In focus groups and interviews, multiple participants reported struggling to manage the physical toll of rotating shifts, night shifts, on-call shifts and long work hours. The inherently taxing nature of nursing work (physically, mentally and emotionally) makes it especially difficult to detach and 'wind down' from, as a Registered Nurse with 3 years' experience demonstrates:

> 'Because you've had so much adrenaline and your mind's going, I find I get into bed, it's taking me a long time to wind down. My head is pounding... my ears are ringing. They ring for a good 2, 3 hours after work from all the noises, and obviously my feet are just pumping... physically it's a lot to come down [from] but if you've had a bad shift or you've been on with some stressful people there's definite anxiety.' (Registered Nurse, Woman, Interview 5)

Along with physical fatigue, nurses and midwives report high levels of emotional exhaustion. Of the survey respondents, 40% said that they feel 'used up at the end of the workday' daily and more than a quarter (27%) said they feel 'emotionally drained from my work' every day. If extended to those who have these adverse work experiences at least once a week, the results look even worse: 76% are 'used up' and 67% are 'emotionally drained' on a weekly basis (see Figure 11).

Figure 11 – Emotional exhaustion



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'In your current job, how often do you feel…?' The question items were: 'Used up at the end of the workday' / 'Emotionally drained from my work' / 'Burned out by my work'. For each question, the response options were: 'Never'; 'A few times a year'; 'Once a month or less'; 'A few times a month'; 'Once a week'; 'A few times a week'; 'Everyday'. For the results shown in the Figure above, we re-categorised as follows: Daily = 'Everyday'; Weekly = 'Once a week' or 'A few times a week'; Less than weekly = other responses options.

In focus groups and interviews, participants discussed how multiple, interrelated factors – including the overwhelming volume of work; a lack of time away from work to recuperate; poor work–life balance; acute work-related stressors (such as abusive patients and families); and not being able to debrief with colleagues after stressful periods – led to feelings of overwhelm, emotional exhaustion, and burnout. As a Registered Nurse with 13 years' experience illustrates, these feelings can generate exhaustion at the mere thought of going to work:

> 'Yeah, burnout. And I guess also the mental stress. I have been verbally abused by patients a lot. And so it's like just the thing of like, oh, I'm going to work. You are already like sort of stressed out… You're not even like looking forward to your work. It's just like I need to pay my bills. I have to go to work.' (Registered Nurse, Woman, FG14)

These cumulative physical and emotional tolls of working in nursing and midwifery are among the troubling, yet foreseeable, outcomes of a workforce operating under unyielding workload strain. As we discuss further below, these symptoms of exhaustion and overwhelm also spill over into stark warnings of intention to leave nursing and midwifery, if nothing changes.

Career disadvantages

A major negative individual-level consequence of inflexibility and a lack of control in nursing and midwifery is career changes to gain greater choice and control over hours and shifts. Although part-time or casual hours can help individuals to achieve greater control over their working time in the short term, they also carry significant, long-term career and financial risks,

including reduced job security, reduced income, and a lack of access to professional training and opportunities for career advancement.

In focus groups and interviews, many participants reported that they had taken a step back in their careers to gain greater control over their hours and shifts, typically by moving to part-time or casual contracts instead of a full-time role. Participants discussed how these contracts allowed them to feel more in control over their time and experience a greater balance between work and life. Casual contracts, in particular, allowed participants to pick up the exact shifts they wanted (and avoid shifts they did not want), outside the strict confines of a roster – as a casually employed Registered Midwife explained:

> ‘I found that I was getting to the stage where night shift was really impacting my health and my mental health. And so I just made a decision that I didn't want to do it. And so, yeah, I took the leap and I went casual. And I haven't looked back. Like I only do day shifts. I very rarely pick up a PM. I never do night shift.’ (Registered Midwife, Woman, FG6)

Notably, several focus group and interview participants reported having navigated *sideways* or *upwards* in their careers to access greater flexibility. Rather than shifting to part-time or casual contracts, these participants described navigating to specific roles or organisational contexts that were more amenable to good flexible work, and that did not have any career or financial penalties (see also Chapter 3). For instance, a Nursing/Midwifery Manager described how she left an inflexible position to seek out a ‘beautiful unicorn job’ that allowed improved work–life interaction:

> ‘Part of the reason I left my last district was because my reduced hours were not supported post return from maternity leave... now I'm in this beautiful unicorn job...’ (Nursing/Midwifery Manager, Woman, FG4)

However, stepping down was viewed as a more common response to inflexibility in nursing and midwifery than stepping up or sideways. Several participants, including a Clinical Nurse Consultant with 16 years’ experience, related stories of individual co-workers (or entire teams) who had taken steps back in their career in response to the inflexibility of their jobs:

