

1.0 Preamble Pages 1 - 2 Lines 7 – 55	NAG Response	Rationale
<b>Anon 1</b> The broad vision is focussed and appropriate. Line 55 include "advanced nursing practice roles"	agreed	Amendment made
<b>Anon 2</b> Good to see clinical supervision included	noted	
<b>Auckland DHB</b> Preamble largely unchanged with the exception of sentence order and a contextual addition at line 32 & 33.	noted	
<b>Canterbury DHB</b> The CTA is to be commended for this workforce development initiative, which has positively impacted on nursing workforce development and service provision in our region.	noted	
<b>Capital &amp; Coast DHB</b> The CTA postgraduate nursing training specifications are clear and well written. There is improved flexibility from the previous specifications e.g. minimum employment FTE defined by the DHB (line 272) and clearer explanation of clinical supervision (3.7). Lines 29 – 34: the EAG is a good forum for discussion of issues that the CTA Co-ordinators are experiencing and the positive step of having a CTA Co-ordinator on this committee is commended.	noted	
<b>Counties Manukau DHB</b> Line 27- add at end of sentence in primary health and private care Line 55- add ... pathway towards ... nurse specialist, nurse educator, nurse manager or Nurse practitioner	Line 27 disagree Line 55 noted	Already includes Primary Alternative amendment made
<b>Hutt Valley DHB</b> Lines 43- 44: Whilst the vision is to ensure National consistency, this in fact is not the reality. Individual DHB's interpret and subsequently apply the specifications differently. Some examples are: Some DHB's pay fees in advance and others pay retrospectively and only on successful completion of the qualification. This is inequitable and in the case of retrospective reimbursement, a potential barrier. (Also see section re: travel and accommodation). There are second 'intakes' during the year managed by 'waiting lists' for access to funding – variability in how this is managed. Lines 54-56: Recommend: "... to advance nursing practice including, but not limited to, the pathway towards nurse practitioner".	Lines 43 - 44 noted Lines 54 -56 - noted	Point to discuss with DONs re national consistency. Alternative amendment made
<b>Lakes DHB</b> Line 55, advances in nursing practice are broader than NP, this statement say includes NP, but the clinical masters pathway is limited to this direction. See final comments.	agreed	Amendment made

<b>MidCentral DHB</b>	Reflects background, vision and principles underpinning CTA PG Nursing Funding. Line 37 & 41: The assumption that training has to be at postgraduate level needs to be challenged as an employer should be able to determine if the level required is specialty practice is graduate level in the first instance, and then postgraduate level. Level 7 and Level 8 papers should be able to be funded for workforce development. The statements it indicates training, then the specification goes on to focus on qualifications only, precluding short course training such as health assessment.	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.
<b>NETS</b>	We support the acknowledgement of the need for access to education funding for nurses working outside hospitals. Lines 54-56: Recommend: "... to advance nursing practice including, but not limited to, the pathway towards nurse practitioner	noted	Alternative amendment made
<b>New Zealand College of Mental Health Nurses</b>	We support the acknowledgement of the need for access to education funding for nurses working outside hospitals. There needs to be some clarity in relation to those nurses working Mental Health Settings. There has been feedback from clinical settings that mental health has its own funding and does not therefore qualify for the postgraduate funding that is allocated through the CTA. This seems to be an understanding with a lot of coordinators overseeing the CTA PG funding. This has created some distress for registered nurses in mental health setting wanting to enrol in appropriate postgraduate study that is not specifically mental health related.	noted	MOH to follow up internally and Nursing Advisory Group (NAG) to invite Te Pou to attend the next NAG meeting
<b>Nurse Practitioner Advisory Committee of New Zealand</b>	Page 2, Line 56. Add bullet point: to enable RNs of NPs to extend scholarship in Nursing through doctoral studies	disagree	Current policy is to fund to Masters level

<p>NZNO</p> <p>L 11 - Health Workforce numbers need updating from 2002. L 15 - Suggest "advanced/extended clinical skills" is a better descriptor of nursing workforce needs than "specialty knowledge". L 31-34 - NZNO notes with concern the difficulty in accessing information about the Expert Advisory Group's (EAG) consultation process the CTA Nursing Advisory Group (NAG) and other stakeholders and derived feedback, in contradiction to the stated CTA vision of delivering a "transparent and consistent model..." (L43-45), and objective to "enhance the accountability and transparency of the funding process"(L48). L 45 - Add "and reduce disparities". L 54-55 - Add "and specialist nurse roles" as per 2006 document. This would ensure that CTA funding for postgraduate nurse training would encompass clinical as well as academic training as is consistent with the nursing role and identified workforce needs. In practice, specialty nurse roles are highly valued, and often vital to safety and quality issues.</p>	<p>noted</p>	<p>Will use new HWIP report instead re L11. L14 will replace specialty with advanced. NAG will discuss options for increasing transparency of processes. CTA will be publishing the submissions and NAG response to the PG Nursing Specification review consultation</p>
<p>We draw your attention to the results of NZNO's 2008 education survey, showing a strong preference for a wide range of educational opportunities, other than the CTA's only funded option of Level 800. The results showed that, even when there was easy access to tertiary educational institutions, workplace options greatly exceeded 'nursing tertiary options' for professional development to meet varying learning needs. Further research needs to be conducted to determine whether workplace options overcome some of the barriers to professional development; whether they are more relevant; or whether they are the most time and cost-effective ways of meeting competency requirements. The CTA's consultation summary from the 37 submissions received regarding the 2006 consultation does not corroborate level 800 only. Numerous responses indicate the need for more than level 800 courses being funded. For example: "It is important the application of CTA funding is not limited to postgraduate nursing training but is inclusive of all post registration programmes that enable RNs to advance nursing practice</p>	<p>noted</p>	<p>L45 and reduce disparities added. L55 alternative amendment made</p>

<b>NZNO</b>	"Programme selection should enable DHBs to be responsible for prioritising appropriate post-registration nursing training programmes rather than limiting the prioritisation to postgraduate nursing training programmes. Some prioritised nursing workforce needs may be able to be met more efficiently and appropriately at a graduate certificate level." "Access to graduate nursing studies at level 7 is vital for a significant sector of our workforce. Perceived as more clinically based and shorter, Graduate Studies provide a cheaper and more effective way of upskilling a sector of our workforce, who do not wish to study at post-graduate level." We note that CTA's feedback for this comprised a compilation of comments with no analysis, and it is concerning, but perhaps not surprising, that, three years later, respondents are having to make many of the same points again.	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. The DONs nationally will be invited to participate in a discussion around this. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access funding for it.
<b>SIT Trainees</b>	Line 45 In order to improve health outcomes of New Zealanders, we would like to see more flexibility around the financing of postgraduate nursing programmes. For example, funding programmes that meet the needs of individual nurses who may not wish to pursue the Nurse Practitioner pathway.	noted	The funding model is designed to encourage nurses to advance nursing practice
<b>UCOL</b>	Line 37: we would like to see it made explicit that all nurses can have access to the funding, as it appears that currently the eligibility is being interpreted as only nurses who are directly employed by a DHB. Line 44: same point. Almost half of the nurses in New Zealand are not employed by a DHB, and the model does not therefore appear "consistent."	disagree	All 21 DHBs are currently funding non DHB employees
<b>University of Auckland</b>	Line 54 We fully support the intention to advance nursing practice and suggest that education for leadership, education and research roles are directly linked to this goal.	noted	
<b>University of Otago</b>	We affirm the need for continuation of this funding of postgraduate nursing training. Line 54-55 We support the model to enable the education of NPs	noted	
<b>Waitemata DHB</b>	Line 54 – 55 should include acknowledgement of other advanced practice roles other than nurse practitioner. Suggestion is "enable registered nurses to advance nursing practice including the pathway to nurse practitioner and other advanced nursing practice roles"	agreed	Amendment made
<b>West Coast DHB</b>	Line 10: Agree nurses are a key workforce (52%) of the regulated workforce. Would like to see a more equitable share of the CTA funding dedicated to this workforce. The funding for the development of knowledge and skills for the nursing workforce is not commensurate with the demands for quality performance from this workforce.	disagree	CTA has not declined any requests for additional funding from DHBs for eligible trainees and has increased the level of funding available to nurses for postgraduate study to \$12.2 million
<b>Whitireia Community Polytechnic</b>	We support the acknowledgement of the need for access to education funding for nurses working outside hospitals. Lines 54-56: Recommend: "... to advance nursing practice including, but not limited to, the pathway towards nurse practitioner".	agreed	Amendment made

2.0 PROGRAMME SELECTION Page 2 Lines 58 - 69		NAG Response	Rationale
<b>Anon 1</b>	Line 65 add PHO and NGO	agreed	Amendment made as per Counties Manukau submission
<b>Auckland DHB</b>	Yes we agree programme selection must remain flexible enough to allow 'local' population health needs to be met. However the meagre funds available result in delays in the preparation of nurses in advanced practice roles and workforce development. This also gives education providers flexibility to offer course at intervals when a sufficient cohort of trainees are both available and enrolled in the courses. Without this flexibility there is a risk to the viability of some programmes through insufficient enrolments	disagree	CTA has not declined any requests for additional funding from DHBs for eligible trainees
<b>Canterbury DHB</b>	Endorsed, with addition: Line 70 Add a dot point "their ability to deliver on stated objectives of this specification" [See Preamble, para1.] Section 4.0 needs to be strengthened to enable evaluation	noted	Already covered
<b>Counties Manukau DHB</b>	Line 65- at end of sentence ... and PHO/providers/NGOs	agreed	Amendment made
<b>DHBNZ - Nurse Practitioner Facilitation Steering group</b>	Line 67- this is not "required" by DHBNZ. The plan is a collaborative DHB activity; DHBNZ only provides the secretariat function for it.	agreed	Amended
<b>DHBNZ Nursing and Midwifery Workforce Strategy Group</b>	Line 67- this is not "required" by DHBNZ. The plan is a collaborative DHB activity; DHBNZ only provides the secretariat function for it.	agreed	Amended
<b>Lakes DHB</b>	Should also be related to the DHB health status reports	noted	Covered under prioritised workforce needs
<b>MidCentral DHB</b>	Line 67-68 How does CTA ensure that programmes selected are based on DHB workforce action plan priorities? How is this monitored?	noted	Process checked through Audit
<b>Nurse Practitioner Advisory Committee of New Zealand</b>	Page 2, Line 76. Add bullet point: Fund level 7, post-registration papers to support the development of foundational speciality practice knowledge and skills.	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.

<p><b>NZNO</b></p> <p>L 60-61 NZNO does not support the addition to this section that "DHBs plan services and forecast future workforce needs for the health of their populations." This entirely devolves responsibility for planning and forecasting to the DHBs rather than their being able to find a lead through the Ministry of Health. The DHBs must be accountable to the Ministry of Health but cannot be entirely responsible for planning training and education programmes for a nationally regulated health professional workforce. Indeed, part of the problem with CTA funding is the lack of a nationally consistent and transparent framework and information from which to be able to draw useful conclusions about funding for nurse training. NZNO has consistently encountered difficulty in accessing comprehensive data from the CTA, even under Official Information Act pathways, other than a table showing the total budgets of Nursing Training Expenditure (see Appendix 1). To try to access data from 21 DHBs would be impossible. These are public monies being spent and should be transparent and open to comment for constructive development.</p>	disagree	<p>Planning for future workforce needs is the business of DHBs. The MOH workforce planning team also undertake workforce planning around nursing. CTA has undertaken analysis of the 2007 and 2008 years and a report will be published with the Purchasing Intentions and will be available on the CTA website</p>
<p><b>Plunket Society</b></p> <p>There is a focus on DHB and workforce plans based on district area plans etc. A concern is that workforce development programmes that sit outside the DHB sector are not obvious, potentially leading to applications being declined.</p>	disagree	<p>DHBs operate at a service level to meet population needs and the District Annual Plans would cover all of those needs, for example Well Child. The NAG encourages NGO nurse leaders to liaise with their DHB DON.</p>
<p><b>Southland DHB</b></p> <p>Often difficult in reality to achieve. Often programs that we want because they meet local need are not NCNZ approved</p>	noted	<p>The NAG refer to Line 80 -82 in the draft revised specification which allows for this flexibility. CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education</p>
<p><b>UCOL</b></p> <p>Line 58 (also 71 and 76-79): The requirement to be undertaking a "programme" presents a significant disadvantage to nurses wishing to undertake postgraduate study without necessarily engaging in a full qualification. Many nurses (by themselves, or at the wish of their employer) wish to undertake a specific targeted paper (or module) as part of updating, professional development, or because they wish to focus on a different (specific) area of practice. Such nurses may already have a Master's degree.</p>	disagree	<p>CTA funds programmes only, not papers. The purpose of the funding is for nurses to have postgraduate qualifications.</p>
<p><b>University of Auckland</b></p> <p>Lines 60-69 The alignment of postgraduate nursing education with strategic directions of DHBNZ and DHBs is essential and is a major platform for its ongoing relevance.</p>	noted	
<p><b>University of Otago</b></p> <p>2.0 we support the priorities as described</p>	noted	
<p><b>Waitemata DHB</b></p> <p>Programme selection should acknowledge input from PHO and NGOs. Suggestion for line 65 is "prioritised workforce needs identified by the DHB and local PHO and NGO"</p>	agreed	Amendment made
<p><b>West Coast DHB</b></p> <p>Line 80: The focus on Nursing Education is narrow. We would like CTA to support nurses to take a broader view with non-nursing but related pathways of education being supported by funding for e.g. papers on rehabilitation; Interpersonal Psychotherapy; to name two</p>	noted	<p>The NAG refer to Line 80 - 82 in the draft revised specification.</p>

