

Investing in Health:

Whakatohutia te Oranga Tangata

A framework for activating primary health
care nursing in New Zealand

*Report to the Ministry of Health from the Expert
Advisory Group on Primary Health Care Nursing*

This document reflects advice and recommendations to the Ministry of Health from the Expert Advisory Group on Primary Health Care Nursing on the implementation of the Primary Health Care Strategy. It does not reflect the view or policies of the Ministry of Health or any other organisation.

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Executive Summary

The extensive contribution that primary health care nursing can make to reducing health inequalities, achieving population health gains and promoting and preventing disease is yet to be fully realised. The Primary Health Care Strategy¹ is intended to achieve this. The Strategy was released in February 2001 and identified primary health care nurses as crucial to its successful implementation. It required the Ministry of Health to ‘facilitate a national approach to primary health care nursing which addresses capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements’.

To achieve the vision and goals in the Strategy, new working relationships need to be negotiated and new systems and processes established. For the nursing profession, this presents an opportunity to critically evaluate and redefine the scopes of practice, address the current constraints to effective practice, and ensure that nurses are strong, effective and visible members of the primary health care workforce. It is an opportunity for a significant culture change, with nursing repositioning itself for new ways of delivering services in primary health care settings and communities, so as to more effectively improve the health of New Zealanders.

This report provides advice and recommendations to the Ministry of Health, District Health Boards and primary health organisations on a framework for primary health care nursing in New Zealand in line with the Government’s Strategy. It explores the concept of the primary health care nurse and the ways in which primary health care nursing can maximise its unique contribution to the health outcomes of individuals, families, whānau and population groups, and to reducing health inequalities for these groups. It is about aligning the current primary health care nursing workforce to identified population health needs. It is about enhancing the generic skills of all nurses working in primary health care, and about more effective utilisation of advances in nursing practice.

For the framework, a definition of the primary health care nurse has been developed to encompass all nurses working outside hospitals and across sectors who need to be prepared, through education and ongoing professional development, for the broad clinical responsibilities of delivering high quality care.

A vision, goals and objectives were established to guide the development of the framework, after taking account of the evidence from the literature, national data and models of best practice. There are five goals: to align nursing practice with community needs; to develop innovative models of nursing practice; and to achieve governance, leadership, and education and career development for primary health care nurses. These goals are outlined in the box (below) and discussed in turn in the main report. While each goal stands alone, to achieve the best outcome a

¹ For the purposes of this report, the Primary Health Care Strategy will be referred to as ‘the Strategy’.

co-ordinated and integrated approach is needed. Evolutionary change is anticipated, as nurses adapt their current service delivery models and evolve new and innovative ways of delivering primary health care. Time for the transition to new ways of working to occur is critical. Primary health care nurses need to seize opportunities inherent in the implementation of the primary health care strategy and play a key role in shaping their own destiny in order to contribute to health gain for all.

This report is a crucial resource for nurses working in community and primary health care settings as a catalyst for positive change to provide more integrated care, and for the health and disability sector to consider the opportunities to maximise nursing's contribution to meeting the objectives of the Strategy and other government priorities.

Vision and Goals for the Primary Health Care Nursing Framework

Vision

To create the environment that enables nurses to provide integrated comprehensive nursing care to individuals and population groups in New Zealand primary health care settings, and that strengthens the primary health care team towards improving health for all.

Goal – Aligning nursing practice with community need

Funding streams, employment arrangements and service delivery patterns will support nurses to adopt an integrated approach to practice and incorporate population and personal health strategies into service delivery.

Goal – Innovative models of nursing practice

New and innovative models of primary health care nursing practice that improve access to primary health care services, and contribute to improved health outcomes and reduced health inequalities for individuals, families/whānau, and communities/iwi.

Goal – Governance

Primary health care nurses will be equal partners alongside other professional groups and community representatives in governance of primary health care organisations.

Goal – Leadership

Primary health care nurses will have clear, accessible, integrated nursing leadership to encourage and promote change and facilitate the development of new roles and models of practice.

Goal – Education and career development

Postgraduate education will support all levels of primary health care practice and be recognised in a national, standardised career pathway for primary health care nurses.

Recommendations

The Expert Advisory Group on Primary Health Care Nursing makes the following recommendations to the Ministry of Health, District Health Boards (DHBs) and primary health organisations (PHOs) to implement the framework for primary health care nursing in New Zealand.

1 Recommendations to the Ministry of Health

The recommendations to the Ministry of Health are to:

- a) invest responsibility with the Chief Advisor Nursing, for oversight of the implementation of these recommendations
- b) establish a nursing position in the Ministry with responsibility to lead the implementation of the primary health care nursing framework to support DHBs and PHOs to develop innovative, integrated and collaborative models of primary health care nursing services
- c) fund, monitor and evaluate innovative models of primary health care nursing practice and disseminate examples of best practice to the wider sector
- d) establish a process for nurses currently working in primary health care to access primary health care funding for relevant postgraduate education
- e) promote and identify any barriers to the introduction of nurse practitioners in primary health care settings
- f) work with DHBs and emerging PHOs to develop information systems and coding mechanisms that assist the collection of data and other information on primary health care nursing for monitoring and evaluation
- g) develop and monitor primary health care nursing performance indicators for DHBs and PHOs
- h) monitor and report on the progress of DHBs and PHOs in implementing the recommendations in this framework
- i) evaluate the Ministry-funded first year of nursing graduate pilot programmes for outcomes relevant to primary health care
- j) monitor the progress of DHBs in implementing a clinical career pathway for nurses in primary health care.

2 Recommendations to DHBs

The recommendations to District Health Boards are to:

- a) work closely with primary health care nursing services and the community when developing service priorities and new service models and assessing health needs, recognising the nurses' explicit knowledge of community health needs
- b) determine their requirement for primary health care nursing services in relation to their population size and demographics and on the basis of their health needs assessment to ensure that population health services as well as acute episodic care are adequately resourced
- c) identify and analyse needs and gaps in the primary health care nursing workforce and develop retention and recruitment strategies with action-oriented plans to address these
- d) work towards establishing a clearly identified primary health care nursing management/ leadership infrastructure at the regional level to provide professional nursing oversight of, and leadership in the development of, the primary health care workforce
- e) acknowledge their obligations under the Treaty of Waitangi and work in partnership with Māori providers and nurses in primary health care settings to allocate sufficient resources to meet future development needs, improve health outcomes and support reducing health inequalities for Māori
- f) recognise and support the contribution of Pacific providers and nurses in Pacific communities by allocating sufficient resources for future development to meet the health needs of the Pacific population
- g) implement mechanisms and audit processes to ensure that recommendations of this framework are met
- h) engage with developing PHOs and regional and local primary health care nursing leaders to:
 - develop and implement new and innovative models of primary health care nursing services
 - shift the accountability for nursing services to nursing management within the PHOs
 - develop service agreements and funding streams that encourage flexible employment arrangements for primary health care nurses to maximise the contribution of nursing to population and personal health gain
 - recognise and support the role of primary health care nurse practitioners within teams and under independent employment arrangements

- i) provide opportunities for primary health care nurses to access leadership development training, recognising the priority needs of Māori and Pacific nurses
- j) support the development of the primary health care nursing workforce by implementing the national framework for post-registration education developed by the Nursing Council of New Zealand and supporting primary health care nurses, including Māori, Pacific and rural nurses, to access postgraduate education (eg, scholarships or grants, release time for study and travel expenses)
- k) support new graduates to transition directly to primary health care nursing practice, and experienced secondary or tertiary care nurses who wish to move into primary health care practice, through appropriate education and training programmes
- l) report to the Ministry on progress with developing a clinical career pathway for nurses working in primary health care
- m) report to the Ministry on progress with developing the role of nurse practitioners in primary health care.

3 Recommendations to PHOs

The recommendations to primary health organisations are to:

- a) work closely with primary health care nursing services and the community when assessing population health needs and developing new service models, recognising their unique knowledge of community health needs
- b) establish a nursing infrastructure within the organisation with responsibility for providing leadership, overseeing professional development and practice, and aligning accountability for primary health care nursing practice, employment and service delivery that responds to community health needs
- c) establish employment arrangements for primary health care nurses with appropriate scopes of practice to ensure the effective delivery of integrated and innovative primary health care nursing services relevant to population needs
- d) establish evaluation processes to ensure that the governance, management and leadership recommendations of this framework are being met
- e) appoint primary health care nurses at an appropriate level, with appropriate financial reimbursement according to qualifications and experience, and consistent with a clinical career pathway based on the national education framework
- f) align accountability for nurses' professional and employment arrangements to nursing leadership within their organisation's structure

- g) acknowledge their obligations under the Treaty of Waitangi and work in partnership with Māori providers and nurses in primary health care settings to allocate sufficient resources to meet future development needs, improve health outcomes and support reducing health inequalities for Māori
- h) recognise and support the contribution of Pacific providers and nurses working in Pacific communities by allocating sufficient resources for future development and to meet the health needs of the Pacific population
- i) support primary health care nurses to access leadership development training to ensure they are appropriately prepared and supported in governance and leadership roles
- j) support their primary health care nurses, including Māori, Pacific and rural nurses, to access postgraduate nursing education (eg, scholarships or grants, release time for study and travel expenses)
- k) implement a clinical career pathway for primary health care nurses based on the national education framework
- l) support new graduates to transition directly to primary health care nursing practice, and experienced secondary or tertiary care nurses who wish to move into primary health care practice, through appropriate education and training programmes
- m) provide and resource regular ongoing professional development for primary health care nurses in their employment.

Chapter One: Developing a Framework for Primary Health Care Nursing

1.1 Purpose of this report

Investing in Health: A framework for activating primary health care nursing in New Zealand provides advice and recommendations to the Ministry of Health on a national framework for primary health care nursing in New Zealand. The Government's Primary Health Care Strategy identified primary health care nurses as crucial to its successful implementation, and required the Ministry of Health to 'facilitate a national approach to primary health care nursing which addresses capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements' (Ministry of Health 2001).

A 10-member expert advisory group was appointed to work with the Ministry to develop this advice according to agreed terms of reference (see Appendix 1). The members were appointed for their knowledge and expertise in primary health care, and their understanding of the sector. They do not represent specific organisations or groups.