> ‘There's a lot of ED [Emergency Department] nurses who don't have or weren't granted enough flexibility, so they ended up reducing their hours and some ED nurses have dropped down to 0.8 [FTE]. And will pick up shifts because management wasn't as supportive in giving them their roster. So it's kind of a career risk, but that's what they were forced to do.’ (Clinical Nurse Consultant, Woman, FG12)

While many participants reported being happier and no worse off after moving to a part-time or casual contract, others noted substantial negative financial and career consequences of such moves. For instance, one Registered Nurse described how she moved to a part-time contract to manage her caring responsibilities as a single mother, which pushed her into a state of greater financial stress:

> 'I have a contract for 6 days a fortnight... 0.6 full-time equivalent roster. I'm working in a clinic that's only open from 8:00 till 4:30, so that's, you know, fairly good... Which is manageable, but it does keep me in a very tight financial pattern. Like, you know, that means more than half of my income goes on rent...' (Registered Nurse, Woman, Interview 1)

Others discussed how stepping down, particularly via casual contracts, reduced their ability to access professional training; reduced their job security; and denied them access to sick leave, annual leave and long service leave. As one casually employed Registered Nurse and Midwife with 27 years' experience noted, 'My decision to remain casual gives me flexibility, but with the downside of reduced security and no sick or holiday leave' (Registered Nurse and Midwife, Woman, FG11).

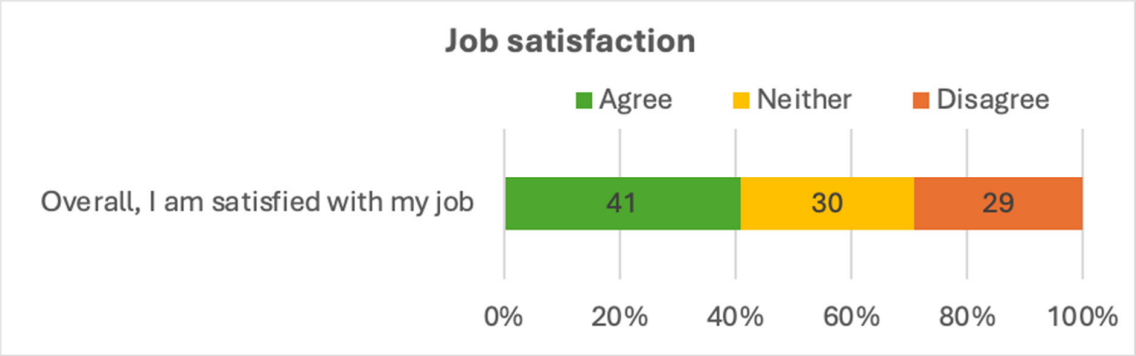
In these ways, while changes in roles or hours do provide nurses and midwives with some degree of control over their hours and shifts, it ultimately is a form of *bad flex* because of the associated, and often significant, career and financial penalties.

Middling job satisfaction

There were very mixed views among nurses and midwives about the quality and agreeableness of their current jobs. Survey respondents expressed only moderate levels of job satisfaction, despite the inherent love that many feel for their work.

When asked if 'Overall, I am satisfied with my job', 41% of respondents agreed that they are satisfied, 30% were neither satisfied nor dissatisfied, indicating substantial ambivalence, and the remaining 29% *dis*agreed (see Figure 12).

Figure 12 – Job satisfaction



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question item was: 'Overall, I am satisfied with my job', and the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

Focus group and interview data sheds some light on this apparent ambivalence. Multiple focus group and interview participants stressed that they love and feel passionate about their work *itself*, but that this love is dampened by the poor conditions and lack of flexibility they experience on a day-to-day basis. A Clinical Nurse Educator illustrated this push-pull dynamic:

> 'Love my job. But in a word, lately it's been probably overwhelming. So busy... I still love what I do and I still really enjoy it... So I don't want to whinge, but it's just, it's just hard.' (Clinical Nurse Educator, Man, FG12)

A Registered Nurse explained concisely, 'the workplace is probably worse than the work at the moment' (Registered Nurse, Woman, Interview 5).

Arguably, the middling levels of overall job satisfaction reported by survey respondents are *better* than might have been expected, given the various unmet aspirations and challenges faced by this workforce. One interpretation is that the inherent enjoyment that many get from their work – the 'intrinsic reward' of being a nurse or midwife, which often led them into this work in the first place – provides a sort of protection against some of its downsides. Yet, this devotion also creates a potential vulnerability, which researchers have described as becoming 'prisoners of love' (Chesters and Baxter 2011; England 2005). In effect, the strong motivation, or love, that nurses and midwives feel for their work can make them more tolerant of difficult working environments and low pay, effectively 'trapping' them in lower quality jobs.

