

# **Overview of the Evaluation of the Eleven Primary Health Care Nursing Innovation Projects**



A Report to the Ministry of Health by the  
Primary Health Care Nurse Innovation Evaluation Team

Citation: Primary Health Care Nurse Innovation Evaluation Team. 2007. *Overview of the Evaluation of the Eleven Primary Health Care Nursing Innovation Projects: A Report to the Ministry of Health by the Primary Health Care Nurse Innovation Evaluation Team.* Wellington: Ministry of Health.

Published in September 2007 by the  
Ministry of Health  
PO Box 5013, Wellington, New Zealand

ISBN 978-0-478-331213-3 (online)  
HP4472

This document is available on the Ministry of Health's website:  
<http://www.moh.govt.nz>

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### **Acknowledgements**

The evaluation team would like to thank the nurses, and the communities in which these nurses work, for the opportunity to work with them on this evaluation. Thanks also to those who have made themselves available for interviews, phone calls and participation in the workshops. We also acknowledge the support of the District Health Boards, primary health organisations, non-government organisations and the Ministry of Health staff in establishing these innovative services and for supporting the evaluation.

### **Disclaimer**

This report was commissioned by the Ministry of Health and is part of a portfolio of projects evaluating the implementation and intermediate outcomes of the Primary Health Care Strategy. The views expressed in the report are those of the authors and do not necessarily reflect the views of the Ministry of Health. The Ministry of Health takes no responsibility for any errors or omissions in, or for the correctness of, the information contained in this report.

# CONTENTS

Primary Health Care Nursing Innovation Evaluation Team	iii
Acknowledgements	iii
Disclaimer	iii
Executive Summary	v
Findings	1
The 11 innovations	1
Overview of the Two Models of Innovation	7
Overview of Key Issues	9
Establishment issues	9
Leadership in primary health care nursing	9
The role of DHBs and PHOs	10
Workforce development	10
Funding of the innovations	11
Implications for Policy and Planning	12

## EXECUTIVE SUMMARY

The present New Zealand health care system is founded on the principles and objectives of the New Zealand Public Health and Disability Act 2000. This Act initiated a shift in focus to population health and a strengthening of local community input to decision-making about health and disability support services. Several strategies resulted from this Act, one of which was the Primary Health Care Strategy,<sup>1</sup> which identified primary health care nurses as crucial to its successful implementation.

Next, the Ministry of Health appointed an Expert Advisory Group for Primary Health Care Nursing, which developed a framework for activating primary health care nursing.<sup>2</sup> Among the recommendations of the framework was one to ‘fund, monitor and evaluate innovative models of primary health care nursing practice and disseminate examples of best practice to the wider sector’.<sup>3</sup>

In 2003 the Ministry of Health announced contestable funding, available over three years, for the development of primary health care nursing innovation projects throughout Aotearoa/New Zealand. The Ministry looked for proposals that would:

- support the development of innovative models of primary health care nursing practice to deliver on the objectives of the Primary Health Care Strategy
- allow new models of nursing practice to develop
- reduce the current fragmentation and duplication of services and
- assist in the transition of primary health care delivery to primary health organisations (PHOs).

These were the four goals that the Ministry wanted to see reflected in the proposals and 11 innovations were selected on that basis. They were:

- Nursing Integration Leaders (Northland District Health Board [DHB])
- Kaupapa Māori Primary Nursing Service (Auckland DHB)
- Counties Manukau Primary Health Care Nursing Innovation (Counties Manukau DHB)
- the Integrative Nursing Service Scheme (Lakes DHB)
- Health Reporoa Incorporated (Lakes DHB)
- Tairāwhiti Innovative Nursing Team (Tairāwhiti DHB)
- First Health Taranaki and Royal NZ Plunket Society (Taranaki DHB)
- Combined Primary Health Care Nurses Group (MidCentral DHB)
- Piki-te-Ora – Family Wellness Wairarapa (Wairarapa DHB)
- Hutt Valley Youth Health Service (Hutt Valley DHB) and
- Neighbourhood Nurses in Reefton (West Coast DHB).

<sup>1</sup> Minister of Health. 2001. *Primary Health Care Strategy*. Wellington: Ministry of Health.

<sup>2</sup> Ministry of Health. 2003. *Investing in Health: Whakatohutia te Oranga Tangata: A framework for activating primary health care nursing in New Zealand*. Wellington: Ministry of Health.