2.1 PROGRAMME DESCRIPTION Pages 2– 3 Lines 71 – 96	NAG Response	Rationale
<p><b>Anon 1</b></p> <p>Line 78 add BN (Hons) programmes as the papers for this qualification are drawn from the MN schedule. Agree with broadening line 76 - 79</p>	agreed	added to 2.2 Programme Levels
<p><b>Auckland DHB</b></p> <p>Lines 80-82 the change to enable nurses to credit towards a PG Dip or masters approved by Nursing Council of New Zealand (NCNZ) is a much appreciated alteration. This takes into account the wide variety of courses relevant to advanced nursing practice that are available in Universities but not necessarily through a school of nursing. NCNZ approval seems currently to be geared towards approving uni-disciplinary nursing courses. To our knowledge no model yet exists for an interdisciplinary programme of study achieving endorsement by the NCNZ. The draft states the programme 'be approved by the NCNZ or credited towards a PG Dip or Masters approved by NCNZ. If the NCNZ looks at how the language is used here then interdisciplinary courses should be recognised – these are considered as contributing to the nursing body of knowledge e.g. Public health papers and epidemiology, bio-stats, research into public health care etc. There is a place for nurses to think and study in a broader field if they can articulate how this will contribute to their (I.e.nursing)advanced practice. Interdisciplinary education philosophically</p>	noted	The NAG refer to Line 80 -82 in the draft revised specification which allows for this flexibility
<p>aligns with a number of different work streams particularly for those in primary health care (as it align with the Primary Health Care Strategy) and rehabilitation, as it is fundamental to clinical practice in this area. In addition interdisciplinary programmes can be viewed as meeting the government's strategic ideas about working collaboratively. Furthermore nurses are asking for their qualification to reflect more closely their specific practice area e.g. Public Health rather than be an advanced nursing qualification. Overall the strength of opinion is that interdisciplinary education and training should be included and is a key method of increasing capacity within the health workforce. The deletion from the draft of PDRP National framework as a document to be consistent with is sensible given the document focuses primarily on levels of practice as applied to staff nurses and does not per se focus on advanced practice. Line 83-84 The goal may not always be to integrate theory and clinical practice, but for example to integrate theory and leadership or theory and resource allocation; as there are a wide range of specialty areas that fit be highly relevant and essential to workforce capability and population health (e.g. ethics, health policy, research, quality management). More flexibility in the title of the qualification awarded is required.</p>	noted Line 83 - 84	
<p><b>Canterbury DHB</b></p> <p>Lines 80 to 83 Add "or be approved by the DHB's DON/ EDON as meeting all requirements for that DHB's programme selection". (as specified in clause 2.0, with addition above) See Additional Notes below. Given the signalling of moving to models of care with core competencies, it is important to ensure the nursing workforce continues to have access to a range of clinically based post-graduate (level 8) education/training to ensure most efficient deployment of the health workforce. This will require flexibility including access to interdisciplinary courses as well as those provided by nursing departments. Access to interdisciplinary courses is particularly important to the aged care sector. Access to graduate nursing studies at level 7 is vital for a sector of our workforce. Perceived as more clinically – based, relevant and shorter, Graduate Studies provide a cheaper and effective way of upskilling a sector of our workforce, who do not wish to study at postgraduate level.</p>	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.

<b>Capital &amp; Coast DHB</b>	Line 80 – 82: this point remains too narrow and excludes the needs of many nurses in the Aged Care, Community and Primary Health Care settings pursuing expertise relevant to practice e.g. Aim High, Publicly funded Youth Health Services, PATH’s, school based nurses, public health nurses, inter-sectoral specific roles. We suggest there are 2 options with lines 80 – 82 which are to remove reference to Nursing Council NZ or rewrite it to something like this: “be relevant to the trainees current role and be credited towards a Postgraduate Certificate, Diploma or Masters providing this relates to trainees current nursing practice and is approved by the Director of Nursing.” The above dot point could be merged with lines 87 – 89: or just have the lines 87 – 89.	disagree	The NAG refer to Line 80 -82 in the draft revised specification which allows for this flexibility. CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education
<b>Counties Manukau DHB</b>	Line 78- add such as.. Bachelor of Nursing Honours... Line 85 change to- acknowledge the cultural diversity of NZ society that... CMDHB welcomes the broadened statement- “or be credited towards a PG Diploma or Masters approved by NZNC. This gives recognition to programmes for education and management which is required for these roles and promoting interdisciplinary papers.	Line 78 - agreed Line 85 - disagree	Line 78 - BN Hons added Line 85 - disagree - already covered in Specification
<b>DHBNZ Nursing and Midwifery Workforce Strategy Group</b>	Lines 80-82- Remove the need for approval by NCNZ. The regulatory body should not be taking on this role. It is bureaucratic and only drives up the cost to DHBs who have to pay for the NCNZ to complete these tasks.	disagree	CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education. We refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme
<b>Hutt Valley DHB</b>	Lines 76-79: Recommend the following: “...lead to a nationally recognised qualification at level 8 on the National Qualifications Framework i.e. a postgraduate certificate, a postgraduate diploma or Masters degree”. Lines 80-82: recommend “be approved by the Nursing council of New Zealand (NCNZ) or be able to be credited towards a Postgraduate Diploma or Masters approved by NCNZ, or advance nursing practice in line with clause 2.0 of this specification”. (Also see additional comments at the end of this submission). Line 92: recommend insert “and” at the end of the first dot point.	Lines 76 - 79 noted Line 92 disagree	Lines 76 - 79 meaning around suggested rewording not clear. Line 92 - disagree - not required
<b>MidCentral DHB</b>	Line 73-89 Make it clear that all of these criteria must be met, it is not either or (unless specified). Line 76 funding for level 7 nursing entry to specialty practice (grad certs) programmes as staircase to MN. Line 83 it is not clear what "integrate theory and practice" means as currently a paper does not have any hands on clinical practice but would be meeting the proposed specification.	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.
<b>NETS</b>	Lines 80-82: change wording to “towards an approved programme”. (Potentially a PG paper or PG Certificate not accredited by NCNZ will still articulate into a NCNZ approved programme at PG Dip or Masters level.)	agreed	Amended

<b>New Zealand College of Mental Health Nurses</b>	Lines 80-82: change wording to "towards an approved programme". (Potentially a PG paper or PG Certificate not accredited by NCNZ will still articulate into a NCNZ approved programme at PG Dip or Masters level.)	agreed	Amended
<b>Northland DHB Nurse</b>	76-79 reads disjointed. Suggestion: 'Lead to a nationally recognised qualification at level 8 on the National Qualifications Framework, such as post grad cert, post grad dip or masters degree, which informs advanced nursing practice.	agreed	Alternative amendment made
<b>Practitioner Advisory Committee of New Zealand</b>	Page 3, Line 96. Should refer to 2008 NCNZ competencies for NP	agreed	Amended
<b>NZNO</b>	<p>L 75 – NZNO notes with concern that "and subsequent clinical experience" has been removed from the description and strongly recommends its reinstatement. In comparable funding for other health professionals" training specifications, the focus is on both academic and clinical components, as is proper, and NZNO questions the lack of it for nurses. We draw your attention for instance to the Medical Radiation Therapy Training Specifications which require: both a theoretical and practicum paper; placements where advanced clinical experience can be obtained; direct clinical supervision as part of the suite of research, formal teaching and individual study requirements; close liaison between educational and clinical supervisors to ensure opportunities for reflective learning on clinical experience in the light of current literature and research and assist the trainee to integrate theory and practice etc.</p>	disagree	The intent is to broaden access and remove barriers to nurses undertaking postgraduate study
<b>NZNO</b>	<p>Postgraduate nursing training, including academic research, should similarly take place in a clinical environment where the relevance of the clinical procedures to clinical care is understood. NZNO strongly recommends that PNT is not be limited to 800 level and that there is due recognition of and support for clinical experience, training and expertise. L 80-82 - NZNO questions limiting funding to courses approved by the Nursing Council of NZ (NCNZ). NZNO's legal opinion of the role of NCNZ as determined by the HPCAA (2003) Section 118 is that it is one of oversight rather than prescription.</p> <p>"Sections 118 (a) (e) (i) and (k) refer to the council's role in terms of (a) accrediting and monitoring educational institutions and degrees, courses of studies or programmes; (e) recognizing, accrediting and setting programmes to ensure the ongoing competence of nurses; (l) setting standards of clinical competence, cultural competence, and ethical conduct to be observed by nurses, and last but not least, in general - it is charged with promoting education and training in the profession (k). Overall I would conclude from the language of the Act that the council has wide ranging responsibilities for, ultimately public health and safety, through the undergraduate and ongoing professional development education of nurses. However the latter role is more of an overseeing role rather than a prescriptive one, although there is room in the language of the Act for the council to get as involved as setting programmes in the latter role."</p> <p>Margaret Barnett-Davidson, NZNO Legal Advisor.</p>	disagree	CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education. We refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme

Nursing Council's role was questioned in the CTA's 2006 feedback. For example: "The NCNZ does not have a process of recognising nor is it appropriate or necessary for the NCNZ to approve programmes that have already been peer assessed as part of the accreditation mechanisms of NZQA, ITPQ, and CUAP. This creates unnecessary additional expense for academic institutions. As there are increasingly multidisciplinary programmes being offered, again it is not necessary or appropriate for NCNZ to approve these programmes." "The current Nursing Council approval process steers nurses towards study in uni-disciplinary contexts. There is an unfounded belief within some nursing groups that only NCNZ approved courses contribute to the professional development component of RN practicing certificates. However, nurses currently undertaking study in a variety of non-NCNZ approved courses find these meet their need for advanced education in subjects such as rehabilitation, primary health care, public health, psychological medicine, ethics, research."

NZNO notes that the strength of nursing analysis at policy level within the Ministry has not been met since the disestablishment of the Ministry of Health's nursing division in the late 1980s. Consequently, Nursing, has avoided the hard discussions that would bring the oversight, accreditation, monitoring and evaluation through designated professional standards as determined by advanced nursing practitioners. Instead, the regulatory body, with a small cadre of nurse educators, tries to fill these roles due to this described void. As with medicine, clinical roles and health settings have become more diverse, with both skills and scopes overlapping: cross disciplinary training is urgent and essential. NCNZ have, inexplicably, excluded interprofessional and interdisciplinary programmes from the list of approved courses, ironically in contradiction to required nursing competencies which call for interprofessional capabilities.

Currently nurses are prevented from taking the Public Health papers offered by the Otago School of Medicine, in spite of continued invitations to do so, because they are not NCNZ approved. Less obviously, new skills in areas which may not be traditionally part of the nursing role should not be excluded: marketing, for instance, is relevant for a range of primary healthcare initiatives. Business management is increasingly relevant as senior nurses become responsible for significant budgetary decisions impacting on healthcare. As one member comments: "I wish to work toward my employers values and goals examples of which are: effectiveness, innovation, and leading performance improvement... Researching quality improvement at the uni's led me to Massey which has an excellent diploma in quality systems management. It is a generic cross disciplinary course, but, as it not run through the school of nursing and instead run through the school of engineering it is not approved to the detriment of myself, the organisation I work for and ultimately the patients in our care." Leigh Anderson, Senior nurse Operating rooms and

In Good Hands calls for team work and the need for better workforce synergies. This will be more quickly and effectively achieved with increased cross disciplinary professional learning and training opportunities. L83 The word "clinical" has been removed and should be reinserted. L90-97 We see no reason for removing the requirement to be consistent with the "National Professional Development and Recognition framework (2003/2005)" and recommend it is reinserted

noted

The NAG refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme

disagree

It is not a compulsory process and therefore not all nurses have access and nor is the PDRP aimed at postgraduate education.

