New Zealand Nurses Organisation

Submission to the Ministry of Health

on the

Discussion paper Nursing's Role in After Hours Primary Health Care Services

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SUMMARY

1. The New Zealand Nurses Organisation would welcome the opportunity to consider this report thoroughly through our usual robust processes of consultation with members, all colleges and sections, Te Runanga o Aotearoa, and staff including professional nursing advisers, policy analysts and board members.
2. However, the unreasonably short timeframe for feedback of nine working days has not allowed us to consult adequately and we advise that our comments here are preliminary only.
3. Unedited submissions from The New Zealand College of Practice Nurses and a representative group of rural nurses are presented in addition to, and following, comments from other NZNO contributors.
4. NZNO agrees that:
    - there is a need to improve access to quality, affordable after hours primary health care (PHC) services;
    - there is a lack of clarity about the responsibility for, function of, and coordination between Emergency Care and after hours PHC and telephone triage services;
    - there is a shortage of appropriately trained nurses;
    - nursing services are poorly utilised; and
    - new models for service delivery need to be developed and resourced.
5. We offer suggestions for improvement and working towards sustainable after hours PHC which are safely integrated with other services to provide 24h hour care.
6. In particular, NZNO recommends
    - strengthening the nursing workforce in Primary Care and Emergency Department (ED) supporting advanced nursing roles; and
    - facilitating the more effective use of nurse practitioners and practice nurses.

7. We suggest that funding and service delivery models need to change to reflect the shared responsibilities of healthcare provided by multidisciplinary teams (MDT) and the current environment.

8. NZNO is concerned that the subtext implicit in this document is that nurses will step into the current afterhours service gap at a reduced cost. This is both unlikely and undesirable. Safe, quality 24 hour care cannot be provided by replacing one group of health professionals with another; a coherent strategy for coordinating services and clinical teams is necessary.

9. NZNO is not in favour of extra charges for after hours care, especially in the current environment where flexible working hours are widespread and encouraged, and where there is clear evidence many find it difficult to pay for day services. However, if deemed necessary, we recommend a maximum of fee of $5.00 above the daytime rate.

10. In this context we also note that in the ED triage cannot be used to separate PHC and emergency care (NZNO, 2008a).

11. NZNO supports telephone triage in PHC afterhours service and offers suggestions for improvements.

12. NZNO does not believe that $9 million spread across 21 District Health Boards (DHBs) will effect significant improvement and recommends targeting funding to support alternative models in specific locations where need is paramount.

13. We draw your attention to two recent NZNO submissions which are relevant to this discussion, namely:

    - NZNO's submission on *Seeking a system capable of delivering an ideal interface between the public requiring urgent health care and the health system:: A process and sorting tool to assist people to access the most appropriate health care*, (NZNO, 2008a); and

    - NZNO Submission to the Working Group for Achieving Quality in Emergency Departments, (NZNO, 2008b).

14. NZNO expects that there will be further opportunities for engagement on the matters raised in this document, as they will impact on the professional practise of primary health care nurses and their conditions of employment.

ABOUT THE NEW ZEALAND NURSES ORGANISATION

15. NZNO is a Te Tiriti o Waitangi based organisation. It is the leading professional body and nursing union in Aotearoa New Zealand, representing over 42 000 nurses, midwives, kaimahi hauora, students, health care assistants and other health professionals. Te Runanga o Aotearoa NZNO comprises Māori membership and is the arm through which our Treaty based partnership is articulated.

16. The NZNO vision is "Freed to care, Proud to nurse". Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships and are united in their professional and industrial aspirations

DISCUSSION

Consultation

17. The Ministry states that the purpose of this paper is that it "wishes to engage the nursing sector in a discussion of afterhours PHC service planning and delivery." If the Ministry were serious about its intent to engage the nursing sector with this important discussion paper it would allow a sufficient timeframe for meaningful discussion and debate to occur. Nine working days - from the date of receipt by NZNO, November 27, to the submission deadline December 10,is totally inadequate. NZNO strongly objects to this short timeframe and the unwillingness of the Ministry to agree to an extension.

18. We advise that we have been unable to consult with our members as robustly as usual and advise that comments within this submission are preliminary only.

19. We draw your attention to the State Services Commission's Guidelines for Consultation which states "*A key element in consultation is the requirement to provide sufficient time for those consulted to prepare a meaningful response*." We suggest that the principles and practise outlined there are adhered to (State Services Commission).