The expert group, through analysis of available evidence and consultation, developed a framework. A literature review was undertaken to examine the evidence for the impact of primary health care nursing teams on health outcomes, and to identify components for consideration in a national framework for primary health care nursing. A survey of registered nurses working in primary health care and community settings was carried out in co-operation with the Nursing Council of New Zealand. Questions covered demographics, work type, employer, place of work, education, ability to access education, organisational nursing leadership and management structures, clinical career pathways and barriers to effective collaboration with other professionals.

The Ministry analysed previous reports on primary health care, current contractual and funding arrangements for primary health care nurses, and Nursing Council of New Zealand workforce data. It also held informal discussions with stakeholders, including providers and interest groups. The method and the focus of data collection are detailed in Appendix 2.

1.2 Context for change: The Primary Health Care Strategy

Primary health care covers a broad range of health services, and is defined in the Strategy as:

- participating in communities and working with community groups to improve the health of the people in the communities
- health improvement and preventive services, such as health education and counselling, disease prevention and screening
- generalist first-level services, such as general practice services, mobile nursing services, community health services, and pharmacy services that include advice as well as medications
- first-level services for certain conditions (such as maternity, family planning and sexual health services, and dentistry) or using particular therapies (such as physiotherapy, chiropractic and osteopathy services, traditional and alternative healers).

The Strategy sets out six key directions:

- 1 Work with local communities and local populations.
- 2 Identify and remove health inequalities.
- 3 Offer access to comprehensive services to improve, maintain and restore people's health.
- 4 Co-ordinate care across service areas.
- 5 Develop the primary health care workforce.
- 6 Continuously improve quality using good information.

Historical patterns of primary health care have not always provided the best service delivery, nor aligned it with health needs. Services have often evolved as a result of a mix of organisational and environmental factors, or funding and employment arrangements.

The intention of the Strategy is that primary health care and community-based services will be increasingly co-ordinated and provided according to the needs of communities rather than the needs of providers. Service delivery will adopt a population health focus with greater emphasis on teamwork, collaboration, health promotion and preventive care, and community involvement. The active involvement of communities ensures that services are accessible to high-needs groups, identified as being Māori, Pacific peoples and the socioeconomically disadvantaged.

The Strategy is clear that no one profession or discipline on its own can provide primary health care, and calls for a multidisciplinary approach that makes the best use of all primary health care practitioners. It also signals the further development of systems and structures to improve health outcomes for individuals and communities through better co-ordination, use of information, and resources. This framework acknowledges the need to strengthen nursing in ways that ultimately strengthen primary health care teams.

Primary health care is recognised as crucial to reducing health inequalities, and the further development of Māori and Pacific capacity is a priority.

To achieve the Government's vision for primary health care, health provider and professional groups need to evaluate critically both their specific contribution to health care delivery and how they provide services to ensure that the best mix of services is achieved for client groups. Implementing the Strategy will result in organisational and funding changes that better align health services with community needs and facilitate new ways of working and providing services.

Principles underpinning the implementation of the Strategy

The Strategy will be implemented over time and may not be realised for 5 to 10 years. During this transition there will be flexibility in how new initiatives are developed. General principles for implementing the Strategy are to:

- protect gains already made and build on successful initiatives
- involve, discuss and collaborate with the primary health care sector, providers and communities
- focus on stepwise, evolutionary change that is consistent with the Strategy
- give first priority to groups with the greatest health needs in terms of both additional services and reducing financial barriers to first-contact services.

The development of primary health organisations (PHOs)

Primary health organisations (PHOs) will evolve as the Strategy is implemented. PHOs will be not-for-profit organisations funded by District Health Boards (DHBs) to provide primary health services for an enrolled population. They will use information about the health status and characteristics of their populations to address population health objectives and reduce inequalities by identifying groups in their community that, historically, have found difficulty in accessing services.² A PHO will provide services directly, by employing staff or through its provider members.

² Minimum requirements for PHOs are available on the Ministry of Health's website at www.moh.govt.nz.

Funding for PHOs will be through DHBs, via a national population-based funding formula that will replace existing fee-for-service arrangements. General practices that choose to belong to PHOs will be paid according to the needs and number of their enrolled populations, instead of the general medical subsidy (GMS) for general practitioners or the practice nurse subsidy for practice nurses. Recognition for areas that have a high-needs population or high Māori and Pacific population will be reflected in new funding arrangements. Fee-for-service arrangements will still exist, however, to fund casual or non-enrolled individuals.

PHOs will provide essential first-line services as well as co-ordinating and planning health care for their populations. Stronger links and collaborative arrangements will develop between primary health care services serving the same population, to ensure increased co-ordination, minimise duplication and fragmentation, and ensure that the most appropriate provider provides the most appropriate services.

DHBs have the primary responsibility to fund services that meet the health needs of their populations. They will work with emerging PHOs and communities to implement the Strategy and meet the objectives of the New Zealand Health and Disability Strategies. DHBs have the responsibility to determine the best configuration of primary health care services to meet their community health needs, and to develop priorities for service delivery.

1.3 Opportunities for primary health care nurses within the Strategy

The Strategy creates exciting and challenging opportunities for nurses working in primary health care to better align their expert practice with the health needs of individuals and populations. Opportunities for delivering more integrated care include:

- developing innovative methods of service delivery
- improving co-ordination of care across services
- strengthening collaboration in multidisciplinary teams
- building stronger links across sectors.

The Strategy provides a platform for developing a high-quality primary health care nursing workforce. New nursing roles are already emerging and boundaries between disciplines are shifting as primary health care changes in response to government policy, changing health care demands, demographics, technological advances, and the shifting balance between hospital and community in providing health services.

The move towards a greater focus on local population and an emphasis on a wider range of services requires a well-educated workforce with opportunities for developing advanced skills in particular areas of professional practice. In particular, it provides a platform for nurse practitioners to practise as part of a primary health care team, and for the Māori and Pacific nursing workforce to develop capacity, take ownership of the direction for future development and become better placed to work alongside the community to deliver services to previously untargeted population groups.

1.4 Developing a framework for primary health care nursing

The Expert Advisory Group acknowledges the success of existing models of nursing practice and the gains these contribute to primary health care.

Developing a framework for primary health care nursing in line with the Strategy involved identifying barriers to moving forward to achieve the vision and goals for the future. The Group also identified the need for a substantial culture change within nursing in order for it to align with the Strategy and emerging PHOs. Innovative ways of working together need to be established across nursing disciplines and traditional boundaries. These changes will take time and require a carefully planned transition process.

Principles to guide the development of new ways of working

Partnership

- Sharing power and authority in decision-making
- Commitment to a process of mutual obligation and benefit

Participation

- Involvement and ongoing communication from the beginning

Protection

- Professional autonomy over practice and practice environment

The Expert Advisory Group acknowledged that the principles guiding the development of this framework needed to align well with the key directions of the Primary Health Care Strategy, and in particular to recognise the partnership of the Treaty of Waitangi. The Group agreed that the overarching principles should be patient-, whānau- and community-centred, and respond to the needs of individuals and communities.

This framework challenges primary health care nurses to engage fully with their employers in developing new nursing practices, roles and responsibilities, and to ensure that their professional partnership with clients and communities is nurtured and protected. It also challenges employers to support primary health care nurses through appropriate employment and funding arrangements.

What is the evidence?

To inform development of this framework, the Ministry of Health commissioned a literature review to examine evidence for the impact of primary health care nursing teams on health outcomes, and to identify the key components for consideration in developing a national framework.

The evidence reviewed shows there is widespread agreement on the characteristics of an effective primary health care nursing team, and suggests that primary health nursing teams offer patients increased access to a broader range of services. There is evidence, also, that structural and institutional arrangements are crucial, including accountability, governance, leadership, funding and employment arrangements, and that the move towards integrated teams has significant education and career implications for nurses.

International studies provide an opportunity to analyse the clinical and financial effectiveness of nurse practitioners. Nurse practitioners offer an approach derived from the art and science of nursing, which focuses on patient and family response to health and illness in the context of daily life (Ministry of Health 2002).

Fall et al (1997) evaluated the benefits and costs of a nurse-led ear care service in Rotherham and Barnsley in Britain. They concluded: 'Nurses trained in ear care reduce costs, general practitioner workload and the use of systemic antibiotics, while increasing patient satisfaction with care. Such care provided by nurses is an example of how expanded nursing roles bring benefits to nursing practice.' *Nurse Practitioners in New Zealand* (Ministry of Health 2002) provides further evidence about their practice internationally and outlines the regulation, policy framework, and implementation of nurse practitioners in the New Zealand context.

There is evidence of barriers to more effective ways of delivering nursing services in New Zealand. Fragmentation caused by different funding and employment mechanisms has contributed to the under-utilisation of nurses in many settings. Some have been unable to deliver a full range of nursing services as contractual arrangements – rather than health needs, or competence – often dictate roles and responsibilities (Ministerial Taskforce on Nursing 1998).

Nurses in primary health care have had little ability to access professional development, and no clear career pathway to progress in clinical practice. Improving their capacity and skill base has been affected by the lack of support or opportunities for educational programmes in this area. Some nurses have been able to practise for long periods without post-registration education or training.

For Māori and Pacific nurses, their capacity is not in proportion to the needs of their population groups. The findings of the literature review are discussed in greater detail as appropriate throughout the report.

1.5 Elements of the framework

Based on the problems identified in the literature review, the elements of the framework for future primary health care nursing workforce are discussed in the following chapters, under the headings:

- the nature of primary health care nursing in New Zealand
- aligning nursing practice with community needs
- developing innovative models of nursing practice
- governance and leadership
- education and career development.

It will take time to successfully implement all elements of the framework.

1.6 Primary health care nursing – evolution milestones

Table 1.1 shows the proposed transition milestones over a three-year timeframe to achieve the vision of the future framework for primary health care nursing in New Zealand.