NZNO

<p><b>SIT Trainees</b> Lines 76-82 As stated above, some nurses may wish to pursue other modes of study, that may meet their individual needs, but may not be approved by the NCNZ.</p>	disagree	CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education. We refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme
<p><b>Southland DHB</b> Requiring NCNZ approval does limit access to some valuable programs</p>	disagree	CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education. We refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme
<p><b>UCOL</b> Line 76: the words “qualification,” and/ or “level 8,” excludes: a. Nurses who do not want to study for a qualification, but want to enrol in a paper, or papers (whatever the level); b. Nurses who already have the qualification, but want to study (another) paper at that level (or other levels); c. Nurses who want to enroll in papers that are not offered at level 8. This would include, especially, clinically focused papers at level 7. These would be available for nurses who wish to clinically update e.g. as part of their continuing education requirements for registration, or who e.g. wished to change their clinical focus from one speciality to another. In addition, there are a large number of overseas trained nurses now registered in New Zealand who may require upskilling in areas not well covered in their undergraduate curriculum, but not necessarily at level 8. d. The current UCOL (level 7) paper FPR 327: Effective Preceptorship. There is a nationwide shortage of properly prepared preceptors able to supervise student nurses in clinical practice settings. DHBs currently get around the requirement by sending staff on short (as short as half day) “updates,” or by ignoring it completely, but we believe that such nurses should be adequately prepared. We would want to see this replaced properly prepared nurses are vital in the education of future learners. It is our submission that the specification should be widened by removing “qualifications,” and changing the wording to “level 7, or above.” Lines 80-82. If the requirement for programmes was removed, there should equally be no requirement, or justification, for the Nursing Council to be involved at all. Even without the change we suggest, the Nursing Council should also have no role in approving level 8 programmes which do not lead to a scope of practice e.g. a Master’s degree in research.</p>	disagree	CTA funds programmes only, not papers. The purpose of the funding is for nurses to have postgraduate qualifications. The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.
	disagree	CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education. We refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme
<p><b>University of Auckland</b> Lines 80-82 Should read: “Education that credits towards a PG Certificate, PG Diploma or Masters approved by Nursing Council of New Zealand (NCNZ)” also needs to include other approved by NCNZ postgraduate programmes that benefit advanced nursing practice e.g.. Bachelor of Nursing (Hons)</p>	Lines 80-82 disagree BN Hons agreed	Lines 80-82 Already covered BN Hons added to 2.2 Programme Levels
<p><b>University of Otago</b> Lines 71-96 Support identified regulatory mechanisms. Line 80-82-It is essential the requirement for programmes to be Nursing Council of NZ approved be retained.</p>	noted	

<p>There has been considerable confusion in the past about eligible programmes and it is good to see the clarification in the area around crediting of qualifications into the approved Masters <b>Waitemata DHB</b> programmes</p>	<p>noted</p>	
<p><b>Whanganui DHB</b> There should be some flexibility to fund level 7 courses that contribute to the professional development of the Registered Nurse.</p>	<p>disagree</p>	<p>The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this. Line 83 - bullet point removed as programme standards are covered by accrediting body</p>
<p><b>Whitireia Community Polytechnic</b> Lines 80-82: change wording to "towards an approved programme". (Potentially a PG paper or PG Certificate not accredited by NCNZ will still articulate into a NCNZ approved programme at PG Dip or Masters level.)</p>	<p>noted</p>	<p>amended</p>

<b>2.2 PROGRAMME LEVELS Page 3 Lines 98 - 102</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Anon 1</b>	Support - Line 100 add BN (Hons)	agreed	added BN Hons
<b>Auckland DHB</b>	Section unchanged. Comments: Rationale for future/ further funding should be contingent on the trainee's success in completing a PG Cert and where the study they are undertaking fits with the workforce plan and trainee's ability to complete the higher qualification i.e. through to completion of a Master's. Again we comment - why not include Doctoral degrees? To enhance nurses capacity to competently undertake clinical research and win contestable research grants, nurses must be actively supported to Doctorate level. Consideration could be given to professional doctorates if research doctorates are considered outside the remit of CTA.	disagree	We note the feedback for funding of Doctorates - the current MOH position for post entry clinical training is to support Level 8 through CTA.
<b>Canterbury DHB</b>	Add Post masters Practicum – A few RNs on NP pathway previously attained a Masters, not NCNZ approved, and only need CTA funding to complete the Practicum.	noted	Tertiary education providers will confirm with each trainee what papers they need to complete in order to meet Nursing Council requirements for the NP pathway. As these papers will be on the NP Pathway they will be eligible for CTA funding. The existing and draft revised specification do not exclude this.
<b>Capital &amp; Coast DHB</b>	Lines 98 – 102: the more open explanation as to what can be funded (2.1 and 2.2) means that senior nurses studying "non-clinical" papers such as research, management, education, policy can also apply for funding. This gives us more flexibility in developing the whole nursing workforce whatever their role and level of seniority. We have also assumed that those nurses aiming for nurse practitioner who already have a masters but who now have to do the prescribing practicum, can access funding for post Masters study at level 4.	noted	The existing and draft revised specification do not exclude this.
<b>Counties Manukau DHB</b>	Line 100- add funded at Bachelor of Nursing Honours, postgrad....	agreed	added BN Hons
<b>DHBNZ Nursing and Midwifery Workforce Strategy Group</b>	Line 102 - needs clarity - should read 'decide to continue with further training'	agreed	amended
<b>Hutt Valley DHB</b>	Lines 101-102: What does this mean? What is meant by programme completion? Is this completion of the qualification? Recommend clarification of this statement.	agreed	The criteria has been clarified
<b>Lakes DHB</b>	We have received a number of comments that only allowing post-graduate papers is a problem, particularly in some primary/community settings. Nurse leaders there would like undergraduate level papers to be available for those staff who have never studied at graduate and post-graduate level as an easier way to get used to studying	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.

<p>Line 101 add Trainees will need to apply on annual basis to the DHB for funding until programme completion. Line 101-102 Why not level 7 for specialty practice, and Phd funding, as development of research capacity/capability is a workforce objective for evidence based practice. Again why the focus only on qualification rather than learning cycle when the nurse has a 3 - 40 year life long learning cycle. It would be useful to include the clinical practicum and supervision for the NP candidate who is completing the final advanced practice requirements before submitting their portfolio to Nursing Council ( post prescribing and Masters)</p>	disagree	<p>The NAG note the feedback for funding of Level 7 and Doctorates - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this. See clause 3.6 for clinical supervision for NP</p>
<p><b>MidCentral DHB</b></p> <p><b>Nurse Practitioner Advisory Committee of New Zealand</b></p> <p>Page 3, Line 101. Should read “ ...programmes will be funded at Postgraduate Certificate, Postgraduate Diploma, Masters or doctoral degree level. Page 3, line 101. Add sentence relating to the funding of a Nurse Practitioner Candidate Programme leading to registration as a Nurse Practitioner by the NCNZ.</p>	disagree	<p>We note the feedback for funding of Doctorates - the current MOH position for post entry clinical training is to support Level 8 through CTA.</p>
<p><b>NZNO</b></p> <p>L100 – Unless the programme description is widened to include courses other than those approved by NCNZ, and other than level 800, “eligible” will continue to apply only to a narrow range of the post graduate nursing training that is deemed to be required. L100-102 - NZNO strongly opposes limiting CTA funding to level 800 which is a major barrier to upskilling nurses in the areas of most need and limits opportunities for learning, innovation and leadership. There is no evidence supporting the exclusion of the uptake of other post-registration opportunities, and indeed the opposite is true. NZNO recognises that one of the drivers of Level 800 education is to increase the rigour of scholarship that is understood and practiced by its graduates, and is aware of the difficulty of keeping tertiary nursing programmes afloat under current Tertiary Education Commission funding structures, particularly in the area of research performance where nursing has come last (out of the 42 tertiary subject areas) in the 2003 and 2006 Performance Based Research Funding round. However, limiting the funding opportunities for nursing postgraduate training to level 800 is not the answer, nor are funding structures which essentially channel decision-making into the hands of the Responsible Authority (RA) and a small cadre of nurses without reference to, and support from, other educational, professional and ministerial input to ensure that national workforce and health needs are met. NZNO suggests that the CTA cannot fulfill its responsibilities to the public by ascribing funding for nurse training which limits nurses access to other levels of post-registration courses on offer. It is entirely inappropriate, for example, that nurses in hard-to-staff provincial areas have been turned down for funding to attend recognised, short duration diabetes courses because the financial support is unavailable from either the CTA or their employer. These courses increase the safety and quality of nursing care while better meeting identified health needs. The NZNO Education Survey showed that 49% of the respondents identified that 'cost in fees' was a significant barrier to accessing training (p. 14). We suggest that in the current economic situation that is even more likely to be the case.</p>	disagree	<p>L100 - CTA policy is to utilise the regulatory authority to provide quality assurance for health professional education. We refer to the amendment to Line 80 - 82 which allows nurses to undertake papers that are non NCNZ approved as long as they can be credited into a NCNZ approved programme</p>
	disagree	<p>The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.</p>

<b>NZNO</b>	The results from NZNO's recent Workforce Survey showed a very high proportion of nurses working part-time and a significant number working overtime. It is not unlikely that with reduced employment assurance, nurses may be reluctant to undertake long-term tertiary education courses and will look for shorter on-the-job training, especially given their away-from-work responsibilities (child care, dependents) and the expressed desire for improved work/life balance.	noted	
<b>UCOL</b>	Section 2.2 To be consistent with our submission, the word programme should be removed, and papers substituted.	disagree	CTA funds programmes only, not papers. The purpose of the funding is for nurses to have postgraduate qualifications.
<b>University of Auckland</b>	Line 100 As above 2.1	agreed	added BN Hons
<b>University of Otago</b>	Support levels as described.	noted	
<b>West Coast DHB</b>	Line 100: We would like to see level 700 programmes eligible for CTA funds. Current funding exclude the large numbers of nurses who choose not to pursue level 800 but who would like to continue clinical education	disagree	The NAG note the feedback for Level 7 - the current MOH position for post entry clinical training is to support Level 8 through CTA. Currently employers fund Level 7. CTA is not prohibiting access to Level 7 papers, individual DHBs must make the decision around funding Level 7 and then access alternative funding for it both internally and from other organisations. The DONs nationally will be invited to participate in a discussion around this.

2.3 PROGRAMME FUNDING Page 3 Lines 104 - 112		NAG Response	Rationale
<b>Canterbury DHB</b>	It is assumed that Mental Health nursing PECT will continue to be funded by the "Mason monies" via Te Pou. Otherwise additional revenue will be required.	noted	
<b>Lakes DHB</b>	Whether or not funding is ring fenced it still requires coordination so within this there needs be acknowledgement of and access to resource to administer it. Whilst it is true that increasing trainee numbers will increase the administrative workload there is a certain amount that is necessary regardless of the number studying. The current model of topslicing from some funds does not model the real time requirements well. It would be better to have a fixed sum for admin. With the ability to topslice a smaller amount once trainee numbers reach a certain level.	noted	The costing model is covered by the Service Agreement not by the Specification
<b>NZNO</b>	We believe the wording of the previous specification that "From time to time Government health initiatives may result in a requirement to direct funding to specific clinical service areas or training needs" is more robust than its replacement in this draft ("The CTA may be directed by Government to target funding to particular clinical service areas of training needs" L106 - 107) which implies that the CTA will respond to Government direction only, rather than through the analysis of Government health initiatives. In NZNO's view this is both inappropriate and unsound, potentially relieving/undermining the CTA's responsibility for analysis and reinforcing the current mismatch between nursing workforce needs and funding for training. We suggest dedicated or targeted funding are more appropriate terms than "ring-fenced"	disagree	CTA as part of the MOH is obliged to implement Government policy. Ringfenced is MOH terminology.
<b>West Coast DHB</b>	Line 106: ok with this but the lead time for targeted education needs to be achievable; for e.g. the lead time was very tight with the LTC funding last year. Targeted programmes should also be developed to fit existing programme frameworks. For e.g. the LTC PG cert doesn't fit the NP pathway requiring nurses to do more papers than they would normally in order to qualify	disagree	The PG Cert in LTC is Nursing Council approved and therefore is part of the NP pathway

3.0 PROGRAMME COMPONENTS Page 3 Lines 114– 123	NAG Response	Rationale
<p>Lines 122-125: The specifications say that the CTA PG Nursing Funds must be spent on the following components: 3.1 Programme Coordination. Is this correct? If funding for coordination is to be allocated separately this needs to be clear in the specifications. It currently reads as if coordination, fees, accommodation, travel etc. all come from the same allocation.</p> <p><b>Hutt Valley DHB</b></p>	noted	The costing model is covered by the Service Agreement not in the Specification
<p>L 116-118 - The new draft directs the reader to concurrently visit the CTA Head Agreement and relevant Service Agreement which are legal documents setting out the contractual terms to be agreed between the signatories. In this context, NZNO recommends adding a requirement to demonstrate how the DHB has assessed the health needs of its population and how that relates to the assessment of the learning needs of nurses working within that DHB. L 118-120 - states that "Funding can only be accessed once the details of trainees undertaking PNT programmes are forwarded to the CTA in Report One." The focus seems to be on the details of the trainees, rather than the wider brief (as described in L63 - 69) that calls for the basis on which DHB decisions are made for CTA nursing funding. This lack of focus, as an integrated brief, can only serve to weaken the outcomes that are sought, while casting further doubt on the rigours of the process(es).</p> <p>L 147 – “quality improvement processes” are not defined or tied to health outcomes. If the vision of the CTA PNT model is to ensure that "funding is targeted to meet prioritised local needs and Government strategies (L49-50)" there must be a proven connection between patient outcomes and public spending. NZNO strongly recommends that quality improvement processes are linked to outcomes and suggests adding/amending the bullet point to read “the assessment of the nurses' learning is matched with the DHB's health needs assessment(s) ”</p> <p><b>NZNO</b></p>	noted	This is addressed through processes set up by DHBs and checked through Audit

