New Zealand Practice Nurse Leader UK Tour – July 2008

Report for Ministry of Health

Debbie Davies, Wendy Findlay, Rachael Calverley and Varina Flavell
Introduction

In July 2008 four Practice Nurse leaders and two representatives from the Ministry of Health traveled to England and Wales on a two-week study tour.

The purpose of the study tour was for New Zealand Practice Nurse leaders to learn about different and innovative types of primary health care nursing, and to share this within the New Zealand primary health care nursing environment. The group saw many primary health care nursing initiatives, with a specific focus on providing services and support for high-need populations and for those with long-term conditions.

The group spent the first week attending the Royal College of Nurses, Practice Nurse Association Conference in Cardiff, Wales and the second week visiting different practices in England and Wales, ranging from small to large practices and offering a range of health care services.

The members of the group were:

- Mark Jones, Chief Nurse, Ministry of Health
- Gabrielle Roberts, Senior Analyst Nursing, Ministry of Health
- Debbie Davies, Nurse Coordinator Practice Development, MidCentral District Health Board, Chair, New Zealand College of Practice Nurses (NZCPN) New Zealand Nurses Organisation (NZNO)
- Wendy Findlay, Professional Nursing Advisor, Southland PHO, National Committee Member, NZCPN
- Rachael Calverley, Practice Nurse Wanganui, National Committee Member, NZCPN,
- Varina Flavell, Practice Nurse Whangarei and Te Runanga representative.

Gabrielle Roberts’ excellent preparation and tour organisation enabled the group to talk to and understand each other, resulting in a cohesive New Zealand representative group. The knock-on affect was the group’s ability to mix debate and discussion with UK colleagues on the variability of primary health care nursing. Both Mark and Gabrielle were approachable and valued company, and added to the group’s energy, enthusiasm and exchange of ideas throughout the tour.
Royal College of Nursing, Practice Nurse Association Annual Conference: Celebrating 25 years, now going for gold

9–11 July, Cardiff, Wales

The theme of the conference was ‘Celebrating 25 years, now going for gold’ and the main focus was primary health care. The Welsh practice nurses particularly welcomed the New Zealand contingent and made them feel at home. Breaks were spent talking to strategic and clinically based Practice Nurse Leaders from the Practice Nurse Association (PNA) from Wales and England, and to University and Welsh Assembly representatives. These discussions gave an insight to the increased specialisation that is evident within the Practice Nurse workforce in the UK.

The content of the conference was inspiring with a mix of strategic and clinically based presenters. Most presentations were thought-provoking and stimulating, and raised questions within the New Zealand context.

Mark Jones was recognised for his immense contribution to the development of Practice Nursing during his 10-year employment with the Royal College of Nursing (RCN). As Chief Nurse, New Zealand, Mark Jones has a catalogue of credentials and is obviously well respected and regarded among his UK colleagues and the professional leaders the group met.

Presentations from the conference included:

* An historical overview of practice nursing development in the UK – June Smail, OBE, Non executive director, NHS Trust, Wales
* The contribution of practice nurses to community health – Dr Marion Lyons, Lead consultant in communicable disease control, National Public Health Services, Cardiff
* Teenage sex issues – John Guillebaud, Emeritus Professor of Family Planning and Reproductive Health, London
* Designing of men’s health service – Jane Deville-Almond, Nurse consultant men’s health
* An overview of the year’s achievements of the England PN Association – Kate Howie, Chair, UK PN Association.
* Practice Nursing – A time for challenge and change – Peter Carter, General Secretary & Chief Executive, Royal College of Nursing
The presentations gave the tour group the historical context of Practice Nursing development in Wales and England, along with an insight into challenges and barriers to progress. Key levers that have both helped and sustained the role of the Practice Nurse as valued contributors to the primary health care team and the health outcomes of the community, were also demonstrated. Below are some of the presentations in more detail.