20. NZNO expects that there will be further opportunities for consultation with our members on the matters raised in this document, as they will impact on the professional practise of primary health care nurses and their conditions of employment.

Workforce

21. NZNO acknowledges that General Practitioners do not always offer after hours services, which may be attributable to a more gender balanced workforce as well as lifestyle choices. However it should not be assumed that nurses, who are mainly women, will not want the same lifestyle choices and will be prepared to fill the gap without support or incentive. It is certainly clear that nursing scopes of practice are quite different to GPs and we believe there is a potential risk to both public health and safety and industrial relations if one cadre of health professionals replaces another. The nursing and medical professions work closely together, relying on and respecting each other's strengths and skills. It is essential that any changes to the provision of after hours PHC are considered holistically with due regard to both professions and modern clinical practice which entails working collaboratively in MDTs.

22. All health professionals must work within their regulated scopes of practise under and any changes in the extent, responsibility or nature of the after hours nursing care will need to be considered in the context of the relevant legislation, The Health Practitioners Competence Assurance Act 2003. The Registered Nurse scope of practise does not cover medical diagnosis, for instance, and this would need consideration in any redesign of work . We note also that there are still many legislative barriers to the full utilisation of nurse practitioners (NP).

23. NZNO notes that there are nursing shortages throughout the health sector , though these are often ill defined because of the lack of coordinated data. However an NZNO survey in 2006 indicated that there was a chronic nursing workforce shortage at that time. Although that has dropped as a result of better wages and conditions for nurses under the PHC Multi Employment Collective Agreement, we understand that there are still significant workforce shortages. NZNO acknowledges that there has been an increase in nurses pay since this time but pay parity with DHB nurses of the same skill level is still not reached and the chronic nursing workforce shortage will still remain until this is resolved.

24. The facilitation and implementation of advanced primary health care nursing roles are essential in New Zealand and should continue to be developed and supported.

25. NZNO is concerned that the devolution of Clinical Training Agency (CTA) funding for post-graduate studies to DHBs have created a gap in marketing and thus access for PHC nurses. For example, DHBs operate promotion of education and training, policies, and application details via their staff intranet services. These intranet services are generally NOT available to any health provider outside of the DHB provider arm and as a consequence PHC nurses may have limited or restricted access. The solution to this is the replication of the entire information to be available on the DHB's external website, however, it has been NOTED that some DHB's choose which of the information is selected for the external sites as each new information or update to a website is a cost to the DHB.

26. The Nurse Practitioner role has the potential to augment GP services and needs to be seriously considered as part of primary healthcare services. However, we point out that there are only a few dozen NPs and few of these are in PHC. Barriers to taking up this role include onerously demanding academic requirements which can exclude excellent clinical practitioners, expense, lack of employment opportunity and the lengthy application process through Nursing Council of NZ..

27. Advanced nursing roles however, rely on experienced nurses and NZNO points out that a quarter of new graduates never practise in New Zealand – possibly because of the lack of New Entry To Practise positions - and the attrition rate is extremely high though, again, this is unquantified.

28. We note that Clinical Training Agency funding for nursing, the largest and most flexible workforce, is consistently poor in comparison, for example, with the medical workforce in spite of the considerable advances in healthcare that both professions need to keep abreast of . Such policy choices send a clear signal about the perceived value of nursing and do nothing to enhance the recruitment, retention or advancement of nursing skills in PHC .

29. There is an urgent need to support future nurses to fill the PHC nursing role which means addressing student nurse barriers such as fees; implementing a national career pathway for PHC nurses; reviewing current funding models of PHC nurses; and financially supporting the development and trail of innovative models.

30. Pacific peoples are underrepresented in the nursing workforce (though as we have pointed out previously, there is a pool of unregistered Pacific nurses here whose

skills are underutilised because of the language prerequisite which is culturally and occupationally inappropriate for nursing communication in Aotearoa).

31. It should also be noted one third of the nursing workforce is overseas-trained and may need additional cultural support/training working in PHC where they may be practising in relative isolation.