3.1 PROGRAMME CO-ORDINATION Pages 3 – 4 Lines 125 – 173	NAG Response	Rationale
<b>Anon 1</b> Would like to see a standardised amount indicated for programme co-ordination i.e. ring fenced. Line 163 inappropriate/incorrect use of the term clinical supervision	noted	The costing model is covered by the Service Agreement not by the Specification. Line 163 refer to 3.7
<b>Auckland DHB</b> A statement indicating how the Programme Co-ordinator is funded is needed for consistency and perhaps the collaborative relationship the co-ordinator has with tertiary education providers could be explicit. While we agree ensuring the funds are spent as intended and systems and processes are in place to ensure all nurses are aware the funding is available the wide array of reporting creates a significant administrative burden of reporting and tracking trainees. Our estimation of 0.4FTE for over 300 trainees (headcount) is probably an under estimate added to this is 0.1 – 0.2FTE Administrator time. At this time when bureaucracy is being challenged every effort should be made to reduce/eliminate this burden	noted	The costing model is covered by the Service Agreement not in the Specification.
<b>Canterbury DHB</b> Funding for this is welcomed and needs to be explicit. It should cover monitoring / reporting costs as well.	noted	The costing model is covered by the Service Agreement not by the Specification.
<b>Capital &amp; Coast DHB</b> Coordination for cultural support should be added to any calculation of programme coordination costs as the input is substantial.	noted	
<b>Counties Manukau DHB</b> CMDHB would like to see a standardised 'ring fenced' amount indicated for programme coordination nursing position that is responsible for clinical management and input into the delivery into tertiary education. It should be noted that often this role incorporates a strategic component around postgraduate education for the DHB to ensure the maximum efficient usage of CTA funding. - suggest Grade 5 of the senior nurse pathway as per DHB/NZNO MECA. Line 154- add.... Education providers, PHO Nurse Leaders Line 160- add ...providers and PHO occurs Line 166- add at end of sentence- (Maori/Pacific mentors, Maori/Pacific Cultural Units) Line 167- clarity is required around the meaning of career plan Line 174- add 'facilitation of cultural supervision'	noted	The costing model is covered by the Service Agreement not by the Specification. Line 154, 160, 166 & 174 already addressed.
<b>Nursing and Midwifery Workforce Strategy Group</b> Line 167- There doesn't need to be a career plan in place for everyone. For some the education will be enhancing current practice, which is not a career plan.	disagree	Revised specification will retain the requirement for trainee to have a career plan
<b>Hutt Valley DHB</b> Lines 165-166: Recommend the following so it aligns to the actual funding available: that trainees eligible for Maori or Pacific Cultural support funding are identified and subsequent cultural support planned, facilitated and reimbursed as appropriate.	noted	Covered under Programme Specific Terms in Service Agreement.
<b>Jan Radomske NASC assessor</b> Line 130 who has been , or is on a ..... Line 165 should it say facilitated access?	noted	Line 130 - already says this. Line 165 - disagree

<p><b>MidCentral DHB</b></p> <p>Line 146 - our experience to date is the tertiary providers will not share the evaluation data - currently, separate evaluation occurs, and can then be shared through Tertiary Advisory Committee. Line 150 Co-ordinator liases with tertiary providers to ensure regional approach to education (tertiary responsibility rather than co-ordinator - co-ordinator can recommend). Line 163 Co-ordinator cannot ensure that trainee needs are met - but can ensure the available resource is allocated to trainees for release and supervision requirements - the employers are responsible for ensuring release and supervision is managed. Line 165 Co-ordinator can make trainees aware of cultural support resources but is not a co-ordinator responsibility to access these for the applicant. Line 170 Trainees should reflect WAP needs/requirements in the first instance - evaluation should reflect customer satisfaction with programme.</p>	disagree	<p>Line 146 Disagree - DHBs should be coordinating their own evaluation of the trainees' experience. Line 150 - disagree - already allows for this to occur. Line 163 - disagree - clause refers to arrangements not enactment. Line 165 - Noted - access is required for Maori &amp; Pacific Peoples Support. Line 170 - noted</p>
<p><b>New Zealand College of Mental Health Nurses</b></p> <p>see 1.0</p>	noted	see response to Preamble 1.0
<p><b>Northland DHB</b></p> <p>167- There is no definition of career plan. Is career plan interchangeable with professional development plan? If not how is this assessed? If so suggest change in terminology in order to align with current practice: 'Trainees study programme is inline with their professional development plan'.</p>	noted	
<p><b>Nurse Practitioner Advisory Committee of New Zealand</b></p> <p>Page 4, Line 164. Clinical release and clinical supervision arrangements should meet trainee and employer needs.</p>	disagree	<p>Trainees should have employer support prior to commencing programme</p>
<p><b>NZNO</b></p> <p>L 155-156 - indicates that the promotion of PNF is to be part of the costs to be considered. The percentage of the budgets to be spent on marketing is not made clear and NZNO is not wholly convinced that the quality (and costs) of marketing will necessarily be related to the quality of the programme. NZNO strongly recommends that the CTA provides guidance on the mechanics and possibilities for marketing on a local and/or national basis. L171-172 – NZNO does not support the blanket exclusion of funding on the basis of concurrent receipt of (unspecified) scholarships, because of widely varying scholarship funding. For example, NZNO's Nursing Education and Research Foundation grants cover a spectrum of financial input from \$250 - \$2,000. There are also many small community grants of a few hundred dollars, often made on the basis of addressing socio-economic disparities, which it would be cruelly ironic to use to exclude recipients from additional funding. We recommend that the specification clarifies an amount or source for exclusion based on a concurrent scholarship being awarded. It is important to clarify the documentation requirements for this potential exclusion.</p>	noted	<p>Line 155 - 156 addressed by costings model and through CTA NAG. Line 171 -172 this clause only refers to MOH funding and the rationale is to ensure one trainee does not receive two sets of funding for the same study.</p>
<p><b>Southland DHB</b></p> <p>Programme coordination role needs to have separate funding allocated (as is the case with Midwifery and Maori Health) Cultural support – Notification (calling for applications) timeframes too short. Need to know (in advance) that this will be an annual event.</p>	noted	New process for 2010
<p><b>UCOL</b></p> <p>Line 133-135. There does not appear to be any requirement for the CTA coordinator to consider any of the wider needs of the local community provided by non DHB providers (see our comment on line 44)</p>	disagree	<p>DHBs does not only refer to the provider arm</p>

<b>University of Otago</b>	Support mechanisms as described	noted	
<b>Waikato DHB</b>	Role holder needs to be at an academic level that provides a lived experience of tertiary education	noted	Already specified
<b>Waitemata DHB</b>	Line 163-164. It should be noted that the co-ordinator can play a large role in the actual facilitation of clinical supervision arrangements especially for nurse prescribing practicum. Suggestion “the facilitation of clinical supervision arrangements” added to line 163 or as a separate responsibility. Line 173. Clarification around the words ‘career plan’ is required	noted	Line 163 - 164 already allowed for. Line 173 Noted
<b>West Coast DHB</b>	Line 163: Money for clinical release and clinical supervision does not accurately reflect the true cost of the activities.	noted	Separate costings exercise underway

<b>3.2 TUITION FEES Page 4 Lines 175 – 178</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Auckland DHB</b>	Agree full tuition fees paid for the course	noted	
<b>Canterbury DHB</b>	Endorsed. It is noted that TEC payments to polytechnic providers of level 8 courses is less than the amount paid to university providers. Yet these clinical certificates are vital to nursing workforce development, and just as costly to provide.	noted	
<b>Hutt Valley DHB</b>	Lines 177-178: Recommend reads as follows: "The tuition fees charged by the tertiary education provider will be fully paid by the DHB at the beginning of each semester".	noted	CTA has adjusted funding model to allow for this
<b>Lakes DHB</b>	At DHB's that have no local education provider it is difficult for trainees to get access to text books. Could a small portion of the funds be available to purchase appropriate texts for the hospital library	disagree	Hospital library responsibility of DHB
<b>MidCentral DHB</b>	Line 177 Does this exclude Student Association fees and Programme Enrolment fees? - useful to define what is covered by 'tuition fees' here.	agreed	added to specification
<b>NZNO</b>	L 177-178 - NZNO strongly supports full payment of tuition fees charged by the tertiary education provider.	agreed	As per specification full tuition fees should be paid.
<b>Southland DHB</b>	Mistiming between the need for coordinator to allocate support package and the finalisation of university fees	noted	
<b>Whanganui DHB</b>	To deliver a transparent and consistent model of funding nationally suggest a dollar figure be agreed per paper or pathway. For example: 30 point paper \$1500 regardless of the Tertiary provider. PG Cert \$3000 regardless of the Tertiary provider. Not all DHBs are paying full tuition fees and there is inconsistency in the sector	noted	Service Agreement will be amended to address this. As per specification full tuition fees should be paid.

3.3 TRAVEL Page 5 Lines 180 – 184		NAG Response	Rationale
Canterbury DHB	Endorsed. The travel subsidy should be funded in a manner that does not incur inordinate transaction costs. (i.e. obviate the need for contract variations if volume change is within the DHB's funding envelope ).	noted	will be addressed through Service Agreement
Hutt Valley DHB	Line 182- 184: Recommend standardising the subsidy and making it explicit here i.e. per kilometre, amount for average cost of return flight etc. As it currently reads, subsidy is too broad, and decreases the consistency required across DHB's. Also, recommend a statement around the tertiary education provider's responsibilities for accommodation and travel reimbursement when they initiate changes to the location of the programme delivery after enrolment.	noted	will be clarified through Service Agreement
Lakes DHB	Line 183: The >100km disadvantages nurses who don't have a local provider and must travel, we would like to see this set at >50km for districts without an education provider. It might also be worth looking at the amount of money in the bands as longer distances often include additional overnight stays as travel options can be more restricted.	disagree	This is a subsidy as per CTA Travel policy
MidCentral DHB	Line 183 How was the 100 km identified? Would an urban/rural definition would be more equitable? In our district, some applicants live in rural areas 60 - 80 km one way from Tertiary provider but have no access to public transport - Some who are eligible for travel subsidy do have access to public transport. Also is place of work the location of the trainees DHB or their actual work setting? Again this makes a difference to the allocation of the travel subsidy.	disagree	This is a subsidy as per CTA Travel policy
NZNO	L182 - Travel costs are a significant barrier as indicated in the NZNO Education Survey. There are also additional "time and distance of travel" costs and support and staffing costs. We strongly oppose the change from the previous draft from subsidy "for" travel to subsidy "towards" travel, which leaves it at the discretion of individual Committees and may be inconsistently applied. We note that in the recently released Public Health Medicine Training Interim Specification that the emphasis is on subsidising actual costs. Nursing has historically and consistently been allocated comparatively poor proportions of the CTA funding. Though nurses comprise over 50% of the health workforce they receive around 24 times less funding than their medical colleagues. The stark contrast between CTA funding per nurse of \$543 and per doctor of \$13 3421 is neither supportable or sustainable and again highlights the lack of sound planning and accountability of funding for health professional training which is currently NOT evidentially linked to health workforce needs and patient outcomes.	disagree	This is a subsidy as per CTA Travel policy.
Plunket Society	100km is over and above the normal daily travel to and from home for most Plunket nurses as a result most travelling over their normal travel distance i.e. to tutorial will result in claims for reimbursement for this travel	disagree	This is a subsidy as per CTA Travel policy. The criteria states that travel is applied to travel from place of work to tertiary education provider.

<b>Rural Canterbury PHO</b>	This could be too limiting. 1 Nurses who live in Marlborough and need to travel to Wellington would not have 100kms to travel, but they should be eligible for assistance. 2 Some of our nurses have had to make several trips to Methven as part of their study and this is a distance of 94kms, which although under 100kms, when repeated, becomes significant.	disagree	This is a subsidy as per CTA Travel policy. Nelson Marlborough trainees can access travel subsidy as we do account for distance between north and south island. The specification has been amended to remove "by road".
<b>SIT Trainee</b>	Lines 182-184 This mileage reimbursement parameter disadvantages those who need to travel to access postgraduate education. We recommend that the reimbursement parameter be set at 100km for a return trip.	disagree	This is a subsidy as per CTA Travel policy.
<b>Southland DHB</b>	Whilst it is excellent to have support towards travel, travel, from the bottom of the South Island to North Island University is very expensive.	noted	
<b>West Coast DHB</b>	Line180: If a DHB wishes to support nurses by having the course taught locally, as the regulations currently stand, they are unable to claim for fees charged by a university for teaching away from the university (at the DHB site) (refer to letter sent to Daria April 1 2008 from the WCDHB). The rules around travel mean DHBs are twice disadvantaged because as well as not being able to claim the university teaching charges they are not able to apply for the higher band PU that they would normally with nurses who are based over 250Ks from the university. Allowing DHBs to claim the higher PU would assist in recovering their costs	noted	CTA NAG will refer to NETS to explore options for addressing this
<b>Whanganui DHB</b>	To deliver a transparent and consistent model of funding nationally suggest a dollar figure be agreed per band needs and this needs to be made clear in the specification: For example: Level 1 = Nil, Level 2 = \$1500 maximum, Level 3+ \$2000 maximum	noted	will be clarified through Service Agreement

<b>3.4 ACCOMMODATION Page 5 Lines 186 – 189</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Canterbury DHB</b>	Endorsed, as above see 3.3	noted	
<b>Hutt Valley DHB</b>	As above see comments under 3.3 Travel	noted	Will be clarified through Service Agreement
<b>MidCentral DHB</b>	Line 188 Add DHB will define the maximum \$ for accommodation e.g. \$135 per night	noted	Will be clarified through Service Agreement
<b>NZNO</b>	As above see comments under 3.3 Travel	disagree	This is a subsidy as per CTA Travel policy.
<b>SIT Trainee</b>	Lines 188-189 We feel that there needs to be more flexibility. We recommend that the accommodation reimbursement be negotiated between the DHB CTA programme co-ordinator and the nurse, and that it be dependent on the location of the study.	noted	Will be clarified through Service Agreement
<b>Southland DHB</b>	Due to long distance and infrequent flights accommodation cost increase for South Island students travelling north for study	noted	Longer distances have a higher band for funding. Will be clarified in service agreement
<b>Whanganui DHB</b>	To deliver a transparent and consistent model of funding nationally suggest a dollar figure be agreed per band needs and this needs to be made clear in the specification: For example: Level 1 = Nil, Level 2 = \$1500 maximum, Level 3+ \$2000 maximum	noted	Will be clarified through Service Agreement

