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
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The Evaluation of the Eleven Primary Health Care Nursing Innovation Projects: A Report by the Primary Health Care Nurse Innovation Evaluation Team

PRIMARY HEALTH CARE NURSING INNOVATION EVALUATION TEAM

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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.
### ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACC</td>
<td>Accident Compensation Corporation</td>
</tr>
<tr>
<td>CEO</td>
<td>chief executive officer</td>
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<tr>
<td>DHB</td>
<td>District Health Board</td>
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<tr>
<td>DoN</td>
<td>Director of Nursing</td>
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<tr>
<td>DoNPHC</td>
<td>Director of Nursing, Primary Health Care</td>
</tr>
<tr>
<td>FTE</td>
<td>full-time equivalent</td>
</tr>
<tr>
<td>GP</td>
<td>general practitioner</td>
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<tr>
<td>GST</td>
<td>Goods and Services Tax</td>
</tr>
<tr>
<td>HPCA</td>
<td>Health Practitioners Competence Assurance Act</td>
</tr>
<tr>
<td>JNL</td>
<td>Juken Nissho New Zealand Ltd</td>
</tr>
<tr>
<td>MeNZ B</td>
<td>Meningococcal B Vaccination</td>
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<tr>
<td>NGO</td>
<td>non-government organisation</td>
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<tr>
<td>PHO</td>
<td>primary health organisation</td>
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<tr>
<td>SIA</td>
<td>Services to Improve Access</td>
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INTRODUCTION

In 2003, as part of implementing the Primary Health Care Strategy (Minister of Health 2001), 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.

This report describes the findings from the evaluation of the 11 primary health care nursing innovations selected for funding by the Ministry of Health. It provides an overview of the innovations’ success and of the lessons learnt from this policy initiative.

Background

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 (Minister of Health 2001). Others included He Korowai Oranga: Māori Health Strategy (Minister of Health and Associate Minister of Health 2002), the Pacific Health and Disability Action Plan (Minister of Health 2002), and the New Zealand Disability Strategy (Minister of Disability Issues 2001).

The Primary Health Care Strategy built on the population health focus and outlined how a different approach to primary health care would improve the health of all New Zealanders. District Health Boards (DHBs) became the new local health organisations responsible for funding and planning services in their districts, and now provide many hospital and community services, and purchase services from community-based providers, including for primary health, mental health, disability support and care for the elderly. DHBs are accountable to the Minister of Health. The Ministry of Health provides policy advice and funds DHBs, but also contracts directly for some services, such as disability support services.
Another key facet of the Strategy was the establishment of primary health organisations (PHOs) – not-for-profit bodies funded on a capitation basis to provide a set of essential services to enrolled populations. PHOs began to be established in July 2002. The vision and direction of the Strategy were to be expressed through PHOs, which would provide both first-line services and population/preventive health services. PHOs include both the community and providers in their governing processes. The six key directions for primary health care described in the Strategy are for PHOs to:

- work with local communities and enrolled populations
- identify and remove health inequalities
- offer access to comprehensive services to improve, maintain and restore people’s health
- co-ordinate care across service areas
- develop the primary health care workforce
- continuously improve quality using good information (Minister of Health 2001: 7).

The Primary Health Care Strategy identified primary health care nurses as crucial to its successful implementation and required the Ministry to:

... facilitate a national approach to primary health care nursing that would address the capabilities, responsibilities and areas of professional practice, as well as setting educational and career frameworks and exploring suitable employment arrangements. (Minister of Health 2001: 23)

Primary health care nurses – who work in a wide number of roles in a variety of settings such as homes, schools, general practices, clinics, workplaces and marae – are explicitly identified in the following definition as:

... 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 group of the people determine models of practice. Partnership with people – individuals, whānau, communities and people – to achieve the shared goal of health for all, is central to primary health care nursing. (Expert Advisory Group on Primary Health Care Nursing 2003: 9)

A 2001 survey of nurses practising in primary health care and community settings had identified a number of issues and barriers that prevented these nurses from practising to their full potential (Ministry of Health 2003b). These included:

- low numbers of Māori and Pacific nurses
- an ageing primary health care nursing workforce
- uneven geographic distribution of primary health care and community nurses
- role fragmentation
- uneven access to education because of lack of time, finance and relief staff
- few clinical career pathways and leadership positions
- deficient communication and collaboration.
To help the Ministry achieve its goals for primary health care nursing and nurses’ contribution to the Strategy, an Expert Advisory Group for Primary Health Care Nursing, consisting of nurse leaders from throughout New Zealand, was appointed by the Ministry. In 2003 the Expert Advisory Group developed a framework for activating primary health care nursing (Ministry of Health 2003a) in response to the Primary Health Care Strategy. The framework stated that the fragmentation of nursing services caused by different funding and employment mechanisms had contributed to the under-utilisation of nurses in many settings. It made a number of recommendations to the Ministry of Health, DHBs and PHOs for implementing the Strategy. These focused on:

- aligning current primary health care nursing practice with community need
- developing nursing leadership to facilitate the development of new roles and models of practice
- encouraging nurse involvement in the governance of PHOs
- education and
- developing a national career pathway for primary health care nurses, as well as advanced nursing programmes and nurse practitioner programmes.

Among the other recommendations made to the Ministry 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’ (Ministry of Health, 2003a: ix).

In response to this document, the Ministry allocated $7 million to fund nursing innovations for a three-year period from July 2003 to July 2006. The aim was to build on the gains made by existing models of nursing practice in primary health settings and to support a culture of change within nursing to align it to the Primary Health Care Strategy and the establishment of PHOs. A total of 139 proposals were submitted to the Ministry through DHBs for consideration for funding (Ministry of Health 2002a), and 11 were selected for funding.

In addition to funding the innovations, the Ministry allocated $300,000 for the independent evaluation that is the subject of this report.

**The 11 innovation projects**

Eleven innovation projects were selected by the Ministry of Health, and were evaluated for this report. They were as follows.

1. **Nursing Integration Leaders** *(Northland DHB)* appointed three nurse integration leaders 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.
2. **Kaupapa Māori Primary Nursing Service (Auckland DHB)** was located in Auckland and 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.

3. **Counties Manukau Primary Health Care Nursing Innovation (Counties Manukau DHB)** developed a nursing leadership infrastructure across the primary health care sector to support the DHB’s Primary Health Care Plan.

4. **The Integrative Nursing Service Scheme (Lakes DHB)**, based in Turangi, aimed to develop a new form of primary health care nursing practice within Tuwharetoa Health Services Ltd in Lakes DHB.

5. **Health Reporoa Incorporated (Lakes DHB)** 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, where general practitioner (GP) services were diminished and where there was no public transport.

6. **Tairawhiti Innovative Nursing Team (Tairawhiti DHB)**, based in Gisborne, was formed through a partnership among 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.

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

8. **Combined Primary Health Care Nurses Group (MidCentral DHB)** was a DHB-wide project. 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.

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

10. **Hutt Valley Youth Health Service (Hutt Valley DHB)** aimed to develop the role of nursing within VIBE (the Hutt Valley Youth Health Service), 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.

11. **Neighbourhood Nurses in Reefton (West Coast DHB)** 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 provided.
Nursing in primary health care settings

Internationally, the potential for nurses to contribute extensively to primary health care by facilitating improved access to first-level care and thereby help reduce inequalities in health has been widely recognised since the Alma Ata Declaration of Primary Health Care in 1978 (Barnes et al 1995; Carryer et al 1999; Cherrington 1986; Shaw 1986, 1986b; World Health Organization 1978). Increased nurse involvement in primary health care is acknowledged to be an effective way not only to reduce inequalities in health but also to improve population health in a way that is cost effective to the country (Ministry of Health 1998; Roe et al 2001). Nursing is recognised as being philosophically aligned to primary health care, and is also strongly aligned with the health promotion philosophy espoused by the Ottawa Charter (World Health Organization 1986) and the Jakarta Declaration (World Health Organization 1997; King 1994). Nurses in New Zealand are considered to be well positioned to work in more effective ways to utilise their abilities and to improve the health and wellness of individuals, families and communities (Carryer et al 1999).

There is also a long tradition of autonomous and innovative nursing practice and outreach in relation to community and population need in Aotearoa/New Zealand (Carryer et al 1999). Historically, nurses have provided primary health care services for people in homes, schools, workplaces, and health and wellness clinics. Prior to the 1980s and the advent of primary health care terminology, these nurses were known as ‘nurses working in the community’.

New funding that became available during the 1970s and 1980s specifically targeted the development of community-based primary health care. Generally, nurses identified with their employing body or the particular population group with whom they worked. The diverse roles undertaken included (among others) the district nurse, public health nurse, Plunket nurse, iwi nurse, youth health nurse and school nurse, as well as the more recent practice nurse role situated in general practices. Specialties covered by primary health care nurses were also diverse, and included disease-state management, Māori health, Pacific health, Asian health, migrant health, older persons’ health, child health and occupational health (Sheridan 2005). The practice of nurses in primary health care was designed to integrate with and be complementary to (and in some scenarios substitute work undertaken by) other primary health care providers, mainly GPs.

By the 1990s the emphasis in health funding changed to a more targeted approach, one outcome of which was the development of a number of nurse-led services. However, changes to health service structures in the 1990s also encouraged a competitive output-focused climate, and contracts precipitated a reduction and change in the specific contributions of nurses to the community, such as public health nurses and district nurses (Carryer et al 1999). This period is described by these authors as bringing about a ‘steady erosion of the confidence of nurses and a growing invisibility around their contribution’ (p. 11). It also resulted in fragmented funding streams for primary health care nursing delivery. However, the nurse-led initiatives did provide evidence of the capacity of nurses to step out of the more constrained roles of nursing in primary health care and function in more responsible and autonomous ways. As such, they foreshadowed the present innovations funded by the Ministry of Health.
Internationally, changes in nursing practice such as the emergence of case management, the integration of primary health care teams and the development of nurse practitioners also influenced the direction of nursing in New Zealand (Connor et al 2005). Advanced nursing practice roles and case management are evidence of this international influence, which is also seen more generally in primary health care nursing. Such shifts in nursing delivery were seen as early models for developing the potential of nursing, as advocated in the Primary Health Care Strategy.

The move towards establishing nurse practitioners in New Zealand began in the mid-1990s and included – but was not restricted to – primary health care. The Ministerial Taskforce on Nursing (1998) saw that a major constraint on advancing nursing practice to its full potential was the lack of recognised skills, mainly in relation to the diagnosis and treatment of disease. Restrictions on prescribing of medication, limited access to diagnostic laboratories, and limited acceptance of a nurse’s authority in signing for sick leave or referral to specialist services were cited as issues to be addressed. These constraints had also been identified earlier (Brash 1986; Hawken and Tolladay 1985). Since the Taskforce made its recommendations, the scope of practice for the New Zealand nurse practitioner (Nursing Council of New Zealand 2001) and a process for gaining registration for this scope of practice have been developed (Nursing Council of New Zealand 2002).

Nurse practitioners are ‘expert nurses who work within a specific area of practice incorporating advanced knowledge and skills’ (Nursing Council of New Zealand 2001). They can register with or without prescribing rights. By July 2006 there were 25 registered nurse practitioners, nine of whom had prescribing rights. Of these, 16 were reported as being employed as nurse practitioners (Ministry of Health 2006). Five of these nurses have primary health care named as their area of practice; others, such as those who have youth and diabetes as their area of practice, also undertake some work in primary health care.

It was against this background of a long tradition within New Zealand of nursing in the community, combined with recognition of the role and potential contribution of nursing to goals of the Primary Health Care Strategy, that the innovation funding was made available. The innovations would build on the gains made by existing models of nursing practice in primary health settings and support a culture of change within nursing to align it to the Primary Health Care Strategy and the establishment of PHOs.
THE EVALUATION

The evaluation was designed to reflect the innovative nature of the projects. The nature of innovation meant it was important that the research be able to capture the unexpected and not only data on pre-identified topics. The design took cognisance of the vision and goals in the framework for activating primary health care nursing in New Zealand (Expert Advisory Group on Primary Health Care Nursing 2003), which had identified key developments if nursing were to successfully contribute to improving the health of the people of New Zealand.

Aims

The aims of the evaluation were to:

- describe the process of establishing and operating the 11 innovations
- identify the extent to which the innovations achieved the outcomes they were contracted to achieve with the DHBs
- identify the factors that explain the degree to which the innovations succeeded
- draw lessons from the overall evaluation that will assist other nurses and groups to develop the role of primary care nurses
- disseminate the results of the evaluation in a format that is accessible to other nurses and organisations interested in primary care nurses (Ministry of Health 2003c: 8).

Each of the 11 innovations was evaluated with a view to providing information in line with the Ministry of Health’s request to explore the experience of the individual projects and the overall lessons to be learnt from all the innovations. Such information would inform future developments for primary health care nursing in New Zealand. In addition, four case-study sites were investigated to provide more in-depth understanding of the issues faced in establishing nursing innovations. Ethical approval for the research was gained from the Multi-region Health Ethics Committee.

The evaluation plan included capturing the views of national stakeholders, undertaking separate evaluations of each of the 11 innovations as well as of the innovations as one initiative. The design aimed to:

- describe the history of the development of nurse-led services in New Zealand, including identifying factors that affected their success
- establish national stakeholders’ understanding of the history of the development and vision held for primary health care nursing, the primary health care pilot innovations, workforce issues and policy implications, and to inform the design of the evaluation
- describe the development of each innovation and the extent to which they achieved the goals identified in their contracts with DHBs
- identify the factors that affected each innovation’s development
identify the strengths and weaknesses of the innovations and innovation models, both individually and as a whole

describe and analyse the interactions of the innovation nurses with PHOs, DHBs and Ministry of Health personnel and how these contributed to the innovation

identify the workforce development needs of the nurses involved and how these were, or could be, addressed

identify the extent to which the innovations affected the improvement of health services for Māori and population groups with particular needs

identify the extent to which the innovations contributed to the reduction of health inequalities.

A comprehensive literature review highlighting the features and context of primary health care nursing innovation in New Zealand was completed to inform the evaluation (Connor et al 2005). The evaluation used a participatory approach, which involved the researchers engaging with participants in the construction of knowledge (Schwandt 2000; Stake 1995). Central to this approach was the involvement of innovation personnel, including employers and advisory group members. The approach adopted is consistent with Māori aspirations for research (Bishop 1998; Durie 1998; Tuhiwai Smith 1996, 1999) and with primary health care practice. The overarching framework involved gathering data and experiences from each innovation separately and from the 11 innovations as a group, on pre-identified topics such as funding, staffing, relationships and activities. The framework also recognised that it was important to capture what was unique and unexpected in each innovation.

**Methods**

Methods for gathering data were selected to uncover and describe the features of the innovation initiative as a whole as well as each of the individual innovations. Methods included:

- interviews with national stakeholders
- site visits to each innovation, which involved interviews with innovation personnel and local stakeholders and a review of documents
- annual workshops with innovation project personnel.

Where possible, to enable comparison, a standardised approach was used for data gathering in the national stakeholder interviews, within innovations, among the innovation sites, and across the three workshops. These methods are discussed in more detail below.
Interviews with national stakeholders

Interviews were undertaken with Ministry of Health stakeholders, a number of national nursing leaders, and Health Workforce Advisory Committee members at the start of the three-year innovation term, and with Ministry stakeholders at the end of the evaluation period. The initial interviews aimed to establish stakeholders’ views of their hopes, interests and concerns about the 11 innovations and about the development of primary health care nursing. The final interviews aimed to establish issues the Ministry had identified relating to developing the primary health care nursing workforce since the establishment of the innovations. The interviews were tape-recorded and/or notes were taken.

Site visits

Between two and four visits were made to each innovation site. At these visits key informant interviews were undertaken and observations made of the everyday reality and progress of the 11 innovations. Relevant written and website documentation was also gathered. The purpose of the initial visit was to reach an understanding of the background, development, experience and activities relating to establishing the 11 innovations, and of the contractual arrangements and accountabilities required by DHBs. The later rounds of data gathering focused on the activities and progress of the 11 innovations in relation to their goals, and the views of stakeholders on the impact the innovation was having on the delivery of primary health care by nurses.