Table 1.1: Proposed transition milestones, 2002–05

2002/03	<ul style="list-style-type: none"> • Development of the framework for primary health care nursing report – finalised and published. • Innovative models of primary health care nursing practice funded by the Ministry of Health. • Process established for funding primary health care nurses to access postgraduate education. • First PHOs established and nurses represented in governance positions. • Primary health care leadership structure developed in DHBs and PHOs. • Primary health care education framework established. • Primary health care nursing resources focused on needs analysis as a basis for service planning. • Primary health care workforce analysis and recruitment and retention strategies developed. • Nurse practitioners implemented in primary health care scope of practice.
2003/04	<ul style="list-style-type: none"> • Innovative models of primary health care nursing practice funded by the Ministry of Health. • Beginning evaluation of innovative models of primary health care nursing practice. • Introduction of primary health care nurse practitioners. • Nursing leadership positions in place in DHBs and PHOs. • Primary health care education framework in place.
2004/05	<ul style="list-style-type: none"> • Continue evaluation of innovative models of practice and promulgate successful models to the sector. • Primary health care nurses supported to gain competency-based annual practising certificates. • Evaluation of initial gains to community: community and provider satisfaction surveys. • Primary health care nursing framework fully implemented. • Primary health care nurses have access to appropriate postgraduate education. • Primary health care nurses credentialled and functioning in primary health care nursing teams.

Chapter Two: The Nature of Primary Health Care Nursing in New Zealand

2.1 The vision for primary health care nursing in New Zealand

Vision

To create the environment that enables nurses to provide integrated comprehensive nursing care to individuals and population groups in New Zealand primary health care settings, and that strengthens the primary health care team towards improving health for all.

Primary health care nursing will be crucial to the implementation of the Strategy and will have significant implications for the number, mix, distribution and education of the primary health care workforce (Ministry of Health 2001: 23). The Expert Advisory Group developed the following definition of a primary health care nurse.

Definition of a primary health care nurse

Primary health care nurses are registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first-point-of-contact care and disease management across the lifespan. The setting and the ethnic and cultural grouping of the people determine models of practice. Partnership with people – individuals, whānau, communities and populations – to achieve the shared goal of health for all, is central to primary health care nursing.

The vision is for primary health care nursing to be delivered by registered nurses with knowledge and expertise in primary health care practice.³ This knowledge will be derived from the undergraduate nursing degree (or its equivalent prior to the degree programme) and ongoing education relevant to their scope of practice. The ongoing education may be for specific practice areas (eg, district nursing, practice nursing) or for additional skills (eg, asthma management, immunisation).

³ Some enrolled nurses currently work in primary health care settings, but all references to nurses in this report refer to registered nurses only.

Primary health care nursing will be delivered in a variety of settings in city, urban and rural areas, in partnership with individuals, families/whānau or population groups, and will provide for case-management of individuals across the primary, secondary and tertiary interface.

Primary health care nurses will be directed by evidence-based practice and will assume responsibility and accountability for their own practice. Their education and nursing skill base will support them in making sound clinical decisions, identifying and managing common conditions, and co-ordinating consultation and referrals.

Primary health care nurse practitioners will become leaders in primary health care nursing practice. A proportion of experienced nurses working in primary or community settings will gain clinical master's qualifications, practise as nurse practitioners within this scope of practice (as primary health care nurse practitioners) and have prescribing rights.

Primary health care nursing will be undertaken in collaboration with other health professionals, and/or in multidisciplinary teams. In primary health care organisations, nurses will be included in governance arrangements and influence all decisions affecting their practice. Priority will be given to improving health outcomes and reducing health inequalities according to the Government's health and disability strategies and the identified health needs of the community.

New Zealand can benefit from the international studies on the contribution nursing can make to improving primary health care outcomes and to reducing inequalities for populations. The international experience set out below reinforces points already made in the report.

The Canadian Nurses Association (CNA) defines primary health care as 'essential health care made accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost the community and country can afford ... and as first level health care professionals, nurses provide comprehensive nursing care, and assist individuals to make appropriate use of the services for physicians, other professionals, hospitals and other community resources' (Berland 1992).

The Ontario Ministry of Health expands this CNA definition to include 'not only those services that are provided at first contact between the patient and the health professional but also responsibility for promotion and maintenance of health and for complete and continuous care for the individual including referral when required' (Jones 1980).

The CNA believes that all Canadians should have reasonable access to essential health services with no financial barriers, and that nurses provide more options for accessing health services by:

- acting as an entry point for clients in the health care service
- providing nursing care and treatment for health problems
- helping clients to identify and use health resources, both formal and informal
- acting as a source of health information for clients.

The American Nurses Association (ANA) views primary health care delivery as increasing consumer roles, providing co-ordination and links to other community services, and – in accessible, familiar sites – leads the way to increased early diagnosis, treatment and prevention of more serious illness. The ANA believes that registered nurses are a pool of cost-effective, under-utilised primary health care providers (American Nurses Association 1993).

In the United Kingdom, the National Health Service’s modernisation programme is opening up exciting new roles and new ways of working. The British government is committed to strengthening the role of nurses, midwives and health visitors working in primary care settings, and to showcasing the innovative work being done in primary care practice so that practitioners can initiate new ways of working that meet the needs of local communities (Department of Health [London] 2000).

2.2 The current primary health care nursing workforce

The term ‘primary health care nursing workforce’ covers the collective practice of registered nurses providing care in the community and outside the hospital in a variety of settings, including urban and rural general practice, public health, Plunket, community-based clinics (including marae), and in people’s homes. It includes public health nurses, Plunket nurses, practice nurses, district nurses, rural nurses, nurses providing care to specific groups (eg, respiratory and diabetic patients) and nurses working in Māori and Pacific health provider organisations.

Recently, many nurses have been employed using new titles that more appropriately represent their work in the new health service environment. Many of these practitioners work in relatively narrow scopes of practice, and some clients may be receiving care from more than one practitioner at a time. Other practitioners, such as rural nurses, work in a comprehensive scope of practice that is holistically responsive to health needs in a community in order to achieve integrated health care (Litchfield 2001).

A summary of responses to the discussion document on the Strategy (Ministry of Health 2000: 19) in relation to workforce and training stated:

many of the responses including those from other health professionals highlighted the significant and increased role they saw nurses having in delivering the new strategy. They were seen as having a potentially greater role in the delivery of population based services ... including nutrition advice, a wide range of preventative strategies, sexual health services and home visiting for early intervention, assessment and on-going primary health care.

Nursing Council workforce survey

The Nursing Council does a workforce survey each year, based on a workforce questionnaire that accompanies the annual practising certificate (APC) application form sent by the council to all nurses and midwives on the New Zealand Register or Roll of Nurses. The 2001 workforce survey data provides statistical information about the active⁴ registered nurses, midwives and enrolled nurses working in both the private and public sectors in New Zealand (Nursing Council of New Zealand 2002). As of 31 March 2002 there were 35,100 actively practising registered nurses in New Zealand, of whom 90 percent were female, nearly a third were aged between 40 and 50 years, 76.2 percent were European/Pākehā, 5.9 percent were Māori, and 2.8 percent were Pacific peoples.

The Nursing Council survey collects statistics on employment settings and types of work, although this does not always capture the number and range of nurses working in the community and primary health care. In 2001, 3238 registered nurses or midwives identified as working in primary health care, including practice nursing, including 70.5 percent (2227) practice nurses. Many other nurses may work in primary health care or community settings but are captured in other categories (eg, public health, palliative care, child health or district nursing). To get more detailed information, this project surveyed registered nurses in primary health care and community settings, with the assistance and co-operation of the Nursing Council.

⁴ There are three criteria for a nurse or midwife to be defined as 'active': they must be included in one or more parts of the Register or Roll of Nurses (under the Nurses Act 1977), hold an APC, and be currently working in one or more types of nursing or midwifery in New Zealand (this can be on a part-time or casual basis).

Primary health care and community survey 2001

A survey was developed and sent to 7617⁵ registered nurses whose responses to the 2000 workforce survey indicated that their type of work or employment setting could include primary health care. Completion of the survey was voluntary and 3562 active registered nurses responded (a response rate of 47.9 percent). Survey questions included demographics, work type, employer and place of work, education, ability to access education, organisational nursing leadership and management structures, clinical career pathways and barriers to effective collaboration with other professionals. The survey method is discussed in Appendix 2.

Table 2.1: Work type of active primary health care and community nurses, 2001*

Nursing practice	Responses	Percentage of respondents
Practice nursing	1606	45
Health education and promotion	1016	28
Specialist primary health care or community nursing	965	28
Well child or child health nursing	731	21
District nursing	639	18
Mental health nursing	585	16
Family planning/sexual health nursing	431	12
Public health nursing	361	10
Rural health nursing	274	8
Māori health nursing	259	7
Occupational health nursing	219	6
Pacific health nursing	101	3
Other	321	9

* Note that respondents could indicate more than one work type.

Other results from the survey are summarised below.

- The three main settings of service delivery were in the home, a clinic, or general practice (note that respondents could indicate more than one setting).
- The two main employer groups were general practitioners (32 percent) and DHBs (32 percent).
- The main ethnicity group was European/Pākehā (80.5 percent).
- For Māori, 259 (7 percent) self-identified as Māori nurses; 185 (5 percent) worked for a Māori provider; and 140 nurses worked on a marae.

The NZHIS is analysing the survey results and the Ministry of Health will be publishing these results separately.

⁵ Survey forms that were returned to sender have been excluded from this number.

2.3 Nursing workforce issues

The Strategy acknowledges that the current mix and distribution of the primary health care workforce has been a largely unplanned response to demand and to various incentives and initiatives in the health and disability sector over the years.

Nursing workforce issues of recruitment and retention are of national and international concern. Nursing shortages have an impact on all practice settings, including primary health care. A skilled and educated workforce in primary health care nursing is critical to meet the changing emphasis from treatment-based care to care based on health promotion, preventive strategies, and population health care; and to provide the specialist nursing practice required for the higher level of patient acuity care for patients either discharged early from hospital or with acute or chronic conditions managed in the community.

Māori nurses are under-represented in the workforce in relation to the Māori population. Although Māori health is a key priority of the New Zealand Health Strategy, issues of accessibility, affordability and appropriateness of health services for Māori continue to be of concern. Nursing and nurses must demonstrate leadership in meeting the needs of Māori by developing and working in partnership to deliver appropriate services. This means attracting Māori into the nursing profession and preparing them to work in primary health care settings. Carryer et al (1999) propose that:

primary health care nurses should undergo training to improve their effectiveness when working with Māori. This training should be delivered within a local context and build on the core cultural safety programmes embedded in the undergraduate degree.