Barriers for Māori

32. Seven out of eight Māori use mainstream health services (Kai Tiaki, 2008). Improving access to primary health care services (PHC) for Māori requires a multi systems approach that includes support for: affordable costs, assistance with transport, effective communication, whānau centred clinics and increasing the capacity of Māori health professionals working in after hours care services.
33. In the 2006 census, 15% of the total population identified as MāoriEru Pomare Research centre, 2007), the majority of whom live in urban areas in the North Island. Addressing the issue of accountability of mainstream providers to ensure adequate, affordable and culturally appropriate health care services to high needs group such as Māori should be a priority when the Ministry is reviewing after hours care services.
34. Fundamental barriers will continue to impede access to after hours PHC services for Māori, unless equitable access to care and equitble outcomes are addressed including issues of: cost, transport, attitudes, racisim, fear, and mistrust of health professionals.
35. Māori providers offer New Zealanders essential health and disability services. A barrier to the full utilisation of these services is the very short contract lengths, often of one year duration. NZNO is concerned that these timeframes, (by both MOH and DHB) has significant impacts on recruitment of appropriately skilled nurses and thus are limited in their ability to meet population health and personal health outcomes.
36. NZNO suggest that health and disability services have a minimum of 3-5 years duration allowing for appropriate recruitment, training, implementation, development of community knowledge and retention of MDT members in essential PHC services.
37. NZNO notes that, at around 6 percent, Maori are very underrerpresented in the nursing workforce. They are also paid up to 25% less than their mainstream as evidence presented in support of Te Rau Kōkiri the NZNO Maori and Iwi MECA made clear earlier this year.

38. NZNO strongly suggests that to address Māori health needs and equity issues, a commitment to the Māori nursing workforce is essential but anticipating already overworked and underpaid Māori nurses will work after hours, is unlikely to be a successful strategy.
39. *Consultation with Māori nurses working in primary health care organisations indicated that they do not wish to work 24/7 rosters at the current rates of pay and have no wish to change their work life balance lifestyles to accommodate the Ministry's current proposal to increase PHC hours. The nurses were also very dismissive of the Ministry idea that nurses would necessary want to increase their work load or responsibilities in delivery of care. The Māori nurses felt the Ministry document had an unrealistic view of addressing barriers for populations experiencing inequalities given the current capacity issues of Māori staff working in after hours care services.* **(**Māori Nurse Comment)

Funding/Access

40. The funding allocation of 9 million to establish nursing roles in triage, telphone triage and nurse led clinics is insulting when recent additional funding to reduce cost barriers to acessing services, has reached a total of $1.7 billion over six years (Ministry of health, 2008).
41. NZNO is keen to see health outcomes from additional funding to DHBs and PHOs and believe it is essential that communities are involved in the decision making about utlisation of this resource. For example, communities and/or populations that have little or no transport may see that purchase of vehicles and/or transport services and overcomes their greatest barrier.
42. The funding amount intended to address nurses roles in after hours PHC services indicates once again an unrealistic understanding of establishing natonwide frontline services. Appropriate consultation period and funding struture reviews would ensure paltry amounts of funding would not be dumped at short notice into services that require a multi systems approach to ensure staff are fully consulted prior to discussions about changes to: hours of staff roles and responsiblities, capacity of services to reduce barriers for those populations in greatest need.

43. The role of nurses in afterhours PHC services is varied across the urban and rural ettings and therefore would require further consultation and discussion prior to devolvement of the funding available.
44. Population funding may not be appropriate for independant nurse-led clinics providing after-hours services. The current ACC nursing fee-for service model has improved both access to care and timeliness to treatment and from this aspect is successful in meeting the aims of the PHC Strategy. NZNO notes that the fee structure for nursing services needs review and equitable payments for equitable health service is desired.

Service Coordination

45. NZNO agrees that currently after hours emergency and GP services are poorly coordinated. There is also widespread confusion about who is responsible for providing PHC after hours care in different locations and at what point it is acceptable for PHC and emergency care to intersect.
46. The public need to be well informed about what services are available and given guidance as to when and in what situations they should be accessed.
47. Similarly after hours PHC needs to be linked to current DHBNZ and MOH activities relating to the primary secondary interface.
48. The effect of the cost of services to patients on how they access care has not been fully considered. NZNO members are aware of wide disparities in charges for after hours services which are unfair and punitive. The discussion document advocates service provision at the 'right time' and 'right place' but this is entirely subjective. "*The right time may be that Dad has come home from his shift at 10.30pm and can now take his sick child to ED to be seen because they cannot afford to see a GP and have no other childcare/transport/family support.* " (College of Emergency Nurses)
49. Services need to take account of changing patterns of employment, leisure and family activities and meet the needs of patients. There should be no extra cost in providing clinical services outside 'normal' working hours, any more than there is for banking or shopping. 24 hour availability of care should be factored into service agreements.