Semi-structured interviews with innovation personnel and local key stakeholders took place during site visits, which identified issues particular to each site. Stakeholders to be interviewed were identified by the evaluation team in consultation with nurses in the 11 innovations. Stakeholders included DHB funding and planning personnel and nursing leaders, nurses engaged in the 11 innovation activities, and provider managers and chief executive officers (CEOs) such as those in PHOs and other health organisations. Where indicated and available, health practitioners such as GPs and other health and social agencies (eg, Māori service providers) were also interviewed. Interviews were either tape-recorded or notes were taken. Regular telephone and email communication was maintained with innovation personnel over the course of the evaluation. Notes were taken of these conversations.

Four innovations (Northland, Counties Manukau, Hutt and Reporoa) were selected as case studies for more in-depth analysis to provide a fuller understanding of differences between and among the 11 innovations. The case studies were selected in relation to:

- geographical spread
- features of the innovation
- focus of the innovation in terms of client group
- governance
- location in relation to PHOs and DHBs.
The evaluation team made three or four visits to each case study site, where the activities of the project team were observed and the interviews or focus groups with the stakeholders took place. Additional information gained from the case study site visits involved the perspective of community and user groups. For example, in Northland a focus group with Care Plus nurses was held, and interviews with CEOs of Māori providers and PHO board chairs were held. In Counties Manukau a focus group with iwi provider nurses was held and the CEOs of Māori and Pacific providers and PHOs were interviewed. In Hutt two focus groups were held: one with youth and one with school health nurses. In Reporoa representatives from community agencies were interviewed and a focus group held with service users.

**Workshops with innovation project personnel**

Three two-day workshops were held during the evaluation period, and all innovations were funded to send two representatives to each workshop. These workshops were also attended by Ministry of Health nursing personnel. The aims of the workshops were to:

- provide support for innovation development
- understand change and barriers to change
- collect evaluation data from each innovation project and the initiative as a whole
- promote organisational learning within and across innovations, and among the innovation project personnel and stakeholders.

Data on innovations’ progress and developments was generated by participants at the workshops. The forms of data included written, tape-recorded and videotaped material. The series of three workshops provided a cogent history of development over time.

**Analysis of data**

Transcripts of tapes and notes of interviews were reviewed, and through an iterative process the main points made by each informant in relation to key research questions were identified. These were substantiated by cross-checking quotations from the interview. Interviews for each innovation were analysed as a group to gather an overall picture from the different stakeholders’ experiences of the establishment and operation of the innovation. This analysis was then linked to researcher observations during site visits and workshops.

At the workshops, written data from rapid appraisal techniques – brainstorming, mapping, grouping and ranking, modelling, matrix scoring and trend and chance analysis – was collected. Data was collated under the theme each exercise addressed. Inductive analysis was used to identify trends both within and across innovations, and to identify particular and shared issues and recurring themes. Sessions to gather participants’ stories of ‘most significant change’ were held at the first two workshops. Analysis of these involved a participatory review process to identify stories that encapsulated common and different experiences. Attention was paid to identify those issues that required higher-level interventions or had policy implications.
Documents, reports and some innovation records were reviewed to build a coherent description of each innovation’s history, objectives and achievements. Comparisons were made between the intended and actual outcomes, and to identify unanticipated achievements, difficulties and outcomes. Innovations had a responsibility to report three-monthly to DHBs on innovation activity and variance against the project plan. Copies of these reports were made available to the researchers. DHBs had a responsibility to report to the Ministry on spending and project variance. These were confidential reports relating to the contractual obligations of the DHB to the Ministry regarding an innovation’s progress and financial outlay, so they were not sighted by the researchers. This has meant that details relating to variance in innovation funding could not be verified from financial statements.

Triangulation of the analysis was made possible by combining and comparing data from different sources. The findings from these sources combined to give a complete picture of the 11 innovations and of the key findings. Each innovation was sent the summary reports produced by the research team for feedback and confirmation of accuracy.

A framework to assess the success of the innovations was developed. This framework was based on the extent to which the innovations:

- met the indicators for each of the Ministry’s four goals in purchasing the innovations
- made progress on indicators for each of the six directions of the Primary Health Care Strategy
- met the individual objectives and indicators set by the DHB for each innovation
- secured ongoing funding for the future.

Each innovation was evaluated against these 12 areas using a three-point system, whereby three points indicated a high level of success and one point indicated limited or no success.
FINDINGS

Findings from the research are presented in three sections. The first section presents the findings from the interviews with national stakeholders. The next section presents the findings from each of the 11 innovations. This uses a similar template to report on each innovation, covering the objectives, governance, staffing, funding, features or activities, implementation, outcomes, stakeholders’ views, future and lessons from the innovation. The order of presentation of the 11 innovations is from North to South. The third section presents the overall findings from the three workshops held with representatives from the 11 innovations.

National stakeholders’ views

Interviews with Ministry of Health personnel who had responsibilities related to nursing, workforce development, primary health care and integrated care, a number of national nursing leaders, and Health Workforce Advisory Committee members were held at the start of the three-year innovation term, and with Ministry stakeholders at the end of the evaluation period. The purpose of these interviews was to inform the evaluation design and to identify areas of interest to the Ministry reporting the evaluation findings. The findings from the analysis of these interviews are presented below.

The innovations and the Primary Health Care Strategy

Nursing was viewed as a fundamental component of the Primary Health Care Strategy by all those interviewed. It was thought that the Strategy and the new PHOs would create an environment where ‘things could be done differently’ and that nursing would ‘play a bigger role in the future’. It was envisaged that the 11 innovations could ‘lead in all sorts of different directions that could be picked up by a wider group of nurses’.

Opportunities and aspirations for the innovations

Some in the Ministry envisaged that funding for the innovations would give nurses an opportunity to ‘practise to their full capacity unfettered by existing employment, contracting and funding arrangements believed to limit them’. Nurse leaders hoped that nurses in the 11 innovations would ‘make discoveries of health need and design responses appropriately’, which meant they would ‘function more autonomously’ and ‘form new relationships with communities and other health professionals, which result in improved access, which addressed inequalities’.
Others hoped the innovations would enable nurses to provide ‘alternative modes of access to primary health care’ such as in nurse-led clinics and outreach to homes, marae and community settings, and institute ‘changes for better integration of care’. As such, the 11 innovations could contribute to ‘a reduction in avoidable hospital admissions’, and ensure ‘specialised care was more readily accessible to people’. It was also hoped the innovations would ‘strengthen teamwork in primary health care’, and that nurses would work on ‘a more equal footing’ and become key players as PHOs expanded their activities beyond the general practice model of care.

**Anticipated challenges for the innovations**

From the outset, interviewees considered that there were a number of challenges the innovations needed to overcome. These fell into three broad groups: the challenge of establishing innovations in an evolving PHO environment; the challenge of negotiating with and between health professionals and health provider groups; and the need for successful innovations to secure sustainable funding at the end of the three-year term.

It was thought that the rapid establishment of PHOs, based largely on a general practice infrastructure, meant that it was going to be hard to change primary health care delivery to become more multidisciplinary and provide a wider array of services as envisaged in the Strategy. One of the challenges for the innovations was to establish relationships with PHOs and help the development of multidisciplinary service provision.

An associated challenge identified was that some GPs feel ‘threatened’ by the idea that nurses’ practice in primary health care should expand, and that this is fuelled by their ‘memories of midwifery’ as a divisive force which GPs considered had eroded their incomes. Others noted that some GPs are very supportive of nurses working to their full capacity and see that this frees up GPs to deal more adequately with people with complex pathologies. The challenge for the innovations was to manage these inter-professional relationships so that trust and confidence would be established, while the true utility of nursing in primary health care could begin to be realised.

National stakeholders considered that the establishment of working relationships and co-ordinated care with and between health provider groups, including between nursing services, would be challenging. They considered that the health system is ‘health provider centred’ and in order for it to become more ‘people centred’ closer links were necessary between primary health care providers, and between primary and secondary services.

The most common challenge raised by interviewees concerned the long-term sustainability of successful innovations. This was attributed in part to the current mechanisms used by DHBs and PHOs to plan and fund new services, and also to the limited funding streams available for nursing in primary health care. The financial capacity and priorities of some DHBs and some PHOs were also seen to be constraining factors.
Final interviews

At the conclusion of the innovations’ three-year term, interviews were again held with senior staff at the Ministry. They found there had been ‘lots of learning for those nurses’ and that the innovations had created stimulating discussions, debate and conferencing about ways in which nursing could be better utilised, and noted that some DHBs and PHOs had established pilots and innovations of their own volition.

In relation to the innovations that established nurse leaders in DHBs and PHOs, it was considered that ‘getting together groups of nurses from across the sector to work together is a tremendous achievement’. With regard to the new models of practice that had developed, one interviewee considered that ‘nurses have shown that they can work outside of the existing model of primary health care being delivered by walking into a general practice’, and that this might be a model PHOs could consider funding in the future. In relation to the development of the role of practice nurses, interviewees considered that ‘it was never going to be easy in the general practice area’ and that ‘changes in service delivery and modelling inside of PHOs will take a lot longer’.

Ministry interviewees envisaged a continuing need for primary health care nurses to further develop their competencies, and to work with other professionals and allied staff in the sector in order to develop increasing flexibility in the workforce to meet community needs. They were interested in the role and acceptability of nurse practitioners and nurse prescribing in primary health care, and the ways in which the competencies of primary health care nurses could be recognised in the scopes of practice associated with the Health Practitioners Competence Assurance Act. It was considered that nurses from the primary health care sector seemed to have ‘grabbed at educational opportunities’, and that this boded well for the future development of their potential.

Those interviewed also signalled that the Ministry was in a process of transition to the second stage of implementation of the Primary Health Care strategy. They envisaged that DHBs would play a stronger role in the development of primary health care in partnership with the Ministry and PHOs in the future. It was signalled that it was important that primary health care nursing and the innovations be fully involved in these developments.

The 11 innovations

Each of the 11 innovations had distinctive characteristics, but they also fell into one of two general models characterised by their primary focus. One model was the Leading Primary Health Care Nursing Development Model, which focused on leading broad-based change involving primary health care nurses across DHBs and/or PHOs. The other model was the Primary Health Care Nursing Practice Model, which focused on developing new, expanded or modified forms of nursing practice to particular groups of people.
Leading Primary Health Care Nursing Development Model

In this model, new primary health care nursing leadership positions were created in DHBs and/or PHOs to assist with reducing inequalities, to develop the capacity of the primary health care nursing workforce to respond to the Primary Health Care Strategy and integrate and to develop services. 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 what each achieved, broad learnings from each one, and some assessment of their overall success. 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 innovations; (ii) each of the six directions of the Primary Health Care Strategy; and (iii) the individual objectives set by each DHB for each innovation. An additional sign of success was 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\(^1\) 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 primary health care nursing across all primary health care providers, including general practices and iwi providers formally affiliated with PHOs, NGO providers, other iwi providers, and the DHB primary health care services. The nurse integration leaders facilitated the primary health care Nurse Leadership Group, which included leaders from district, public health, practice, iwi, hospice and NGO nursing. This group met six-weekly to share resources and work on regional projects.

Initially the nurse integration leaders focused on building relationships, raising awareness of the different nursing roles within teams of primary health care providers, and building cohesion in primary health care nursing teams at both local and regional levels. Subsequently they moved on to develop clinical projects that spanned nursing services.

The nurse integration leaders report that some of these projects have been completed, others are ongoing and some are now sustained by the professionals, organisations and/or communities involved. Some projects are sector-wide, while others are designed to develop nursing and the nursing workforce. Additional funding for some projects has been sourced from Services to Improve Access (SIA), the DHB, Northland Rural Health consortium and the Ministry of Health Māori Provider Development fund.

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\(^1\) All funding figures provided in this paper are GST inclusive.
Development of the primary health care nursing workforce included:

- continued facilitation of the Regional Primary Health Care Nursing Leadership Forum to guide regional primary health care nursing development
- the establishment of high-quality training and professional support for practice nurses implementing Care Plus
- the establishment of a kaupapa Māori advanced nursing service to phase in the implementation of the nurse practitioner role in primary health care within five iwi providers in PHOs
- annual Māori capacity development hui for nurses and health workers from Māori service providers
- support for practice nurses to establish nurse-led services within the general practice setting.

Service development projects included:

- the establishment of seven new adolescent school-based multidisciplinary health centres
- clinical supervision of nurses in general practice and iwi providers undertaking the screening in a cardiovascular outreach screening programme
- the consultation, development and implementation of a *Chlamydia trachomatis* screening project, which involved sexual health clinic family planning outreach services and general practice.

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

**2007 update**

The three nursing leadership positions continue, with another three years of funding secured between Northland DHB and the six PHOs. The nurse leaders continue to build relationships and teamwork across the primary health care nursing services in the region. This is achieved through involving at least two nursing services in clinical projects, shared learning and training at local and regional levels, and the nurse leaders regularly meeting and working together on regional projects.

**Summary and lessons**

The innovation’s success is attributed to both the history of strong local support for health-related projects and that the proposal was ground up and locally owned. The nurse integration leaders took a service improvement/project management approach, both at a regional level and within their specific locality. The project management approach prioritised issues and engaged health providers and community members to make local and regional changes to develop and strengthen primary health care in Northland. The project management approach also involved teams of health professionals, associated service providers and community people in the design and
The initial time spent by the nurse integration leaders building and cementing relationships with different stakeholders and health providers to establish trust, raise awareness of different nursing roles within teams of primary health care providers, and build cohesion in primary health care nursing teams at both local and regional levels formed a sound basis for the development of the service improvement projects. The stability of the nurse integration leaders and their professional and leadership qualities were also key factors.

**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.

A survey of PHO-affiliated nurses led to workforce development initiatives, including:

- monthly in-service education to develop practice nurses’ clinical practice and cultural responsiveness
- workshops to complete portfolios of practice and professional development to comply with the Health Practitioners Competency Assurance (HPCA) Act
- postgraduate scholarships for nurses to begin on the pathway towards nurse practitioner registration
- collaboration between Auckland DHB and the University of Auckland to establish a primary health care new graduate programme.

In addition, a kuia and kaumātua taumata was established by the nurse leader to provide Tamaki PHO with appropriate leadership in tikanga and give guidance and support on all matters, including the kaupapa relating to nursing services and how to make nursing services culturally appropriate.

A successful Bronchiectasis Road Show to address the incidence of chronic lung disease among Māori and Pacific children in the community was undertaken in collaboration with the respiratory team at Starship Hospital. A new project, Tamaki Toi Tu Kids Service, aimed at addressing the health of high-needs children, is planned, and includes a paediatric nurse practitioner.

The need for nurses to comply with the HPCA Act to achieve competency-based practising certificates provided a catalyst for practice nurses, their employers and the PHO to recognise the importance of professional nursing links and ongoing professional development for nurses that was nurse-led.
This innovation is still in a 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 the scarcity of Māori nurses. It was considered a partial success by stakeholders, meeting some but not all of its DHBs objectives and achieving a high level of success only on the Ministry goal of transitioning 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 the in-service education sessions and the establishment of the kuia and kaumātua 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.

**2007 update**

At the end of 2006 a paediatric nurse practitioner and a community child-health worker were appointed to the Tamaki Toi Tu Kid’s Service. This service has continued to develop and is a diverse, whānau-based whānau ora service, integrated with Tamaki Healthcare PHO provider clinics, well child service providers, after-hours services and hospital services. The taumata group continues to meet bi-monthly and provides leadership and advice in tikanga Māori. Cultural competency training for primary health care professionals has been undertaken and extended to other Māori PHOs within the wider Auckland region. Clinical nurse education monthly sessions continue to be well attended by primary health care nurses, and the nurse leader has established combined clinical nurse education with other Auckland DHB PHOs, thus strengthening networks.

**Summary and lessons**

The concurrent development of this innovation and Tamaki PHO created difficulties for both the innovation and the PHO, especially because Tamaki PHO was a small access PHO with fewer resources than larger PHOs, had a small developing infrastructure, professional workforce recruitment and retention difficulties, and an enrolled population with high needs.