### Identification of Sexuality

**David Evans, Educational Consultant in Sexual Health and Sexual Health Skills Course Manager**

David Evans’ presentation on sexuality aimed to clarify the health benefits of an inclusive, non-discriminatory service. He challenged us as nurses to avoid dumping our prejudices on patients, to win over patients disaffected from health care, and to seriously consider our A B Cs:

A – Attitudes  
B – Beliefs  
C – Clinical practice

He talked about population groups that might miss out on having their health needs/issues addressed. This was highlighted often during conference discussion, in terms of gay and lesbian health and later in relation to men’s health, youth health and the health of vulnerable populations and ethnic minorities. Subtle discrimination conveyed during patient interactions can be covert and overt with the effects on health being disabling and disempowering.
Unfair treatments and negative attitudes are hard to justify, due to their subjective nature and may even become normalised due to perverse conditioning. The simple reference to A B C by David was a clever tool to remind frontline nurses that as health professionals we need to embrace the diversity within and between cultures and individuals if we are to create and enable accessible care pathways to succeed.

**Long-term conditions – a major challenge for health care**

*Sue Thomas, Policy Advisor, Long Term Conditions, Royal College of Nursing, London*

Sue Thomas highlighted the massive population burden of one in three people living with a LTC. She reported how LTC had moved high up on the political agenda with the focus now looking to self-care by patients and their carers, partners in care, continuous community based care, end of life care, tele-health, tele-care and gold standard integrated healthcare systems to avoid duplication. She reported on translation to practice for Practice Nurses via Quality Outcome Frameworks as discussed later on, comprehensive and focused nursing assessment, annual checks, partnerships and teamwork in practice.
Practice-based visits

During the second week of the tour, the group visited a range of practices, including small practices and larger co-located models incorporating a large range of health care services. Some of the practice profiles and approaches are outlined below.

Visit One: Lampeter Medical Practice
Ceredigion Local Health Board, Y Bryn, North Road, Lampeter, Ceredigion, Wales

The practice the group visited in Ceredigion covers a population of approximately 8500. Interestingly, they report a contract-led, target-orientated practice with long-term conditions (LTC) management high on the agenda – especially due to incentivised QOF (Quality Outcome Framework) points. This work is paramount and had resulted in a change in the practice’s workforce. The population is a mix of urban, rural and coastal, with youth (due to a nearby university) and older age groups.

A mixture of employment structures with the GP as employer and the National Health Service Trust means PHC nurses are situated in one general practice building. This includes district nurses, social workers, health visitors, counsellors, specialist nurses trained in chronic disease, a re-ablement team, community mental health and learning disability teams, two Nurse Practitioners and five GPs. Nurse Practitioners work in a similar way to the GPs, assessing, diagnosing, prescribing and referring as appropriate.

Specialist Practice Nurses manage long-term conditions via clinics: asthma, COPD, heart failure, heart disease, chronic renal disease; guideline/protocol use. Treatment room nurses and health care assistants take on a more task-orientated approach to patient care, completing jobs such as administration recalls, phlebotomy etc.
Visit Two: St Johns Medical Practice
Rhondda Cynon Taff Local Health Board, Wales

It was the concept of a facilitative role that the group saw first hand working well in an independently managed, salaried practice set up. Here GPs and a Nurse Practitioner are employed to improve nursing, reorganise care processes, provide structure and redevelop IT services to boost under-served and poorly met patient needs.

Clinical practice nurses and the Nurse Practitioner have a two to three year focus on training, education and up skilling in long-term condition management. National Institute for Health and Clinical Excellence (NICE) guidelines/protocols are used for long-term conditions clinical activity (equivalent to our NZGG evidence-based practice). Additionally, nurses need to be open to change, ensure their skill mix is maximised and peer and collegial education is advocated.

Nursing clinics involved prescribing for patients with complex co-morbidities through drug and medical management review. Patient perceptions, beliefs and values were addressed through specialist nurse and nurse practitioner decision-making, alongside educating patients to the realities of their medical problems.

This working example illustrates clearly the broadening nurse’s role in nurse-led clinics and the shift in care approaches.