Whether or not most nurses and midwives are 'prisoners of love', their widespread feelings of ambivalence towards their jobs are a concern.

4.2 Organisational level

Quality of care

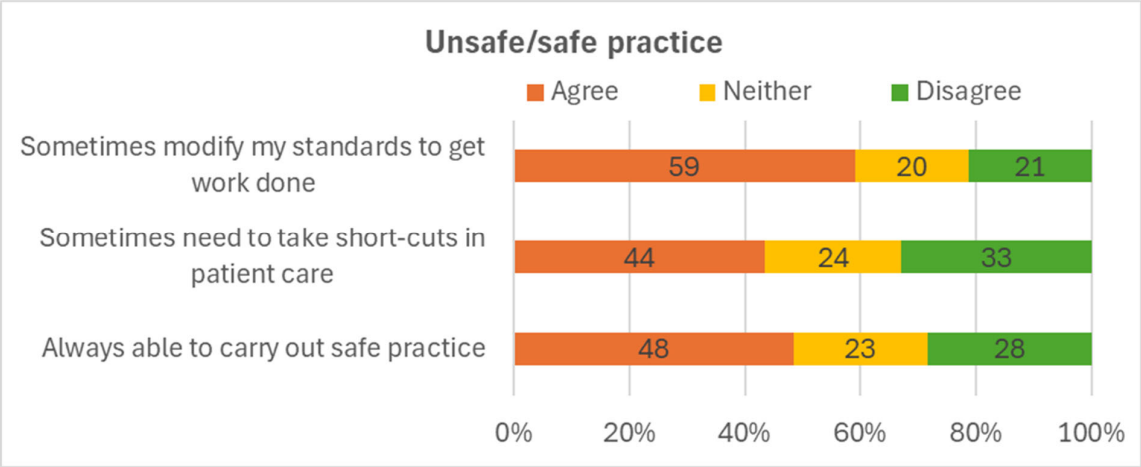
As discussed in Chapter 1, existing research identifies unsafe practice and poor patient care as significant risks posed by nurses and midwives' inflexible schedules. While we did not directly study safe practice and the quality of care experienced by patients in NSW, participants expressed strong concerns about these issues throughout all phases of our research.

In focus groups and interviews, numerous participants expressed concern about the conditions of their work, and the knock-on effects for their patients. They discussed poor patient care as a perceived consequence of the interrelated factors of understaffing, employee fatigue, and emotional exhaustion (discussed above). A Clinical Nurse/Midwifery Specialist with 9 years' experience explained that understaffing is perceived by many to be 'unsafe' and 'untenable' for both patients and employees:

> 'I do think that there are a lot of contributing factors [to burnout]... The biggest one is… across the board we are hugely understaffed, but our workload... doesn't take that into account... like last week we had a morning shift that is supposed to be staffed for 11 midwives. With sick leave and rostering, we had 5, which is horrendous. It is unsafe, it's untenable and people can't continue to work like this.' (Clinical Nurse/Midwifery Specialist, Woman, FG14)

Survey respondents similarly indicated that they felt that unrelenting time pressure, complex patient needs, and chronic understaffing negatively impacted their ability to provide high quality care to patients. Well over half of respondents (59%) agreed that they are 'sometimes forced to modify [their] standards to get the work done'. It is not respondents' preferences that lead to them adjusting their behaviour, but *a lack of choice*, stemming from their circumstances. Similarly, less than half of respondents (48%) agreed that they are 'always able to carry out safe practice' on the job, while more than a quarter (28%) *dis*agreed. In a public health system where safe practice and a duty of care to vulnerable patients is paramount, this is a troubling result (see Figure 13).

Figure 13 – Unsafe/safe practice



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements about your current job?' The question items were: 'I am sometimes forced to modify my standards to get the work done' / 'I sometimes find it necessary to take short-cuts in patient care' / 'I am always able to carry out safe practice'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