<sup>3</sup> Ministry of Health. 2003: ix.

The Ministry of Health also funded an evaluation of the innovations, encompassing:

- the process of establishing and operating the 11 innovations
- the extent to which each innovation achieved the outcomes contracted with the DHBs, and
- lessons from the overall evaluation to assist other nurses and groups in developing the role of primary care nurses.

The evaluation began in January 2004 and continued until the middle of 2006. This overview summarises the findings from the evaluation of the 11 primary care nursing innovations.

The evaluation team undertook research at several levels. For a start, each site was evaluated to provide information on both the experience of the individual projects and the overall lessons to be learnt from the innovations as a whole. Four case-study sites were investigated more intensively to deepen the understanding of the issues faced in establishing nursing innovations. Then workshops were held with innovation personnel to:

- provide support for innovation development
- collect evaluation data from each project and the initiative as a whole, and
- promote organisational learning.

Finally, national stakeholders were interviewed, including staff from the Ministry of Health, a number of national nursing leaders, and Health Workforce Advisory Committee members. These sought stakeholders' hopes, interests and concerns about the innovations, and about the development of primary health care nursing.

The following report provides a brief summary of the work of the 11 innovations and their evaluation, and then looks at the key issues that came out of the innovations project and the implications for primary health care nursing. A much fuller discussion can be found in the full report, *The Evaluation of the Eleven Primary Health Care Nursing Innovation Projects*.

## FINDINGS

### The 11 innovations

Each of the 11 innovations had distinctive characteristics, but they fell into one of two general models according to their primary focus. Innovations in the Leading Primary Health Care Nursing Development Model focused on leading broad-based change involving primary health care nurses across DHBs and/or PHOs. In contrast, the Primary Health Care Nursing Practice Model innovations focused on the development of new, expanded or modified forms of nursing practice delivering a service to specific groups of people.

#### The Leading Primary Health Care Nursing Development Model

In innovations falling under this model, new primary health care nursing leadership positions were created in DHBs and/or PHOs to develop the capacity of the primary health care nursing workforce to respond to the Primary Health Care Strategy, and to enhance service integration and/or development. The innovations that could be described this way included Northland, Auckland, Counties Manukau and MidCentral.

In Counties Manukau and MidCentral the innovation was based in the DHB and extended to PHOs, and in Northland and Auckland the innovations were based in PHOs. Brief descriptions of these innovations follow, summarising their aims and giving some assessment of their overall success. A more detailed description of each innovation is contained in *The Evaluation of the Eleven Primary Health Care Nursing Innovation Projects*.

The success of an innovation was judged by the extent to which it met: (i) each of the Ministry's four goals in purchasing the innovation; (ii) each of the six directions of the Primary Health Care Strategy; (iii) the individual objectives set by the DHB; and (iv) whether an innovation was sustainable, as evidenced by ongoing funding.

#### Nursing Integration Leaders (Northland DHB)

The Northland project appointed three nurse integration leaders in 2003 to three Access PHOs (Manaia Health, Kaipara Care and Te Tai Tokerau), who worked across the Northland DHB region and the six PHOs within it. The project received \$895,500<sup>4</sup> innovation funding over three years. Northland DHB and Te Tai Tokerau Māori Purchasing Organisation subcontracted the positions to the respective PHOs.

The nurse integration leaders' focus was on the integration and development of primary health care services and nursing across all primary health care providers, including general practices and iwi providers formally affiliated with PHOs, non-government organisation (NGO) providers, other iwi providers, and the DHB primary health care services.

<sup>4</sup> All funding quoted in this paper is GST inclusive.

This innovation was considered a success by all those involved. It met its DHB's objectives, and is a highly successful model of primary health care nursing leadership and service development in line with the Primary Health Care Strategy.

### **Kaupapa Māori Primary Nursing Service (Auckland DHB)**

The Auckland project appointed a Māori nurse leader and project manager to Tamaki Health, a Māori-led Access PHO, to develop and build on ways in which nursing services were provided in the PHO with the aim of establishing a kaupapa Māori nursing service. The innovation received funding of \$650,000 over three years, which was held by the PHO under a subcontract with Auckland DHB.

This innovation is still in the development stage, mostly as a result of staff changes within the innovation (the nurse leader and project manager have been replaced) and the Auckland DHB, and also the scarcity of Māori nurses. It was considered a partial success by stakeholders, meeting some but not all of its DHB's objectives and achieving a high level of success only on the Ministry goal of making a transition to the PHO.