Visit Three: Gloucestershire Primary Care Trust

The Gloucestershire countrywide primary care heart failure service is another example of long-term condition management. An established team of three specialist nurses take primary and secondary care referrals, with individual caseloads of approximately 50 patients. They review GP presentations, follow up with rapid ECHO and see patients with other team members to confirm/exclude diagnosis of heart failure and define the precise cardiac cause. They are a crucial link between sectors. They aim to relieve symptoms and empower patients through education about the disease process and their treatment, and to improve their end of life experience. All nurses prescribe, IT capability is organised and medical colleagues
(GPs and consultants) support the service through their involvement and participation in the project from the outset. The nursing service has a credible base, being the largest in England and offers training through modules and study days to all health professionals.
Meeting with the Long Term Conditions Team, Welsh Assembly Government

Improving Health and the Management of Chronic Conditions in Wales: An Integrated Model and Framework for Action emerged in March 2007 in a long-term bid to improve services in terms of managing chronic conditions in Wales. Helen Howson (Senior Health Strategy Advisor and Head of Community Health Strategy and Development Branch) presented the model as a proactive, planned and managed approach to coordinated, consistent, easy accessed, local, integrated services whereby patients are the central focus. The whole concept requires a shift in thinking to present a core chronic conditions management community team to support patients across primary, secondary and social care. Promoting the model in practice is a huge undertaking and Helen reported action in three demonstration sites throughout Wales. Local and national commitment has to be all embracing to maintain momentum, with a delivery framework, incorporating:

- foundations for change
- champions for change (nursing opportunity)
- partners in change
- tools for change
- targets for change.

In addition local action plan frameworks offer specific objectives and markers to taking the process of implementation forward. We look forward to following clinical model outcomes as the project sites mature.


Education and professional development

The tour group discussed careers in terms of what might be required for nurses in New Zealand. They could see the benefits of specialist nurses within a generalist area, especially with the escalating demand in practice due to long-term conditions. The art to making this work would be for these nurses to champion their role and continue to grow and develop their skills while being facilitators and role models for nurse colleagues and patients alike.

Education and career development of nurses within general practice in England and Wales is underpinned by a career framework developed in partnership between the National Health Service (NHS), and the RCN through a WIPP (Working in Partnership Project). This framework enables practice nurses to grow and develop their skills in either a linear or specialised manner.

University of Glamorgan, Pontypridd, Wales

Education was provided mainly by universities like the University of Glamorgan, where education for Practice Nurses is provided at both graduate and post-graduate level.

Professional development is provided for the variety of Practice Nurse levels, for example, a 13-day foundation practice nursing course covering a range of skills in a treatment room. The courses aim for a common core content for all community nurses. Those nurses who choose to specialise can do specified postgraduate education primarily related to the long-term conditions management. Additionally, some undergo prescribing education to enable them prescribe in independent or supplementary capacities. There are currently 46,000 nurse prescribers across the UK!

Similar challenges were described at both the conference and during practice visits regarding ongoing education for practice nurses. Challenges included geographical isolation, release time, funding and ability to provide back-fill. The influence of the employing GP was evident, and should be noted in terms of the possible application of a career framework within the New Zealand context.
The postgraduate certificate study in long-term condition management already advocated by Mark Jones and the New Zealand Ministry of Health offers a prime opportunity in New Zealand to fulfill an educational requirement to managing this approach to care needs, and indicates a dedicated investment in the primary health care nursing workforce. Useful practice tools, guidelines or protocols can provide a structure to long-term condition care. Crucially though, they need to be evidence based and updated regularly to ensure optimal care management and not detract from the essence of a skilled nursing care approach wherein holistic, patient-considered interventions predominate.
Research focus

Research appears to be well integrated at Local Health Board level with a large amount of support for practice nurses to engage in clinical research. Of note, all health policy developed in Wales has a specified research budget to underpin and evaluate the development and implementation processes. The current drive in Wales is to increase quality of service underpinned by research, and training provided to nurses described included a comprehensive structure to support RNs to learn, including the conduct of research, and how to write articles for publication.
Leadership and collaborative practice