3.5 CLINICAL RELEASE Page 5 Lines 191 – 198	NAG Response	Rationale
<p><b>Auckland DHB</b></p> <p>Clinical release and backfilling are troublesome issues. While CTA funds can be used for backfilling the trainee these funds cannot be used to pay the trainee to attend compulsory study sessions for the course. Consideration for the use of this funding as paid study leave where the nurse is in a remote location and/or cannot be replaced should be made. Ensuring the level of funding is sufficient if the nurse is replaced by a locum GP requires consideration. This would necessitate a variable backfill model based on salary costs. Today in most employment situations working within the relevant MECA study leave entitlements is a nonnegotiable requirement in order to deliver service, maintain throughput, productivity and cost efficiency. The addition to this section of lines 196-198 could be viewed as unjust - it completely misses the point of backfill – whether the trainee is on study leave or elects to take annual leave/day off she/he still must be replaced/backfilled as stated above throughput productivity must be maintained. Perhaps a more liberal way of her activities that achieve the desired outcomes.</p> <p>Describing this component of the funding would be – maintaining contracted levels of service delivery – the definition could include backfill as one of the elements along with a range of other activities that achieve the desired outcomes.</p>	disagree	Costing exercise has been completed as part of PG Review which indicates that the contribution for Clinical Release is appropriate.
<p><b>Canterbury DHB</b></p> <p>This section is student focussed and endorsed. With regards to funding, refer to CDHB's recent e-communication.</p>	noted	
<p><b>Counties Manukau DHB</b></p> <p>DHBs require flexibility around the payment options for this money to ensure it meets the clinical needs of the organisation and in particular the area the nurses is being released from.</p>	noted	
<p><b>Hutt Valley DHB</b></p> <p>Lines 193-198: Although this is a significant improvement to the previous specifications, there is still a lack of detail to ensure equitable process within and across services within DHB's and across DHB's. Currently some trainees are asked to take annual leave or leave without pay after a certain number of study days are used. Recommend a statement that clinical release time will not be reimbursed for attendance at study days on trainees 'usual days off'.</p>	noted	This clause will be checked at audit.
<p><b>NZNO</b></p> <p>L193-196 - NZNO notes that "formal" has replaced the 2006 term "compulsory" and that "including academic and clinical supervision requirements during the trainees working hours" has been added. Although we support the broader scope of "formal", we caution that in conjunction with the above added clause, 'formal aspects' of academic and clinical supervision may be interpreted as costs only if they were to occur during the trainees working hours. NZNO recommends that this ambiguity is removed. L196-198 – NZNO agrees that the employer should not be eligible for the recovery costs from the CTA that would normally be incurred when their employee is taking annual leave or leave without pay for their study purposes. However, there is an actual and potential risk that nurses will be expected to take annual leave in order to study which undermines the health and safety aspects of annual leave. NZNO believes the specification should include some protection for the nurse by prefacing Section 3.5 with a statement to the effect that it is expected/strongly recommended that employers provide study leave for trainee's clinical release in order to promote healthy work life balance practices and not erode the trainee's 'free time' through work-related study commitments.</p>	noted	This clause will be audited.

<b>University of Auckland</b>	Line 193 Funding for backfill is essential to enable compulsory class attendance. Payment is also required for nurses directed to take leave without pay in order to attend study days.	disagree	See changes to clause in specification. Employers who direct trainees to take leave without pay will not be able to claim clinical release funding.
<b>University of Otago</b>	Line 194-Regarding release time for the trainee to attend 'formal aspects of their training programme' - given the move to make learning available at any time consideration of the definition of 'formal' needs to accommodate blended and distance learning with equivalent time for replacement staffing for the person to spend on learning that is self-directed but equates to 'formal' in class time. Line 197- agree with tightening this as DHB s should not benefit from the fund intended to assist RNs to attend education.	noted	
<b>Waitemata DHB</b>	WDHB would like to observe that the actual cost of clinical release is hugely variable and dependant on the pay rate of the trainee. In many cases the amount available from CTA does not cover the true cost of clinical release time.	noted	Costing exercise has been completed as part of PG Review which indicates that contribution for Clinical Release is appropriate
<b>West Coast DHB</b>	Line 193: NETP expansion for NGOs and primary practices means that backfill is essential and the current funding does not reflect the true cost of supporting new graduates. As a consequence there is no incentive for NGOs and PHOs to pick up new graduates; as evidenced by low uptake of NETP expansion. We could like to see funding for NETP expansion increased to cover backfill.	noted	Outside of PG Review. NETP Review taking place in 2010
<b>Whanganui DHB</b>	To deliver a transparent and consistent model of funding nationally suggest a dollar figure be agreed and this needs to be made clear in the specification: For example hourly rate based on pay rate for step 5 MECA (DHB / Primary as appropriate)	disagree	DHBs responsibility to determine how they wish to administer clinical release

3.6 CLINICAL ACCESS Page 5 Lines 200 – 203	NAG Response	Rationale
<p><b>Anon 1</b></p> <p>Remove 'Nurse Practitioner' from 3.6 as it is too restrictive. Line 54 talks about nurses to advance nursing practice including the pathway towards NP</p>	disagree	This component of the funding is for the Nurse Practitioner Practicum. Costing exercise will address the costs of non prescribing practicums
<p><b>Auckland DHB</b></p> <p>We are disappointed clinical practicum's are not included. Clinical practicums are becoming increasingly recognised as a necessary component of competence development for advanced practice roles such as Nurse Specialist. Therefore we argue strongly for additional funding to be allocated to clinical practicum's to enable appropriately skilled personnel to provide clinical supervision and adequate time for the trainee to practice and reach competence. We currently estimate the cost of the supervision component of a clinical practicum per trainee is \$90 per hour based on the average SMO hourly rate. This estimate covers only the cost of the individual SMO's salary backfilling the SMO would double the amount to \$180 per hour. Nurses currently undertaking a clinical practicum require a minimum of 36hrs supervision – Cost + supervision + supervisor backfill = \$6,480 per trainee. We agree clinical access is essential if clinical competence is to be appropriately developed and assessed.</p>	noted	Costing exercise will address costs of non prescribing practicums
<p><b>Canterbury DHB</b></p> <p>Practicum - This is needed for Clinical Nurse Specialists and others undertaking the practicum. Either delete Nurse Practitioner from the sentence or add "other advanced nursing roles requiring access". For clarity, specify the six options within NZ? For the absence of doubt, CTA could specify</p> <p>Advanced Health Assessment Papers:  NURX 405 (Otago)  NURSING 705 (Auckland)  NURS 550-555 (VUW)  168.728 (Massey)  588624 (AUT 20 points)  MN/PG8.401 (EIT)  SIT and WINTEC</p> <p>Suggest that there is a new category in section 3.6 or 3.7 or both. This would enable funding for trainees undertaking Advanced Health Assessment paper, with additional funding for clinical supervision. (This is usually a 30 point paper = 0.5 TU). Rationale - Although less hours are required than for the NP Practicum, clinical access is equally essential to meet the requirements of the Advanced Health Assessment paper. We have positive reports of the impact of this foundation postgraduate paper on improved clinical practice.</p>	noted	Costing exercise will address costs of non prescribing practicums

<b>Capital &amp; Coast DHB</b>	Line 202 – 203: there could be two reference points here. The first for prescribing practicum and the second for non prescribing practicum. Both these papers require the same amount of advanced clinical assessment. The only difference is that the non-prescribing practicum does not assess domain 4. Therefore the clinical access, supervision time implications are the same. There is therefore a significant cost to the non-prescribing practicum but the funding is substantially less (\$7258 for non-prescribing and \$25093 for prescribing practicum). The non – prescribing practicum should be paid at the higher rate. Reference to Nurse Practitioner should also be removed as the terminology is not accurate i.e. They are not NP’s at this point, but trainees like the others.	noted	Costing exercise addressing costs of non prescribing practicums
<b>Hutt Valley DHB</b>	Lines 202-203: recommend: “Clinical access costs will be subsidised”. How do you operationalise this to ensure equity? How do DHB’s know what to subsidise? We recommend more detail or a guideline e.g. a maximum amount, who should receive the \$\$?	noted	Guidelines will be provided to DHBs.
<b>University of Otago</b>	Line 203- support plural for practicums as programme designs vary.	noted	

3.7 CLINICAL SUPERVISION Page 5 Lines 205 – 224	NAG Response	Rationale
<p><b>Auckland DHB</b></p> <p>We note this section apart from rewording lines 223-224 remains unchanged. As we suggested previously the time this role takes leads to 'clinical slowdown' thus within the funding formula must be recognised funding should be used to ensure the level of service provision throughput, productivity and cost efficiency, remains steady, ensuring cost effectiveness and maintaining productivity. Alternatively would the supervisor be paid directly? What are the skills and capabilities expected of the person in this role – a required qualification seems vague. How will the effectiveness of the person in this role be evaluated? Previous evaluation has suggested a lack of support from both the educational institution and the supervisors own organisation</p>	noted	Costing exercise will address clinical supervision
<p><b>Canterbury DHB</b></p> <p>Suggest that there is a <b>new</b> category – see section 3.6. Advanced Health Assessment - This would enable a new Unit Code for these trainees with additional funding for clinical supervision provided by the DHB or health provider in the clinical setting. Lines 207, 208 are confusing. Definitions would help as the term Clinical Supervision has a second (different) meaning in nursing circles. [Also need to distinguish from Mentorship or Academic Supervision]</p>	agreed	Amended
<p><b>Capital &amp; Coast DHB</b></p> <p>There is a need for clear definitions around clinical supervision, preceptorship. Perhaps the HPCA Act (2003) definitions should be used here.</p>	agreed	Amended
<p><b>Counties Manukau DHB</b></p> <p>This section requires clarification around the terminology of clinical supervision as the terms means different things to different people. Query- rename the section to coaching and mentoring/ clinical preceptorship. Increased funding required for this section to meet the requirements of payment of the time required for different papers.</p>	agreed	Amended
<p><b>Hutt Valley DHB</b></p> <p>Please clarify 'clinical supervision'. Clinical Supervision is not defined in all sectors of health as coaching and mentoring. 'Supervision for clinical practice' does require coaching and mentoring. Until this is clearly established/defined the rest of this section cannot be accurately commented on. Option 1 – call it 'Supervision of Clinical Practice' Option 2 – call it 'Clinical Preceptoring' Option 3 – allow for Clinical Supervision, coaching and mentoring as three distinct and separate processes. For example: Lines 207-215: "Clinical Supervision, coaching or mentoring is provided to support the trainee to meet the requirements of the training programme when specified by the tertiary education provider or when identified by the CTA PG Nursing Programme Coordinator. The Clinical Supervisor, mentor or coach will be a registered health professional who has the required qualification. Line 217-221: recommend reads as follow: "The Clinical Supervisor, mentor or coach will ensure that: The support is appropriate to the trainee's identified needs. Theory and clinical experience (as appropriate) are well integrated.</p> <p>Trainees participate in reflection and advance their practice. Clinical supervision is only a very small component and HVDHB's experience is that no one requests additional support for clinical supervision – it may be more beneficial to provide additional funds for academic/study support groups at DHB's – this has been requested by trainees, but difficult to resource and facilitate within the current programme coordination FTE.</p>	Comments re clinical supervision agreed	Amended
	Comments re funding academic support groups disagree	Part of employer /trainee responsibility
<p><b>MidCentral DHB</b></p> <p>Line 211 Add to co-ordinators responsibilities 3.1 Again can provide information re available supervisors, but trainee responsibility to access.</p>	agreed	Amended