The development of a kaupapa Māori nursing service was constrained by the range of providers and nurses who joined the PHO, and it was found that the need to contribute to the establishment of the PHO, develop the nursing practice of nurses in the provider organisations, and implement new programmes overshadowed the original goal. However, steps have been taken towards developing a kaupapa Māori nursing service, such as in-service education sessions and the establishment of the kuia and kaumatua taumata group, which provides a link to the community and may over time provide advice and assistance for improving access and liaison between services and the community.

### **Counties Manukau Primary Health Care Nursing Innovation (Counties Manukau DHB)**

The Counties Manukau innovation developed a nursing leadership infrastructure across the primary health care sector to support the DHB's Primary Health Care Plan. Ministry funding of \$750,000 for the three-year term was held by the Director of Nursing within the DHB nursing budget.

The project appointed primary health care nurse leaders, educators and specialists to lead the DHB in its primary health care work with seven PHOs. Workforce development and leadership for Māori and Pacific nursing in PHOs were key features. This innovation met all the DHB's objectives and achieved the Ministry of Health goals. It is a highly successful model of primary health care nursing leadership with a focus on addressing health inequalities.

### **Combined Primary Health Care Nurses Group (MidCentral DHB)**

This was a DHB-wide project centred on developing primary health care nursing capacity and leadership. It aimed to strengthen the primary health care nursing network to enable nurses to improve community health and wellness, and to influence PHO development and service innovation to achieve nursing partnerships with people



through autonomous, collaborative practice. The innovation received \$800,000 Ministry funding over three years and was successful in obtaining approximately \$2 million DHB funding over three years to support and extend the activities of the innovation and facilitate the development of a primary health care nursing professional practice framework.

This innovation was considered a success by all those involved in MidCentral. It met the DHB's objectives and achieved the goals of the Ministry. It is a highly successful model of primary health care nursing leadership and many of those involved contributed to a number of national primary health care nursing initiatives.

### **Primary Health Care Nursing Practice Model**

New, modified or expanded ways of practising primary health care nursing to provide clinical services were developed in Turangi, Reporoa, Taranaki, Tairāwhiti, Wairarapa, Hutt Valley and West Coast innovations. All these innovations provided nursing services that reached out to particular populations who experience barriers to accessing existing primary health care services. Brief descriptions of the innovations in this model are given below.

#### **The Integrative Nursing Service Scheme (Lakes DHB)**

This innovation aimed to develop a new form of primary health care nursing practice within Tuwharetoa Health Services Ltd in Lakes DHB. The innovation received \$650,000 Ministry funding over three years and was subcontracted to Tuwharetoa Health Services Ltd. The funding was to provide for three whānau and family nurses and a facilitator, although one resigned in the first year and was not replaced. The aim was to reconfigure services to improve access for the most vulnerable, needy and hard-to-reach residents in the DHB area. This was to be achieved through the creation and development of a new nursing role of whānau and family nurse.

The practice model was difficult to establish, develop and maintain, and although people were supported to access services and treatments, the impact of the innovation in terms of aligning health services to people's need was minimal. This was attributed by the PHO's chief executive officer to service fragmentation and 'patch protection'. However, recipients of care were positive about the help provided by the nurses. The innovation made some progress on the Ministry goals, but least in relation to making a transition to the PHO. The innovation 'did not really meet' DHB expectations, but the DHB plans to build on the lessons learnt to develop nursing services in Turangi.

After the innovation's funding ended, a collaborative initiative between Lakes DHB and Lake Taupo PHO led to the appointment of a whānau/family nurse, based in the PHO and funded by the DHB. The role of the locally based mobile nurse, who focused on generalist whānau/family health care, had been supported by the community, and the role was seen by the DHB and PHO as providing an opportunity to address Lakes DHB's new chronic care management policy. How successfully these two parts to the role will be integrated is yet to be seen.

### **Health Reporoa Incorporated (Lakes DHB)**

The Health Reporoa innovation is a service-based project, which provides a first-contact nurse-led service for a small rural community. The innovation received \$250,000 Ministry funding over three years and is governed by a community organisation, Health Reporoa Inc.

The project involved three nurses expanding their practice to provide free first-level contact primary health care in outreach clinics and homes for an isolated rural community with limited GP services and no public transport. Two other nurses provide relief during study and other leave taken by the three nurses. Health Reporoa is located in the rural town of Reporoa, with outreach to the areas towards Taupō and Rotorua and to the east into Kaingaroa Forest. The project was initiated by the community.