As outsiders looking in it was obvious that The Royal College of Nursing, Practice Nurse Association provides UK practice nurses with outstanding leadership and professional representation. The Working in Partnership Project (WIPP) between the RCN and NHS has driven standardised role advancement. The development of extensive resources that provide leadership to the nursing profession is just one example of leadership that is making a great deal of difference to the role of nurses. The group was also very fortunate to attend the first meeting of a large group of nursing leaders who were brought together as a Community Nursing Strategy Task and Finish Group. This group’s terms of reference were to produce a Community Nursing Strategy to be presented to the Minister in 2008. The discussion around the table was fascinating as they tried to gain consensus of the definition of a community nurse and what the role would entail. It will be interesting to see how this group progresses and the final report they produce.
Conclusion

The nurse leaders that the tour group met with demonstrated a passion, commitment and energy for primary nursing that was infectious. You couldn’t help but come away from the tour with a renewed enthusiasm for primary nursing and the role nursing plays in communities’ health. Surprising, is that despite dynamic leadership, for many practice nurses their role is dependent on the employing GP, and clinical governance remains a challenge despite full funding from the NHS for nursing services.

One area of concern was how nursing roles were being developed in general practice to help the practice to meet Quality Outcome Framework (QOF) targets. This development of different nursing roles appears to lead to a fragmented nursing service. This was highlighted in one practice the group visited, where a variety of specialist nurses provided care to specific conditions but the role of the generic practice nurse didn’t exist. This meant patient could see three or four nurses at the practice depending on whether they were male or female or on what conditions they had. In New Zealand there is also the potential for nursing roles to be developed around the Performance Management Programme to assist general practice to meet targets. This would be to the detriment of patient-centered, holistic health care delivery and not something we should replicate here.

Collaborative practice was demonstrated at all levels of health care delivery. From the practice visits we witnessed Well Child nurses, District Nurses, Nurse Practitioners, and specialist nurses, working from within the same practice even though they had different employers. This co-location enabled the ability for discussion, collaborative care planning, and the development of respect for each other’s roles and specialty practice.

At the Ministerial level the development of the Chronic Conditions Framework represents the true essence of collaborative practice. From the implementation process utilising demonstration sites strategically placed through the country, to the delivery of care through multi-disciplinary teams. The role of the various nurse specialists certainly demonstrated the meaning of collaboration, by working in partnership with clients, GPs, consultants and nursing colleges. The nurse specialist works as the care coordinator, case manager and is a vital link to both general practice and secondary services. This role appears to deliver care that is client
centered with the most appropriate health professional assisting the client rather than service-driven care.
Personal insights from participants

Debbie Davies

The study tour provided me with a unique opportunity to observe first hand the primary health care service provision in the UK and, in particular, the evolving context of Practice Nursing to gain a sense of how development has occurred. Alongside this we need to be cognizant of the policy context and environment that has been in play in the UK.

It is important to acknowledge my excellent tour colleagues, whose company was wholly engaging, as we proudly represented New Zealand nursing, and worked both as a group, and with our international colleagues. A particular highlight was the ability to openly challenge and debate with colleagues from the Ministry of Health, sharing both visions and challenges, as we were exposed to varying models and opportunities. Alongside this was the overwhelming hospitality at the conference and each and every visit was humbling. The opportunity was both personally and professionally energising, stimulating vibrancy, and growth.

Mark Jones’ 10 years at the RCN must be recognised as integral to the successful advancement and embedding of a nursing context that has a demonstrated career pathway to progress within. Additionally, the practice nurse role is valued in terms of both scope and contribution to health outcomes for communities. This has not been without, nor remains without challenges and barriers reminiscent of the New Zealand’s historic and current context. When we consider key aspects of leadership and collaborative practice, it is evident that practices with established senior nursing roles demonstrate increased autonomy and authority of nursing roles, and nursing leadership is vital to supporting and advancing development of roles within general practice. I believe it is imperative that nurses are supported to contribute fully to their potential in the evolving environment, one that must focus on person-centred, community-driven, and health outcome-focused services.