The low numbers of Māori and Pacific nurses in general, and in primary health care in particular, leads to there being a small pool from which to draw nurse leaders. It also affects the development of appropriate Māori-based services and makes Māori nurse leaders’ tasks more difficult. In this instance, establishing a leadership role in a newly formed organisation unused to nursing leadership took time and was taxing for the first nurse integration leader. If primary health care nursing leadership is seen as necessary to primary health care, then the development of this leadership will take time and investment. In order to develop nurse leaders who identify as Māori and Pacific and who have additional cultural expectations in the leadership of nursing, the time and investment required is likely to be greater.
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 (DoN) within the DHB nursing budget.

A Primary Health Care Nurses Reference Group was established, with representation from all primary health care nursing services in the DHB. One full-time equivalent (FTE) Māori and 0.5 Pacific nurse leaders were appointed to the two Access PHOs, Te Kupenga o Hoturoa and Te Pasefika Health Trust, and provided clinical leadership to Māori and Pacific nurses within the PHOs. A nurse practitioner, initially employed in the emergency department, moved to practise in Trust Health in Te Kupenga o Hoturoa PHO. Processes for future nurse practitioners’ employment and operation were established.

A primary health care nurse leader within the DHB was appointed, with a part-time role with the University of Auckland School of Health. There was also a part-time nurse educator for primary health care, who facilitated education for the primary health care nursing workforce by drawing education resources together from across the DHB and tertiary education in Auckland and Counties Manukau. Additional DHB funding and staffing for three additional primary health care nurse specialists in the DHB supplemented aspects of this innovation and built on it.

Key achievements included:

- the involvement of primary health care nurses in all governance and operational committees of the DHB and PHOs
- the development of nursing clinical governance and quality
- successful collaboration to complete the Meningococcal B Immunisation campaign
- links forged across the primary and secondary sector, enabling joined-up care for people with high needs
- devising and operationalising a comprehensive workforce development plan
- achievement of Clinical Training Agency financial support for first-year entry to primary health care practice for new graduates
- partnerships with tertiary nursing institutions to align nurses’ learning needs with curriculum and learning opportunities
- provision of practical support and encouragement for nurses to undertake education
- the establishment of a clinical career pathway for primary health care nurses to enable staged development towards becoming nurse practitioners.
The project appointed primary health care nurse leaders, educators and specialists to lead the DHB in its primary health care endeavours 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.

**2007 update**

The primary health care nursing team continues, consisting of a nurse leader, two nurse specialists, a nurse educator and infection control consultant with links to nurse specialists in outreach roles, and an acute care team that links to primary health care providers to reduce the uptake of emergency care. Regular mentoring and meetings take place to support the team members. There are Māori and Pacific nurse integration leaders in PHOs, and a Māori nurse educator. New graduates have been placed in primary care, with support from the primary health care nursing team using the preceptor programme, and the education initiatives continue, including postgraduate study and portfolio and professional development, two practice nurses working towards transition to nurse practitioner statues, a nurse practitioner (colposcopy) now working in the Māori PHO, and a secondary outreach nurse practitioner role has been established (respiratory).

There is continued collegial support through six-monthly forums and DHBNZ’s Leadership and Management Programme training opportunities for three nurse leaders in the last 18 months. There is continued development of clinics involving secondary outreach nurse specialists (eg, cardiovascular disease, heart failure, sexual health), and a primary health care nursing team supervising and providing clinical support in setting up chronic obstructive pulmonary disease clinics in two PHOs. A workforce project has been completed, covering competencies, contracts, and role definition for primary health care nursing roles.

**Summary and lessons**

The changes required to implement the Primary Health Care Strategy have had clear direction and leadership from this DHB. The DoN’s leadership of the innovation has enabled progress across the sector in terms of development of primary health care nurse leader positions to support the overall Primary Health Care Strategy and to encourage primary health nurses’ professional development. Senior DHB primary health care nursing leadership was established to continue this cross-organisational work.

Significant workforce development takes time to establish for both short- and long-term benefits. Responsibilities for resourcing nurses’ involvement in workforce development are at national, district, local PHO and individual nurse levels. The innovation is beginning to address issues in their control to the extent that resources allow, by working proactively with nursing educational providers and providing in-service education.

It will take some time for the benefits of these workforce developments to be seen. In addition, the development of new skills for practice nurses is constrained by existing
employment relationships in traditional medical model practices and by some nurses’ attitudes to change. While current Clinical Training Agency funding and nursing scholarships are making some difference, it seems that if more rapid change in the role of primary health care nurses is sought, then current funding levels may be inadequate.

**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.

The innovation involved the establishment of a Primary Health Care Nursing Development Team and an elected Primary Health Care Nursing Clinical Council of Nurses. The project involved all primary health care nurses in the MidCentral region and was led by a Director of Nursing, Primary Health Care (DoNPHC), who was initially supported by a DoNPHC (Māori), but more recently by a Māori nurse adviser. The DoNPHC worked alongside the DHB director of nursing and was financially accountable to the general manager (funding) of the DHB.

Innovation activities included:

- working with services to incorporate a primary health care nursing approach
- developing a primary health care nurses career pathway, including a professional development portfolio guide and a new graduate programme
- developing a data set for shared communication
- developing a nursing network for communication to all primary health care nurses
- developing an HPCA portfolio workshop and guide
- supporting integrative practice through formal working relationships with over 100 providers who employ primary health care nurses
- working with the DHB and PHO on strategic plans, workforce plans and initiatives relating to nurses.

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 in purchasing the innovation. The innovation 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.
2007 update

The Primary Health Care Nursing Development Team negotiated funding from MidCentral DHB to maintain and build on the primary health care nursing innovation infrastructure, particularly the development of chronic conditions management across the region. The infrastructure consists of the nursing professional practice model, which encompasses education and research, clinical practice and collaborative practice components.

Summary and lessons

The alignment of the innovation with the New Zealand and MidCentral DHB primary health care strategies has enabled those involved to have strategic input into the DHB, and through this to influence PHO development. Although the benefits of this input may not be immediately attributable to nursing, in time increased nursing activity and altered ways of working will reveal this impact. The infrastructure and systems that have been established in this innovation provide a model for the documentation and processes required to provide such input.

The DHB’s support of the project, and its endorsement by providing additional funding, enabled the project to be given many opportunities within the DHB. The involvement of the DoNPHC at the strategic and policy-making level of the DHB has meant that nursing’s contribution and potential are recognised in many DHB plans. The local nursing leadership (the DoNPHC particular) has supported and mentored the Primary Health Care Nursing Development Team in their new roles. The leadership skills of the DoNPHC have also been important to the success of this project. This nurse and the DoNPHC (Māori) were seen as effective drivers and vital to the success of the project.

The opportunities for some nurses to contribute to further nursing developments can be hindered by funding and employment conditions. However, a broad-based nursing group will provide nurses with a platform to identify areas of duplication and gaps, and to create solutions.

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, Tairawhiti, Wairarapa, the Hutt Valley and West Coast innovations. All these innovations provided nursing services that assisted with reducing inequalities and that reached out to particular populations that 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, and appointees to the new position were to be mentored to develop a new model of nursing practice. The practice of the whānau and family nurses would re-focus health care on the whānau and family, and on how they manage the complexity of their health predicaments, with services mobilised to be responsive to need in an economical way. The two nurses established new roles complementary to other nursing roles by taking a holistic approach to people with high and complex needs, and working with family and whānau to mobilise and tailor health care.

The innovation managed to:
- establish procedures and documentation for practice
- slowly increase the number of clients.
- broaden the sources of referral
- allow both nurses to undertake postgraduate study.

However, 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 on aligning health services to people’s need was minimal. This was attributed by the PHO CEO 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 transitioning to the PHO. The innovation ‘did not really meet’ DHB expectations, but the DHB plans to build on the learnings to develop nursing services in Turangi.

2007 update

Following the end of the innovation funding, 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 the new chronic care management policy. How successfully these two parts of the role will be integrated is yet to be seen.
Summary and lessons

In line with the Primary Health Care Strategy, this project’s model and goals sought to refocus care so that the needs of people were pivotal to nursing practice and to the services offered to people in Turangi. Facilitation of integration was difficult to achieve based within a health provider, given the instability of services and the climate of mistrust between providers and factions of the community. For integration to occur, a vision that is shared by services and practitioners needs to be established, and services and practitioners need to clearly articulate what they can and cannot offer (and understand this in relation to other services), agree there are benefits to closer working relationships, identify the links required to improve integration and be prepared to change so that integration can occur. Once these relationships, understandings and agreements have been established, systems and processes need to be developed to institutionalise this closer integration. Overall, the innovation could have benefited from a broader governance base and a more staged approach to develop integrative practice between nurses and other service providers so that progress was cumulative.

The innovation has been successful in bringing the PHO and DHB together to focus on the ways in which relationships between services can be enhanced, and how the delivery of services can better meet the needs of the population.

Health Reporoa Incorporated (Lakes DHB)

The Health Reporoa innovation is a service-based project, which provides a first-contact nurse-led service for a 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 where GP services were diminished and where there was 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 Taupo and Rotorua and to the east into Kaingaroa Forest. The project was initiated by the community.

The nurses held self-referral clinics that included:
- undertaking triage
- treating minor injuries
- engaging in occupational health
- assessing the health of adults and children
- providing care for people with asthma, diabetes and sexual health issues (including cervical screening)
- undertaking health promotion and maintenance checks with preschool, primary and secondary school pupils.
Standing orders for medications were used to support the care provided by the nurses. Some GPs visited the region on a regular basis to work collaboratively with the nurses and to provide clinics at venues such as the secondary school and Kaingaroa. A robust records system was established, and explicit pathways for informing GPs of patients’ situations were successfully employed. The contract for the innovation sits within other Health Reporoa contracts with other purchasers, such as Lakes DHB and the Accident Compensation Corporation (ACC). Each contract is focused on the health care of the local community to ensure integration and complementarity between contracts.

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 PHOs it met the other goals of the Ministry in purchasing the innovation. This innovation was highly successful and provided essential first-level services to this community.

2007 update

Health Reporoa Incorporated started a new contract with Lakes DHB in July 2006, combining the three contracts held previously, including community specialist nursing, nurse-led self-referral clinics, and school and school-based health services. In addition to the five nurses and the administrator, two part-time community health support workers joined the team in July 2006, one in the Kaingaroa Village and one in Reporoa. Workforce development continues, with two nurses working towards master’s degrees with the Rural Institute of Health and one nurse gaining a scholarship to study full time. There are five clinics per week in Reporoa: four at Reporoa College, two at Kaingaroa Village, one per fortnight at Whare Hauora, and one per week in industry. All clinics are well attended, although district nursing numbers fluctuate from week to week.

Summary and lessons

Nurses willing to respond to rural health needs and to advance their practice through formal study support the expansion of rural generalist nursing practice, a goal of the Primary Health Care Strategy. The nursing practice model Health Reporoa has developed is embedded in their local community. Community need shapes the knowledge and skills base of the practice and is its focus. In committing to this partnership way of working, the practice model will evolve and change as community need changes. As such, it is a transformational model of practice with permeable boundaries in which the sphere of knowledge and activities can evolve in relation to changing circumstances.

The evolution of this model is facilitated by two important factors: the provision of an appropriate Clinical Training Agency-funded education programme that is relatively accessible in terms of the travel involved, and the positive encouragement from employers, who facilitate time away from the service and finance travel and accommodation expenses.
The Health Reporoa service, which provides first contact care to many of its rural population, has developed collaborative relationships with the GPs of their clients while remaining independent practitioners. This dynamic could be upset if a competitive element relating to enrolment funding entered into the relationships as Health Reporoa progress towards some affiliation with the PHOs in their region.

Standing orders and authority for diagnostic tests are particularly useful in outreach nurse-led clinics and in rural isolated areas, but standing orders are dependent on individual arrangements between each GP and the nurses, which is time consuming, especially when a number of GPs are involved. Moreover, people whose GPs do not participate in establishing standing orders and people in transit miss out. A more co-ordinated approach to standing orders, within either a PHO or a DHB, would help to achieve greater equity of access for the whole of a population. Examples of standing orders established by Reporoa have been circulated to other innovations as prototypes for adaptation. The collection of such prototypes at a national level would assist other nurses to establish this facility in other outreach or rural services.

The contribution to strengthening families that is evident in the feedback is another equally important health and wellbeing outcome being made by Health Reporoa. It differs from the instrumental outcomes associated with the overlap of medical and nursing work in that it is primarily relational in its focus. This type of outcome is expected in public health nursing (Gallagher 1999), which is incorporated in the Health Reporoa model of practice but is not always visible in other areas of nursing.

**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, and following a mid-term review each organisation held a separate budget allocation.

Following the mid-term review, the positions funded by the innovation include:

- part-time wellness centre nurse and community health worker positions, co-ordinated by Plunket and focused on child and family health
- part-time nurse and community health worker positions within the Patea Community Action Team, co-ordinated by HT PHO
- a full-time family health nurse position, co-ordinated by the DoNPHC in HT PHO and focused on disease state management in the context of family.

A family wellness centre was established in New Plymouth, and nurses with advanced skills in child health were contracted part time to provide intensive support for families with children with behavioural issues, feeding and toileting problems. Recipients reported high levels of satisfaction with these services, with many treated successfully over a period of four to six weeks. In Patea a nurse and community worker were employed 0.1 FTEs, formed a Patea action community group and convened weekly health promotion activities with isolated families. The community development
approach being undertaken in Patea has progressively involved families in healthy activities and learning, which will support the health of their children. Increased mutual help and reduced isolation are two outcomes.

At mid-term, concern about lack of traction of the innovation led to a review by the DHB, and in negotiation with the Ministry the innovation was expanded. An FTE mobile family health nurse skilled in chronic disease management worked with families to slow the rate of disease progression and reduce the contributory factors for children and families at risk of intergenerational diseases. Computer software was adapted using the Omaha Nursing taxonomy to capture outcomes.

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 primary health care strategy directions. This innovation has been more successful in the latter half of the innovation term.

2007 update

Although the innovation closed at the end of 2006, the participants and stakeholders collaborated to seek funding for those parts of the initiative that proved to be of benefit. These included:

- funding to build the capacity and capability of the primary health care workforce through the development of a new graduate entry programme
- funding for the development of a ‘cascade training and support programme’ to maintain the nursing skills developed during the innovation and to develop a Primary Care Bedwetting/Enuresis Training and Education programme, to be delivered to primary health care nurses in the Taranaki region
- funding for nurses to access a five-day programme for managing diabetes in the primary care setting and developing nurse-led diabetic clinics
- funding for the further development of the Taranaki Nursing Minimum Data Set using the Medtech 32 practice management system
- the full-time role of DoNPHC, part-funded under the innovation, which continues and is sustained through other funding streams.

Summary and lessons

Nurses provided families with intensive early support for specific health issues that could not be addressed under existing contracts, indicating that early and more cost-effective intervention by nurses with specialised skills can result in gains for the health of children/tamariki and families/whānau.

The recent development of the mobile chronic disease nursing role is a new nursing practice model in line with the broader scope of primary health care, envisaged in the Primary Health Care Strategy. Development of this role is still under way but could be time-limited if ongoing funding is not made available. There are limited funding streams for PHOs to support the future development of nursing roles.
Although progress continued on integrating well-child nursing services and developing the outreach service in Patea, wider development of primary health care nursing services from a strategic perspective slowed until HT PHO became fully operational and the DHB became actively involved. In order to address the fragmentation of primary health care nursing services, closer collaboration between PHOs, DHBs and national NGOs will be necessary, as will the development and involvement of nurse leaders in the sector.

**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 (JNL – Juken Nissho New Zealand), where 320 people worked, and the other was for domestic purposes beneficiaries from Work and Income New Zealand. The JNL service involved TINT nurses offering free annual health assessments and screening to all workers who consented. A plan of action to address the needs identified at the assessments was then developed with the person. The Work and Income service involved working with people who were referred by Work and Income staff or by self-referral to address needs affecting people’s health and wellbeing. Both the JNL and the Work and Income service involved nurses seeing people at these sites, in homes, and in the TINT premises.

Documentation from the assessments and information about the care provided was transferred electronically to contribute to personal health records held by GPs. The nurses also undertook health promotion activities and distributed information about health services available in Tairawhiti to people they saw, and to government departments and other services. The co-ordinator submitted her portfolio for nurse practitioner registration in mid-2006.