<b>Jan Radomske NASC assessor</b>	I don't think 3.7 Clinical Supervision is clearly written - I think it is contradictory - Line 210 says clinical supervision will be provided ... by the part. training programme ... but Line 223 states funding is not available for clinical supervision already provided by the tertiary provider. Does this then mean that clinical supervision as 207/208 indicates is or should be provided by the employer/hospital of the nurse? I think this could be interpreted in several ways. Does it indicate that the intention is that hospitals provide nurses as clinical supervisors?, in addition to the programme of the tertiary institution? Maybe the wording needs to be clarified.	agreed	Amended
<b>NETS</b>	Remove 223 -224 " <i>funding is not available for clinical supervision already provided by the tertiary education provider as part of the training programme</i> " TEC funding does not cover clinical supervision	noted	
<b>New Zealand College of Mental Health Nurses</b>	Clinical Supervision needs to be clearly defined as supervision of clinical practice or clinical supervision for role development. There is confusion within the clinical settings as to how this is defined – particularly in the non mental health settings.	agreed	Amended
<b>NZNO</b>	NZNO believes that the provision of clinical supervision is a vital, compulsory component of integrating theory and clinical experiences. It is not explicit that clinical supervision should comprise a substantial part of any training programme. In particular, qualifying the requirement for the provision of clinical supervision with "when required by the training programme or identified by the programme coordinator" implies that it is optional rather than mandatory, and minimises its significance since there is no indication as to what proportion of the funding should be dedicated to clinical supervision. NZNO strongly recommends the reinstatement of the clinical focus with a strengthened provision around clinical supervision.	agreed	Amended
<b>SIT Trainee</b>	Line 223 We note that "funding is not available for clinical supervision already provided by the tertiary education provider". However, we do support funding to be available for clinical supervision/mentoring being provided by experienced nurses who are deemed appropriate by the tertiary provider and the student.	agreed	Amended
<b>Southland DHB</b>	This is often a PG certificate paper requirement. If same required the costing should be included in program fee and the education provider should be responsible for paying mentor/supervision costs. If mentor /supervision cost is to be paid from CTA Level Band support package then increase in allocation of starting dollars needs to be reviewed (for PG certificate level)	agreed	Amended
<b>University of Auckland</b>	Line 213 – 215 More clarity is required regarding required qualifications of mentor. Clinical supervision is relevant for a range of courses specifically in relation to building skills and competence for advanced practice in everyday clinical settings.	agreed	Amended
<b>Waitemata DHB</b>	The use of the term "clinical supervision" has been problematic. While there is a definition in the CTA specs confusion exists in the workplace around this due to the widespread use of clinical supervision models utilised in specific service areas such as mental health. There is also completely insufficient funding available within the purchase unit price for any clinical supervision except for that within the nurse prescribing practicum.	agreed	Amended
<b>West Coast DHB</b>	Line 210: Money for clinical release and clinical supervision does not accurately reflect the true cost of the activities	noted	Costing exercise will address clinical supervision

4.0 Expected Outcomes	NAG Response	Rationale
<b>Hutt Valley DHB</b> <p>Where were these outcomes derived from? Expected outcomes need to be measurable (some here are not). Expectations do not suggest any greater level of performance than those competencies required of an RN by the NCNZ. We would expect an enhanced level of performance.</p>	noted	Section amended

4.1 TRAINEE OUTCOMES Page 6 Lines 228 – 236		NAG Response	Rationale
<b>Canterbury DHB</b>	Surprised to see Section 4.1 diminished. Clearer Expected Outcomes are needed if the state intends to measure the impact of this investment.	noted	Section amended
<b>Counties Manukau DHB</b>	Line 235- add Bachelor of Nursing Honours	noted	Section amended
<b>Hutt Valley DHB</b>	Registration Nursing Education, 2001) and Standards of Practice for Advanced Nursing Practice for Mental Health (Te Ao Matamatanga) and the 'Competencies for NP' (NCNZ). Expected trainee outcomes are: Shows sound [or advanced] levels of judgement, discretion and decision-making in patient/client care. Shows clinical nursing leadership. Monitors and improves standards of nursing through quality improvement processes. Develops nursing practice through research and scholarship	noted	Section amended
<b>MidCentral DHB</b>	Line 234 Development of leadership, management etc rather than provision of	noted	Section amended
<b>Nurse Practitioner Advisory Committee of New Zealand</b>	Page 6, Line 237. Add bullet point: Registration as Nurse Practitioner by NCNZ. Page 6, Line 237: add bullet point: conferring/awarding of a doctoral degree in Nursing.	noted	Section amended
<b>NZNO</b>	NZNO strongly opposes changes in this section which continue the erosion of the clinical focus and diminishment of applying learning in/to the clinical setting evident throughout this document. Feedback to the CTA's 2006 consultation included comments such as, "It is encouraging to see an acknowledgment of the need to integrate theory and clinical practice. All post graduate programmes need to have this aspect incorporated into their programme to ensure that what is learnt in an academic setting has direct relevance to the trainee's clinical setting and skill development." We oppose the deletion of the bullet point "application of evidence based practice in a range of treatment/care models relevant to the health care service setting" that was in the November 2006 PNT specification and recommend its reinstatement. L231 Similarly we do not support the replacement of "clinical care to people and their families" with "application of advancing nursing practice in the provision of care". L234 Nor should "clinical leadership and management" be replaced with the general provision of "leadership, management and mentoring skills". We strongly recommend retaining the adjective clinical to describe those skills.	noted	Section amended
<b>UCOL</b>	Lines 235-236. See our previous comments: the funding should not be directly connected to the awarding of a "qualification."	disagree	CTA funds programmes only, not papers. The purpose of the funding is for nurses to have postgraduate qualifications.
<b>University of Auckland</b>	Line 234 Strongly support the trainee outcome, "provision of leadership, management and mentoring skills" and therefore that funding must be provided to enable nurses to undertake courses explicitly geared to this end. Line 235 Please see 2.1 - BN(Hons) to be added	noted	Section amended

<b>University of Otago</b>	Lines 228-236 Support retention of the 4 broad outcomes identified.	noted	Section amended
<b>Waitemata DHB</b>	Apart from the conferring/awarding of a post graduate degree and individual trainee feedback about their perception of practice improvement there is no obvious instrumentation to measure either the stated trainee and client/service outcomes. Guidance around how these outcomes are to be measured would be helpful	agreed	Section amended

<b>4.2 CLIENT / SERVICE OUTCOMES Page 6 Lines 238 – 249</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Auckland DHB</b>	Section mostly unchanged. To improve readability recommend: Line 240 delete access to Line 248 delete the benefit of applied change the to their Line 249 delete relevant service and the 's' off the word settings	noted	section amended
<b>Canterbury DHB</b>	Add: Contribute to development of clinical leadership and management capability within the organisation	noted	section amended
<b>Counties Manukau DHB</b>	Line 246 & 247 - change to whanau and key Pacific community personnel support	noted	section amended
<b>Hutt Valley DHB</b>	Recommend measurable outcomes such as: Nursing staff retention. Increased skill mix (e.g. increase in ratio of number and type of PG quals held by nurses, increased PDRP attainment at level 3 and 4). Deployment and practice in areas of nursing workforce need. Improved patient outcomes e.g. access, satisfaction, Nurse Sensitive Indicators. Development of clinical leadership through attainment of identified career plan. Successful preparation for, and promotion to senior nursing roles	noted	section amended
<b>Jan Radomske NASC assessor</b>	Line 241 skilled not skilful	noted	section amended
<b>MidCentral DHB</b>	Line 246 Culturally competent care rather than clinical care. Using NCNZ domains, Quality is missing in the outcomes.	noted	section amended
<b>NZNO</b>	L240 - The addition of "access to" in the opening statement potentially dilutes the client/service outcomes. Trainees only have to take responsibility for providing access, which could be subject to wide interpretation, rather than providing improving client and/or service outcomes.	noted	section amended
<b>Waitemata DHB</b>	As 4.1	agreed	section amended

<b>5.0 TRAINEE ELIGIBILITY Pages 6 – 7 Lines 252 – 272</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Auckland DHB</b>	Section mostly unchanged. Line 272: The current position where each DHB sets criteria for minimum hours worked works well and allows flexibility. While this may result in inconsistency across the nation we would not advocate changing the status quo.	noted	
<b>Capital &amp; Coast DHB</b>	Many nurses meet these eligibility criteria but due to the narrow prescriptions of 2.1 are excluded from funding e.g. Service specifications are disappointing in their hospital centric orientation.	noted	
<b>Hutt Valley DHB</b>	Line 272: the FTE should not determine eligibility for CTA PG Funding rather the funding should be determined according to clause 2 of the specification. Currently the statement allows DHB's to set minimum FTE requirements which creates a barrier for the group of those nurses employed on very small FTE basis.	disagree	Intent is to increase access and it is a DHB decision around FTE
<b>Jan Radomske NASC assessor</b>	Re Equitable. I noted this term used in a couple of places and wondered how this will be defined. Equitable in whose eyes? Will this be left open to interpretation or is there already a tighter prescribed definition that I am not aware of?	agreed	Amended
<b>NETS</b>	NETS supports the changed statement on line 272 in relation to FTE	noted	
<b>Nurse Practitioner Advisory Committee of New Zealand</b>	Page 6. Line 264. Be currently employed as a registered nurse or Nurse Practitioner by a service.....	agreed	Amended
<b>NZNO</b>	L 272 - gives complete discretion to the individual DHBs without referencing to a national framework, guideline or standard, which is potentially wasteful of resources, and does not ensure equitable outcomes. Flexibility should not be bought at the cost sensible use of resources to reduce fragmentation, duplication and inequity. Trainees should be eligible according to national guidelines which allow flexibility and are consistent with national health, education and workforce strategies.	disagree	Specification provides sufficient guidelines for standardised criteria while allowing for prioritisation of funding to suit local needs
<b>SIT Trainee</b>	Line 268 We feel that not all employers are supportive of post graduate education for nurses and in some instances, having funding in place is a requirement before a current employer will approve education for that nurse.	noted	
<b>UCOL</b>	Lines 264-265: we think that funding should be available to all nurses employed by any health care provider, without any caveats.	disagree	It is CTA policy that trainees must be employed by an organisation funded through Vote Health
<b>Waitemata DHB</b>	Clarification around the minimum employment FTE is appreciated	noted	
<b>Whanganui DHB</b>	Line 272 – to deliver a transparent and consistent model of funding suggest nationally agree a fte and define this in the specification: For example: 0.6 – 1 fte	disagree	It is the DHBs' responsibility to set this.

5.1 EMPLOYMENT SETTINGS Page 7 Lines 275 – 308		NAG Response	Rationale
<b>Anon 2</b>	Excellent inclusion of PHC variety of settings	agreed	
<b>Auckland DHB</b>	New section Line 289: the addition of Palliative Care is noted. Arguably this overlaps with chronic disease state management which often is a life limiting condition. We do not agree Palliative Care needs to be singled out in this way. Perhaps a broader category that palliative care and other non-DHB provider arm healthcare could fit into should be listed.	disagree	List is not intended to be exclusive
<b>Canterbury DHB</b>	This is clearer	noted	
<b>Capital &amp; Coast DHB</b>	Lines 293 – 296: this point could be extended to the broader settings for teaching nurses that are not currently covered. E.g. youth health (programme not approved) or rehabilitation or leadership.	agreed	Amended
<b>Lakes DHB</b>	Rural ranking scores are not all that useful as they require the presence of a GP. Some of our rural areas are served by nurse led services with no GP and so don't rank as particularly rural.	agreed	Amended
<b>NETS</b>	Specify <b>Child Health</b> either as a separate heading (Line 284) or add under Primary Health Care (Line 293). Rationale: In practice funding access for Primary Health Care: Child Health papers is not always interpreted equitably across the country	agreed	Amended
<b>New Zealand College of Mental Health Nurses</b>	Specify Mental Health either as a separate heading (Line 284) or add under DHB and NGO.	disagree	List is not intended to be exclusive, funding available through Te Pou
<b>NZNO</b>	L 289-291 – NZNO strongly approves of the addition of Palliative Care to the settings.	noted	
<b>Plunket Society</b>	Line 297 Addition of Well Child Tamariki Ora, as so often this is overlooked as Primary Health and is a recognised specialty	agreed	Amended
<b>University of Auckland</b>	Fully support wider scope of eligible employment settings especially in care of the older person settings and palliative care.	noted	
<b>Whitireia Community Polytechnic</b>	Specify Child Health either as a separate heading (Line 284) or add under Primary Health Care (Line 293). Rationale: In practice funding access for Primary Health Care: Child Health papers is not always interpreted equitably across the country.	agreed	Amended

6.0 ASSOCIATED LINKAGES Pages 7 – 8 Lines 311 – 324	NAG Response	Rationale
Canterbury DHB Line 323 after other DHBs, add “within the region” Add “DHBNZ Nursing Workforce Strategy group” and MOH	disagree	already covered under relevant organisations
MidCentral DHB Line 318 add MSOs	disagree	already covered under relevant organisations

<b>7.0 PURCHASE UNIT Page 8 Lines 327 – 360</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Anon 1</b>	The addition of 343 - 344 provides greater clarity around pro rata basis	noted	
<b>Auckland DHB</b>	New section clearly sets out the how the funds are attached to trainees helpful for new programme coordinators. Lines 339 and 341: prescribing is also being undertaken as in addition to a Masters – nurses complete currently and in the past completed, their Masters then return to complete the prescribing requirements outside their Masters usually completing a further PG Cert. Is there or should there be a category for these trainees? Rather than identifying it as final year of Masters with Prescribing Practicum’.	noted	Revised specification allows for this
<b>Canterbury DHB</b>	There is an urgent need to review the price X volume contracting method. Most years a contract variation is needed for each Semester. (Some DHBs report that more than one variation is required each Semester.) The associated transactions costs are too high. [Administrative work associated with each contract variation is resource consumptive.] Consideration should be made to allow mix changes within the DHBs funding envelope without requiring variations. The differentiation could be retained at Reporting Unit level using reporting codes e.g. CTN 211 and CTN 221. Lines 348 – 358 Layout is cumbersome. A table would be simpler. The word “worth” seems inappropriate. Comprises or equates to?	noted	Will be addressed in Service Agreement. " Worth" amended to "equates" to
<b>Counties Manukau DHB</b>	Lines 332-341 reduce number of levels to 3 e.g. postgraduate certificate, diploma and Masters, especially as the funding is the same. Make prescribing practicum similar to overseas course- case by case basis.	noted	Will be addressed in Service Agreement. Prescribing Practicum already covered in existing framework.
<b>Hutt Valley DHB</b>	Lines 332-344: These PU definitions continue to be inconsistent with academic programmes of study. Many nurses use 5 years to complete their masters, and similarly PG Certs are often done over 2 years, as are PG Diplomas, as nurses report workload issues with the current prescribed timeframes. Also, from an academic perspective, prescribing practicums can be undertaken as soon as core papers are completed; this may be in year 3, 4 or 5 of a nurse’s programme of study. Additionally, some nurses have to change locations, therefore can be more than one PU code in one year (i.e. 1 paper in Wellington , 1 in Palmerston North). Recommend that funding is attached to a paper/programme rather than the year of study.	noted	The example is not intended to cover every scenario, please contact CTA for further clarification if required.
<b>Jan Radomske NASC assessor</b>	Don't really understand this but probably don't have to.	noted	
<b>Northland DHB</b>	In the past there has been some confusion as to what a training unit represents. Suggest rewording for clarification as follows: 329-330: Each purchase unit is representative of one training unit which is equivalent to a year of full time study. This could be either: 332-333: PGCert or the first full time year of a PGDip or Masters depending on how the student enrolled.	disagree	Feel that wording is similar and does not require amendment. A guide to calculating training units has been developed and distributed to all DHBs.