Several nursing 'shining stars' really caught my eye and imagination as they shared their journeys and achievements in attaining true recognition as valued health care team members, some as full partners in businesses. Their pragmatic approach to designing and delivery of health care services is remarkable and provided insight to
the possibilities that lie ahead for practice/primary health care nurses in New Zealand.

Clinical governance remains a challenge for nurses in the UK, though there were clearly some robust mechanisms for this to be effective. One would suggest that this is in its infancy here in New Zealand with the implementation of Primary Health Organisations and is contingent on nurses being vocal about the contribution they make to health outcomes.

It is apparent in Wales and England that the embedding of a career framework focused on particular role development and definition around LTC management has offered nurses a valid and tangible pathway to increased specialisation where the nurse has sought this. This pathway is underpinned by specified education and opportunity within practice contexts to apply this knowledge in a broadened scope. This offers exciting possibilities to the evolving context of the practice/primary health care nurses in the New Zealand environment.

I am grateful for the opportunity to participate in this study tour, and continue to reflect on the observations, while further enhancing the robust links I have established both nationally and internationally with nurses committed to focusing on the ultimate outcomes of any of our endeavors- optimal community health and wellness. I am impressed by the remit Mark and Gabrielle work within in the Ministry of Health and by their ability to connect, communicating value and respect for networks of leaders committed to advancing change in the New Zealand context whilst acknowledging each others endeavors.

As a result of participation on this tour I am focused on acknowledging the learnings as described, and working in collaboration with key partners to facilitate professional practice environments for practice/primary health care nurses. I believe the New Zealand College of Practice Nurses is an ideal vehicle for this to be achieved through.
Varina Flavell

When I compare their services to New Zealand general practice, like the one I work for, we do most of the services they do as Practice Nurses in their medical centres. The obvious difference is that we don’t have different tiers of practice nursing or the resources or funding to employ extra staff such as health care assistants. The medical centre I work for has six general practitioners, each doctor employing their own Practice Nurse.

As a Practice Nurse, my role involves being responsible for: triage/telephone triage, immunisations, health promotion, wound management, Care plus, cervical screening, monthly patients recalls, diabetes checks, referrals to district nurses and health services for those patients who have been discharged from the hospital, follow up appointments, speaking to specialists/nurses at hospitals and community services. I also assist the doctor with minor surgeries and ongoing paper work. If we cannot provide the care in a specific area, we tend to refer to other health agencies, for example, district nurses, path labs, child health services. Maybe if medical centres received extra funding for additional training and staff, patient care will improve and we would see less hospital admissions.

We rely on patients to access and see GPs to diagnose and treat patients or their Practice Nurse for any health concerns and care plus. I know the New Zealand health system is now encouraging and educating nurses to become Nurse Practitioners. Currently we do have community/Māori health services that employ nurse practitioners and disease management nurses to work in rural areas. This system seems to work well for patients who are unable to access medical services in the main cities or cannot afford to visit a doctor.

I found from attending the conference and visiting medical services in Wales, Nurse Practitioners are the norm in the UK. There, Nurse Practitioners not only work in partnership with GPs but have a say on how the business is managed and the clinic is run. UK Nurse Practitioner clinics operate with the support from their colleagues. In these clinics, Nurse Practitioners can diagnose and follow up patients with long-term conditions and prescribe medication without seeing the GP. This system has resulted in less patients being referred to hospitals and a reduction in GPs' workload. The other point is that the GP service for patients is free compared to New Zealand
where there is a cost to see a GP. The one thing that I have learnt from this study tour is how important the Nurse Practitioner role is in health and patient care and why we need to encourage more nurses towards that career pathway.