The Pacific Health and Disability Action Plan (Ministry of Health 2002c: 7) has Pacific provider development and workforce development as key priorities, in recognition of the paucity of Pacific health and disability professionals in the sector (eg, in 2000, out of 3064 practice nurses only 49 were Pacific).

As DHBs and PHOs develop retention and recruitment strategies for nurses, they need to factor in the needs of nurses in primary health care. Some of these are discussed further in the following chapters.

2.4 Service descriptions of nurses practising in primary health care settings

The Ministry of Health analysed the current contract service specifications under which primary health care nurses work, examining what services were provided, how they were described and funded, and the population group served. Table 2.2 summarises how some of the larger, better-known groups of registered nurses in primary health care settings are funded, and describes the services they provide.

These give the *usual* status of service delivery. There are regional variations, however, particularly in rural areas where district nurses may be employees of independent practitioner associations (IPAs) or general practitioners (GPs), and among iwi or Māori-specific services, where nurses often provide, to a defined population, some or all of the primary health care nursing services described below.

Most services are funded via contracts between the providers and DHBs, provided directly by DHBs, provided by a lead DHB, or partially funded by government subsidy. The number of nurses in each category is derived from the Nursing Council workforce survey 2000 (which has a 96 percent response rate), and reflects the number of actively practising registered nurses but not full-time equivalents (FTEs).

Table 2.2: Service description of nurses practising in primary health care settings

Nursing group	Service description	
District nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>District nursing services are usually provided by the provider arm of DHBs. In some circumstances they may be provided by a community trust, an IPA or a non-government private provider. District nurses undertake a wide range of treatments and services, generally working in people's homes; they often provide the interface between primary and secondary services. As the level of complexity and acuity in the community increases with the trend to home-based care and early discharge, district nurses are providing increasingly complex treatments and care.</p> <p>Home-based services.</p> <p>Generally, providers of district nursing services are paid a fee per visit, to undertake a specific treatment or procedure. District nurses are employees of organisations providing the services.</p> <p>921.</p>
Iwi or Māori primary health care nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>Several different arrangements exist. In general, nurses provide a comprehensive range of services to a defined population, combining some or all of the other nursing roles described here.</p> <p>Community-based services.</p> <p>A mixture of arrangements, but the majority are block payments for services.</p> <p>Not captured by current data collection.</p>

Nursing group	Service description	
Practice nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>Practice nurses work within general practice services, to provide a comprehensive range of primary health care services.</p> <p>Clinic-based services.</p> <p>The practice nurses' subsidy paid to GP employers partially subsidises the wages of practice nurses. The remainder is paid by their GP employers. Nurses who work for capitated practices are usually employed on a salary.</p> <p>3077.</p>
Public health nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>Public health nurses provide Well Child care for school-aged children, working closely with their communities. Primary prevention and health promotion to improve the health of populations are also focuses of their work. Public health nurses also do infectious disease follow-up in some areas.</p> <p>Community-, school- and home-based services.</p> <p>Public health nursing services are provided by the provider arm of the DHB. Public health nurses are employees of DHBs. Services are funded on a block payment for service provided. Public health nurses target low-decile families by providing additional services to schools in highly deprived neighbourhoods.</p> <p>492.</p>
Rural nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>Rural nurses provide a range of diverse services, depending on the needs of the communities they serve and the service environment. The role of the rural nurse is becoming recognised as a specialty area in its own right. Owing to the isolation and broad nature of the role, rural nurses have to respond to needs as they arise and have a broad range of skills.</p> <p>Home-, community-, clinic- or rural hospital-based services.</p> <p>Again, arrangements are diverse. Nurses may have a combination of contracts as they fulfil multiple roles in their communities, or they may be employees of community trusts.</p> <p>Not captured by current data collection.</p>
Sexual and reproductive health/family planning nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>Specialist first-contact sexual and reproductive health services, provided via community- or hospital-based clinics. These services may include sexual health promotion and education to high-needs groups.</p> <p>Community- and hospital-based clinics, schools.</p> <p>Generally nurses are employees of the service provider, who may be funded by a mixture of fee-for-service and block payment. Nurses are usually salaried employees of service providers.</p> <p>Not captured by current data collection.</p>
Well Child/child health nurses	<p><i>What:</i></p> <p><i>Where:</i></p> <p><i>Payment for services:</i></p> <p><i>Number:</i></p>	<p>Nurses provide care to children up to the age of 5 years and their families, under the national Well Child schedule.</p> <p>Home- and clinic-based care.</p> <p>Plunket nurses are employees of Plunket, a national non-government organisation. Services will be provided under the new framework for Well Child services according to volume. Well Child services are also provided by other Māori or community-based providers. Nurses may be employees of providers who are contracted for services. Many Māori nurses who provide Well Child services may also provide other services to the communities.</p> <p>Not captured accurately by current data collection.</p>

Chapter Three: Aligning Nursing Practice with Community Needs

Goal

Funding streams, employment arrangements and service delivery patterns will support nurses to adopt an integrated approach to practice and incorporate population and personal health strategies into service delivery.

Objectives

Nurses will actively work together to integrate their nursing practice according to the identified health needs of individuals and population groups.

Nurses will be fully involved in the development of models of service delivery to determine the most appropriate nursing response to identified population health needs.

Nurses will be fully involved in the development of new employment arrangements to ensure they reflect the individual nurse's ability, safety to practice, and cultural competency.

Professional and employment accountabilities for nurses will be the responsibility of the nursing leaders within the PHO.

A regional integrated primary health care nursing service will work collaboratively with the PHO to achieve health gains for communities.

The service delivery and funding environment will ensure that nurses respond to their obligations under the Treaty of Waitangi to ensure that Māori-specific health needs are met through Māori-specific primary health care nursing initiatives.

The service delivery and funding environment will ensure that nurses respond to their obligations to meet the specific health needs of Pacific peoples through specific primary health care nursing initiatives.

Create the environment for nursing to respond actively to the particular needs of Māori and Pacific peoples within mainstream organisations and Māori and Pacific health organisations.

3.1 Barriers to aligning nursing practice with community needs

Key barriers to aligning nursing practice with community needs include the existing funding, contracting, employment and service delivery models described in the previous chapter. Nursing services may be delivered through national contracts (eg, Plunket), regional contracts (eg, public health nursing, district nursing), or local contracts (eg, practice nurses through the practice nurse subsidy in general practice). Models of nursing practice vary according to the specific needs of populations and the geographical area. Māori and Pacific providers have developed models of primary health care nursing practice over the last decade that reflect community needs. For many primary health care nurses, however, the barriers impede them from practising to their full potential.

Many groups of nurses contribute to improving population health outcomes for communities, and although all these groups play a part in reducing hospital admissions and preventing injury and disease, the health gains achieved are not often attributed to their services. The explicit contribution of nursing is poorly understood and often not captured in information systems. DHBs and PHOs should develop mechanisms and information systems that identify and track the nursing contribution to health gains and meeting health targets.

Fragmentation limits opportunity

The fragmentation of the many roles of primary health care nurses has led to their under-utilisation in many settings. Separate nursing disciplines often work in isolation from each other within specific contractual boundaries, although they may serve the same population groups, individuals, families or communities. This limits opportunities for collaboration or developing the integrated approach to service delivery the Strategy requires. Below are some examples of where the distribution of resources for providing primary health care nursing does not always reflect community health needs.

- The broad role, responsibilities and number of public health nurses have been slowly eroded throughout the last decade.⁶ This is one of the few groups of health professionals who combine personal and population health approaches in their practice. They work across sectors with high-needs families who often ‘fall through the cracks’ of other primary health care services, and also use targeted population health approaches to work with those whose health needs are not or are poorly met.

⁶ Between 1990 and 1995 the number of public health nurses declined from 557 nationally to 482. In 2000 there were 492 active registered nurses working as public health nurses.

- The subsidy for practice nurses has been directed through GPs. The distribution of practice nurses follows that of GPs, and this reflects utilisation of services rather than health needs. Distribution of primary health care services is related to accessibility (Coster and Gribben 1999).
- District nursing services are funded by a fee per visit, thus encouraging episodic care, which is focused on treatment rather than preventive care.

3.2 The primary health care team

As the Strategy is implemented and PHOs increase the preventive and health promotion focus of primary health care services, the traditional role of some nurses will change, with evidence suggesting^{7,8} that they will become increasingly important in the primary health care team. More integrated ways of working require a team approach, with different nursing disciplines and other health care professionals working together towards shared goals.

There is widespread agreement on the characteristics of an effective primary health care nursing team. Fundamental to team success are shared objectives and well-defined roles for team members that are understood and respected by all, as well as a sense of ownership and commitment to team purpose. Regular and effective communication is also required, as is mutual support.

A project team of the UK Department of Health (Department of Health [London] 2000) developed a list of characteristics of effective primary health care integrated teams:

- a high level of participation by team members
- clarity of vision
- mutual understanding of the roles within the team
- the team feels cohesive
- a sense of ownership and belonging among team members
- emphasis is on members' competencies and skills, not on their traditional roles
- flexible working practices
- opportunities for shared learning.

⁷ For example, in the UK, when primary care groups incorporated population health approaches into care delivery, nurses assumed a greater role in preventive and screening activity than other health professionals.

⁸ The number and role of practice nurses in the UK has also greatly expanded as a result.

Similar requirements are cited by Baileff (2000), Black and Hagel (1996), Ross et al (2000), Gerrish (1999), Heath (1994), and Firth-Cozens (1998).

Despite only a short history of evaluation, there is also agreement on the difficulties facing teamwork in a primary health care setting (Gerrish 1999: 368). Baileff (2000) says that one of the key criticisms levelled at community nursing teams is that the nursing disciplines tend to work in isolation. There is seldom any structured framework for communication between disciplines: members are not clear about one another's roles, resulting in duplication of services and a lack of interim referrals, and when the same service is offered by different disciplines there are no agreed standards to ensure quality and continuity of care. Conversely, teams that have overcome these problems and have an established framework for effective teamwork benefit from a shared philosophy and objectives. They are more likely to be creative and innovative in finding solutions to problems, and to use the skills of the team members appropriately.