This innovation was considered a success by all those involved in Tairawhiti, with the exception of the DHB, which considered 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 goals of the Ministry in purchasing the innovation, 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.

**2007 update**

Ngati Porou Hauora accessed SIA funding to continue the work of the innovation. TINT became the Hauora Industrial Nursing Team (HINT) as the Work and Income portion of the project was developed locally. HINT now includes 10 companies,
including JNL, the largest with 350 staff involved, and other work sites, which vary from 6 to 100 staff. At present 2.5 FTE nurses are employed in HINT.

Summary and lessons
The strengths of TINT include:

- the skills and knowledge of the nurses
- the grounding of the programme in a bottom-up, community needs approach
- the quality and accountability in relation to clinical governance procedures
- the development and use of a systematic information system using Medtech-32
- it was established through a partnerships with community, industry and multiple health agencies.

The co-ordination of care across service areas is a goal of the Primary Health Care Strategy, and this innovation demonstrates how partnerships can be developed to support nurse-led initiatives, and how a nurse-led service can work simultaneously with two PHOs to deliver a service that targets people in the area.

Locating services within a workplace, as at JNL, made them particularly accessible, and there was good uptake by high-risk groups, especially men. The intersectoral partnerships between health and Work and Income also enabled some people with considerable disadvantage access to health care. However, there was some indication that although there was a partnership, Work and Income did not have full buy-in because it was not one of their programmes and they had not committed resources to it. The will was there, but without the impetus for the staff to deliver, the project was not optimally utilised.

Although the DHB set the broad indicators for TINT, the DHB’s needs changed to require evidence of clinical effectiveness rather than the broader outcome measures initially required. TINT nurses achieved many of the immediate, intermediate and final outcomes outlined in the Ministry’s Leading for Outcomes framework (Jones and McLachlan 2006), but providing evidence of this impact is difficult. Key reasons for this are the broad-based nature of the TINT service, the fact that changing population health outcomes takes time, and health service provision is only one of many factors that contribute to health.

The adaptation of the general practice data system (MedTech-32) to better capture nursing assessments, outputs and related outcome data is a model that could be built on to enable other nurses and health workers in outreach clinics to generate information in line with the Primary Health Care Strategy. The system allows the nurses to electronically transfer data collected at outreach clinics to the nursing base, general practices and PHOs, and provides data for use in evaluating the outreach nurse-led service.

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 (one FTE), 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.

Project activities included:

- the development and co-ordination of a multi-agency youth health service in South Wairarapa, which included a weekly nursing clinic
- the delivery of the nursing component of a whānau-based health service, which was established by a local GP at the district’s only kura kaupapa school
- the development and provision of a community-based service targeting Pacific people
- a nurse-led clinic established in partnership with two Māori providers
- the development of information systems for the project
- the co-ordination of a regular forum where all primary health care nurses in the district came together to share their experiences.

A comprehensive set of standing orders was in use in all clinics.

There were some early delays in the development of the innovation because the people involved took some time to understand what the innovation aimed to achieve and to feel at ease with the changes it might initiate or with the direction it might take. However, early concerns were resolved as the innovation developed.

Soon after the project began it was found that fewer people than expected were not registered with the local PHO, leading the innovation to place a greater focus on addressing unmet need rather than on linking people to existing primary health care services.

This innovation was considered a success by only some of those involved. PHO representatives felt the innovation had not transferred 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.

**2007 updates**

The innovation was to transfer to Wairarapa PHO in June 2007, and the outreach clinics are now managed through Wairarapa Public Health. The youth health clinic has closed and two new college-based clinics at low-decile colleges have opened, attended by both nurses and GPs. Previous clinics continue, along with a new outreach clinic at a marae in Masterton. Standing orders are provided to nurses at these clinics, who now have
confidence in using them. Outreach in the region is now regarded as an effective way to reach scattered communities. Although the aims of the innovation to create forums and cross-sector training and support have fallen into abeyance, the PHO has recently developed a Primary Nursing Action Plan, bringing together representation from a wide group of primary health care nurses for a series of six or seven meetings.

Summary and lessons
Lessons included the need to get service timing, location, staffing and privacy issues right from the start, and the need to keep the community and other stakeholders (GPs, schools, community groups) informed as the service developed. While many lessons learnt from the delayed transfer to the PHO will be specific to the Wairarapa DHB, a message for others is the need to bring all relevant parties together early to ensure that correct procedures are followed.

Establishing services such as outreach clinics takes time, because it is necessary to first establish the need and appropriateness of such services. Also, there are no templates of systems, policies and forms readily available for nurses establishing clinics to adopt – nurses are required to design their own. A documentation manual including model systems, legislation, policies and forms to be adapted by nurses establishing nurse-led clinics would reduce this work.

The skills of the nurse co-ordinator in community consultation and community development, and her familiarity with DHB systems, committees, reports and key personnel, have contributed to the success of the innovation. Both nurses’ skills and knowledge in primary health care nursing and of the Wairarapa region have also contributed to the project’s success. The employment of a GP has provided a safe way for the nurse clinics to operate in a number of different sites with groups with very diverse needs. It has also provided a mechanism for the signing of standing orders. Initial concerns by some GPs in the region were addressed openly, and with DHB information indicating need.

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), 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. 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 (10–25 years) in the Hutt Valley. The multidisciplinary team includes the service manager, community youth workers, social worker, operations co-ordinator, peer support workers, sexual health doctor, GPs and nurses. The presence of the youth health specialist nurse, who registered as a nurse practitioner over the innovation term, enabled additional community and school-based health clinics to be established. She provided professional development, liaison and supervision for school nurses and public health nurses working in schools in the Greater Wellington region, and became a
member of the DHB’s Primary Health Care Leadership Group and the DHB’s Youth Health Steering Group.

This innovation was highly successful and 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 in purchasing the innovation. It has resulted in clinical standards for youth services being developed within VIBE and within school nursing across the DHB.

2007 update

Hutt Valley DHB has contracted the nurse practitioner for a further three years. There are now eight VIBE sites, with Medtech linkage at all sites and over 6000 registered clients. Programmes provided include the BirthEd/VIBE youth antenatal initiative, and the development of youth-appropriate pamphlets. There are two new nursing graduates in VIBE community sites and school sites. There is also nurse practitioner pathway support; supervision of a youth health nurse undertaking a prescribing practicum, and support for her portfolio submission; and involvement of a nurse practitioner in a national youth health steering group progressing vocational registration for GPs, career pathways, academic programmes in youth health for doctors and nurses, youth health standards development, promotion of community-based youth health services, school-based service, kids in care services, alternative education, and teen-parent health services.

Summary and lessons

In this innovation the co-location of a youth health specialist nurse in a service designed to reach the youth population has expanded, improved and extended the existing services and established outreach services close to youth, including Māori rangatahi, giving them better access to appropriate services. Accessibility was aided by the development of standing orders for medications, but essential to the gains was the nursing leadership of the highly skilled clinical nurse, close to nurse practitioner endorsement, who acted as a change agent. Youth can be a hard-to-reach group, so the VIBE model could be adapted in other areas where there are high numbers of youth in the population.

Although nursing clinics at schools are not a new development (Clendon 2004; Clendon and Krothe 2004), the VIBE innovation provides a new service model in youth health nursing. Consolidation of the model within VIBE led to quality improvements for the whole service, and to its being adopted by nurses in new outreach school clinics and in the greater Wellington region.

Streamlined health funding mechanisms for NGOs, so that a comprehensive contract is offered with particular reporting streams, would limit the time a health service needs to allocate to bidding for and servicing many small contracts. For such services to continue to contribute in a sustainable and integrated way, work towards formal contractual links between NGOs and PHOs may need to be facilitated by DHBs, who have overall responsibility for oversight of health in their district. This kind of co-location of specialist nurses could also work for other population groups with specific health needs, such as aged care or women’s or men’s health.
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 provided. The innovation received $750,000 Ministry funding over three years, which was administered by the DHB.

During the first year a part-time project manager and consultant worked with nurses in Reefton to develop a community profile and a generic job description for this type of position. Transition arrangements began. Human resource and union processes became drawn out, project management subsided, some nurses became disaffected and the project lost momentum. The project stalled, and after a mid-term review the DHB negotiated for the project to be expanded to other West Coast communities. Active management and governance were re-established and four nurses were appointed in three communities, including Reefton, to develop and trial the new role.

Following this, rapid progress was made and the nurses provided comprehensive and new services in collaboration with GPs and other primary health care nurses. Indications are that this new phase is successful in implementing the generic primary health care nursing role. 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.

2007 update

The neighbourhood nurses have continued in their role and the innovation model is being expanded within communities to develop a model of care which, although generic, will fit the characteristics of local communities. In Hokitika the neighbourhood nurse has been integrated into the District Nursing Service, and there is debate about the possibility of two streams of care – one the traditional district nursing model and another for those with complex needs modelled on the neighbourhood nurse approach. In Dobson the neighbourhood nurse continues working from the local general practice, and in Reefton the neighbourhood nurse continues to provide a comprehensive health service to adolescents and Māori, as well as being part of the community and general practice team.

Summary and lessons

The Primary Health Care Strategy envisages an expanded role for nurses in the primary health care sector, and in this innovation public health and district nurses were involved in a process aimed at redesigning and expanding these existing roles in one locality. In other isolated areas nurses have, of necessity, combined district nursing and public health nursing roles (eg, in Takapau and Ekatahuna, McClellan and Brash 1988; Litchfield 2004), and the West Coast and Southland rural nurse specialist positions have been established to encompass these roles.
The Reporoa innovation, which is part of this report, has expanded existing roles over several years so that nurses provide more comprehensive care, while retaining some specialist knowledge or skills. Common features of these two innovations are strong community support for role redesign, and an absence or reduction of GPs available to the community. Nurses in similar innovations have undertaken advanced studies and skill development so that they become more confident and competent in their expanded role. The above factors were not particularly strong features of the West Coast innovation.

This innovation highlights the difficulties of role redesign within an existing local nursing workforce, and that human resource and employment issues should not be underestimated. The redesign of primary health care nursing roles is a resource-intensive and demanding process for each professional, for organisations and for the health sector as a whole. Providing professionals with the opportunity to actively choose to trial a redesigned role may increase the likelihood of success.

Rural areas have seen a diminishing of services within their communities and some people are suspicious of service changes. Communities need to be kept on board with the process of service changes and the implications they have for them.

**Workshop findings**

Three two-day workshops, attended by representatives from each innovation, Ministry nursing personnel and the evaluation team, were held over the course of the evaluation. These workshops were principally to gather data, but by bringing innovation personnel together an opportunity was also provided for learning within and across the innovation teams. Each workshop had a particular focus, as illustrated by the workshop titles.

Specific information obtained in the workshops about individual innovations is incorporated in the individual site reports. Following are the general findings from each of the workshops.

At the first workshop, Beginnings – Origins Management, Developmental Needs, Plans and Potential Future, some innovations reported delays while others were making good progress. Common to several was the experience of encountering resistance from both nurses and GPs, difficulties with DHB finance systems, and getting the necessary resources. Several innovations noted a change over time in organisations’ and health professionals’ attitudes from doubt about the innovation to acceptance and appreciation of the nurses’ work.

The workshop also highlighted what worked, including the benefit of community consultation, the development of quality documentation systems, the support from some GPs, and the professional and personal satisfaction of starting a service that is meeting previously unmet need. Nurses were reaching people with access barriers and there was immediate uptake of most of the new innovative services. Fragmentation of nursing services was starting to be addressed, and communication within and between sectors was beginning to improve.
At the second workshop, Practice that Makes a Difference, innovation representatives talked about the roles of the Ministry, DHBs and PHOs in supporting both the innovations and other innovative primary health care nursing developments. These might include the organisations’ various policies that supported primary health care nursing, their support for primary health care nursing education, and undertaking consultations that included the community, PHOs and nurses, before developing services.

In DHBs where strong primary health care nursing leadership was present, progress in developing primary health care nursing was noticeable. Limited primary health care nursing leadership within some DHBs was noted, and in some cases there had been difficulties costing contracts or lack of commitment by DHBs to the innovation. There was a general sense that some DHBs and PHOs did not know the range and roles of primary health care nurses working with their population, or did not have an understanding of the potential of nurses to deliver the Primary Health Care Strategy. At the third workshop, Learning: In Hindsight, representatives found that having ‘champions’ in strategic positions helped relationship building and networking, with a flow-on effect leading to greater integration of care for clients and thus better outcomes. Leadership attributes and persistence, risk taking, commitment and motivation were seen as key personal characteristics in the innovation teams. The need for mentors and support groups was acknowledged for nurses to translate their vision into practice in new organisational and practice territory. Nursing leadership at DHB level, a DoN with a commitment to primary health care or a DoN for primary health care, as demonstrated in the Counties Manukau and MidCentral innovations, was seen as imperative, as were other nurse leaders in PHOs.

Although it was believed – by some – that nurses are able to bridge the structural barriers that inhibit their contribution to primary health care, others believed that overcoming these barriers requires considerable support from the Ministry, DHBs and PHOs, whose mission it is to implement the Primary Health Care Strategy. The major barriers cited included:

- funding uncertainty and accompanying DHB deficits
- competitive business models driving PHOs, and consequently the employment conditions of many primary health care nurses
- the present capacity and capability of some PHOs
- resistance from nurses, both in primary health care and in secondary care
- lack of confidence and/or interest among nurses to step up and develop their potential and be more accountable for practising to their full scope.

There was a discussion on how to measure the contribution of primary health care nursing, a quest not unique to New Zealand. Participants believed that it was important to demonstrate that nursing adds value. The value of appropriate technology to capture this, such as a modified MedTech programme, was discussed. Various types of outcomes were acknowledged, including: population health and individual health measures, service quality and access issues, capacity and capability development, and
the achievement of best practice standards. However, most dialogue centred on measuring improvements in individual and population health rather than reporting on outputs, such as the numbers of people seen. Important factors loosely agreed upon were the need for national consistency, a shared language, and the use of both quantitative and qualitative outcomes.
DISCUSSION

The extent to which the innovations have been successful can be assessed on a number of different measures, including the four Ministry of Health goals in purchasing the innovations, or the extent to which they followed the six directions of the Primary Health Care Strategy. They can also be assessed against the extent to which they fulfilled the objectives set by each DHB for each innovation. Whether they are sustainable, as evidenced by achieving ongoing funding, is another measure of success.

This section reflects on the achievements of the innovations within these domains. It then discusses some key areas in relation to the innovations overall: the importance of the roles of DHBs and PHOs, achievements in workforce development, issues for nursing leadership, and issues and implications related to funding.

Achievements against objectives

Achievements in relation to the Ministry of Health goals

The four Ministry goals for the innovations were to:

1. support the development of innovative models of primary health care nursing practice to deliver on the objectives of the Primary Health Care Strategy
2. allow for new models of nursing practice to develop
3. reduce current fragmentation and duplication of services
4. assist in the transition of primary health care delivery to PHOs.

The innovations most successful in meeting the Ministry’s goals for innovation were Northland, Counties Manukau, Tairawhiti and MidCentral. Those that mostly met these goals were Reporoa, Wairarapa and Hutt, and those least successful were Auckland, Taranaki, Turangi and West Coast. Following is a more detailed discussion on the progress made on each of the four goals.

1. Support the development of innovative models of primary health care nursing practice to deliver on the objectives of the Primary Health Care Strategy

All the innovations became established and were operational by the end of the innovation term. Two encountered difficulties by mid-term (Taranaki and West Coast). These were reviewed by the DHB, with Ministry involvement, after which governance was revitalised and the direction expanded. Turangi and Auckland both experienced difficulties establishing their model of practice, in part because of the organisational environment, high-needs population and mix of staff available. All of the innovations made progress over time.
Nursing leadership was fundamental to facilitating all the innovations at either a clinical or an organisational level. As a group, the innovations were most successful in contributing to the Primary Health Care Strategy directions of working with the community, addressing inequalities and providing comprehensive services. Integration with other services posed difficulties for some. Some achieved significant workforce development in part because it was not one of their central goals. Although all innovations developed, obtained and used information to improve quality, the extent to which this occurred systematically and generated an evidence–based approach to innovation development varied.