This innovation was considered a success by all those involved in Reporoa: it met the DHB's objectives, and although not leading to a transition towards PHO care, it met the other goals of the Ministry in purchasing the innovation. Overall this innovation was highly successful and provided essential first-level services to the community.

### **First Health Taranaki and Royal NZ Plunket Society (Taranaki DHB)**

The Taranaki innovation developed well-child and family nursing services to address service delivery gaps in targeted locations within a partnership model with First Health, and later Hauora PHO and Plunket. The innovation received \$600,000 Ministry funding over three years, which was initially subcontracted to the PHO. At midterm, concern about lack of traction of the innovation led to a review by the DHB. Following the mid-term review each organisation held a separate budget allocation, and in negotiation with the Ministry the innovation was expanded.

Overall, the innovation made moderate progress on all of the Ministry goals, met some of the DHB's objectives and made a moderate contribution to the directions of the Primary Health Care Strategy. This innovation was more successful in the latter half of the innovation term.

### **Tairawhiti Innovative Nursing Team (Tairawhiti DHB)**

The Tairawhiti innovation was formed through a partnership among the Tairawhiti DHB, two PHOs (Ngati Porou Hauora and Turanganui a Kiwa) and Employ Health, a privately owned occupational health nursing service. The innovation involved the formation of the Tairawhiti Innovation Nursing Team (TINT), which established services targeting two high-risk groups. Ministry of Health funding of \$750,000 over three years was received.

The TINT nurses included a nurse co-ordinator and nurses seconded from the partner organisations. One service was for workers at a forestry industrial site (Juken Nissho New Zealand), where 320 people worked, and the other was for domestic purposes beneficiaries from Work and Income New Zealand.

This innovation was considered a success by all those involved in Tairawhiti, with the exception of the DHB, which felt that the innovation had not sufficiently demonstrated

its impact on health outcomes. The innovation did, however, meet the objectives initially set by the DHB. It achieved all the Ministry goals, and demonstrated how services can be developed jointly by PHOs to address health inequalities. The development of electronic transfer of data sets meant the service integrated well with existing services.

### **Piki-te-Ora – Family Wellness Wairarapa (Wairarapa DHB)**

The Wairarapa innovation provided first-level primary health care nursing services in outreach clinics for population groups (including youth, Māori and Pacific people) who previously did not have ready access to such a service. This innovation was located in the DHB and received \$560,000 funding over three years. The project centred on two primary health care nurses, who were responsible for establishing and co-ordinating the nursing service. In the final year of the project the nurses were joined by a new graduate nurse.

This innovation was considered a success by only some of those involved. PHO representatives felt that the innovation had not made a transition to the PHO as intended, which limited its success, and one provider raised issues relating to service integration. Although the innovation met many of the objectives set by the DHB, the DHB considered that improved ways of demonstrating impact were needed. The innovation achieved all the goals set by the Ministry, with the exception of the transition to the PHO: it established services that were increasingly well attended and valued by the community served.

### **Hutt Valley Youth Health Service (Hutt Valley DHB)**

The Hutt Valley innovation aimed to develop the role of nursing within VIBE (the Hutt Valley Youth Health Service)<sup>5</sup> so as to provide clinical oversight for the multidisciplinary team working at VIBE, increase the clinical nursing capacity of the service, and support professional development towards nurse practitioner status by appointing a youth health nurse specialist. The innovation received \$300,000 Ministry funding over three years.

This innovation was considered a success by all those interviewed. It met the DHB's objectives, and apart from not leading to a transition towards PHOs, it met the goals of the Ministry of Health. It has resulted in clinical standards for youth services being developed within VIBE and within school nursing across the DHB. Hutt Valley DHB has contracted the nurse practitioner for a further three years.

### **Neighbourhood Nurses in Reefton (West Coast DHB)**

The West Coast Neighbourhood Nurses Innovation aimed to develop a generic and advanced primary health care nursing role for nurses within one community to facilitate a more holistic and comprehensive approach that improved the continuity of care

<sup>5</sup> VIBE is an NGO, which is supported by the Hutt Valley DHB and operates outside of a PHO. The service provides free health, support and education services with and for young people (aged 10–25 years) in the Hutt Valley.

provided. The innovation received \$750,000 Ministry funding over three years, which was administered by the DHB.