Another thing I observed that was not the same as New Zealand is that all ethnic groups in the UK come under one umbrella. Wales is bilingual and the Welsh language is recognised, translated into English and Welsh on street signs, government buildings, health services and shopping centres. I feel in the future the Welsh language will be as strong as the Māori language and so will their care in delivering health and education services for all cultures in Wales. We visited a university in Glamorgan and I met a professor who visited New Zealand and had written a paper about cultural safety and his view was one approach to integrating cultural components into nursing care. He was interested knowing more about Māori health and culture safety so he could share with nursing students and his colleagues. I also went to a hospital board meeting where they were interested developing a health service through the Welsh language.

Through this study trip, I have learnt that the Ministry of Health plays an important role when it comes to delivering and promoting good quality health outcomes in New Zealand. It was evident that our health service is recognised around the world, with the number of people I met wanting to learn as much from our group as we wanted to learn from them about what they do in their countries. I am now in regular contact with the people I met at the conference and the medical centres we visited around Wales.

I can say that when it comes to providing a service for Māori in New Zealand, we really stand out among other ethnic groups around the world. Through recognising the Treaty of Waitangi, we have the opportunity to work together in partnership, have protection and participation when it comes to any health issues that we face as Māori. We are the high-risk indigenous group when it comes to long-term health conditions in New Zealand. When you deliver a service for Māori by Māori, there is strong evidence that the health outcomes can be achieved – the same for Europeans and ethnic groups who live in New Zealand. I hope to share my findings with other health services and Māori providers and keep in regular contact with the study tour group.
Rachael Calverley

On day two of the RCN practice nurse conference, in his opening remarks Mark Jones referred to practice nursing as a ‘discrete specialty’. This for me deliberately offered Practice Nursing and those nurses striving for excellence in practice their unique identity. In order, however, to harness this distinctiveness we need to be astute, think openly, connect with all our related colleagues and articulate audibly in terms of effecting change for our patients. Certainly by communicating these connections among each other as nurses primarily is the key and not always easy. However, if we can master this unity it will give us good grounds to move forward as focused, equitable and above all credible players in the business of health.

It was these connections and many musings among not only the tour group members but also the many nurses, researchers, educators, presenters, and leaders within health care we met during our tour that provided the richness, depth and impact for me, both personally and professionally.

Exemplary nursing leaders that caught my eye

In my written bid to be chosen for this tour, I touched on the need to aspire to excellence, by aiming high and doing ordinary things extraordinarily well. I will comment on those people who influenced me over the duration of the tour and appeared to be working in this fashion.

**Eileen Munson**

*Msc NP, Bsc (Hons), specialist practitioner, RM, RGN, RNT, PGCE, Independent prescriber, Asthma Dip; COPD Dip, Menopause Dip; FP cert ENB 901; Diabetes Dip ENB 928; ENB 998, Chair of RCN PNA Wales, Senior Nurse Lecturer University Glamorgan*

Eileen had an incredible number of letters and titles after her name; she chaired and hosted the conference and I believe was instrumental in liaising with Gabrielle on the tour plans. However, it was her acutely energetic and dynamic approach to demonstrating a positive and professional nursing identity; speaking up for nursing and the need for the nurses’ critical eye in terms of driving for research and educational developments and her continued connections with the clinical reality through her work as a nurse practitioner that caused me to straighten my back, pause and think, that’s what makes a difference. We look forward to continue networking with Eileen.
Jane DeVille-Almond
Independent Nurse Consultant, vice president and Chair Men’s Health Forum, Vice Chair National Obesity Forum

Jane identified a clinical gap; it’s present here in New Zealand also. Men’s health, the gender issue, we are not tapping their market, their needs, their wants, their desires! Jane presented innovative approaches to health care that have been successful and sustainable. She recommended lateral thinking suggesting over burdened GP surgeries were not always the best places for services. She set up health services, in barber shops, pubs, Harley Davidson showrooms, race festivals and other venues. Of 100 men turning up over a three-day period, 72 percent had one or more previously undiagnosed long-term health risk problems. Clinical consideration highlighted a massively untapped arena of need, additionally she noted ‘if you don’t ask you don’t know’ – sensitive issues for men such as depression and erectile dysfunction would not be admitted to. Food for thought, what are we missing here in New Zealand, we’ve got more work to do on the clinical floor. Jane succeeded in firing me up!