Nurses benefit from integrated ways of working. Carnwell and MacFarlane (1999) identify the gains as empowerment, development of new skills, reclaiming skills, personal development, increased confidence, closer working relationships, and support.

The Strategy provides opportunities for nurse practitioners to practise as part of a primary health care team, to lead 'specialty-focused' clinics in community settings, or to establish independent primary health care nursing practices offering a range of assessment, diagnostic, treatment and support services.

In areas with a high Māori population, as in any community, primary health care nursing teams would respect the principles of the Treaty of Waitangi and work in partnership with Māori communities to ensure that culturally competent services are being delivered appropriately. Where Māori nurses are part of a primary health care team, or the team is collaborating with Māori providers, appropriate consultation and shared goals are important to improve health at the level of the individual, whānau, hapū and iwi (Carryer et al 1999).

3.3 Collaboration with other health professionals

The nature of collaboration with other health professionals will vary. Whatever the arrangements, responsibility for care is ongoing, and may be shared or sit with one practitioner. If shared, this means equality in making decisions about the needs and problems of patients, and equity in distribution of rewards. The American Medical Association believes nurse-physician relationships should be founded on 'mutual respect, collaboration and co-operation' (Formica 1994).

Nursing practice is based on collaboration, which has been defined for nurse practitioners as ‘interprofessional relationships between the nurse practitioner and other health team members based on:

- concern for mutual goals
- equality in such dimensions as status, power, prestige and access to information
- diversity in expertise, skills, knowledge and practice.

This translates into a practice environment where joint decision-making occurs, with the overriding goal of better health care uniting the professions, rather than controlling each other’s practice’ (Hughes, in press).

Nurses and other health professionals centre care on patients, with problems of patient care providing the impetus for professional interaction. Collaboration produces action that results in the attainment of mutual goals for the patient’s needs. By definition, it excludes unilateral, isolated or independent actions by professionals as a general style.

The nurse practitioner role is focused on patient and population needs and improving health outcomes. While internationally there has been debate among health professionals about the nurse practitioner role, evidence shows that discord among health professionals about the introduction of the nurse practitioner is not in the best interests of the patient. While a nurse or a physician may at times act individually, the two are in joint practice if they have a mutual concern for patients and families, and have acted on this concern to produce a concerted, synchronised effort. Collaboration eliminates duplication of effort, unnecessary conflict and energy-depleting discord (Smoyak 1977).

3.4 The way forward

The broad vision for primary health care in the Strategy provides opportunities for new collaborative and multidisciplinary approaches to providing services:

- between primary and secondary health services (eg, to best manage people with chronic conditions such as diabetes)
- between primary and public health services to improve, promote and protect population health (eg, immunisation strategies, health promotion programmes)
- between primary and disability support services (eg, to ensure barriers to accessing primary health care services are minimised for people experiencing disabilities)

- between primary and mental health services (eg, to respond effectively to most mental health problems that can be managed in primary health care settings)
- for specific population groups (eg, older people who have changing health needs over time and may require a range of care and services from different providers).

Integral to the delivery of all these services is the professional practice and expertise of primary health care nurses working together and in collaboration with other health professionals, community workers and others.

To achieve the goal of a better co-ordinated and integrated primary health care nursing service that is an integral part of the primary health care services for the region, the way in which services are funded, managed and linked to one another needs to be co-ordinated and overseen at DHB level. If a 'big picture' strategic view of the wider primary health care service environment is not taken as PHOs develop, there is a risk of further fragmentation, duplication or isolation of services. This goal can be reached through the development of strong collaborative arrangements, or direct employment of a wider range of nurses by the PHO.

Commitment is needed from employers, nurses and other professional groups to ensure that old demarcations between them are gradually broken down and more integrated ways of working together are developed. Services should be based on community health needs rather than the needs of providers, and make best use of the skills of all practitioners in primary health care settings.

Chapter Four: Developing Innovative Models of Nursing Practice

Goal

New and innovative models of primary health care nursing practice that improve access to primary health care services, and contribute to improved health outcomes and reduced health inequalities for individuals, families/whānau and communities/iwi.

Objectives

Primary health care nurses will work together to develop new integrated ways of working to deliver on the objectives of the Strategy.

Primary health care nurses will work in collaboration with other health professionals in primary health care teams to offer access to comprehensive services that improve, maintain and restore people's health.

Innovative models of nursing practice will be established nationwide and evaluated to provide examples of best practice to the wider sector.

New models of nursing practice will build on recent gains in Māori health care delivery and be developed in partnership and participation with Māori and Māori communities/iwi.

4.1 Overview of current models of nursing practice

The Strategy sets the scene for new ways of delivering nursing services that build on existing models. Although PHOs will not be responsible for providing all health services, they will co-ordinate care for their enrolled populations. As the central point of contact for both community and secondary care providers, PHOs will be responsible for the information about their enrolled populations and for linking them to appropriate service providers.

Historically, many differing models of nursing practice have evolved in New Zealand. These have been important to meeting the health and community needs of the time. In recent years, however, the contract culture of the health system has arguably altered many of these services so that instead of meeting community health needs, the market model has driven them. The result has been increasing specificity and specialisation in many community nursing roles. Although this allows one type of nursing expertise to be developed, it can also reduce the strength and usefulness of generalist nursing practice. The outcomes are that some clients are required to access multiple services, and more generalist skills are under-utilised or lost as nursing practice becomes increasingly specialised.

Primary health care nursing practice spans the entire continuum, from first-level services for certain conditions to participating in communities on population health strategies. All primary health care nurses require generalist core competencies as the basis for their practice, and the opportunity to develop specialist competencies according to their scope of practice (see Chapter Six).

4.2 Evidence for new ways of delivering nursing care

For nursing teams to become successful units, several areas need to be addressed, including employment arrangements and accountabilities.

Some UK studies identify different employment arrangements for different members of integrated nursing teams as being a difficulty: when different employers and different members of the team have different pay and conditions it can be a stumbling block to integration (Black and Hagel 1996; Forrester and Kline 1997). One study recommended that individual contracts be used when nurses assume new roles, as these will provide clarity regarding boundaries with other health professionals, and security to avoid exploitation and overlap (Williams and Sibbald 1999).

The literature is clear that muddled lines of accountability create problems (Black and Hagel 1996), and that all accountabilities must be discussed and clarified at each stage of the team development (Forrester and Kline 1997). From the perspective of a New Zealand rural practitioner, Ross (2000: 21) wrote:

Accountability is an integral part of being professional and accepting responsibility. As the roles of nurses develop further, the profession should be aware of the boundaries of practice – they should choose whether or not they will provide advanced practice. They should not be pressured to work beyond their competence and confidence. They need to understand that they are ultimately responsible for the consequences of their actions just as all registered practitioners are accountable for their own practice and liability which cannot be shared or handed onto someone else.

4.3 Approaches to models of nursing practice

Models of primary health care nursing practice can take either a settings or a specialist approach.

Settings approach to primary health care nursing practice

A settings approach means that primary health care nursing practice is generalist, with comprehensive care provided to all people of all ages across the life-span, disease categories or levels of need. The scope of practice is broad and the setting of care delivery may vary.

In some areas – in particular, rural areas and Māori and Pacific health services – nurses are providing comprehensive generalist care to a defined population as the primary health provider in collaboration with others. This model has developed in the absence of other appropriate health professionals or providers.

The example below outlines a settings approach to nursing practice in a primary health care setting – a mobile Māori primary health care nursing service.

Mobile Māori primary health care nursing service

This service utilises the expertise of a generic nurse, integrating aspects of the roles of public health nurse, district nurse, practice nurse and Plunket nurse. These nurses provide generalist care to a defined population, linking and referring to other services as necessary to ensure that fully comprehensive care is provided.

The Māori primary health care nursing service focuses on health promotion, disease prevention and disease management across the life-span. A significant focus of activity by these nurses has been on the eight Māori health gain priority areas identified by the former Health Funding Authority: mental health, oral health, diabetes, asthma, hearing, immunisation, smoking and injury. As well as health promotion, disease prevention and disease management, the nurses:

- do comprehensive health assessments
- plan health care interventions
- provide disease management
- make referrals as necessary.

There is a strong emphasis on information-sharing and health education with clients, and on self-management rather than creating dependency on the nursing service. The primary health care service delivered by these nurses is unique in that they not only are skilled nursing practitioners but also bring knowledge of Māori tikanga and often te reo as well. The services are mobile, and are largely delivered in the patient's own home, school, marae or other community facility, although clinic-based services are also provided. The nurses work as a member of a multidisciplinary team, alongside kaumatua and kuia, community health workers, medical practitioners, mental health workers and disability support personnel.⁹

Specialty approach to primary health care nursing practice

In a specialty approach, the nursing practice is specified and/or specialised, caring for particular population groups or specific conditions or disease states. These nurses have developed expertise and competence in defined scopes of practice, and often complex chronic conditions can be managed in the community as a result. These services also focus on early detection and intervention, and thereby increase the client's ability to self-manage chronic illness and prevent avoidable admissions to hospital.

For example, sexual and reproductive health nurse specialists offer comprehensive sexual health screening, management and education (including contraceptive services) in special-purpose youth health services. These services are similar to those already operating in 'one-stop-shops' such as Centre 198 in Christchurch and CAFE Youth Health in Taupo. Nurse practitioners will be well placed to offer such services in the future. The example below outlines a specialty practice in a primary health care setting – the diabetes nurse specialist.

⁹ Liane Penney, Clinical Manager, Te Tai Tokerau Māori Purchasing Organisation (MAPO).