The innovation made moderate progress on the Ministry goals, with least progress made in relation to transition to the PHO because the PHO is still in development. The innovation has now largely met the DHB's goals and has made a variety of contributions towards the directions of the Primary Health Care Strategy. The neighbourhood nurses have continued in their role, and the innovation model is being expanded to develop a model of care which, although generic, will fit the characteristics of the local communities.

## **Conclusions**

All the innovations were established and operational by the end of the innovation term. Overall, they met with a range of success, with some making good progress against the Ministry's goals, but all achieved on some level. Individually the innovations met the DHB objectives set for them at each site, although some experienced delays and some were re-focused mid-term.

Fundamental to the progress made in establishing and facilitating the innovations was nursing leadership, demonstrated at either a clinical or organisational level. Other key factors were:

- the support for innovations from within DHBs and PHOs
- the development of communication and collaboration between primary health care nurses and other health professionals and providers across regions
- the establishment of clinically sound systems which connected services, and
- consultation and collaboration with local communities of interest.

The main barriers to the development of the innovations included the early stage of development of the PHOs within which innovations were integrated, the diversion of nurses into the Meningococcal B vaccination programme, shortages of nurses with the right skills, shortages of Māori and Pacific nurses, absence of or lapses in leadership, and (sometimes) insufficient buy-in from nurses or other providers.

## OVERVIEW OF THE TWO MODELS OF INNOVATION

The two models were effective in different ways. The Leading Primary Health Care Nursing Development Model was effective for short- and long-term initiatives to develop the nursing workforce. It involved developing and integrating services and addressing the quality of care provided by nurses in primary health care at the organisational level and, in some instances, at a practice and provider level. The establishment of leadership roles with a brief to span the boundaries between organisations and between primary and secondary services enhanced this capacity.

Primary health care leadership at the DHB and/or PHO levels provided a mechanism for nurses to be involved in policy-making, practice development and the organisational configuration of primary health care service delivery. This involvement seems to be essential if DHBs and PHOs are to:

- focus on reducing inequalities
- expand the potential of nursing in primary health care, and
- increase the integration between nursing services and general practice and other primary health care services to ensure better co-ordination of care for people when they access different services.

This model also drew together local nursing knowledge and expertise resulting in a deliberate, planned and feasible approach to expanding the potential contribution of nurses in primary health care. The innovations in this model developed the leadership infrastructure and inter-organisational networks to enable a range of future developments and facilitate the diffusion of other innovative services. As a result, these innovations have provided a mechanism for ongoing development in primary health care nursing. The impact of this model is likely to be cumulative if the momentum and direction are maintained.

The Primary Health Care Nursing Practice Model explored ways in which nurse-led outreach services could be developed for population groups known to have difficulties accessing first-level primary health care services, or with particular needs that were not well served by existing services. The innovations showed varying degrees of success. Where the practice model complemented existing services it was more difficult to show the difference the innovation made. In others, which had established a new first-level service or had expanded an existing service, the differences were more apparent because the population was well defined and systems to capture data well developed. These innovations demonstrated the capacity of initiatives led by nurses to substitute for some general practice services and provide holistic care.

Key to the success of these nurse-led innovations was the capacity of nurses to provide clinically sound outreach services in suitable locations, with a focus on health screening, triage and treatment of common conditions using standing orders and diagnostic testing, and providing health education and referral to other services. Nurses required clinical competence and confidence to practice independently. To be effective these nurse-led outreach initiatives relied on links and/or support systems from general practitioners and other primary health care providers. Innovations in this model were more likely to have difficulty if relationships between providers were strained.

The successful innovations in this model demonstrated the future role nurse practitioners could play in reducing inequalities and developing or expanding nursing services. There is no one ideal form of primary health care nursing service. The forms that developed in the practice innovations addressed health inequalities by providing alternative modes of access to primary health care for populations known to be hard to reach or at risk. As a population health approach is increasingly taken up by DHBs and PHOs, planning outreach services for populations identified as having access difficulties will require nurses with advanced and comprehensive practice skills and back-up support.

## OVERVIEW OF KEY ISSUES

The evaluation brought to light a number of key issues of interest to the development of primary health care nursing initiatives. These issues are set out below.