2. Allow for new models of nursing practice to develop

New models of primary health care nursing leadership were established at the DHB and/or PHO levels in Northland, Counties Manukau, MidCentral and Auckland, with the first three being particularly successful at leading the development of nursing practice. Auckland was affected by leadership changes and had difficulty establishing the kaupapa Māori model, largely because of the mix of staff available within the PHO.

New, expanded or modified models of nursing practice were developed in the remaining innovations, which delivered outreach services to particular population groups. Of these, Reporoa, Tairawhiti and Hutt were the most successful in developing new ways of providing services to meet the particular priorities of the populations they served. Wairarapa successfully developed an outreach model, but encountered difficulties making the transition from the DHB to the PHO. Turangi, West Coast and Taranaki made some progress, and the main factors slowing development were insufficient buy-in from nurses and/or other primary health care providers, lapses in leadership, and difficulties integrating with other services.

Key factors in success were expert clinical leadership and the establishment of clinically sound systems that connected services.

3. Reduce current fragmentation and duplication of services

Innovations in the leadership model were well placed to work on integration and did this by bringing nurses from various services to work together on joint projects. This was particularly successful in Northland, where the nursing leaders had a focus on integration across services in the DHB from their position in PHOs. In Counties Manukau and MidCentral, district-wide primary health care nurse forums brought nurses in the sector together and provided opportunities for better communication and common understandings, and processes to be developed. Auckland brought previously isolated practice nurses in the PHO together for shared professional development and worked with secondary services on a relevant health promotion project.
In the practice models Hutt, Tairawhiti and Reporoa established strong connections with other relevant services, which facilitated the exchange of clinical information and the development of shared quality standards for clinical practice across services, and ensured that pathways of care for people were continuous. A culture of teamwork and collaboration was established within these innovations, which extended to relationships with other health professionals and providers. While Taranaki, Turangi and West Coast had a focus on integration, bringing this into practice was difficult because the advantages of reducing fragmentation did not seem to be fully appreciated by some nurses and services. The Wairarapa innovation had some success with reducing fragmentation and duplication, but the lack of transfer of the innovation to the PHO limited this.

4. **Assist in the transition of primary health care delivery to primary health organisations**

This goal had the most variation in success across the innovations. Northland, Auckland, Counties Manukau, Tairawhiti and MidCentral achieved considerable success in relation to this goal. Two were based in PHOs, one had PHO involvement from its inception and the two DHB-based innovations supported nursing development within PHOs. Reasons for lack of achievement in other innovations included PHOs still bedding down, the innovations being fully engaged in establishing the nursing model, and the relationships and responsibilities between the innovations and the PHOs not having been worked through. These innovations had working relationships with GPs and practice nurses affiliated with PHOs, but did not have formal relationships with the PHOs.

In part this lack of progress seemed to be related to the contractual relationships the innovations had with other funding organisations. Reporoa, Turangi and Hutt were based in NGOs that receive considerable support and funding from their respective DHBs. Part of the Taranaki innovation was based in an NGO with national contracts with the Ministry of Health. Similarly, West Coast and Wairarapa were aligned with the community services in the provider arm of the DHB. In these cases, the primary contractual relationship was not with a PHO, and funding for the nursing services provided was not held by PHOs. Moreover, the geographical area in which the organisation provided services – with the exception of Turangi and West Coast – did not align with the enrolled populations of one single PHO, making the establishment of contractual relationships complex.

DHBs could play a role facilitating arrangements between PHOs, the provider arm of the DHB and NGOs, while bearing in mind that such arrangements may be burdensome on small organisations. DHBs and PHOs could share decision-making regarding services, and/or the funding for them might be transferred to the PHO so that new loyalties are created. In some instances this would require the establishment of a new entity, which would add to the operational costs of services. In addition, the transition of services from one organisation to another requires a long lead-in time and careful human resource management.
Achievements against DHB objectives

Innovations that fully met the DHB objectives were Northland, Counties Manukau, Reporoa, Tairawhiti, MidCentral, Wairarapa and Hutt. Those that mostly met these objectives were Auckland, Taranaki and West Coast, while Turangi met some DHB objectives. The extent to which each innovation met DHB objectives is fully reported in the individual site reports.

Ongoing funding

Ongoing funding for a year or more has been secured by Northland, Counties Manukau, Reporoa, Tairawhiti and Hutt. MidCentral has six months’ funding, which will be reviewed before the new financial year. Turangi has three months’ funding while a review of the direction is undertaken by the DHB, and future funding has not been decided for Auckland, Taranaki and West Coast innovations. Wairarapa was to transfer to the Wairarapa PHO in 2007.

The innovations and DHBs and PHOs

DHBs initially submitted 139 different proposals to the Ministry of Health for innovation funding, indicating their high level of interest in and support for advancing primary health care nursing. DHB personnel interviewed as part of the evaluation varied, and included CEOs, DoNs, nurse leaders and funding and planning staff, and those in DHB provider arms who were directly engaged with an innovation. These interviews revealed that although the hopes and aspirations for the innovations differed across DHBs, each of the DHBs believed the innovations were an opportunity to expand the nursing workforce capacity, improve service integration, and deliver outreach services to groups known to have specific or high needs and who were currently not well served. The aspirations of DHBs for the innovations were aligned in all cases with the innovations’ objectives.

PHOs were new, and in some cases not yet established, so they were not always engaged in developing the proposals. In the four innovations (Northland, Counties Manukau, Auckland, Tairawhiti) where PHOs were involved, the innovation was designed to complement and extend the PHO’s work. In some other innovations (MidCentral, Wairarapa, Hutt) engagement with the PHOs was either an objective or a feature of the implementation plan. Few PHO representatives were interviewed early on. However, during mid-term and in the last few months of the innovation funding, interviews were held with PHO representatives in most innovations, as by then PHOs were beginning to address strategic, funding or policy issues related to primary health care nursing developments. As with DHBs, the aspirations of the PHOs for the innovations were aligned with their planned direction, the health needs of their enrolled population and the Primary Health Care Strategy.
Roles of DHBs in relation to innovations

The innovations reported on their contracts through DHBs. This meant that funding and planning staff had a key role in contract monitoring throughout the innovation term, negotiating changes and facilitating discussion about the development and future funding of the innovation. In innovations that stalled, such as West Coast and Taranaki, DHB personnel were instrumental in resolving issues and forging a new direction. Where innovations were embedded in a DHB (Counties Manukau, MidCentral), the DHB took responsibility for the financial management and governance of the project.

MidCentral worked successfully in part due to the strong leadership and management within the DHB. For example, governance was within the DHB, the general manager of funding and planning was the project sponsor, the DHB DoN was the project manager, and the DoNPHC held the budget. A Clinical Governance Council of nurse representatives from the sector was, however, pivotal to overseeing the direction of the project. In this region there is now nursing representation on many governance, clinical quality committees and operational planning groups throughout the DHB and all PHOs. Counties Manukau was another successful innovation where the DHB DoN held the budget, led the innovation and established a Primary Health Nurses Reference Group of nurse leaders. DHB support for, and investment in, the innovation’s programme of change was one of the important factors in the success of these innovations.

In some innovations, DHB DoNs provided mentoring support to innovation nurses, while in others their role was limited. DoNs generally provided support with the development of proposals, pulling together governance committees or nurses groups, and implementing workforce development initiatives such as setting up new graduate programmes in Auckland and Counties Manukau.

Financial support from some DHBs included providing additional funding or facilities. In some cases, such as in West Coast and Wairarapa, support provided included rooms and facilities, and in Wairarapa funding for a part-time GP. DHBs also had a role in providing expertise in budgeting and planning, or linking innovations with expertise in the provider arm.

The level of involvement of DHBs varied, with some taking active and regular interest while others seemed to leave the primary health care sector and the innovations to PHOs or NGOs.

Roles of PHOs in relation to innovations

The roles of PHOs in relation to the innovations varied considerably. In Northland and Auckland the innovations were part of PHOs from the outset, and the activities of the innovations were closely linked with the development and operation of PHOs. In Taranaki and Taipaiwhiti, PHOs were partners in the projects and so were involved in the governance of the innovations, and in Counties Manukau the DHB-led innovation also involved Māori and Pacific nurse leaders in PHOs. There was less direct contact between PHOs and the Reporoa, Turangi, and Hutt innovations based in NGOs, and the Wairarapa and West Coast innovations in the provider arms of DHBs, although these innovations worked with health providers associated with PHOs.
Financial support from PHOs included the provision of additional funding, largely through avenues such as SIA and health promotion funding (eg, in Northland). In Tairawhiti one PHO provided a room for study days, and the nurses could access general practice rooms and equipment when necessary.

The innovation nurses also sometimes had roles within the PHOs. In MidCentral, for example, nurse leaders advised some PHOs on their workforce strategy and developed a support group for nurses who were on PHO boards.

**Issues related to DHBs’ and PHOs’ roles and relationships**

The innovations began when PHOs were at various stages of establishment and bedding down. Responsibilities for primary health care were beginning to be worked out between PHOs and DHBs, and this has been ongoing. At times this led to confusion within some innovations about DHBs’ and PHOs’ respective roles. This confusion was exacerbated when there were changes in personnel in either the DHB or PHO, with a resultant loss of continuity and knowledge of the history of the innovation. This was further complicated by the emergence of management services organisations that support and represent clusters of PHOs.

DHBs and PHOs are both involved in commissioning primary health care services, including primary health care nursing. In the innovations providing a service that intersected with several PHOs, such as in Reporoa and Hutt, it was unclear how the innovation’s services should integrate with those of PHOs. DHBs continue to fund these innovations, but there is a need for the organisations to work together to ensure better co-ordination of services across the region to prevent significant duplication.

At the final workshop, some innovations reported experiences of PHOs working together on set projects, while others were given the impression that this was not possible. It was apparent that in some areas collaboration between PHOs to integrate care was being undertaken at PHOs’ own volition, in others DHBs were acting as key facilitators of collaboration, and in others the innovations considered there was little evidence of collaboration between these organisations. These differences can in part be explained by the newness of these structures, but they do highlight how the roles and responsibilities of key organisations in the current health structures need clarification in order to be more widely understood. It is also the case that DHB and PHO roles and responsibilities relating to primary health care nursing are still in a state of flux.

In Northland, where populations enrolled in PHOs are geographically aligned, the innovation was able to work successfully within and across a number of PHOs. In this region there was significant collaboration between the six PHOs, and strong support by all PHOs for the work being done by the nurse leaders to integrate services.
In setting up the innovations, nurses sometimes experienced negative reactions from other health managers, other health services and health practitioners, although this was often resolved over time. Nurses require collegial working relationships with other health professionals to ensure pathways of care are integrated and clinically safe. DHBs and PHOs could facilitate integrated care by facilitating these relationships.

The experience of the Wairarapa innovation highlights the complexity involved when services provided by DHBs transfer to a PHO. Such transfers need considerable lead-in planning time, human resource and union input, and clear plans about the short- and long-term direction and security of the activities.

**Implications related to DHBs and PHOs**

When opportunities arise for DHBs to do something new, such as with the innovation funding, DHBs generally embrace this and develop projects to meet their own objectives and vision.

Adoption of an innovation depends in part on the attributes of the organisations within which it might be assimilated. Such ‘system antecedents’ include the structure, capacity to absorb new knowledge and receptivity to change of organisations and communities within which the innovations are to become embedded (Greenhalgh et al 2004: 15). As we have seen in many cases the PHOs that were to host the innovations were not yet established or were in the very early stages of development. While this meant there was ample flexibility and likelihood of greater receptivity to change, it also meant structures were not yet formalised and institutional knowledge was not yet focused – both of which are associated with a higher likelihood of innovation assimilation.

DHBs and PHOs are still relatively new, and the roles and responsibilities of these key organisations in current health structures are not yet widely understood. While the roles and responsibilities of DHBs and PHOs in relation to primary health care nursing are also still in a state of flux and will continue to develop over time, there is a need for greater understanding of these structures.

Another contextual factor for innovation uptake is ‘system readiness’ (Greenhalgh et al 2004: 17). In general, the intention of the innovations – in terms of their alignment with the Primary Health Care Strategy, reducing fragmentation and increasing integration of services – sat well with the visions of DHBs and PHOs. However, although the innovations may have had similar goals to the organisations with which they were working, they often had different ways of working and were concerned with redesigning both the ways that nurses were currently organised and the service models that were currently used. This meant that in some cases local organisations and communities were not ready for such ‘innovation’, although others welcomed the change, particularly when the innovation was championed by a nurse leader. DHB and PHO nurse leaders play an important role in supporting and mentoring nurses leading change. Part of this role includes ensuring that nurses engaged in developing services know the various roles and responsibilities of the different health managers and where nurses can go to obtain the advice and expertise they might need.
DHBs have a role in working with PHOs to ensure new and existing services are co-ordinated across the region to prevent significant duplication. There is also a role for DHBs to assist PHOs to work collaboratively to support the provision of primary health care nursing and NGO services.

When planning transfers of services from DHBs to PHOs, in addition to contractual and funding issues, workforce, union and human resource matters need to take prominence in early discussions. The earlier all parties are brought on board, the more likely it is that a successful and timely transfer can occur.

**Workforce development**

Advancing primary health care nursing practice was a key focus of the innovations, and so all of them were involved in developing nursing workforce capacity and capability. Development activities mainly involved the innovation nurses and the existing primary health care nursing workforce. Initiatives were undertaken at both an operational and a strategic level, and involved formal and in-service education to advance clinical skills and knowledge, as well as the development of systems and policies for ongoing nursing workforce development.

The research findings from the innovations indicate that they have played a key role in progressing workforce development initiatives that begin to address the issues and obstacles identified in the 2001 survey of primary health care nurses (Ministry of Health 2003b). These initiatives have been undertaken within the innovations and at local, regional and national levels. Some innovations have begun to address the recruitment of new graduates into primary health care and to provide support for the first year of entry into primary health care practice; have provided access to both in-service and postgraduate education; and have developed career pathways. The innovations have provided leadership for primary health care nurses and facilitated communication and collaboration between groups of nurses across the sector. For primary health care nursing workforce development to continue, these initiatives will need to be sustained and expanded.

In New Zealand the primary health care nursing workforce is ageing, and the recruitment of nurses is important in order to maintain the workforce. Two strategies were employed by the innovations to encourage this recruitment. One was to stimulate the interest of undergraduate students in primary health care nursing as a career option through engaging with tertiary education institutions in curriculum development to include primary health care. The other was to provide high-quality primary health care clinical experiences. Supportive first-year entry to practice programmes where nurses have access to a range of experience, limited responsibility and clinical preceptorship (guidance) was developed to assist in the recruitment and retention of nurses to primary health care and their establishment in practice. A remaining key obstacle to both recruitment and retention is the pay disparity between the primary and secondary sectors.
The innovation nursing workforce

Each innovation involved nurses with advanced practice skills in primary health care. The skill of the nurses ranged from the new graduate nurse through to the highly experienced nurse practitioner. This variation of experience had implications for the innovations that provided clinical outreach services. In these clinic settings the nurses often work alone, providing an autonomous yet interdependent and collaborative service. Innovations that employed (Tairawhiti, Wairarapa) or hosted (Hutt) a new graduate nurse found that the new graduate needed support from a preceptor to advance their skills before they could practise alone, and once working alone still needed extra support systems in place. In Hutt the new graduate salary was paid by the DHB’s primary health care new graduate programme and the nurse was employed on a supernumerary basis. In contrast, the salaries of new graduates in Tairawhiti and Wairarapa were paid with innovation funding.

The support needed was a cost to the innovation because the new graduate could not initially work alone and required preceptorship. Providing this support is important, but affects the workload output of the preceptor nurse and needs to be incorporated into her/his job description. The experience highlights an issue relating to the level and type of resources needed to support new graduates into primary health care.

Nurses need broad generalist advanced nursing knowledge and skills and good communication skills. Nurses reported that such knowledge and skills are developed through reflective practice, clinical supervision, learning from colleagues, formal study and in-service education. These skills were reported by stakeholders as pivotal to effective nursing practice, whether dialogue was with individuals, families, whānau, communities or other providers.