The diabetes nurse specialist

While working within a multidisciplinary and collaborative framework, the diabetes nurse specialist has an active role in providing health care, health teaching, follow-up care and referral as necessary to people with diabetes, their family/whānau and other health professionals. The role is clinically focused on actual or potential health problems. Some of the key roles in the practice of a diabetes nurse specialist are:

- **diabetes education** to the person with diabetes, their family/whānau and other health professionals in both primary and secondary care. Attention is paid to the cultural, social and behavioural influences on a person's life
- **clinical management**, such as advice on appropriate diabetes medications. A case example is a man referred to a nurse specialist with Type 2 diabetes who had had repeated invasive investigations for chronic diarrhoea with no diagnosis over the previous two years. As one of his diabetes medications is well known to cause this side effect, advice was given to withhold this medication for one week. His symptoms disappeared and he had no further problems with diarrhoea. Alternative diabetes medications were arranged
- **crisis intervention** (eg, for those acutely unwell owing to their diabetes, to avoid hospital admission as appropriate)
- **consultancy role** to health professionals across the primary and secondary care continuum
- **research**, both nursing research and clinical trials, to ensure that nursing practice is evidence-based and to extend nursing knowledge, thus contributing to diabetes knowledge itself
- **leading and/or contributing to national professional nursing** initiatives in both the specialty of diabetes and the wider nursing profession.

All these activities directly and positively influence patient outcomes in improved quality of life, reduced hospital admissions and reduced risk of complications.¹⁰

¹⁰ Helen Snell, clinical nurse specialist – diabetes (accredited diabetes nurse specialist, NZNO).

4.4 New government funding for innovative models of nursing practice

The Government has committed substantial new funding to support implementation of the Strategy. A significant proportion of this funding is to support the development of new and innovative models of primary health care nursing practice. This acknowledges the value the Government places on the role of primary health care nurses in implementing the Strategy, and its confidence that they will make a difference. This funding is a significant investment for nursing and will facilitate the transition of this framework to the PHO environment.¹¹

The funding will be used to contract up to 10 innovative models of practice nationwide, spread over two three-year periods, for supporting nurses currently practising in primary health care to access postgraduate nursing education and for evaluating the models. The Ministry will manage contractual arrangements. All applications will come through DHBs via a two-stage process involving initial registration of interest (ROI), followed by detailed proposals from successful ROIs. The changes to nursing service delivery or practice supported by this innovations funding must be sustainable beyond the three-year period.

4.5 The way forward

The implementation and evaluation of innovative models of primary health care practice throughout New Zealand will provide evidence for more effective ways of delivering services. The lessons learnt will inform future PHO development and provide leadership to support further developments in the sector.

PHOs will be funded according to the populations they serve via a population-based funding formula. This will help to reduce inequalities by directing resources to communities of greatest health need. The Strategy (p.14) states that ‘when funds are not tied to particular numbers of services or types of practitioners, there are no barriers to using the most appropriate health practitioner in each situation’.

This creates opportunities to fund the primary health care nursing workforce in different ways. The challenge for DHBs and PHOs is to review current employment arrangements for primary health care nurses and to establish funding mechanisms to ensure an integrated and innovative nursing service. PHOs also need to develop the infrastructure for nurses to manage and co-ordinate a range of primary health care nursing services. These could also include nurse-led clinics, or contracting nurse practitioners.

¹¹ Primary Health Care Nursing Innovations Funding is part of the Primary Health Care Funding Package for implementation of the Strategy announced by the Minister of Health in June 2002.

Chapter Five: Governance and Leadership

5.1 Governance issues for primary health care nurses

Goal

Primary health care nurses will be equal partners alongside other professional groups and community representatives in the governance of primary health care organisations.

Objectives

Primary health care nurses will be represented in governance positions in proportion to their presence within organisations and be adequately prepared and supported for governance roles.

Primary health care nurses will have significant input into and influence on decisions relevant to their practice.

Primary health care nurses will have the authority and accountability to ensure that PHOs are delivering and co-ordinating appropriate primary health services to their enrolled individuals, families, whānau and communities.

Effective nursing governance and leadership are particularly relevant in a changing primary health care sector in order to develop the role of nurses and ensure that the nursing contribution to improving health outcomes and reducing inequalities in health status is in line with international best practice. Many nurses contribute significantly to population health objectives (eg, immunisation rates, smoking cessation programmes) but have not been party to decisions that define what their contribution should be, or decisions about the distribution of resources and benefits accrued from meeting targets.

Governance in health care is one way a philosophy of care can be made operational in practice settings. It is a process whereby stakeholders may influence decision-making and partake collectively in the steering of an organisation. For groups of health professionals, governance is influential in assuring accountability for standards of practice, quality of care and the introduction of evidence-based research into practice through clinical governance (Rafferty et al 2001).

Various models of governance currently exist in primary care organisations, many of which are likely to become PHOs as the Strategy is progressively implemented. These organisations will have to adapt their governance structures and processes to meet the minimum requirements that state that PHOs ‘must demonstrate that all providers and practitioners can influence decision-making and that the community must be involved in governing processes’.

In many existing organisations that are likely to become PHOs, representation at governance level is predominantly by GPs (CLANZ 2001). Although many such organisations are building multidisciplinary relationships, and some have appointed nurses to board positions, this has been relatively recent. Nurses are still poorly represented in these roles relative to their numbers within such organisations.

For New Zealand, this has meant that other professionals who have limited knowledge by which to assess effective and safe nursing practice often oversee nurses’ professional practice. This has left many registered nurses in primary health care settings isolated from other extensive developments in the discipline (Ministerial Taskforce on Nursing 1998).

Under-representation of Māori and Pacific nurses in the sector highlights the importance of developing capacity for these nurses and their need to be actively involved in the management and decision-making at governance level. This is particularly relevant for PHOs when establishing themselves in areas with high Māori and/or Pacific population groups. For Māori, it is essential that the recent gains in Māori health care provision are not lost. For Pacific communities, further building of Pacific capacity is central to improving health outcomes for Pacific peoples. Building a more balanced and representative primary health care nursing workforce will increase access for these groups and help to reduce identified health inequalities.

In organisations where community governance prevails and no one professional group dominates, the employment arrangements and roles of staff are quite different (Crampton 1999). Job and service descriptions for nurses are more likely to reflect the health needs of the population served instead of being bounded by historical funding and employment arrangements. One such model is community owned health services (such as the Newtown Union Health Services) where nurses are integral to the governance arrangements and practice as part of the multidisciplinary team (Regan 1991). This is a form of governance that many Māori and Pacific providers use.

The literature shows that as nursing and other professional disciplines developed over time, boundary issues have developed (Hughes, in press). Birenbaum (1990) describes how ‘any role expansion will inevitably cause conflict if it is perceived as threatening to another profession’s traditional tasks and prerogatives’. Nurses have a unique perspective, a community-centred approach, an integral knowledge of the communities and families with whom they work and a philosophical approach in line with the concepts of primary health care. For example, a British study compared the priorities of a sample of nursing and medical board members of primary care groups. The authors found large differences between the views of GPs and those of their

nursing colleagues on priorities of work. In summary, nursing board members were more concerned about improving health generally, and medical board members about commissioning of services (Lucas and Bickler 2000).

Effective governance and leadership of nursing in primary health care requires nurses to participate in decision-making at all levels of the health and disability sector, from policy and strategy development and funding issues through to service management and delivery. Nurses need to have skills in these areas and the ability to represent wider interests at governance level to reflect professional nursing interests within organisations.

5.2 Leadership issues for primary health care nurses

Goal

Primary health care nurses will have clear, accessible, integrated nursing leadership to encourage and promote change and facilitate the development of new roles and models of practice.

Objectives

The development of nursing leadership structures within the primary health care nursing workforce will:

- develop formal and integrated networks at national, regional and local levels to ensure nursing collaborative practice across all speciality areas, including the primary/secondary/tertiary interface
- have accountability for co-ordinating and developing an integrated nursing service that allocates relevant nursing speciality skills resources to health needs at the regional level
- be involved in the development of new roles and responsibilities for nurses and new service delivery patterns to improve access and address inequalities in health.

With the increasing emphasis on the primary health care sector to improve health status and reduce health inequalities, nursing leadership is crucial. International evidence demonstrates that where nurses have strong leadership in the health sector, patient outcomes are improved (Shamian and Gerlach 1997).

As the literature review identified, effective leadership is one of the critical success factors in developing teamwork and integrated working, supporting changing practice roles, promoting quality of care and overseeing change management. Professionally led development in the health sector is much more likely to succeed than a bureaucratically imposed framework from above (Majeed and Malcolm 1999).

Leadership for Māori and Pacific nurses needs particular support and active development to increase capacity to deal with the specific health needs of their people and communities.

Nursing leadership in the primary health care sector

Submissions to the Ministerial Taskforce on Nursing indicated that there are significant gaps in nursing leadership in general, but that these gaps are particularly apparent in primary health care settings. In most instances nurses were not in a position to influence or determine the nature of the service they provided, or to be held accountable for the outcomes of that service (Ministerial Taskforce on Nursing 1998: 69).

In recent years the paucity of nursing input into the organisation and planning of services and allocation of resources has meant there has been little scope to support the development of nursing practice through effective leadership. Frequent restructuring and changes in the health sector have interrupted succession planning. As a result, many nurses have had limited opportunities to develop leadership and management skills. The lack of a defined career pathway has meant that nurses who may have the required attributes often leave clinical nursing roles or the profession in pursuit of other career options (Miles 1996).

Carryer (2001) states that ‘the lack of visible leadership structure for nurses in community settings makes it difficult for intending practitioners to make the transition to community practice’.

Nurse practitioners in primary health care will be key leaders of the future. The introduction of the role of the primary health care nurse practitioner is a fundamental opportunity to showcase their expert scope of practice and leadership qualities, and to be inspirational role-models for primary health care nurses. Although full implementation of the nurse practitioner model in New Zealand may take over a decade (Nursing Council 2001b) during the transition phase the Nursing Council will consider applications from practising registered nurses who have significant clinical expertise in the relevant scope of practice and a clinically focused master’s degree or equivalent. This offers an opportunity for experienced nurses to take up this challenge, and for DHBs and PHOs to support them to do so.