### Establishment issues

- Most innovations commenced as planned, but there were delays in some due to the early establishment activities in PHOs within which innovations were embedded. Others delays were due to staff turnover in either DHBs or PHOs, or delays in the appointment of nurse leaders.
- Some innovations had difficulty getting buy-in from local nurses or other health providers, although generally the various stakeholders responded positively. Support from other health providers, in particular GPs, was essential to an innovation's success, but was not always immediately forthcoming. However, in most cases this gradually developed over time.
- Nurses in the innovations valued the independent and collaborative relationships they were able to develop with GPs, enabling them to develop new ways of working, increasing their responsibility and accountability in client care.
- Although most nurses, health service providers and stakeholders welcomed the innovations, there was sometimes resistance to change from nurses.
- The innovations benefited from the expertise of the managers and support from governance groups.

### Leadership in primary health care nursing

- Three levels of leadership were demonstrated in the innovations: at the DHB or PHO level, leadership provided a platform for developments in primary health care nursing; at the provider level, leadership contributed to service development and service integration; and at the clinical level, leadership was shown in advancing nursing practice and developing the nursing workforce.
- The innovations developed nurse leaders both within the innovations and within primary health care nursing generally. The investment in primary health care nursing leadership at all levels (DHB, PHO and clinical practice) has led to primary health care nurses' representation and input into governance, strategy and operational development.
- Where leadership was strong and effective, innovations were likely to flourish. Conversely, where it was limited, innovations showed lack of progress.
- Many innovations that experienced difficulties could have benefited from more robust, cohesive and active governance or project management.

- Strong leadership and support from Directors of Nursing within DHBs was a feature in some successful innovations, through their support of the innovation and their input at a strategic and policy-making level within the DHB.
- In innovations that were less focused on developing nurse leaders as a key goal, were successful largely because of the skills and abilities of the nurses leading projects in community development or because of their clinical expertise.

## **The role of DHBs and PHOs**

- A range of support was provided for the innovations from DHBs and PHOs, providing governance, management and budget support when innovations were embedded within PHOs or DHBs, through to the provision of additional funding either directly or in kind, such as rooms, cars, equipment and other resources.
- A key factor in the success of innovations embedded in DHBs was the strong support and direction from these organisations. Others that were embedded within PHOs or received a high level of support from PHOs or NGOs were also better able to become established and make progress.
- Workforce development was one of the successful aspects of the innovations and was supported by DHBs and PHOs in a number of ways, such as providing venues for staff development, providing staff with paid time to undertake study, and putting in place mentoring and other workforce development initiatives.
- There was some confusion over the roles and responsibilities of DHBs and PHOs, which can be partly explained by the newness of these structures and that they are still in a state of flux.

## **Workforce development**

- Innovations provided educational, clinical and professional support to nurses through the development of in-service education and workshops, links with tertiary education to develop undergraduate and graduate programmes, portfolio development assistance, clinical supervision and mentorship, and networking opportunities for nurses across the sector.
- Innovation funding was of significant benefit for some nurses in small organisations and rural areas to cover the costs of postgraduate education and to employ relief nurses. Other nurses in the innovations were recipients of Ministry of Health scholarships or courses and programmes<sup>6</sup> funded Clinical Training Agency.

<sup>6</sup> Clinical Training Agency funding was used to establish first-year entry to practice programmes in three innovations as a means to recruit new primary health care nurses.



- National and regional shortages of Māori and Pacific nurses created difficulties for innovations setting up in areas with high Māori and Pacific populations, or with new Māori or Pacific models of nursing. There were even fewer Māori and Pacific nurse leaders, which placed significant strain on the few available and increased the likelihood of staff turnover as these nurses were in high demand.
- The majority of innovations undertook some activities related to nurse practitioners, either employing a nurse practitioner or supporting individual nurses in their preparation towards applying for nurse practitioner registration. In the two DHB-led initiatives, career pathways leading to nurse practitioner registration were established as part of the DHB career framework.
- Pay disparity between DHB-employed nurses and most nurses working in primary health care has implications for the primary health care nursing workforce in terms of recruitment and retention.