Māori nursing leadership is important, but the shortage of nurses who identify as Māori is problematic for recruitment in some innovations. Given the growing number of Māori-led services, those who were recruited were often sought after, several leaving innovations to work in other positions that were known to have more secure funding and cultural support. The change of Māori health nursing leadership in MidCentral from being the responsibility of one individual to having several people being able to represent Māori on health and nursing matters offers a different model, which could be considered by others.

Some innovations found recruitment and retention of primary health care nurses difficult, and in some instances the time limit of three years with no secure future worked against them. The workplace environment was very stressful at times, leading to some resignations. Balancing these factors were the opportunities to be involved in the development of primary health care nursing and further professional development.
Workforce development and the innovations

Most of the innovations paid attention to general primary health care nursing workforce issues. Workforce stocktakes and/or learning needs assessments were used to develop workforce development plans and educational activities in order to build capacity and capability in Northland, Auckland, Counties Manukau, MidCentral and Wairarapa. Workshops were also held with the West Coast innovation nurses to identify learning needs, and a programme of in-service education was established.

Several of the innovations distributed information about professional development opportunities, courses, primary health care developments and new initiatives to all primary health care nurses in their respective DHBs. This information was mainly provided through regular newsletters for nurses. Identifying the primary health care nurses and the most efficient way of distributing information was problematic in areas such as MidCentral. Recently this innovation developed a database of all nurses within the area to ensure the distribution of information to all nurses.

The nurses employed to work in the innovations all personally engaged in professional development. Support for advancing nurses’ practice came from clinical supervision, clinical education, colleagues, postgraduate courses, and GPs and other health professionals. No one aspect was identified as more important than any other. Several innovations also provided mentorship and clinical supervision and coaching, and in some cases tikanga support and guidance. Mentoring included providing advice for nurses to develop their portfolios as required under the HPCA and providing a mechanism to engage nurses in the development of their own career pathway.

All innovations enabled primary health care nurses to have access to a variety of courses and training opportunities, including formal qualifications. Northland, Auckland, Counties Manukau, Tairawhiti, MidCentral and Wairarapa played key roles in organising and participating in regional in-service forums for nurses. In others, such as West Coast, innovation staff contributed to forums. Issues covered included clinical topics such as child health, cervical screening and chronic diseases, and also career development and professional issues such as ethics, standing orders and the HPCA requirements. A key feature of the educational forums was the networking opportunities they provided. Some workshop activities have been held for specific groups such as practice nurses and residential care nurses, while others have been open to all primary health care nurses. Innovations also promoted networking through overnight hui (planned for Auckland), and through a regional school nurse group in the Hutt.

Counties Manukau opened DHB in-service training to all nurses working in the primary health care sector, and in MidCentral work is under way on a shared orientation programme in primary health care nursing for new graduate nurses. Many nurses had commenced postgraduate study before the innovation, and the innovation provided an opportunity to accelerate their progress. In six of the seven innovations providing nursing services, nurses had either undertaken or were currently enrolled in postgraduate nursing study. Several of the nurses were awarded Ministry of Health nursing scholarships. In other instances the innovation funded nurses’ time and travel...
costs to attend lectures, and in the case of Reporoa relievers were employed to cover staff absences for study purposes.

A number of the innovations highlight the barriers for nurses who work in small organisations (eg, in rural settings, some general practices and many NGOs) to participate in the postgraduate education essential for development towards nurse practitioner. Small organisations sometimes do not have the flexibility or funding to relieve staff for education. This is also the case for attendance at clinical in-service education. Financial barriers to attending postgraduate education were addressed by the Ministry-funded scholarships and through Clinical Training Agency-funded courses for some nurses. These Ministry initiatives have been crucial in progressing primary health care nurses towards nurse practitioner registration.

Considerable emphasis was placed by some innovations on developing career pathways and addressing the requirements of the HPCA Act. Counties Manukau, MidCentral and Auckland developed either new graduate primary health care nursing programmes or first-year entry to practice courses. Several innovations provided education about the regulatory requirements and supported nurses to complete their portfolios. The Act also gave impetus to the development of professional development opportunities and clinical in-service education programmes. Professional development for nurses in the primary health care sector appears to have been neglected in the past, as these opportunities to develop practice were sought after and well attended. Work by the MidCentral innovation informed the development by the New Zealand Nurses Organisation of a nationally available primary health care professional development programme. This programme was designed to enable nurses from across the primary health care sector to demonstrate their competency over four levels: fundamental, competent, proficient and expert.

Counties Manukau worked with Manukau Institute of Technology to establish a ‘return to nursing’ course to recruit nurses into primary health care and to develop the undergraduate curriculum so that population health became an underpinning tenet. Student nurses, along with trainee GPs, were able to acquire clinical experience with the Wairarapa innovation.

**Nurse practitioner developments**

All innovations undertook some activities related to nurse practitioners. Counties Manukau and MidCentral innovations each employed a nurse practitioner. The nurse practitioner in Counties Manukau had a child and youth registration with prescribing. She was employed in Accident and Emergency until a position was created in a PHO iwi provider with a multidisciplinary team of GPs, nurses and community health workers. The nurse practitioner in MidCentral had a nursing people with diabetes registration with prescribing rights. Her role combined clinical work in diabetes with strategic development work on the management of diabetes for the innovation.

Many innovations supported individual nurses in their preparation towards applying for nurse practitioner registration. In Hutt this support resulted in the youth health specialist nurse attaining nurse practitioner registration in youth health in December 2005, and in Tairawhiti the co-ordinator submitted her portfolio in May 2006.
Pathways leading to nurse practitioner registration were established as part of the MidCentral and Counties Manukau DHB career framework. In Counties Manukau processes to prepare and support new nurse practitioners into advanced practice in primary health care teams and facilitate processes to secure laboratory testing and prescribing have been implemented. Funding was sought to appoint a child health nurse practitioner to Auckland PHO, and scholarships were awarded for postgraduate study. In Northland, five advanced nurse appointments were by iwi providers with a view to their becoming established in practice as they complete their study and apply for registration as nurse practitioners with a primary health care scope.

The preparation required to be registered as a nurse practitioner is lengthy, given that the regulations prefer the nurse to have a master’s degree, research and policy experience, as well as considerable practice experience. This means that it currently takes nurses approximately six years to register after they have become competent primary health care nurses. Some nurses consider the registration process itself to be particularly arduous. Employment opportunities for nurse practitioners within a primary health care scope of practice are also currently seen as limited.

Implications for workforce development

All of the innovations focused on workforce development in some way, with strategies directed towards recruitment, development and retention. A number of these strategies are designed to be long term, so the benefits may take some time to be realised.

Some innovations have used stocktakes and surveys to inform workforce development plans, and learning needs analyses to develop appropriate clinical in-service education. Primary health care nursing workforce development and planning infrastructure at both the DHB and PHO levels may be needed to keep this information current and to maintain momentum.

The ability for nurses to access workforce development opportunities is dependent on their location and timing. In some cases, practice nurses were unable to attend courses/workshops during the week because of other commitments – and the time is unpaid. In other cases, the organisations that employ them may not be willing, or have the capacity, to support and recognise this development. This may lead to retention issues, with nurses moving to larger organisations, particularly if the career pathway in these is linked with remuneration. Employers may need to be convinced that the professional development of primary health care nurses adds value to their services, expands the capacity of the primary health care team and relieves work pressure on other staff members.

DHBs and PHOs may have a role in supporting small primary health care organisations to understand and meet their obligations in relation to the HPCA Act. Support for the development of the primary health care nursing workforce in rural settings, some PHOs, general practices and NGOs may require a multi-pronged funding approach that includes travel and fees, as well as provision for funding relief staff by the Ministry of
Health, DHB and PHOs. Ongoing scholarships for primary health care nurses to complete study will be required in the immediate future.

Although nurses in some innovations have made rapid progress towards registration as nurse practitioners, as more come on stream DHB and PHO support will be required to establish them in practice. Work at a national level is needed to see if there are ways to minimise the time and energy going into finding funding, creating and establishing nurse practitioner positions, as there will soon be many more nurse practitioners ready and available to work at this advanced level of practice. Progress is being made on this by the Ministry of Health through the Nurse Practitioner Employment and Development Working Party, the transfer of funds to District Health Boards New Zealand for the implementation of a nurse practitioner facilitators programme, the continuation of the primary health care nurse practitioner rural scholarships, and addressing the legal barriers to effective nurse practitioner practice.

The establishment of new graduates in primary health care nursing practice requires experienced primary health care nurses who are skilled as preceptors, and initial funding to support their development into the role. The differential pay scale between DHB employed nurses and those employed by other organisations is highly problematic, and works against workforce development generally. Solutions are urgently needed.

The allocation of innovation funding and other funding provision has led to a considerable focus on workforce development and training. This suggests that funding is a key driver in this development.

Role of nursing leadership

Many nursing leadership positions in the public health sector were disestablished and replaced by general managers in the reforms during the 1990s, leaving countywide gaps in nursing leadership (Connor 2004). These positions began to be restored in the late 1990s, but overall leadership in the expanding primary health care sector lagged behind. As a result, leadership was an issue in all these innovations. The preceding discussion on the models of innovation demonstrates the importance of nursing leadership in primary health care: innovations with strong leadership have mostly been successful in achieving their key goals and objectives.

This is evident in several ways. First, four innovations explicitly set out to provide leadership for primary health care nursing at the DHB or PHO level, using innovation funding to provide a platform to lead further developments in primary health care nursing. Second, some innovations showed how important nursing leadership can be in relation to service development at the provider level in terms of bringing a systems view to operation, planning and development, and influencing nurses to contribute; others have shown the importance of clinical leadership in practice to model and teach best practice, and in workforce development so that clinical knowledge and skills are transferred to other nurses. Third, a lack of progress with some innovations can in part be put down to problems due to a lack of leadership.
The Northland innovation focused on nursing leadership for integration, and the nursing integration leaders there were reported to be succeeding in creating a strong voice and visible profile for primary health care nursing. This was in spite of losing some strategic direction with the disestablishment of the DoNPHC at the DHB. This leadership, and the relationship building that accompanied it, has enabled a considerable number of service improvement projects to develop. Importantly, the nurse leaders developed their leadership skills, which have helped the success of this innovation.

In Counties Manukau, nursing leadership was important to the successful development of links across primary health care nursing services and in planning and implementing workforce development. In this innovation, primary health care nurses are now represented on all DHB and PHO governance, strategic, operational, quality assurance and clinical governance committees, providing a means of communication and collaboration between services and multiple PHOs. The Pacific and Māori nurse leaders in PHOs are also reported as having had a significant impact on care, and now all seven PHOs in the district have appointed nurse leaders. Nursing leadership, and the innovation approach, are now seen to be embedded in the DHB and PHO infrastructures. The leadership of the DoN was also significant.

In MidCentral, DHB primary health care nursing leadership has provided an important platform for primary health care sector-wide nursing development. The importance of the leadership role at this level is also evident not only in terms of supporting the innovation and providing input at a strategic and policy-making level within the DHB, but also in providing additional funding for the innovation. The innovation is aligned with the MidCentral DHB Primary Health Care Strategy. Leadership in this innovation has extended to developing a leadership framework for primary health care nursing, enabling workforce development activities and collaboration across nursing services.

In the Auckland innovation there are indications that problems with leadership contributed to slow progress. There were delays in the innovation getting up and running, with the start up development of the PHO within which a nurse leader was to be appointed. There was also discontinuity of nursing leadership at both the DHB and PHO level, which has slowed progress. A shortage of Māori and Pacific nurse leaders, and the pressure on such nurse leaders, was also an issue in this innovation. Nevertheless, the nurse leader was able to build information to support the development of a kaupapa Māori nursing service, to develop links, and to encourage professional development. A key lesson from this innovation is that if nursing leadership is seen as necessary to primary health care, then its development needs time and investment, particularly for Māori and Pacific nurses.

**Clinical leadership and service development**

Although some innovations did not have developing nursing leadership as a key goal, leadership featured as one of the reasons some were more successful. In Reporoa and Tairawhiti, for example, service development and clinical leadership were factors in their success. The co-ordinator in Tairawhiti had advanced practice skills, and she established systems, supervised and mentored staff and held weekly meetings to review work and identify where progress could be made. In the Hutt innovation, the
appointment of a work-ready youth health nurse specialist with leadership skills, along with a newly constructed model of practice, led to the innovation commencing promptly. Her leadership in working with VIBE is also credited as a key contributing factor to the success of the innovation. In the Wairarapa innovation, the skills of the co-ordinator in community development and her familiarity with DHB systems contributed to its success.

An identified lack of leadership within the innovations regarded as less successful is also evident from the research. The Taranaki innovation could have benefited from continuous, cohesive and more active governance, project management and consistent leadership and staffing early on. More recently, a DoN has been appointed to the PHO and it is felt that this will enable greater leadership and collaboration, and will enhance the potential of the innovation. In the Taranaki and West Coast innovations, an initial lack of leadership was identified as a problem in achieving key goals. In the West Coast innovation more progress has been made since a mid-term review and the introduction of more robust governance, project management and support systems, with the DoN playing a key role, along with a willingness to explore new ways of working. This contrasts with the earlier period of the innovation and demonstrates the impact that good leadership can have on innovations and the development of nursing services.

The Ministry of Health played a leadership role in the early days of the innovations. In addition to visiting to find out more about them, Ministry nursing personnel took a role when establishment issues arose, such as in Taranaki and West Coast. When it became apparent that some DHBs were not intending to continue to fund an innovation, such as in Tairawhiti, Ministry staff met with the DHB to discuss their commitment.

**Developing primary health care nursing leadership**

The innovation funding has enabled the creation of nursing leadership positions and infrastructural arrangements in Northland, Auckland, Counties Manukau and MidCentral, and clinical leadership and service development in the Hutt, Reporoa, Wairarapa, West Coast, Turangi and Taranaki innovations. It is likely that without this funding, nursing leadership would not have developed to the extent it has within the innovations. Some DHBs and/or PHOs may well have prioritised nursing leadership and new nursing services within their existing budgets, but research in New Zealand suggests that the development of new services and approaches is contingent on new funding and/or the successful reprioritisation of existing funding, which is difficult to do (Coster 2004). Further encouragement of innovations such as these, and of nursing leadership, is therefore likely to be dependent on new funding or reprioritisation.

In the New Zealand environment at present, leadership in relation to primary health care nursing may be particularly important at the DHB level. This could include strong support for primary health care and for implementing the Primary Health Care Strategy, as well as recognition of the role of nursing services within this. Two innovations (Counties Manukau and MidCentral) focused on developing nursing leadership at the district (DHB) level. It is too early to say if this focus on developing a leadership infrastructure across a district enables a stronger or more permanent focus on primary health care nursing. It appears that this is the case in Counties Manukau, which has a
strong emphasis on primary health care broadly, and although this is also true in MidCentral, it is not yet clear how much ongoing support there will be for the structures and positions that have been developed. On the other hand, the Northland innovation demonstrated that primary health care leadership can also promote successful nursing development without the active support of the DHB. Here, leadership and collaboration across PHOs contributed significantly to the success of the innovation.

The development of nursing leadership at any level within the sector is dependent on identifying nurses with leadership skills and experience and/or the ability to step into these roles with support and mentorship. Many of the innovations were able to recruit and retain – as well as develop – nurse leaders, and their successes are in part due to this. But not all innovations managed to successfully recruit and retain key staff to enable successful leadership, and hence a successful innovation. This requires a sector willing and able to identify potential leaders, and to provide them with training and support. Where there are difficulties in recruiting and retaining staff, there are likely to be ongoing difficulties in developing and retaining capable nurse leaders. In the Auckland innovation, the ability to recruit and retain skilled Māori and Pacific nurse leaders was an issue for the innovation, affecting its success. In small centres, too, success in innovations such as these can come down to the leadership and vision of a single individual, with leadership and service development vulnerable to the loss of key individuals. If nursing services are to develop across New Zealand, organisations need to invest not only in leadership development but also in succession planning to ensure that developments continue and can be built on over time.