<b>Nurse Practitioner Advisory Committee of New Zealand</b>	Page 8, Line 342. Add bullet points: First year of doctoral degree Second year of doctoral degree Third year of doctoral degree Fourth year of doctoral degree.	disagree	We note the feedback for funding of Doctorates - the current MOH position for post entry clinical training is to support Level 8 through CTA.
<b>NZNO</b>	We note the weightings within the tertiary education sector are different to the equivalency ("One Training Unit") given to the varying levels of education programmes" regardless of increasing complexities and critical thinking processes and suggest this is revisited. We also ask if any consideration has been/should be given to continuity of funding for students. For example, if a student has completed part of a course will they have assured or preferential funding to complete over new trainees? The guarantee of continuing funding for completion of a long course is an important consideration for most nurses undertaking PNT.	noted	This is a DHB process, refer to clause 2.2
<b>Waitemata DHB</b>	Clarification around allocation of training units is appreciated	noted	
<b>West Coast DHB</b>	Line 332: Rather than the funding being for at minimum a PG certificate we would like to see funding for individual papers. This would be helpful because not all nurses want to complete a post graduate certificate in a year	noted	Part time study is funded under current and revised specification

8.0 REPORTING REQUIREMENTS Page 9 Lines 361 – 365	NAG Response	Rationale
<b>Auckland DHB</b> New section. Useful to direct programme coordinators to information on reporting requirement and where the detail is.	noted	
<b>Canterbury DHB</b> Our previous correspondence refers. Format for Report Two (on-line) needs to be revised. We would be pleased to contribute to a design revision	noted	CTA will be revising Report Two Evaluative and will seek DHB feedback and input
<b>Counties Manukau DHB</b> It is good that this section has been introduced as it gives some clarity	noted	
<b>Lakes DHB</b> There should be some work done to simplify the reporting process. Because of the time lag from expressing interest to starting on papers we have significant numbers of people for whom circumstances change also institution pull or alter papers due to enrolment numbers etc. and all this under current arrangements leads to considerable work varying contracts numerous times and lots of administrative activity around reporting.	noted	The revised costing model will address these problems
<b>NZNO</b> Robust processes and requirements that demonstrate the link between patient health needs and nurses' learning needs must be apparent.	noted	

<b>9.0 QUALITY REQUIREMENTS Page 9 Lines 368 – 372</b>		<b>NAG Response</b>	<b>Rationale</b>
<b>Auckland DHB</b>	New section. Useful to direct programme coordinators to information on quality requirements and where the detail is.	noted	
<b>NZNO</b>	NZNO questions the robustness of these requirements having previously experienced the lack of accountability by the CTA when trying to access data as to what information they requested from the DHBs re where money was spent or even the aggregate trainee numbers and their education choices made. After a protracted and difficult process, only limited information was received, with no analysis of the 2006 consultation being given as requested. The CTA was "unable to provide an example of how DHBs prioritise postgraduate nursing as this information is not currently held..." and moreover proposed to "impose a charge of \$38 per half hour or part thereof" on NZNO due to the "substantial research and collation required in order to satisfy your request"! We trust these quality requirements will be strengthened and audited.	disagree	As per previous comment re audit. Submissions and NAG responses to be published. Further data to be published in Purchasing Intentions.

**Additional Comments - all noted and have been covered in responses to earlier sections or are outside of scope of review**

**Anon 1** Much improved document, my key message relates to clarification re the use of term clinical supervision, more useful to use clinical preceptorship instead.

**Anon 2** Thanks for the opportunity. An excellent document, easy to read and make comment - even though these were sparse.

**Auckland DHB**

1. The CTA is to be commended for working towards ensuring transparency and accountability in funding processes at a time when the financial imperative under which all DHB's function could influence the prioritisation process in regard to postgraduate nursing education funding.
2. Mental Health Nurse training funds – the present arrangement of having funding for Mental Health nurse advanced training managed separately has not been successful. Eligibility differs significantly from CTA PG Nursing Training funding and this is viewed as unfair by nurses who are seeking funding support. In addition the programmes offered are limited and entry restricted rather than the nurse being able to choose a course of study relevant to her/his practice. Post-graduate funding for mental health nursing was not clear in the purchasing intentions and is not clear in the draft revised specification, further clarification is required. We do understand Te POU holds the contract for mental health nursing funding (both new graduate and post-graduate) but the current funding model is not responsive to the needs within ADHB's mental health nursing services. For example, access to mental health nursing post-graduate programmes is via nationally specified programmes delivered by tertiary education providers. This model was changed for all other CTA -funded programmes some time ago in favour of allocation of funds to DHB's based on a population-based formula to enable DHB's to purchase appropriate programmes. The allocation of funds to DHB's has we believe been demonstrated to be a superior system, responsive to the needs of individual nurse and DHB needs and more valuable in terms of workforce planning. It seems out dated to perpetuate the separation between physical and mental health given the prevalence of people with a combination of physical and mental health needs. Moreover compartmentalising health needs in this manner does not reflect generally accepted philosophies of providing comprehensive (holistic) care. Just as nurses need to study and work with other health disciplines so mental health needs to integrate with all other aspects of health care.
3. The allocation of funding for nurses undertaking the prescribing practicum (\$25,093 per training unit) is currently set at about 3 times greater than that for other training programmes on the basis that the cost of clinical supervision by an authorised prescriber (currently medical practitioners) is more costly. Changes in senior nurse roles (including but not limited to Nurse Practitioner) and the RMO workforce shortage have resulted in some senior nurses undertaking activities of care that require the use of extensive assessment and diagnostic reasoning skills developed through a practicum. Like the prescribing practicum this practicum requires a medical practitioner as the clinical supervisor. We believe the CTA should exercise greater flexibility and expand the practicum criteria to include clinical practicum's at the same level of funding as the prescribing practicum. Similarly in Primary Health the development of the Nurse Practitioner role is selectively dependent upon GP support for mentoring and supervision. Some additional incentive and structured support is urgently required.
4. The pool of money available is too small to provide education and training to the number of nurses needed in order to create the skilled workforce so critically needed. To this end we believe every effort should continue to be made to secure such funding
5. There is a continuing sector track record of under delivering in nursing workforce development, post registration; policy to date has not been backed up by appropriate levers for change or with appropriate funding i.e. Nurse Practitioners, primary health care. The lack of any robust funding methodology or appropriate funding allocation must be acknowledged and the group working with the CTA have a responsibility to ensure that occurs.

Additional Notes about Section 2.1: The background to this issue is complex. Nursing Council website states: "The following educational institutions offer programmes that are approved by the Council as clinically focussed postgraduate nursing programmes."

<http://www.nursingcouncil.org.nz/educa.html#pg> On the Council's website, Massey and the University of Auckland have one generic Masters qualification. Therefore they have met CTA Specification and Council requirements as above. Under that blanket qualification, there could be RNs undertaking research-based masters by different pathways. RNs undertaking research-based masters at VUW and Otago. MA Applied (Nursing) & MHeal Sc (Nursing). Some nurses are not clear about their final career destination and wish to take a substantive thesis as part of their formation. As nursing is an applied discipline, their theses are clinically-based. Findings help inform nursing service provision or policy and some will directly improve health outcomes. These RNs have the full support of their DON. We believe these RNs meet the requirements of clause 2.0 and should be eligible for CTA funding. If they were enrolled in Massey or Auckland's Masters programme, they would be CTA funded.

<b>Canterbury DHB</b>	Redesign of Report 2 – Evaluation data - Longitudinal monitoring of career destinations of funded trainees should be considered. This may need to be a commissioned study.
<b>Capital &amp; Coast DHB</b>	Prescribing Practicum CTA funding – now that we have further developed the process for the Prescribing Practicum it is evident that the funding does not cover the full costs (I note that specification 3.6 identifies “subsidised clinical access costs for Nurse Practitioner prescribing practicums”). The funding is approximately 1/3 of the true cost of Nurse Practitioner prescribing practicum's for Primary nurses. The advanced clinical assessment and clinical decision making papers have just as high a requirement regarding clinical access, supervision and release as the prescribing practicum. Both these papers require the same amount of advanced clinical assessment. The only difference is that the non-prescribing practicum does not assess domain 4. There is therefore a significant cost to the non-prescribing practicum but the funding is substantially less (\$7258 for non-prescribing and \$25093 for prescribing practicum). This is inequitable and if addressed this will make a tangible difference to the level of assessment skills and confidence achieved through these papers and a 'culture shift' towards nurses integrating tools of advanced assessment.
<b>Counties Manukau DHB</b>	CMDHB appreciates the continued availability of funding for nurses to undertake postgraduate education. Welcomes the opportunity to comment on the review of the CTA nursing specifications. CTA needs to consider funding for level 7 graduate certificate specialty courses that would assist nurses advance nursing practice as there are nurses who will never undertake postgraduate education. There is an educational need for this level of education especially in the aged care facilities. This would assist in the addressing of the inequalities of health while increasing nursing knowledge and skills. Whilst CTA is helping nurses complete the clinical masters and advance nursing practice, one objective that has not been fully achieved is the steps to NP. We may need to look at clinical release for an internship programme for this role. This would allow training across the sector and across DHBs.
<b>DHBNZ Nursing and Midwifery Workforce Strategy Group</b>	Consider extending funding for those on the NP pathway to funding NP candidate (aka intern) programmes. It is just too hard for many currently. Support would be: Paid release/backfill Paid mentorship arrangements Thank you for the opportunity to comment. The Nursing and Midwifery Workforce Strategy Group would like to commend CTA in their method of consultation and giving the sector the opportunity to feedback on the specifications.
<b>DHBNZ - Nurse Practitioner Facilitation Steering group</b>	The Nurse Practitioner Facilitation Programme steering group recommends that CTA consider another stream of funding in the NP pathway; to provide support for NP candidate roles in supervision, release time, portfolio development and additional practice experience in the period prior to NP employment. This could be in the form of an NP candidate programme.
<b>Hutt Valley DHB</b>	1) Whilst programme coordination is clearly defined, there is little reference to the high administration requirements for the PG Nursing Funding and no funding provisions for the same, therefore HVDHB has needed to utilise funds out of programme coordination to ensure the required administration associated with the specifications is achieved. This has negatively impacted on the FTE left available for actual programme coordination and comprehensive quality activities. It is acknowledged that the set up phase (i.e. first year or two) will be more time intensive than subsequent years, but the administration to date has taken up more time than anticipated. 2) A lack of standardisation of the overall programme means that the stated transparent and consistent approach is NOT the reality. It would be advantageous to have standardised application forms, databases, cultural plans, career plans, some policies, either developed by CTA or by a working group derived from the bigger national programme coordination group. Currently we are all duplicating many activities. Similarly, travel, accommodation, payment of fees are all inconsistent across DHB's.
<b>Jan Radomske NASC assessor</b>	I'm a nurse at TDH utilising the excellent CTA funding to do my masters at EIT - I am in my 3rd year (1 paper 1 yr) and have commented on this draft from a nursing perspective. I think a more transparent process for CTA funding would be good.
<b>Lakes DHB</b>	Our understanding is that NCNZ informs and approves the education programmes and levels that are required for scopes of practice, the clinical masters relates to the NP and also fits with Nurse Specialist and expert nurse on the PDRP etc, however we see very real value in encouraging NZ research as part of the masters whether or not you do a full thesis / dissertation, or a smaller project as this contributes to the body of evidence supporting practice in NZ. Other Nursing Masters programmes support advanced practice other than clinical for example those related to leadership and to education and would like to see these programmes approved as well. We would like more access to CTA funding for midwives, across a wider range of topics than currently. We are also aware that overseas midwives are expected to complete a number of undergraduate papers before they are able to obtain a full APC. Access to funding for these would be very useful in maintaining our midwifery workforce.