## **Funding of the innovations**

- All innovations' funding covered salaries for some of the nursing staff and some working costs for equipment or activities undertaken. A few innovations received additional funding, either directly from DHBs or through PHOs or NGOs. Host organisations, community groups and industry often provided additional support in the form of rooms, equipment, resources or administration.
- Some innovations earned additional income for small contracts or for delivering specific clinical services. Occasionally, nurses contributed by carrying the costs of providing their own computers or cars. Nurses in the innovations and those supporting innovation activity freely contributed their own time to support innovation activities.
- Where decisions have been made, funding for the continuation of innovations has been secured for periods ranging from three months to three years, and is from DHBs, PHOs or a combination of both. Decisions about ongoing funding have depended on DHBs' views on the success of the innovations, DHBs' financial positions and the status of negotiations between DHBs and PHOs.
- These decisions indicate that where there are perceived needs, such as gaps in service provision or access difficulties, DHBs are prepared to fund providers other than through PHOs. This may have future implications for both DHBs and PHOs.
- PHOs collaborated to support and fund innovations in two cases, but the enrolled populations of these PHOs were well defined by geographical location in one case, and were iwi-based in another. It is unclear whether PHOs without such distinctive populations would manage such collaboration.
- There is a perception that most PHO funding moves directly to GPs, and that because there is no longer a targeted practice nurse subsidy there are limited opportunities for nurse-led services outside the GP environment. Although Services to Improve Access is one potential source of funding, the size of this funding pool may be small due to the size of the PHO. Another issue likely to pose problems for nurses establishing new services is that Services to Improve Access funding may be time limited.

## IMPLICATIONS FOR POLICY AND PLANNING

The two models developed by the innovations show that expanded practice can develop through effective nursing leadership at an organisational level in DHBs and PHOs, and through clinical nursing leadership by nurses with advanced practice at a service delivery level. Nurses with advanced skills have the capacity to establish and deliver a different model of first-level care from the predominant general practice model. Such a model is particularly suited to populations who have difficulty accessing existing services, or who have broader health needs than services currently provide.

Facilitating the establishment of nurse practitioners in primary health care is likely to increase this capacity. Links with general practice and secondary services are crucial for these new models to avoid becoming just another silo of care. Therefore, support for the development of nursing leadership and the advancement of primary health care nurses' clinical knowledge and skills are two important aspects for consideration in future policy and planning.

Continued investment in primary health care nursing workforce development at a national, DHB and organisational level is required to support postgraduate study, the establishment of career pathways and the development of structured professional recognition and education programmes.

DHBs and PHOs have a role in leading this development by providing nurses in their employ and across their regions with relevant clinical nurse education opportunities. The findings from the evaluation show that the clinical skills among nurses in the sector are variable, and that nurses are willing to undertake further development of their skills when they are supported by their organisation.

The establishment of career pathways and structured professional recognition and development programmes within employing organisations will support the ongoing development of the nursing workforce capacity. The career pathways that were developed in some innovations bridged the scopes of practice between registered nurse and nurse practitioner that were established by the New Zealand Nursing Council as the professional regulatory body as part of the introduction of the Health Practitioners Competence Assurance act (2003). This would seem to indicate that there is growing acknowledgment that these two scopes may not be adequate and may need to be reviewed in the future.

The innovations that developed new modes of access to primary health care by providing outreach services utilised the existing standing orders regulations under the Medicines Act. While these regulations facilitated the supply of timely medications for common conditions for people in nurses' care, the administration of them seemed unnecessarily time consuming and cumbersome for the degree of risk involved. The current arrangements are also viewed as problematic for both nurses and GPs. The current Ministry of Health review of this policy is therefore timely, and consideration needs to be given to how the regulations can be adjusted so they are more workable for nurses in outreach services in primary health care.

Findings from these innovations also highlight the need for further development of primary health care information technology software capacity such as MedTech 32, not only in terms of recording and capturing nursing work and for administering referrals to and from nursing services, but also for developing the capacity to analyse the outcomes of care over time, by practitioner and by service.

The current funding streams that support primary health care nursing are complex and largely embedded in service contracts with DHBs, PHOs and NGOs. As these organisations will work more closely together during the next stage of the implementation of the Primary Health Care Strategy, it is important that attention is paid to teasing out how service contracts and subsequent funding streams contribute to the fragmentation of primary health care nursing services and inhibit the full utilisation of nurses' skills. Key resource people to include in such work are Directors of Nursing, primary health care nurse leaders, and groups of nurse leaders from organisations in the primary health care sector where these have been established, along with funding and planning personnel from their organisations.

The Ministry of Health's initiative to fund primary health care nursing innovations has established some new models of service delivery in primary health care which provide examples to the sector of the potential of nursing, and have seeded a number of nursing leadership initiatives that can be used to diffuse further initiatives. The challenge for the sector, and for nurses within it, is to capitalise on the lessons learnt from these as the implementation of the Primary Health Care Strategy is taken to the next phase.