**Implications for nursing leadership**

A number of innovations have focused on building nursing leadership infrastructure. This infrastructure has brought previously disparate groups of nurses together to work on the development of primary health care nursing, and so is beginning to address the fragmentation of nursing services, the integration of care and quality issues across the sector. It would be interesting to see if such a focus leads to greater sustainability and acceptability of primary health care nursing in the future. Additional reviews would be helpful to identify how this develops over time.

Overall, leadership appears to be a key factor in the success or otherwise of the innovations. Innovations demonstrated the importance of leadership at the district and PHO level, as well as at the service and clinical levels in order to promote service development and high standards of clinical care. Disestablishment of positions, staff changes and recruitment problems all appear to have been issues affecting leadership. In one innovation, a shortage of Māori and Pacific nursing leaders has been a key issue.

The stability and quality of the nurse leaders contributed to the success of the innovations. If primary health care nursing services are to develop further, identifying potential future nursing leaders, training and experience would all be key aspects of policy and planning for the future.
Funding

In New Zealand, funding for primary health care nursing services currently comes from various sources, including DHB provider funding and contracts, national NGO contracts (eg, Plunket), other NGO funding, other government agency funding, PHO funding through private businesses (especially general practices), industry sources, ACC payments, community-raised funds, and co-payments by patients. This piecemeal approach to funding primary health care nursing – and arguably other aspects of primary health care – has meant that initiatives and demarcations between services have often created service silos and gaps in care (Minister of Health 2001). The innovation funding has provided a way for nursing to begin to bridge these silos and develop services to fill gaps in care.

Most innovations received funding in line with the budget proposed, although the Reporoa innovation received more funds than requested, while MidCentral and Turangi received less. All innovations also received other financial and/or in-kind support to cover their activities. For some, such as MidCentral and Counties Manukau, DHBs provided additional funding for primary health care nursing development and therefore indirectly to the innovation. This funding enabled the employment of additional people and extended activities. The sizes of these projects were adjusted to accommodate these differences. For others, the support included access to rooms, vehicles and running expenses, equipment, resources and administration from their host organisations. Several that set up outreach services also received community support in the form of rent-free clinic space.

In innovations such as Hutt and Reporoa, the funding also enabled an extension to work funded under other contracts. Reporoa, Tairawhiti and MidCentral earned additional funding, mainly for small contracts or for delivering specific clinical services. Other innovations such as Northland obtained SIA funding.

The funding provided the salaries for some nursing staff in all of the innovations as well as the working expenses for some of the equipment and activities undertaken by these nurses. Outreach nursing services – particularly those that were mobile – were not always fully costed in the original budget. There were also hidden costs, such as administration or clinical supplies, which DHBs, PHOs and NGOs sometimes met. In addition, many nurses – including those employed by the innovations, those on advisory groups and nurses generally – contributed considerable unpaid time to support the work of the innovations.

Uncertainty about future funding was an issue for the nurses in most innovations in the final year. In Northland the uncertainty was also a concern to other stakeholders, who were worried that nurse leaders would move on as a result of this uncertainty. Subsequently, however, three fulltime positions over four geographic locations have been jointly funded by the PHOs and DHB for three years. In Tairawhiti, limited-term funding meant considerable energy was spent engaged in activities to secure the future of the service at the expense of actually providing a service.
Issues related to funding

The innovations illustrate the gains that can be made depending on where the funding is allocated. For example, by funding nursing leadership positions it is possible to have an impact on developments in primary health care nursing generally. Such funding provides a way to integrate and develop nursing work, and to develop the nursing workforce in the primary health care sector. Funding nurses to establish and practise in outreach services, on the other hand, enables nurses to directly address needs and contribute to the reduction of health inequalities through service provision.

Ongoing funding arrangements for the innovations point to the ways that primary health care nursing might be funded and developed in the future. Leadership positions, funded jointly by the DHB and PHOs (as in Northland), provide a mechanism for the integration of nursing across the region. In the Northland area, the relationships between PHOs are manageable given that the PHOs have enrolled populations determined by specific geographical location. In the cities and in regions where the enrolled populations are not determined geographically, DHBs and PHOs will need to find other ways to fund nursing positions to lead integration. These may include, for example, joint arrangements between PHO management support organisations and DHBs. The Tairawhiti innovation illustrates how a private health business, PHOs and the DHB can work together to provide a nurse-led service. In some cases, DHBs are continuing to support innovations providing first contact care, indicating that where there is a gap in services (eg, where a population group has particular needs or where access proves difficult), DHBs can meet this need through funding non-PHO services. However, unless there are close working relationships between DHBs, PHOs and NGOs, such funding arrangements could risk duplication given that the DHB, NGO providers and PHO may all be engaged in providing outreach services for the same populations at risk.

Although the capitated population funding to PHOs could provide some new opportunities for funding primary health care nursing work, this development seems to be limited at present. One PHO spokesperson described this funding as the ‘diarrhoea dollar’: most funding that goes into the PHO moves straight through the system, directly to the GP as a private business owner, and the PHO influence on how this funding is expended is limited. This appears to be the result of government policies aimed at ensuring new funding leads to a decrease in user fees. PHOs do have some funding flexibility with rural, SIA and health promotion funding. However, because this funding is related to the number of people enrolled in the PHO, in small organisations the amount of money available may be very limited.

SIA funding is a likely source of funding for nursing outreach services, but the nature of the contracting for this poses some problems. Tairawhiti, for example, has received ongoing funding as an SIA project, but this funding can only be assured for 12 months. This time limit, which is considerably shorter than the three years for which the innovations were funded, is likely to pose problems for nurses, not only in establishing new services but also in demonstrating their impact. Such time limits and lack of security of employment may result in a high turnover and a high level of stress among nurses, but also, most importantly, unstable service provision for people known to have high levels of health need.
The relatively new role of nurse practitioners in primary health care also poses funding issues, because currently there are no specific funding streams to support their practice. A nurse practitioner in the Counties Manukau innovation considers access to funding to be the biggest hurdle for nurse practitioners in primary health care: ‘It is not possible to initiate a nurse practitioner role in primary health care without financial support and advocacy at the DHB level; that means the Primary Care Directorate, Funding and Planning and the Director of Nursing’ (Renouf 2005: 6). To support those seeking funding for nurse practitioner positions, the Nurse Practitioners Advisory Committee (2005) has created a business case tool kit.

DHBs’ decision-making around whether to provide ongoing funding for some of the innovations has also highlighted issues related to contracting and measuring the impact of outreach nursing services and the outcomes of primary health care in general. The indicators established in several service specifications by DHBs were inputs, processes and outputs rather than health outcomes. While nurses in the innovations had delivered on the set indicators, some DHBs considered these were no longer enough to justify further investment. Jones and McLachlan (2006) capture the present interest in outcomes and present a beginning framework for this to develop. However, this has only emerged recently and was not available when the innovations began. The development of outcomes for the primary health care sector in general seems to be at an early stage. While the innovation funding was clearly important in providing funding for leadership and for workforce development activities – including networking and training, and improved access for certain groups – the extent of their contribution to health outcomes generally is unknown.

The provision of ongoing funding for these innovations by DHBs and PHOs raises a number of issues related to primary health care nursing, such as who should fund innovative nursing services like these, whether all primary health care services need to shift from DHBs to PHOs, and the role of the DHB in increasing integration among services. In geographically isolated areas, and with groups such as youth, which are known to face access barriers, funding nurse-led and NGO services provides DHBs with a way to address their whole population’s needs. Nurse-led services funded between PHOs and with other organisations can provide the opportunity to target enrolled populations within regions.

**Implications related to funding**

The funding for the innovations has resulted in the development of new outreach services and a nursing leadership infrastructure.

The primary health care environment is still turbulent and rules, relationships, responsibilities and funding are still being worked out. The existing funding arrangements for primary health care nursing services continue to contribute to the fragmentation of care, which signals that DHBs and PHOs will need to continue to work together to integrate and fund services for some time.
Short-term funding for new services has benefits in enabling new services to be established and trialled, but also has drawbacks in the absence of upfront criteria for continuation. Developing such criteria within the current structures and primary health care funding models and structures is problematic.

Outcomes of primary health care nursing – as with those of other primary health care providers – are likely to be long term, and the work of the nurse is only one of many factors that influence an individual’s health. This creates difficulties in demonstrating success in the short term to secure continued funding. Although the present outcomes frameworks capture the impact of interventions on specific conditions, further development is needed to establish ways that primary health care can demonstrate population health outcomes.

The provision of some funding targeted directly at nursing can result in other funds and resources being made available. Additional funding from organisations and in-kind support has subsidised the outreach services. Although funding support from a variety of sources (including in-kind support) may assist in the establishment of innovations, the lack of full-cost funding may later become a barrier to securing ongoing funding. While it is ideal that services are fully funded, where this is not possible knowledge of the full costing of such services is required.

Toolkits similar to that for the nurse practitioner business case could help nurses to gain an increased awareness of when, where and how to access funds. Nurse leaders also have a role to play to ensure nurses know how to access funds from within their local environment.
OVERVIEW OF THE TWO MODELS

Each of the innovations had distinctive characteristics, as is clear from the individual site reports. However, at a broad level they fell into one of two general models characterised by their primary focus (see Table 1). One group, referred to as the Leading Primary Health Care Nursing Development Model, focused on leading broad-based change involving primary health care nurses across DHBs and/or PHOs. The other group, referred to as the Primary Health Care Nursing Practice Model, focused on developing new, expanded or modified forms of nursing practice delivering a service to particular groups of people.

<table>
<thead>
<tr>
<th>Primary model</th>
<th>Innovations</th>
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<tbody>
<tr>
<td>Leading Primary Health Care Nursing Development</td>
<td>Northland, Auckland, Counties Manukau, MidCentral</td>
</tr>
<tr>
<td>Primary Health Care Nursing Practice</td>
<td>Taranaki, Reporoa, Turangi, Tairawhiti, Wairarapa, Hutt, West Coast</td>
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These two innovation models are now discussed in relation to their features, establishment and sustainability.

The Leading Development Model

In this model, new primary health care nursing leadership positions were created in DHBs and PHOs to develop the capacity of the primary health care nursing workforce to respond to the Primary Health Care Strategy. Within DHBs the newly appointed leaders established a nursing infrastructure at the DHB level to provide professional nursing oversight of advancing nursing practice for the development of the primary health care nursing workforce. PHO nurse leaders provided leadership for professional and practice development, and for the alignment of nursing services to respond to community health needs within their PHO, and in conjunction with the DHB and other PHO and primary health care providers.

The nurse leaders in the DHBs each led a development team of nurses within the DHB and established regional primary health care nursing forums, which included nurse representatives from PHOs, NGOs and the provider arm of the DHB. While the teams and forums had different purposes in different innovations, all brought previously disparate nursing services in touch with one another and have become ongoing core mechanisms for quality assurance and service development projects in the regions.
The PHO and DHB nurse leaders became involved in the governance, management and clinical committees related to primary health care in their organisations, enabling them to understand the high-level issues facing the organisations and to contribute a nursing perspective to DHB and PHO decisions and developments. Involvement in governance and management also meant that the nurse leaders could align their innovation work with that of DHB and PHO strategic directions. They contributed a nursing perspective to DHB and PHO policies, and created ways for all nurses and select groups of nurses (eg, those on PHO boards) across a DHB’s region to come together to strengthen the nursing voice.

In order to address the fragmentation of primary health care nursing services, the leadership-based innovations drew together nurses from different services to work on projects and issues. These included service development projects, which focused on integrated care and multidisciplinary teamwork. A population approach was used, and health issues affecting those enrolled with the PHO were identified, enabling nurses to optimise their practice contribution at a local level.

Shortage of information about the primary health care nursing workforce led to nurse leaders undertaking comprehensive workforce stocktakes and surveys to identify the primary health care nurses within a region, and to establish where development might be possible or necessary. Workforce development plans were made, and nurses undertaking postgraduate education were identified and supported. Nurses with leadership skills were also identified and encouraged to become active contributors to clinical and operational committees. Databases of the primary health care workforce were established, maintained and updated. These are increasingly being used for regular communication with nurses across the sector about service developments and educational opportunities.

**Issues establishing innovations that lead primary health care nursing development**

Initial work in these innovations involved the nurse leaders familiarising themselves with DHB and PHO structures and planning and decision-making processes so that they could facilitate sector-wide change. Special emphasis was placed on identifying and building relationships with three groups: DHB and PHO managers, primary health providers, and primary health care nurses and other health professionals. At first, the newly appointed leaders found that while many DHB and PHO managers and providers were open to working and supporting their professional leadership role, others were suspicious of what this role might mean for their organisation in a business sense. Both formal working relationships (eg, MidCentral’s memorandum of understanding with health providers) and informal working relationships were established. Nurses and other health professional groups’ responses to the new leadership roles also varied. Ongoing contact with the three groups was maintained by the nurse leaders, which over time resulted in an appreciation of the value of professional leadership.
The recruitment and retention of nurse leaders, most particularly Māori nurse leaders, posed problems for some innovations. There were also heavy demands placed on the Māori nurse leaders to ensure the cultural appropriateness of services and to broker relationships between iwi, the innovation and other health providers, which added an extra load to already demanding positions. There were also issues of isolation for Māori nurse leaders. The new role was taxing on nurse leaders, and some resigned.

In some innovations there were difficulties establishing the nurse leader roles, especially in newly formed organisations. In some cases the notion of nurses leading nursing change was new, and there were early difficulties gaining acceptance of the new role. Related to this was an initial failure by some managers and health professionals, including nurses and GPs, to see the benefits of nursing collaboration between providers and sectors.

Changes in key DHB personnel slowed a number of innovations. In Auckland this occurred when the Associate DoN Māori, who held the project vision, was promoted, and it took some time to replace her and for the new person to establish relationships. In Northland, the disestablishment of the DHB’s DoNPHC led to diminished DHB strategic direction for primary health care nursing in the region.

Innovations such as Counties Manukau found that the speed of change in primary health care nursing service delivery needed to be tempered because of the strain on staff in the sector, particularly due to their involvement in the MeNZ B campaign and other new initiatives. In Auckland, the innovation was to be established within a small developing PHO serving a high-needs population.

The innovations involved in broad-based change (Auckland, MidCentral, Counties Manukau) and in role and service redesign (Northland) needed to engage nurses. Although many nurses responded immediately to what the innovations were offering, others resisted. This resistance seemed to be more common with practice nurses. While bringing these other nurses on board immediately may not be necessary, it is required over time for sustainable change. In Northland some projects were also difficult to implement because of this resistance to change. Gaining the support of those directly affected and from other stakeholders was pivotal to the work of the innovations.

**Factors contributing to the effectiveness of innovations in the Leading Development Model**

The innovations that led development were all effective at focusing and developing the primary health care nursing workforce in the direction of the Primary Health Care Strategy, despite some problems. The features contributing to this success were the stability and qualities of the leaders themselves, and their ability to forge relationships at the governance level of their organisations, with health providers and health professionals, and (most especially) with nurses working in primary health care. Their credibility relating to clinical matters was essential to earn the respect and co-operation of nurses and other health professionals.
In addition to the qualities of particular nurse leaders, the establishment of groups representing nursing from across regions was essential to the success of an innovation bringing about broad-based change. In Northland, this extended to multidisciplinary service development because of the integrative focus of the nurse leaders situated in PHOs. The Clinical Governance Council in the MidCentral project ensured policy and operational developments were applicable to all nursing groups in the region, and in Counties Manukau and Auckland the leaders linked services across the primary and secondary sectors. These ways of working laid the foundation for the further integration and co-ordination of nursing services.

The Northland nurse leaders’ brief to facilitate integration at all levels of primary health care services – not just those within a PHO or within nursing services – distinguishes these positions from some other nursing leadership positions in PHOs, which seem to focus on developing the practice of the practice nurses within affiliated providers. The broader leadership focus taken in this innovation seemed to be a critical factor in service development to address population health priorities, and in the development of teamwork both within and between providers. This team approach meant that at the provider level support for the expansion of nurses’ contribution to primary health care grew.

Another important feature was the direction and support the leaders received from their organisations, and the organisations’ capacity to provide expertise and help to access additional resources. Where DHBs had a strong commitment to implement the Primary Health Care Strategy and DoNs who understood the primary health sector and were committed to the development of nursing in primary health care, nursing leadership was effective. The support of the PHOs was also an important feature. DHBs and PHOs provided support through mentoring or development of management/governance structures to support innovations, overseeing the development of proposals, pulling together governance committees or nurses groups, setting up workforce development programmes (eg, education programmes), and providing additional funding or facilities.