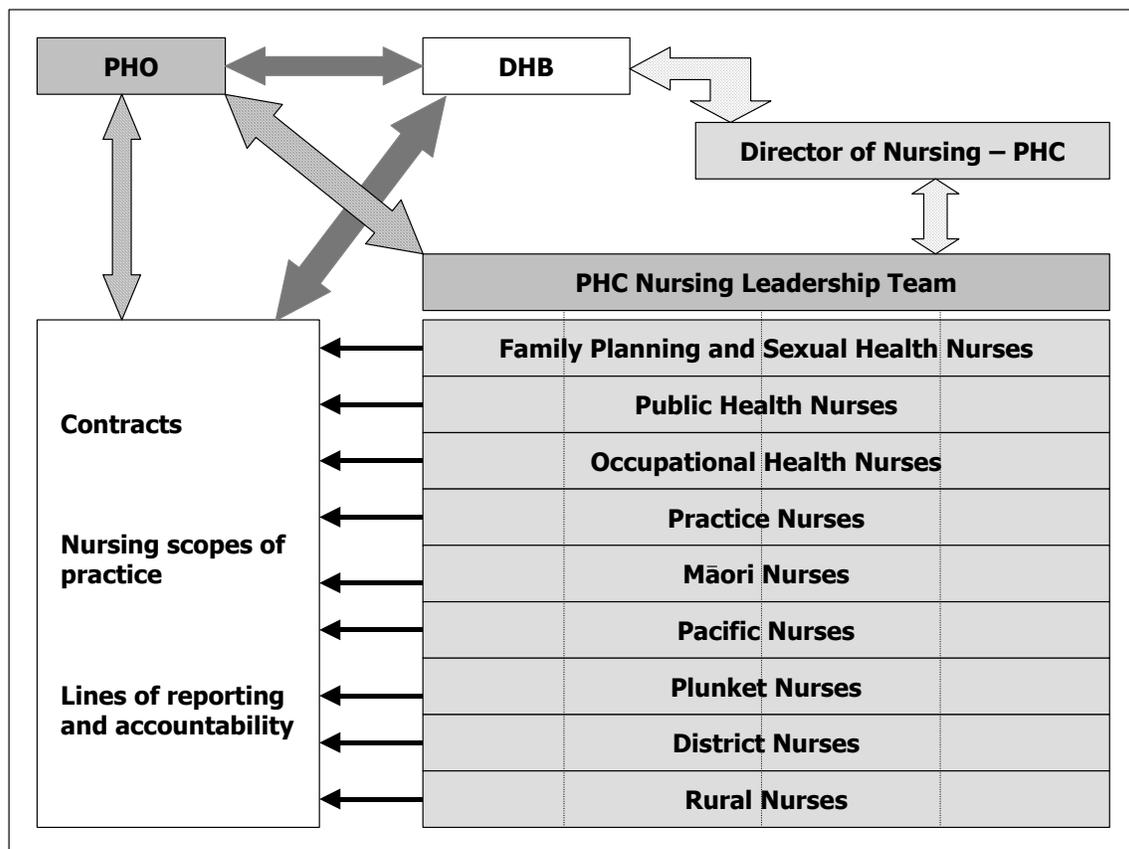
5.3 The way forward

The organisational changes that will result as the Strategy is implemented will require effective leadership. Anecdotal evidence suggests that many expert nurses working in primary health care settings have the knowledge, clinical expertise and education to undertake leadership roles. The opportunity also now exists for the expert role of nurse practitioner in the scope of primary health care.

The Strategy provides opportunities for these nurses to demonstrate leadership and guide the transition to new ways of working across traditional nursing disciplines and boundaries. Effective nursing leadership will draw the fragmented primary health care nursing sector together to form a more cohesive workforce to better align with PHOs and deliver on the objectives of government strategies.

Figure 5.1 shows the primary health care nursing leadership model developed by the Expert Advisory Group. The proposed key functions of nursing leaders are described below Figure 5.1.

Figure 5.1: Primary health care nursing leadership model



Director of Nursing – Primary Health Care

A Director of Primary Health Care Nursing would work strategically with nursing leadership to facilitate workforce planning and co-ordinate regional primary health care nursing services. Proposed key functions are:

- provide professional nursing leadership and direction in primary health care nursing services
- contribute as a member of a DHB executive team to advice on strategic and operational management of primary health care nursing
- align PHO development with PHO nursing leadership teams to oversee the development of primary health care nursing services.

Primary health care leadership team

A primary health care leadership team would work strategically with the DHB Director of Primary Health Care Nursing to align PHO development with the appropriate delivery of primary health care nursing services. Proposed key functions are:

- develop primary health care nursing services so they align with strategic directions of the DHB
- develop collaborative and integrated relationships between the regional/local primary health care nursing services
- provide clinical leadership and professional development
- oversee the linking of professional accountability and employment arrangements for primary health care nurses.

Chapter Six: Education and Career Development

Goal

Postgraduate education will support all levels of primary health care practice and be recognised in a national standardised career pathway for primary health care nurses.

Objectives

Postgraduate education programmes (including Entry, Specialty, Advanced and Nurse Practitioner) for primary health care nursing practice will be developed in line with the Nursing Council framework.

A national standardised career pathway will be developed for primary health care nurses.

6.1 Barriers to accessing postgraduate education

One of the major difficulties created by the current diverse roles and titles of nurses in primary health care is the lack of a unifying focus for post-graduate education in this context (College of Nurses Aotearoa (NZ) 2001).

Several key barriers make it difficult for nurses working in primary health care to access appropriate postgraduate education. These barriers need to be addressed in this framework. They include:

- the lack of any nationally approved (by the Nursing Council of New Zealand) postgraduate nursing education programmes dedicated to primary health care nursing
- limited access to government-funded post-entry clinical training programmes (eg, access to Clinical Training Agency (CTA) courses relevant to primary health care)
- the requirements for clinical replacement time and transport and accommodation costs for nurses to attend educational programmes (greater for nurses working in community and (especially) rural settings)
- the lack of organisational infrastructure to support developing primary health care nurse practitioners

- limited support and opportunities for nurses to transition to primary health care practice including for:
 - new graduates to enter directly into primary health care through supported programmes in the first year of clinical practice
 - experienced nurses practising in secondary or tertiary health settings to transition to primary health care practice
 - Māori and Pacific graduate nurses, who often prefer to work within their own communities in primary health care settings.

Specific barriers for Māori nurses

Specific barriers for Māori nurses accessing postgraduate education have been identified in a strategic plan for post-entry clinical training for Māori (Lawson-Te Aho 1997). This plan concluded that Māori nurses preferred primary health care practice over hospital-based practice and were not engaging in post-entry clinical education due to financial and information barriers.

6.2 Pathway to postgraduate education

The Nursing Council of New Zealand framework for post-registration nursing practice (Nursing Council 2001a) establishes a national direction for formal development and recognition of post-registration nursing practice education. The framework outlines a pathway of educational preparation for registered nurses, extending from the first year of practice through to advanced nursing practice and culminating in the nurse practitioner role. The Nursing Council standards provide the basis for assessing, approving and monitoring clinically focused programmes within the framework. The majority of primary health care nurses practise between specialty and advanced level.

The proposed Health Professionals' Competency Assurance Bill will require nurses to document their practice as registered nurses, including self-assessment and evidence of ongoing education, in a personal professional profile, which will be subject to random audit. Included in the guidelines is a requirement to undertake a return to practice programme, approved by the Nursing Council, when there has been a break of five years or more in professional practice.

6.3 A framework for primary health care nursing postgraduate education

Although nurses working in community and primary health care settings practise in different settings and scopes of practice, there is a core body of knowledge related to primary health care nursing. A cohesive framework for primary health care postgraduate nursing education, based on Nursing Council competencies for practice, needs to be developed.

The development of postgraduate nursing education over the years has generally been in response to local demand. This has led to ad hoc and inconsistent programme development. Other factors – such as limited nursing leadership and capacity, and barriers to accessing education – continue to impact on both increasing the primary health care workforce and improving its capacity and skill base. While many nurses have vigorously pursued the education or professional development opportunities available, others have practised for long periods with no access to these. This not only limits the opportunity to improve nursing practice, but also reduces the confidence of many experienced practitioners to take on extended or more challenging roles.

Since 1997 nurses have been educated through undergraduate programmes leading to a baccalaureate degree. Such programmes comprise both academic and clinical components. While most include a focus on community nursing and wellness, the opportunity for student nurses to gain experience in primary health care nursing during their undergraduate programme is limited by the clinical placements available. During these placements, students can often be only observers while the registered nurse interacts with the client. Many nurses and employers are still of the opinion that new graduates require hospital consolidation of practice prior to working in the community and primary health care settings, although there is no real evidence to support this assertion.

Orientation to community practice is varied and includes short, self-paced orientation that is frequently ad hoc and informal. In many cases it is expected that the newly employed nurse can learn a wide range of skills on the job – often with little support or mentoring. Each employing agency has a different expectation of and role in the education of the new practitioner. Programmes range from self-paced learning packages to full-year diploma programmes. Many mature student nurses, often of Māori or Pacific ethnicity, now come into the profession to serve their people in their own communities.

To support entry and specialty programmes, adequate funding to ensure relevant skilled staff can act as preceptors in each practice area will be required. Following these programmes and a period of consolidated practice, nurses could undertake advanced nursing programmes and nurse practitioner programmes in a natural progression as their experience and scope of practice develop.

The Nursing Council's minimum requirements for approval as a nurse practitioner are a clinically focused master's degree or equivalent, and four to five years' experience in the relevant scope of practice. In addition, satisfactory completion of an approved pharmacology course will be mandatory for nurse practitioners seeking prescribing rights.

Each step of competency development will be linked to the career pathway, to provide an incentive for nurses to complete education programmes and to develop advanced competencies. These competencies would include research, leadership and governance roles.

6.4 What programmes are available?

The CTA-funded programmes are clinically focused and cater for nurses employed in primary health care settings. Programmes currently funded by the CTA need to meet set specifications that are linked to government priorities. Relevant programmes to date include advanced programmes in child and family nursing and some components of mental health nursing programmes (ie, community mental health at new entry and advanced competency levels). However, these programmes are very limited in availability and access throughout the country.