4.3 Structural level

Poor retention and loss of senior workers

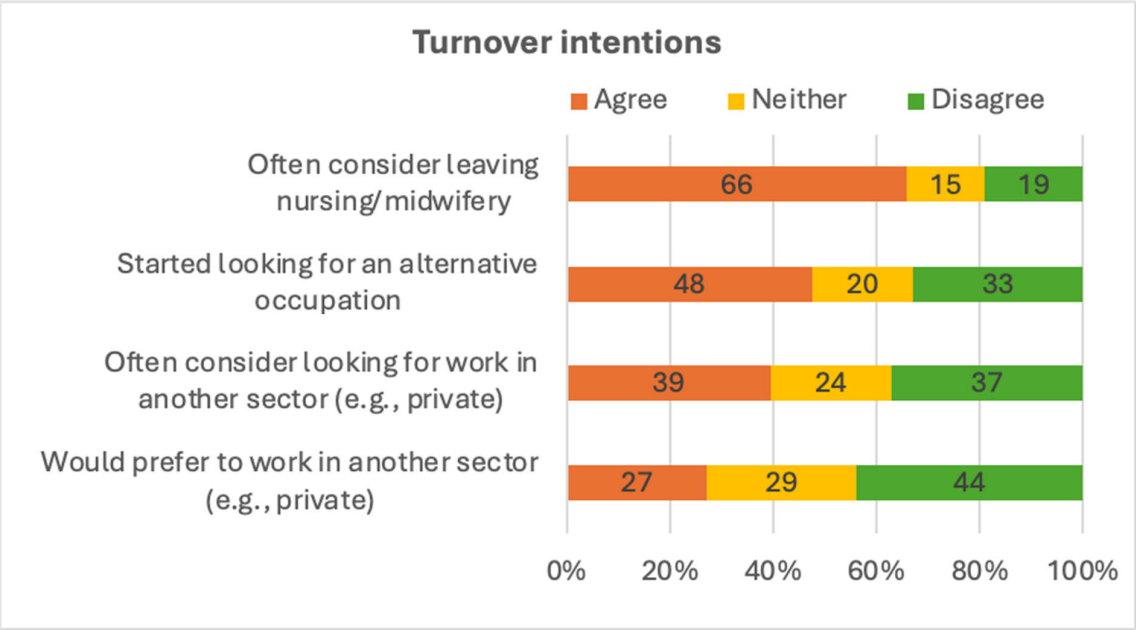
The challenges discussed above represent a significant risk to nursing and midwifery at the structural level, through poor staff retention and the compounding costs of high staff turnover. In all 3 research phases, we found striking numbers of nurses and midwives were considering leaving their jobs. In focus groups and interviews, participants discussed how the current state of their profession had made their jobs (and the jobs of their colleagues) fundamentally unsustainable. In particular, participants discussed how a lack of good flex and high rates of emotional exhaustion and burnout were causing many to leave – or to consider leaving – the profession, as a quote from an Enrolled Nurse with 5 years' experience illustrates well:

> 'I won't be staying here for that much longer... I'm looking to move elsewhere. And you know, I see the new grads come through. I get to, you know, hold their hand for a little while and they're gorgeous. But they get burnt out so quickly.' (Enrolled Nurse, Woman, FG2)

While nurses and midwives' love of their work can make them more susceptible to staying in bad jobs (as noted above), many survey respondents were in fact contemplating leaving their current jobs or leaving nursing and midwifery altogether. The results vary somewhat according to the questions we asked, but in all cases, respondents had substantial 'turnover intentions',

with at least one quarter – and sometimes as many as two thirds – willing to work elsewhere. Most worryingly, 66% agreed that 'I often consider leaving nursing/midwifery' (see Figure 14). This indicates a very pronounced level of frustration with current working conditions, even if not all these respondents 'follow through' and eventually leave.

Figure 14 – Turnover intentions



Source: Survey of NSWNMA public sector members.
Note: Respondents were asked: 'To what extent do you agree or disagree with the following statements?' The question items were: 'I often seriously consider leaving nursing/midwifery' / 'I have started looking for an alternative occupation' / 'I often seriously consider looking for work in another sector in health (e.g., private sector, aged care facilities)' / 'I would prefer to work in another sector within health (e.g., private sector, aged care facilities)'. For each question, the response options were: 'Strongly agree'; 'Agree'; 'Neither'; 'Disagree'; 'Strongly disagree'.

To gauge the strength of turnover intention, we also asked whether respondents 'have started looking for an alternative occupation'. The proportion who agreed they have done so is lower (48%), but still disconcertingly high. Turnover among nurses and midwives of even near this level would paralyse the public healthcare system. Finally, our survey results suggested that nurses and midwives in the NSW public system, by and large, do not intend to switch sectors and take a job in the private sector. Only 27% agreed that 'I would prefer to work in another sector within health'. The survey results showed the risk of attrition and skills loss from nursing and midwifery into different occupations altogether, rather than a transfer across sectors. Such losses are costly and would compound existing workforce pressures in the system.