This model of innovation was particularly effective at addressing workforce development through both long-term and short-term initiatives. At a PHO level the project management approach to service development taken in the Northland innovation was also effective in establishing new initiatives with a range of providers to address population health issues. Associated with this, and also evident in Counties Manukau and MidCentral, was the capacity of this model to support better integration of services and the potential to identify and address fragmentation and duplication between services. At this stage this model is less able to demonstrate entirely new approaches to primary health care nursing practice on the ground, which are more apparent in some of the smaller practice models discussed in the Primary Health Care Nursing Practice Model (see below).

In addition to local and regional activities, innovation nurse leaders also contributed to national activities related to the Primary Health Care Strategy, to particular clinical and nursing initiatives.
The Primary Health Care Nursing Practice model

New, modified or expanded ways of practising primary health care nursing to provide new or extended clinical services were developed in the Reporoa, Turangi, Tairawhiti, Taranaki, Wairarapa, Hutt Valley and West Coast innovations. Each of these innovations developed differently in relation to their local context, with the needs of local people paramount, reflecting the approach encouraged in the Primary Health Care Strategy (Minister of Health 2001) and the Framework for Developing Primary Health Care Nursing (Expert Advisory Group on Primary Health Care Nursing 2003).

These innovations all involved nursing services that reach out to particular populations who experience barriers to accessing primary health care services. These populations were identified through a process of community assessment, which included drawing on population demographic data and health needs assessments, community consultation (especially with key community members), and nurses’ local knowledge of communities and people. The barriers to access were sometimes contextual; for example, geographical isolation, transport difficulties, or sparse and unstable primary medical and health care services. Other times they concerned the characteristics of the population group. Populations served included those living in high deprivation areas, those whose life circumstances limited their ability to access timely care, Māori, Pacific peoples, youth and young families (Tairawhiti, Turangi, Taranaki, Wairarapa, Hutt). In most cases these populations were recognised by DHBs as having health issues that were not being adequately addressed by existing services and were ‘hard to reach’ and ‘high risk’.

In isolated geographical areas or with populations with limited transport, where limited mobility was recognised as a barrier to access, the innovation nurses provided mobile outreach services to homes, on marae and at convenient community venues. Nurses used consultation and local knowledge and networks to determine the most suitable location for services. Financial barriers were addressed by providing the service free, in locations that were easy for people to get to, or in their homes.

Nurses worked to overcome cultural barriers primarily by seeking to appoint nurses who identified with the cultural group served. Where this was not possible, nurses enlisted support and participation from community members to act as advisors or as members of their governance and advisory committees to ensure culturally appropriate services were developed. A taumatua group was formed in Auckland, and nurses in Taranaki and Reporoa worked alongside Māori community health workers. In Turangi, Hutt and West Coast, nurses participated in in-service cultural education opportunities to increase their capacity to respond appropriately.

Age- and life-stage-related barriers, particularly for youth and young families, were also addressed by most innovations. Barriers for youth included location, cost and access to services that had the capacity to fully address the broad range of health concerns and health risks related to their stage of life. Some innovations worked to overcome barriers faced by families with young children who had concerns for their children’s health and development. These barriers included social isolation, cost, lack of transport, and finding the right services and health professionals with the time and expertise to deal adequately with their issues.
The nursing practice adopted by the nurses drew on existing and traditional nursing roles, particularly public health, district and in some cases well child and practice nursing, but it was not confined to these. Public health nurse roles include primary prevention, health promotion, prevention and containment of infectious diseases, and working with low-decile families. District nurses’ roles include providing treatment and care in homes during recovery and rehabilitation post-hospital, and palliative care. Well-child nurses’ roles involve providing care for children and families up to the age of five years. Practice nurses provide a wide range of services, working in general practices to provide a comprehensive range of primary health care services that are generally clinic based (Ministry of Health 2003). In general, the findings show that the innovations tended to merge a population-based public health approach, which includes education for prevention, with personal clinical health support and treatment. All of the innovations took a broad approach to health which recognised that people’s lives and health are embedded in their family, community and social world, and are in turn shaped by these.

**Issues and difficulties establishing the Primary Health Care Nursing Practice Model**

For some innovations, getting started involved an extension to, or re-organisation of, existing services, while for others the process involved establishing something new. These different emphases meant that the nurses focused on different tasks in the set-up phase and took different times to get established. Innovations that involved reorganising or extending services required time for nurses to negotiate the review and amendment of existing services, establish extensions to contracts, and ensure information systems accommodated the expansion. In comparison, innovations that involved establishing new services required time for the nurses to locate facilities, establish and manage human resource systems and issues, and identify and establish links and relationships with stakeholders. Systems and documentation for clinical practice and referral to and from the service also needed to be established.

Both starting points required the nurses to share and work with their communities to develop their ideas and plans. Innovation personnel report that although the initial networking and consultation in communities to build relationships was important to position the innovations on firm local ground and within the intent of the Primary Health Care Strategy, these were more time consuming than anticipated and are ongoing. Establishing a system to maintain clinical records was also crucial, and some innovations developed IT software to record and administer nursing work and begin to analyse the outcomes of care over time; others adapted the MedTech 32 system used in general practice for this purpose.
Difficulties encountered by the innovations in delivering services included recruiting and retaining suitably qualified staff; the timing of PHO developments, and whether or not PHOs were established and able and willing to engage with the innovation on service direction; changes in DHB and PHO personnel involved in governance and project oversight; and difficulties getting existing staff or communities on board with the innovation. Innovations that had continuity of staff from the time of proposal submission, and had strong and consistent stakeholder ownership, were able to move beyond the establishment phase more quickly.

There was sometimes a tension when it came to prioritising the provision of services for prevention through education and health promotion, or treating existing conditions. Sometimes difficulties were created by the pressure to provide services while simultaneously developing the new nursing practice; in other cases innovations immediately modified the original vision following a reassessment of local needs as the projects began.

Support was also needed from other practitioners, particularly GPs, as part of developing and operationalising the nursing service. For some this support was not immediately forthcoming, although over time all innovation nurses providing a clinical service reported they received support from almost all GPs in their area. The opposition to the work of the innovations was often about the ways the service contributed, complemented and integrated with a region’s services as a whole rather than resistance to nursing development as such. Addressing this opposition sometimes took time away from developing the innovation itself. The support of stakeholders was also needed to enable nursing practice to advance in some cases. For example, the development of standing orders required time and trust, and greater time was needed when a number of GPs were involved, such as in the Wairarapa and Reporoa.

Some innovations encountered difficulties bringing about change in the nurses’ role. Sometime nurses were reluctant to change, and at other times there were issues relating to employment arrangements.

Relationships between practice innovations and DHBs and PHOs varied, and a key factor seems to be the local PHO contexts. The Hutt and Reporoa innovations worked with population groups who were enrolled in more than one PHO, and the respective DHB funding and planning sections recognised that the innovation was filling a gap in the existing services provided by PHOs and gave strong and continued support. DHBs may need to facilitate the establishment of new funding mechanisms between PHOs and NGOs in cases such as these in the future. Both of these innovations are in NGOs with contractual relationships with the DHB but not with local PHOs. However, on clinical matters, the nurses in these innovations communicated directly with GPs on individual client needs.
Factors contributing to the effectiveness of innovations in the Primary Health Care Nursing Practice Model

The Ministry of Health innovation funding enabled nurses to determine the nature of their professional practice in relation to their local community, and to have the flexibility to be directly responsive to the needs of local people rather than provide service responses defined by existing contracts. The services that developed took a population health approach and focused on providing access to primary health care.

Although all the innovations had worthy attributes, those that the researchers saw as most fully developed and functioning in line with the Primary Health Care Strategy, and therefore as most successful, were Reporoa, Tairawhiti and Hutt. The common features of these were that the governance and advisory groups had strong involvement and support from a range of community members, and quality relationships with nurses. From this basis, relationships that are mutually respectful have been negotiated with other health professionals so that bidirectional referrals occur, ensuring co-ordination of care for people. These innovations were well connected to other health and social services, and the nurses worked intersectorally at a local level – two with schools, two with industry and one with Work and Income.

Each of these three innovations in the practice model had a clearly identifiable and recognised leader with advanced clinical skills who maintained an emphasis on the quality of clinical care and in-service development. Hutt Valley is led by a nurse practitioner, Tairawhiti by a nurse who has submitted her portfolio to the Nursing Council for nurse practitioner registration, and the nurses in Reporoa are undertaking postgraduate study towards nurse practitioner registration. Comprehensive nursing assessment tools were used, and clinical records were standardised and shared. Two made progress with electronic data capture and information transfer.

Reporoa and Hutt were both located in NGOs that had good working relationships with clinicians such as GPs, but were not affiliated with PHOs. Both of these innovations have ongoing funding from their respective DHBs. In contrast, Tairawhiti, which was initially developed out of a partnership among two PHOs (the DHB provider arm and a private occupational health nursing business) has ongoing funding from one of the two PHOs.

Nurses in these innovations recognised the social determinants of health that lead to inequalities, identified barriers to access and, where possible, addressed these. They had the flexibility to provide care that was mobile or in clinics embedded in the locations where people work and live. Nurses had the confidence and competence to work flexibly across the continuum of care and used standing orders to provide timely access to medications.
Although the innovations can demonstrate that they have proactively tackled health inequalities at a population level, largely by providing outreach access, demonstrating the effectiveness of this access is not currently possible. Capturing the outcomes of primary health care nursing practice is not easy because of the interactional and process nature of much nursing work. This is particularly the case in preventive work, where the outcomes only become apparent in the long term. The development of IT capacity, which has begun in several innovations, is a move in this direction which needs further investment. DHBs and PHOs are likely to have resource people who might be encouraged to provide this type of expertise.

**Implications of the two models of innovations**

There are differences in implications for the two models given that they each functioned at different levels. Both were developing new ways of working for nurses in primary health care, but the leadership model functioned at the DHB/PHO level and focused on leading change in primary health care nursing across the DHB/PHO districts, while the practice model functioned at the level of practice, developing new ways of working and new roles for nurses in primary health care.

The two models were effective at creating change in different ways. The Leading Development model was good at undertaking short- and long-term initiatives to develop the nursing workforce, 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 provides 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 a necessary precondition for DHBs and PHOs to expand the potential of nursing in primary health care, and for increasing the integration between nursing services and general practice and other primary health care services, ensuring better co-ordination of care for people as they access different services.

This model also drew together local nursing knowledge and expertise so that there was a deliberate, planned and feasible approach to expanding the potential contribution of nurses in primary health care in the future. These innovations developed the leadership infrastructure and inter-organisational networks that could enable a range of future developments or facilitate the diffusion of other innovative services. They have thus provided a mechanism for ongoing development in primary health care nursing. The impact of this model is therefore likely to be cumulative if the momentum and direction are maintained, and is most likely to develop the capacity of all facets of primary health care nursing to contribute to the Primary Health Care Strategy.
The innovations in the 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, with varying degrees of success. In innovations where the practice models complemented existing services it was more difficult to demonstrate the difference the innovation made. In others, which established a new first-level service (such as in Hutt and Tairawhiti) or expanded an existing service (as in Reporoa), the differences were apparent because the population was well defined and systems to capture data were 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 their success 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 (where necessary) referral to other services. Necessary attributes of the nurses were their clinical competence and confidence to practise independently. To be effective, these nurse-led outreach initiatives relied on links and/or support systems from GPs 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 developing or expanding nursing services. There is no one 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.
TRANSFERABLE LESSONS FROM THE INNOVATIONS

The evaluation provides some key lessons for DHBs and PHOs for the further development of nursing in primary health care. The commitment of DHBs is clearly important, but the level of this seemed to vary across the innovations, with some apparently leaving primary health care development to PHOs while maintaining contracts with primary health care services through their provider arm and with the NGO sector. Other DHBs seemed more active in the sector, and the establishment of nursing leadership at a DHB level provided professional oversight for the development of nursing in the primary health care sector, established a clear link between the DHB policies and plans for primary health care and nursing, ensured the contribution of nursing was fully considered at a policy and governance level, and brought nurses from PHOs, NGOs and the provider arm together for development purposes.

The establishment of a communication system with nurses working in primary health care and facilitation of local nursing forums were important mechanisms to continue development. These DHBs also provided additional resources to establish a DHB primary health care nursing development team, which was able to take a strategic view across the district and establish short- and long-term development strategies in collaboration with all parties, including the tertiary education sector. This approach is commended for its capacity to reduce fragmentation of services, facilitate quality improvement and progress workforce development.

At a PHO level, different innovations were instructive in various ways. Where there was a brief to facilitate integration at all levels of primary health care services – not just those within a PHO or within nursing services – nurses and primary health care providers and NGOs became connected, thus reducing fragmentation and facilitating the development of multidisciplinary pathways of care and new initiatives to address population health problems. PHOs might consider establishing such positions or expanding the brief of nursing leaders to actively work on integration and development across the sector, which seems more in line with the intentions of the Primary Health Care Strategy. Such developments will also be likely to help facilitate closer working relationships between nurses in the NGO sector and nurses working with PHO-affiliated providers. These relationships may then be built on at a PHO level to create more formal arrangements with NGOs.

The development of nursing practice to better meet population health needs requires the development of nurses’ clinical expertise. Clinical leaders who have developed specialty knowledge related to a particular field or population group have a role in supporting the development of nursing practice and clinical services. Some nurses in NGOs have developed considerable clinical expertise and knowledge in relation to population groups, which might be shared more broadly. DHBs and PHOs could identify expert nursing resources and invest in the diffusion of this expertise to relevant groups of nurses at policy and practice levels.
A number of innovations developed outreach services to population groups who faced barriers to accessing existing services. Consultation with members of the community of interest was vital to inform the location and operation of these services so that they were appropriate. Clear clinical leadership and well-developed policies and protocols were necessary for successful outreach services. Outreach services also needed strong back-up support from the next level of care, GPs in particular. The development of IT software and processes to record, transfer and analyse nursing records is essential to ensure integrated services and to evaluate the quality and effectiveness of care. The capacity for outreach nursing services to partially substitute for overstretched or sparse general practice services is particularly evident in the Reporoa innovation, and other DHBs or PHOs who are faced with situations like this might like to consider this model.

The Ministry of Health initiative to fund the 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 has seeded a number of nursing leadership initiatives which can be used to spread further initiatives. Testament to the success of the Ministry of Health initiative is that many developments of the innovations have already begun to be adopted by others involved in leading primary health care nursing and by those developing and delivering primary health care nursing services. The challenge for the sector and for nurses within it is to make the most of the learning from these and other innovations as the implementation of the Strategy is taken to the next phase.
FURTHER DEVELOPMENT OF NURSING IN PRIMARY HEALTH CARE

The findings from this evaluation confirm the potential for further development of the contribution of nurses in primary health care to the Primary Health Care Strategy and the health of New Zealanders. The evaluation has provided some evidence about what is supporting the development of primary health care nursing to deliver on the Strategy and what is inhibiting this development. It therefore also provides some insights into what could support further development of primary health care nursing.

The two models the innovations have developed 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. 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 education opportunities. The findings from the evaluation show that the clinical skills among nurses in the sector are variable, but that nurses are willing to undertake further development of their skills when they are supported by their organisation.

The two DHB-based innovations that developed career pathways each delineated graduated progression of primary health care nurses’ professional practice over four and five steps. These steps bridge the scopes of practice between registered nurse and nurse practitioner, which were established by the 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 growing acknowledgement within this arm of the profession that the current scopes of practice 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. Although these regulations facilitated the supply of timely medications for common conditions, 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 in relation to the practice of nurses in outreach services.

Findings from these innovations also highlight the need for further development of primary health care IT software capacity, such as MedTech 32, not only in terms of recording and capturing nursing work and for the administration of 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 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 the ways that 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 DoNs, 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 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 spread further initiatives. The challenge for the sector, and for nurses within it, is to capitalise on the learnings from these as the implementation of the Strategy is taken to the next phase.
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