Programmes funded by the Ministry of Education are provided and funded on an equivalent full-time students (EFTS) based system by any accredited education institution or private training establishment (PTE), provided the accreditation criteria are met. As the criteria include a clinical component of less than 30 percent, these programmes are more academically than competency focused, and their development and sustainability are driven by demand. Students pay fees for which they can take out student loans, although part-time nursing students are not usually eligible for loans and allowances, and most students are only partially supported financially by their employers. Many nurses undertake these programmes at undergraduate (registered nurse to Bachelor of Nursing), master's and PhD levels, self-funded and in their own time. Most programmes include reflection on practice and self-development in the area of clinical practice, but are not specific to primary health care nursing.

6.5 The way forward

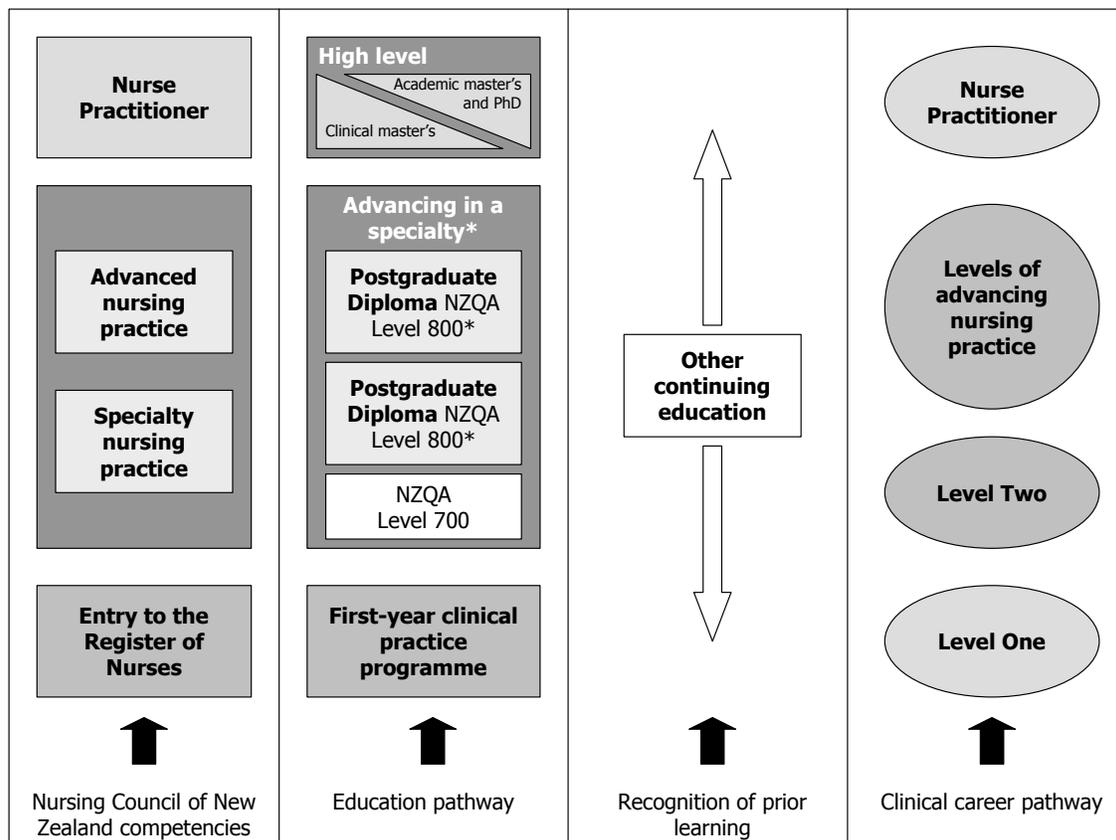
Further work is required to define the key elements of primary health care nursing practice and education that will form a common core of knowledge for all primary health care nurses. A well-developed postgraduate clinical education programme will then build on this with evidence-based best practice. Primary health care nurses could then select optional papers related to their specialty (eg, child and family health, mental health, elderly care, Māori health, chronic disease management).

The introduction of nurse practitioners to New Zealand provides a new career option for nurses in primary health care and provides leadership for other nurses to follow.

There is also the opportunity for a multidisciplinary approach to postgraduate education relevant to primary health care settings. Some New Zealand universities offer multidisciplinary programmes to registered health professionals in specialty practice areas. For example, the University of Otago offers a multidisciplinary Postgraduate Certificate and Diploma in Health Sciences (covering rural health, primary care and public health), and Auckland University offers multidisciplinary postgraduate courses in gerontology, rehabilitation and social care. This increasing trend should encourage nurses and medical professionals to develop strong collaborative approaches to primary health care delivery.

Figure 6.1 presents the model of an education and career pathway in primary health care nursing proposed by the Expert Advisory Group.

Figure 6.1: Proposed education and career pathway model



* Some nurses may choose to complete Level 700 programmes or go straight to postgraduate certificate, diploma or master's programmes. It is anticipated that 700-level programmes will be transitional only, as an increasing proportion of the profession are already prepared at this level.

Conclusion

Repositioning the primary health care nursing workforce to meet the objectives of the Strategy will take time, energy and commitment from the nursing sector. It will also require working closely with other health professionals, the community and the sector to get it right. This will involve a culture change, as nursing services integrate to co-ordinate patient care across service areas, and have a greater emphasis on population health. There will of necessity be a transition time to establish and move nursing delivery models forward in line with best practice and available evidence.

The principles of implementing the Strategy must underpin these changes to ensure a stable and constructive transition. These principles are:

- protect the gains
- work with providers and communities
- stepwise evolution.

Different ways of working will evolve as new funding mechanisms influence health service delivery models. Collaboration between health professionals will be crucial to the success of primary health care teams. Evidence of improved population health outcomes and reducing health inequalities will be critical success factors.

This framework is proposed as the central focus for developing a more cohesive and integrated primary health care nursing workforce that delivers the right services to the right people at the right time.

Nurses are at the centre of this framework. They need to continue their ongoing commitment to their patient and client groups, extend their expert practice that makes a difference to others every day, enhance their clinical expertise, take opportunities to advance their own education, share their experiences and knowledge of how communities work, and, above all, work collaboratively with one other and with other health professionals to provide the best primary health care to all New Zealanders.

Appendix 1: Development of a Framework for Primary Health Care Nursing – Expert Advisory Group

Terms of Reference

This Terms of Reference sets out the objectives for developing a national framework for primary health care nursing in New Zealand.

Background

The Primary Health Care Strategy released in February 2001 recommends the Ministry of Health:

- facilitate the development of a national approach to primary health care nursing that will address capabilities, responsibilities and areas of professional practice
- set educational and career frameworks and explore suitable employment arrangements.

There is currently an uneven distribution of primary health care providers, and primary health care nursing services are fragmented, delivered without national consistency, and not aligned to meeting the needs of communities. Current models of primary health care nursing do not facilitate the most effective delivery of primary health care nursing services.

The opportunity now exists to develop models to align the primary health care nursing workforce to improve the health of populations and communities. A clear nursing service structure at PHO level which includes integration of nursing activities within this structure is needed.

Objectives

The objectives of the Expert Advisory Group are to:

- 1 review draft criteria for primary health organisations
- 2 review current arrangements for the delivery of primary health care nursing services in New Zealand
- 3 review the current employment arrangements for primary health care nurses
- 4 provide advice on future employment arrangements for primary health care nurses.

Objectives (updated October 2001)

The objectives of the expert advisory group are to:

- 1 review the minimum criteria and best practice guidelines for PHOs
- 2 provide direction and sign-off on components which facilitate the development of a national approach to primary health care nursing
- 3 provide nursing direction to the Ministry of Health and District Health Boards (DHBs) on any proposed primary health care development in order to ensure a national approach to primary health care
- 4 review current models of primary health care nursing practice in order to develop suitable models for implementation of primary health care nursing
- 5 review and provide direction on future funding and employment arrangements for primary health care nursing
- 6 provide nursing leadership and direction in order to inform nursing, PHOs, DHBs, and the Ministry of Health on future nursing development
- 7 provide direction on career and educational frameworks to ensure national consistency and implementation of the primary health care nursing requirements
- 8 provide direction on information systems and information management requirements for primary health care nursing.

Expert Advisory Group composition

The Expert Advisory Group consists of people who have been appointed for their knowledge and expertise in matters regarding primary health care, and their understanding of the sector. Members of the Group will not be representing specific organisations or groups. The Expert Advisory Group will include officials from the Ministry of Health as appropriate.

Note: Members of the Expert Advisory Group are listed at the front of this report on page 4.

Appendix 2: Method

The overall aim of data collection and preparatory analysis was to develop a coherent picture of the practice environment for primary health care nurses and to identify barriers to nurses' meeting the objectives of the Strategy. Key themes were identified through this process and, with guidance from the advisory group, the components of the framework were identified and developed. The primary methods of data collection are detailed below.

Literature review

New Zealand Health Technology Assessments (NZHTA) undertook a comprehensive literature search on primary health care nursing, both in New Zealand and internationally, answering the following key questions:

What value can the development of integrated primary health care nursing teams add, in terms of improved health outcomes for individuals, communities and populations? What are the key components that should be considered in developing a framework for primary health care nursing? The latter included the following aspects:

- how a nursing team relates to the wider primary health care team
- funding arrangements and accountabilities
- leadership and input into planning of service delivery
- incentives to encourage collaboration
- relationship with other professionals and members of the team
- organisational structures and systems
- education and career pathway or professional development needs for primary health care nurses
- the role of advanced nurses/nurse practitioners in a primary health care team
- doctor/nurse substitution, cost effectiveness and health outcomes
- disease state management models: what role do nurses play in improving health outcomes for individuals with chronic diseases?

Primary Health Care and Community Nursing Workforce in New Zealand: 2001 Survey

In July 2001, the Ministry of Health commissioned the New Zealand Health Information Service (NZHIS) to do a survey into registered nurses working in primary health care and community nursing.

The objective of the Primary Health Care and Community Nursing 2001 Survey was to gather feedback from registered nurses about their education opportunities and career pathways, the barriers that exist for them to achieve effective collaboration with other primary health care and community nursing services, as well as demographic and geographic variables.

The NZHIS is analysing the survey results and will produce a full report. There was a 47.9 percent response rate for the questionnaire.

Contract analysis

In addition to the survey of nurses, current contract service specifications under which primary health care nurses work were analysed, examining what services were provided, how they were funded, how the services were described, and the population group served.

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