	<p>Graduate versus postgraduate and qualifications versus structured learning - This is an area we believe needs thoughtful analysis in regards to the intent of the CTA funding programme. From an employer perspective the education is to facilitate fit for purpose, evidence based practice, professional development of individuals, and succession planning. Given the generalist preparation of nurses, for many the next step in the education and training is strengthening general knowledge and building depth in the area of practice. Currently when a nurse enters postgraduate education for specialty practice they complete the specialty paper once are measured against NP competencies. This means they complete their entry to specialty practice and postgraduate specialty practice and NP training all in one degree. Also building depth in the specialty occurs at the same time they are mastering the academic scholarship requirements.</p> <p>We would argue for a nurse to be fit for purpose they need to building foundations for specialty practice at level 7 to gain more depth post registration. Also a more vocational approach in this area would value clinical learning in the role, enrich practice environments, and deliver the Safe Staffing Healthy Workplaces recommendation that clinical learning occur in the practice environment. This would provide scaffolding for more advanced education and scholarship, enable entry pre requisites to be met so that level 8 education could be more targeted to advanced practice. The approach to qualifications needs to be tempered with the knowledge that most nurses will work for.30 - 40 years in the profession (we hope). While it is useful for papers to articulate, the aim should be for learning to meet practice needs.</p> <p>Vocational training - specialty practice needs to be more vocational in nature. The term "integrate theory and practice" needs to be defined and more specific to give guidance to programme designers to narrow the disconnect between the general theoretical education on a clinical topic to requiring clinical competence as well as the theoretical preparation. There needs to be more ability to extend CTA funding to vocational training for advanced practice roles such as Nurse Practitioner Candidates.</p> <p>3.1 Programme Co-ordination - This section could be reworked for clarity: perhaps group as Strategic and Operational/Process aspects of Co-ordinator role.</p>
<b>MidCentral DHB</b>	
<b>NETS</b>	<p>NETS is pleased to provide feedback on this revised draft specification for postgraduate nursing education funding. The revision has overall improved clarity of the process and there is very little that required further comment</p>
<b>Northland DHB</b>	<p>The definition of ring fenced funding has not been clear. Some coordinators around the country believe that programme management costs associated with the administration of these funds cannot be taken from this allocation. Is this correct and if so could clear guidelines be provided. Thank you for the opportunity to provide feedback and comment on this document. We appreciate the opportunity to provide nursing staff in our region with quality education opportunities, which may not have been possible for them without the financial assistance provided by CTA, as our region is predominantly lower socio-economic.</p>
<b>Nurse Practitioner Advisory Committee of New Zealand</b>	<p>Work is currently underway by the Nurse Practitioner Facilitation Programme, supported by the Nurse Practitioner Advisory Committee of New Zealand to develop programme specifications for Nurse Practitioner Candidate Programmes. Currently Registered Nurses on the Nurse Practitioner pathway are supported via CTA only to develop their theoretical knowledge. Total reliance is then placed on the individual Nurse and his/her employer and practice setting to provide the opportunities to implement newly acquired knowledge in order to advance clinical practice skills. This leads to inconsistencies in preparation of nurses as some practice environments lack the required attributes to support the nurse to advance skills. Funding of the final year or two of development of the RN in a recognised NP Candidate Programme will support improved quality of preparation and consistency of standards.</p>
<b>NZNO</b>	<p>Thank you for the opportunity to comment on this draft specification. We advise that in addition to feedback from members, our submission is informed by advice from our Professional Service Team which comprises Nursing, Research, Policy and Legal advisers. We also note that our submission is supported by NZNO's 23 specialist Colleges and Sections and trust that it will be given that weighting rather than considered as a single submission. In general NZNO has found that this specification for nursing training funding has a narrow academic focus which precludes the breath of opportunities needed to enhance the development of nursing knowledge, skills, and leadership for an innovative nursing workforce able to meet New Zealanders health needs in the 21st century. We are concerned that it retains the inequities and inadequacies of the existing funding model. Though it is inevitable that nursing learning needs will be poorly and unscientifically assessed while New Zealand's health needs continue to be focussed on addressing single-focus, tangible disease-state(s), we had hoped for a more holistic funding model.</p> <p>We are particularly concerned in this draft revised specification by: the erosion of the clinical focus; the limitation of courses to those that are NCNZ approved; the restriction of funding to 800 level courses; the lack of accountability with funding being evidentially linked to health workforce needs and patient outcomes; and the lack of a national perspective led by the Ministry of Health.</p>

We believe the continued devolution of funding control to the RA and the DHBs entrenches existing disparities in access to and outcomes from PNT, which are difficult to quantify based on the inadequate data available. We are not confident that this model is rigorous and will ensure that public monies are directed to PNT which will deliver the best health outcomes. We believe that unless the above concerns are addressed this specification will be a barrier to: Cross disciplinary and inter professional learning; „just in time“ education (right time, right place, right content); Transparency, consistency and fair allocation of resources where needed; and Nursing workforce development.

As indicated NZNO is concerned by the continued lack of analysis of funding requirements for nursing training post registration and lack of accountability which has seen the perpetuation of discriminatory funding structures which are patently not meeting New Zealand nursing or healthcare needs. The singular focus on Level 800, PBRF and Nurse Practitioner training without determining and analysing patients' health needs and aligning nursing education accordingly has consequences, as evidenced by the Health and Disability Commissioner's recent report on Case 07 HDC 217022 which found that the standards of nursing care fall short. The HDC enjoined "All nursing schools ... to consider the report's implication for nursing education" (p6) and listed a number of recommendations for nursing structures which echo the perspective NZNO has tried to convey in this submission in order "to strengthen nursing leadership, enable multi-professional partnerships, and to give a voice and heart to the largest key asset of the organisation, the nurses."

Finally we draw your attention to three NZNO documents which may be of assistance and which are online through the research section of our website:

[http://www.nzno.org.nz/Activities/Research.aspx#research\\_review](http://www.nzno.org.nz/Activities/Research.aspx#research_review) Collating for collaboration: Tertiary Education Commission Funding Structures

NZNO Education Survey Report: Implications for practice

"Holding up" the first biennial NZNO Employment Survey

**NZNO**

The draft revised CTA Postgraduate Nursing Training Specifications provide the ability for Plunket nurses to apply for CTA funding from DHBs for Postgraduate study. The Royal New Zealand Plunket Society is a significant employer of primary health care nurses with over 500 registered nurses working in well child health. The Plunket Society and Whitireia Community Polytechnic work in partnership to provide postgraduate education in well child/tamariki ora nursing in the form of a level 8 Postgraduate Certificate in Primary Health Care Nursing (well child tamariki ora speciality nursing). This postgraduate certificate is offered twice a year semester 1 (March to November) and semester 2 (August to May). The programme is offered to Plunket, iwi, Pacific and DHB well child provider registered nurses. Annually 80 to 90 nurses undertake the programme. Current Clinical Training Agency postgraduate funding for Plunket nurses - Local DHBs have provided CTA funds to some Plunket nurses to undertake the Postgraduate Certificate in Primary Health Care Nursing and for a few nurses to undertake further postgraduate study.

Complexities/Issues (1) There is a level of unpredictability of which Plunket nurses receive allocated DHB CTA funding. This has resulted from each DHB's internal priorities and level of demand from staff. Unfortunately this does not capture the needs of a national organization. (2) All nurses undertaking postgraduate study do not have the ability to apply for CTA funding because of the 'funding round' timing. This occurs because: With the Postgraduate Certificate being integral to the nurse's professional development in primary health they are unable to wait for the November application round for CTA funding. Nurses are employed in Plunket when a job vacancy occurs. Often this occurs between the DHB CTA November funding round cut off date and enrolment date for the semester 1 postgraduate certificate (2nd Feb), as a result these nurses are unable to apply for CTA funding. • With the main CTA funding round being in November some nurses undertaking the Semester 2 programme commencing in August have been unable to apply for funding for paper 1. They have been able to apply for funding in November for paper 2 (commencing in February the following year).

This has meant that if their application is successful, they can only gain a maximum of funding for 1 paper not 2. (3) Plunket nurses working for PlunketLine have been unsuccessful applying for CTA funds as they provide a nation-wide phone service rather than a service in a DHB geographic area. Recommendations

As a national organization applying to 21 separate DHBs is inefficient. We ask that you to consider other models for national organisations. This could be in the form of direct funding or having a lead DHB for national organizations. Additionally we would like to see more flexibility to enable all nurses to apply for funds for both semester 1 and semester 2 programmes. This could be achieved by funded primary health positions and a more flexible timetable for funding allocation.

**Plunket Society**

**Rural Canterbury  
PHO**

I have few specific comments to make in relation to the paper, except that the availability of this funding to primary health care nurses is extremely valuable.

<b>SIT Trainees</b>	To whom it may concern, We are a group of Registered Nurses who are currently undertaking postgraduate education at Southern Institute of Technology. This submission is a combined effort; drawing from different nursing backgrounds and experiences. Our group has three nurses who are currently working in primary care and two nurses who practice in secondary care. We are familiar with CTA funding and have been grateful for its benefits in our professional career. For that reason, we are excited to be able to contribute to the consultation on the draft revised CTA postgraduate nursing training specification document. We agree with the general direction of the document and believe that CTA funding has an important role in opening the way for many nurses to expand their professional opportunities. However, there are some areas that we would like to draw your attention to. These are discussed in the attached the filled in feedback form.
<b>Southland DHB</b>	Currently no designated ring-fenced coordinator funds allocated therefore postgraduate study (general) bears the brunt of top slicing. Long-term conditions program currently underutilised due to inflexibility of program criteria and access
<b>Taranaki DHB</b>	Overall I support the changes and intent outlined in the document, although outside of the actual specification I wonder if there might be an opportunity for the CTA NAG to review the costings/budget associated with the specification, i.e. a specific budget line for the coordinator/administration component of the contract. A focus on costings for tuition fees, clinical release etc in terms of being specific around amounts so that it is applied consistently nationally. On the whole we are supportive of the changes made to the specification. Please give me a call if clarification is required or if you have any queries.
<b>UCOL</b>	Thank you for the opportunity to make a submission. There is a strong clearly identified demand for postgraduate clinical updating of registered nurses, many of whom have no aspirations whatever to undertake Master's degree study, and it is our firm belief that PG funding must be extended to level 7 papers which would satisfy this demand, and enhance the care of the great majority of clients in the primary care sector in particular. There is also, we believe, a well recognised and extremely urgent need for clinical updating of staff working in the private sector, especially in elderly care, and they do not appear to have access to funding under the present specification.
<b>University of Otago</b>	We support the Programme description (2.1) and feel strongly that the profession of nursing must not be undermined by the dispersal of identified nursing monies to other educational programmes. Some argue that interdisciplinary programmes ought to have access to this funding, we believe interdisciplinary learning is achieved in Nursing Council approved programmes and accredited nursing qualifications. Nurses have always been cognisant of the contribution of other professionals working alongside many other disciplines. We support the intent of the specification and congratulate the Ministry and EAG on the revisions.
<b>Waikato DHB</b>	5.1 Would it be appropriate to have Midwifery and Mental health under the same umbrella. Provides for easier management of the programmes against DHB requirements.
<b>Waitemata DHB</b>	WDHB would like to acknowledge the clarification of several areas noted in the comments above. Issues do exist around clinical supervision and the funding for this within the non-prescribing papers. There are requirements for a mentor for several papers our trainees access and we have been unable to supply any funding for this to occur. Because of this, already over-burdened nurse educators and clinically experienced nurses have little acknowledgement of the extra time and effort they have put into providing this support for other students. It is the reality that the provision of this clinical supervision is extremely difficult to facilitate and therefore meet the trainees' needs in this area and much of this is directly attributable to the lack of funding.
<b>West Coast DHB</b>	Thank-you for the opportunity to comment on the draft specifications. In putting together these comments we have only focused on the areas we have had concerns about, The limited number of comments reflects our genuine appreciation for the funds, the process, the staff at the CTA and the work of the Expert Advisory Group. These comments were put together after a group discussion with CTA Coordinator (Karyn Kelly) the Nurse Managers Secondary Services (Michele Barber) and Primary and Community services (Maureen Frankpitt) and the Associated Director of Nursing Mental Health Services (Anne Tacon).

Access to appropriate education and training for nurses that practise outside the District Health Board (DHB) setting needs to be addressed. Investment in postgraduate education be increased to support the ongoing development of the role of the nurse practitioner. Additional incentive and structured support be provided in primary health care for the development of the nurse practitioner role. Concerns regarding eligibility for CTA funding being limited to those programmes / courses of study that are within Nursing Council of New Zealand approved programmes. There is a view that only Nursing Council approved programmes contribute to the professional development component of Registered Nurse practising certificates. However nurses undertaking study in a variety of other non Nursing Council approved programmes find these meet their need for advanced education in subjects such as primary health care, public health, psychological medicine, ethics and research. Also there should be funding for level 7 papers that contribute to the professional development of a Registered Nurse.

**Whanganui DHB**

Name of Organisation
Anon 1
Anon 2
Auckland DHB
Canterbury DHB
Capital & Coast DHB
Counties Manukau DHB
DHBNZ - Nurse Practitioner Facilitation Steering group
DHBNZ Nursing and Midwifery Workforce Strategy
Hutt Valley DHB
Jan Radomske NASC assessor
Lakes DHB
MidCentral
NETS
New Zealand College of Mental Health Nurses
Northland DHB
Nurse Practitioner Advisory Committee of New Zealand
Name of Organisation
NZNO
Plunket Society
Rural Canterbury PHO
SIT trainees
Southland DHB
Taranaki DHB
UCOL
University of Auckland
University of Otago
Waikato DHB
Waitemata DHB
West Coast DHB
Whanganui DHB
Whitireia Community Polytechnic