Clear messages:
✓ de-medicalise men’s services
✓ make health more real/fun; consider what is important to men and the way they live/think!
✓ innovate – location – location - location
✓ more training of health professionals in men’s health
✓ DHB/PHO (equivalents) needs to consider services and strategies in terms of commitment to improving men’s health
✓ audit your population groups
✓ men’s need analysis.

Mark Jones
Chief Nurse

As our Chief Nurse, New Zealand, Mark has a commendable inventory of credentials and is obviously well respected and regarded among his UK colleagues and the professional leaders we were fortunate to mix with on tour. The significant strategic groundwork and promotion of practice nurses whilst with the Royal College of Nursing (RCN) impacted greatly on their current position. I have a greater understanding of the huge remit he works with at the Ministry of Health, but have
been impressed overall by his communications. This has to be a two-way process, whereby speaking, listening and understanding of all nursing levels, conveys investment in this valuable workforce and keeps alive the ability to build and grow networks of leaders and change makers who are prepared to stimulate thinking and, most importantly, acknowledge each other’s endeavors unreservedly. Mark neatly offered us, via this tour, opportunity to challenge process through discussion, share our visions, and consider alternative care approaches through broadening our exposure. The key for me is in **sustaining this link** and ensuring our pathways of communication with Mark and his team continues to cross. Additionally by engaging with all nurses both locally and nationally in the long term we may potentially affect positive and professional future outcomes.

**Making A Difference**

**Monica Fletcher**  
*Chief Executive, Education for Health, Warwick*

Again it was the energy generated by Monica that struck me. She was clear, purposeful in her presentation and challenged the status quo. She focused her discussion around the UK quality outcome frameworks (QOF), utilised in a bold attempt to improve the quality of UK primary health care alongside the use of incentives as motivators. Partnerships and teamwork in practices emerged in terms of practice decision-making, and only moderate improvements in long-term condition management, ie, diabetes were noted. Target expectations were exceeded; GPs benefited well financially, their consultation numbers decreased, whereas nurse consultations increased. Important points to consider in terms of quality which we should reflect on here in NZ include the following.

- Is there a risk in focusing on QOF activity at the expense of guideline aspirations?
- Is a money incentive the answer or does professionalism become less valued?
- Delivery mechanisms are so variable, how can one size fit all?
- Are we just fulfilling the statistician’s templates?
- Is this the way to embrace nursing skill level?
- With the GP in the gatekeeper role, choice remains limiting.
Are objective measures the only markers for quality?

Karen Daniel
Nurse Practitioner, Practice Partner

I met a number of Nurse Practitioners throughout the tour. We met Karen on our last visit to a Primary Care Trust in Gloucester. Her role was as a Nurse Practitioner, prescriber and a partner in the practice; and she presented an unassuming, calm, confident and realistic picture of her clinical reality. As a partner she had to be in tune with her co-partners – the doctors; she challenged, debated and discussed how to improve services, how to optimise care and how best to maintain and strive for quality outcomes. She reported a much greater empathy for the financial and business side as this was essentially her investment; drive and commitment was linked to leading by design. In her words, absolutely all practice members worked as a cohesive team and the pay was good; this extra valuing of staff was crucial to a forward-thinking clinical practice environment but had to be worked at. When asked where she viewed the key strengths in nursing to be she expressed:

✓ education
✓ communication – not one way
✓ keeping networks alive
✓ speaking up for yourself.

For me, Karen encapsulated the wider picture, she was there to meet a need, she was autonomous in leading a nursing service, accepted, respected and recognised alongside her GP partners. Their unique skill sets were equally crucial to the quality of care delivered and the global view of the health care team as a whole was additionally essential to a valued and effective team. Any jobs going I asked!!
Wendy Findlay

Attendance on this kind of tour is something that every nurse should have the opportunity to do. I have come back from the tour and found a new energy for nursing and the contribution we can make to people’s lives and society as a whole. Going to the other side of the world with a group of strangers certainly moved me out of my comfort zone. However, the end result was the development of great friendships, solid collegial relationships and a great deal of fun and fond memories. It is now up to those of us who were fortunate to attend the tour to share our learning with colleagues and our communities, work with the Ministry to promote primary health nursing, and maintain our enthusiasm and drive to effect change.