Further, many focus group and interview participants expressed concern about the high number of skilled, *senior* nurses and midwives they had seen exit their jobs. Participants

reported that this loss of experienced staff posed serious issues for training and knowledge transmission. Participants also stressed that without senior nurses and midwives, more junior and mid-career staff have responsibilities they may not yet be equipped for. Focus group and interview participants argued that this not only worsens issues of heavy workloads and burnout but also poses significant risks for safety and patient care. As a Registered Nurse with 3 years' experience passionately argued, seniors 'are the glue' that holds the healthcare system together, meaning that their absence from any workplace is sorely felt by other nurses and midwives:

> 'There's not a nursing shortage. There's not. We've got nurses. We have a senior shortage. It's – that's the issue and my biggest thing is without seniors people die. Seniors are the ones protecting the junior baby nurses and the patients. They are the ones that are the glue in the facility... if we had more seniors we wouldn't be so junior heavy and we probably wouldn't have some of the problems that we do.' (Registered Nurse, Woman, Interview 5)

As we elaborate upon in the conclusion to this report, this final, structural risk of poor retention is particularly dire because it creates a cycle that worsens the conditions that created it. That is, poor retention contributes to chronic understaffing, which worsens workloads and impedes access to good flex, which drives more nurses and midwives away from the profession, further exacerbating and entrenching this cycle.

Conclusion: addressing the poor job quality cycle

NSW nurses and midwives want greater flexibility, choice and control over their hours, rosters and shifts. However, significant barriers prevent good flex for nurses and midwives, leaving many of them instead with overwhelming workloads, overtime, fatigue, emotional exhaustion, career disadvantages, and plans to leave the profession altogether.

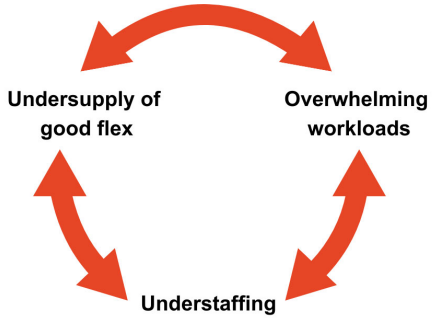
The barriers and risks that many nurses and midwives face in their jobs and workplaces constitute a cycle of poor job quality (see Figure 15). This cycle has 3 major elements, which simultaneously cause and are caused by one another: understaffing, overwhelming workloads, and an undersupply of good flex.

Understaffing leads to overwhelming workloads when there are not enough employees to properly cover a shift. Understaffing also makes it difficult for managers to write fair rosters that simultaneously suit employee needs and ensure safe practice.

The overwhelming workloads that are caused by understaffing then lead to regular overtime (as nurses and midwives scramble to cover gaps in the roster, and manage complex workloads without the assistance of skilled, senior staff), which damages work–life interaction – leaving nurses and midwives with less time and ability to manage their caring and other domestic responsibilities.

This time pressure, overwork and poor work–life balance then lead in combination to fatigue and emotional exhaustion, which drive worn-out nurses and midwives out of their jobs. At the same time, retention is worsened by an undersupply of good flex, in that nurses and midwives who cannot find ways to gain control over their working time seek part-time or casual contracts or leave their jobs altogether. Additionally, as above, the supply of good flex is damaged by understaffing, when managers are forced to roster around gaps. Consequently, unsustainable workloads and an undersupply of good flex feed back into understaffing, accelerating the cycle.

Figure 15 – The poor job quality cycle



While the 3 factors of understaffing, overwhelming workloads, and an undersupply of good flex compound one another, we argue that this cycle is entrenched at the structural level by the chronic understaffing of nurses and midwives throughout the state. That is, understaffing can be thought of as the 'starting point' of this cycle. The structural foundation of this cycle is important, as it emphasises that the issue is not caused by the actions of individuals or specific organisations. Rather, nurses and midwives across the state are dealing with similar issues, caused by the same structural condition of understaffing.

The one positive of this cycle is that any small intervention to improve any of these 3 factors is likely to have beneficial knock-on effects for the entire cycle, because the 3 factors are so thoroughly interrelated. For instance, helping nurses and midwives to gain greater control over their hours and shifts (e.g. by creating conditions that allow for more regular shifts) would help, at least to some extent, to stem poor workforce retention and understaffing, which would help to alleviate heavy workloads, and so on. While this may not correct the entire cycle, it would benefit the many nurses and midwives who currently experience overwhelming workloads and limited choice and control over their working time. Thus, for the sake of nurses and midwives' job quality – as well as the sustainability of healthcare sector as a whole – it is important to identify specific actions that begin to incrementally, and then cumulatively, improve this cycle.

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