The welcome that we received from all those we came in contact with on the tour was heart warming, each person/group that we spoke to was really willing to share their knowledge, experience and resources with us. As part of this hospitality they provided us with Welsh cakes and lovely food at each visit, which didn’t do much for our waistlines by the time we returned home! Attendance at the Practice Nurse Conference was enlightening. When we first discussed that we would be attending the conference I thought WOW this will be great and it was, but be reassured the Practice Nurses conferences that we have in New Zealand are just as good as that we went to in Cardiff. The only slight difference I thought was the depth of speakers; the clinically focused presenters had extensive clinical experience but were also very much embedded in the academic world and had published extensively. Those presenters who delivered a strategic/political focus came with a long list of credentials and are integral to the development of primary health care in the UK.

The trade stands at conference were probably not as good as what I have experienced here in New Zealand and I think that we are fortunate that our conferences are so well supported by companies involved in primary health care. As part of the conference we attended a gala dinner at the Cardiff City Hall, a fantastic historical venue for such a regal event. Attendees were dressed in black tie and the majority of the women were in full-length dresses. During this event, awards were presented for the Welsh Practice Nurse of the Year and runners up. These awards were well patronized by the practice nursing community and a great way to recognise those nurses who are providing innovative, evidence-based and creative models of care for differing population groups in their community. We have awards similar to
this as part of the College of Practice Nurses NZNO but each year we struggle to get nurses to put themselves forward to the awards. This didn’t appear to be the case in Wales and I wonder what is different in the New Zealand nursing culture that makes nurses reluctant be a tall poppy!

The various practice visits provided a real insight into the primary health care environment in Wales. These visits gave us an opportunity to talk with nurses at the coalface and to discuss how they deliver primary health care services. There were various models of delivery and also various educational preparations of the nurses working in primary health care. We spoke with Nurse Practitioners through to treatment room nurses. The visit to the University of Glamorgan provided an opportunity to hear about their strong research culture and provision of ongoing education and professional development for practice nurses in Wales. Here we visited their skills lab and were in awe of the equipment that they had for their undergraduate and postgraduate nurses and midwives to practice on. The different types and number of mannequins available was extensive and expensive! The mannequins in the photo could talk, breath, cry and had a pulse – so life like. He was also wire-less so he could be taken anywhere to enact out different scenarios. The University lecturers are extremely proud of their state of the art skills lab and were very keen to show us this facility.

Not only did I learn a great deal about primary nursing and primary health care delivery whilst in the UK, I also had the experience of driving a boat, negotiating a canal lock (unsuccessfully), riding a horse, trying clotted cream and visiting castles and historic buildings. We would spend our days rushing from visit to visit and then our nights digesting not only our dinner but all we had experienced during the day. We would debate, debate and debate some nights and at times agreed to disagree. However, by the end of the tour we had clear objectives of what we need to achieve to continue the development of primary health care nursing in New Zealand. Being part of the tour was a fantastic opportunity and a great experience.

My thanks to Mark for his proactive approach to move practice nursing forward, to Gabe for her fantastic organization skills and ‘mothering’ during the tour and to the other tour members for being such sensational company.

In closing some memorable quotes from our study tour colleagues:
“Hearts and minds approach” does not always work- change management requires a considered approach, you cannot expect for all to change hearts and minds. (Primary Care Support Unit Manager.)

“It is arrogance of success to think what you did yesterday will be sufficient for tomorrow” (William Pollard)

Hutia te rito o te harakeke
Kei he te komako e ko
Kia mai kia ahua
He aha te mea nui o tenei ao
He tangata, He tangata, He tangata
Pluck out the heart of the flax
Where will the bellbird get its sustenance?
Ask me what is the most important thing in the World
And I will say to you
It is people, It is people, It is People