50. We note that in some areas considerable investment seems to have been made in solid assets like buildings and smart clinics at the expense of investment in personnel.

51. Population based funding does not distinguish those areas that have high health needs, for example older populations, or those with chronic conditions, or those who have no other support. New migrants, for instance, rely on someone to translate and the right time for them to seek healthcare is when a translator is available.

52. NZNO does not support triaging people away if they arrive in ED as this has been proven impractical and unsafe. Nurses should not be expected to be the gatekeepers between paid and unpaid services.

53. Consideration need to be given to investigating and further trialling innovations such as after hours care of the elderly by the DN services at Midcentral DHB where GPs refer elderly who they would otherwise refer to hospital for 24 hour observation.

54. The MOH has undertaken significant enquiry into the function and management of patients presenting to Emergency Departments. Whilst this discussion document looks at patients prior to emergency admission consideration must equally be given to bed blocks in hospital and patient flows. (whole of system approach)

55. This work also needs to have a strong link to the current DHBNZ and MOH activities relating to the primary secondary interface. In particular, nurses must have ready access to GP and medical support both in PHC and within hospital services. Our nurse members have informed us the disregard and lack of respect they receive when telephoning medical staff within the hospital for advice about their assessment and referrals.

QUESTIONS

1.What is / should be nursing's role(s) in after hours PHC services?

35. Appropriately qualified and trained nursing staff , as part of an integrated MDT, should be able to provide safe effective after hours PHC in both urban and rural settings. This is however very much dependant upon workforce availability, access to appropriate training and favourable conditions and remuneration to attract and retain appropriately qualified nurses.

36. If DHBs had supported the expansion or even the establishment of NPs or MDTs with a district nurse/ambulance person and GP on call each day after hours, then many problems could be dealt with close to home by the appropriate person.

2. What is the role of telephone triage in PHC after hours services?

56. NZNO supports a role for telephone triage in providing clear practical advice, following agreed care pathways and working with families/whanau on how best to meet the need at that time.
57. The ability for nurses to advise and direct patients to appropriate locally available services which is difficult to achieve with a centrally located system. Good communications pathways need to be established to ensure that local knowledge is made available for this service.
58. Some members report that patients have difficulty getting through to Telephone Triage and then are referred to the Emergency Department which is the safe option when the patient cannot be seen. Others report that patients are not sanguine about the service and take themselves to ED for "'second opinion".
59. Some of our members are concerned those after hours services provided to the far north communities offer telephone triage by nurses in Auckland with subsequent referral and appointment with a GP at a nearby medical centre. A local nursing telephone triage service with knowledge of community resources and perhaps even of the patient and their support may prevent unnecessary travel and attendance by a GP.
60. NZNO recommends that current MOH work on shared health records and development of IT infrastructure is given a high priority and expedience. Telephone triage systems and after hours services would be more efficient if health providers had access to patient clinical records such as recent hospital admission information, current prescriptions and current service providers. This work will also have positive outcomes on patient flow in the primary/secondary interface and within ED and the entire hospital system.

61. Attention must be given to the unintended consequences if DHBs devolve funding to all PHOs with a requirement they each provide an after hours telephone service. Smaller PHO's will have a limited ability to provide services over the entire period, eg

5pm to 8am. The resources required for this are nursing workforce on a daily basis, nursing workforce to cover leave periods, including cover for professional development and training leave, clinical supervision, nursing leadership and operational support. A national service delivered in local regions may be more cost effective and deliver a better service.

3, How and where should nurse-led / nurse only services and / or nursing in general, fit into the following three settings: a. current service configurations? b. new service configurations? c. triage services?

62. a*) current service configurations*: Work needs to be done to review, educate and promote nursing/nurse led services in PHC and GP settings. Current service configurations entrench traditional hierarchies and power imbalances and in too many areas nurses remain underutilised, under resourced, under-respected and underpaid.

If the PHC Strategy is implemented with its full intention, then

1) expansion of the PHC nursing role would be given urgency and recommendation 3b. of the Report to the Minister of Health from the Workforce Taskforce, May 2008 would be undertaken in 2009.

Recommendation 3: That to, provide professional leadership and clinical governance b) DHB's work with the primary health sector to develop a nationally consistent approach to the development of primary health care nursing. (Working together for better primary health care, 2008)

2) pay parity with DHB's would be achieved for all of the primary health care workforce, including nurses and allied health professional working with Maori health providers. NZNO acknowledges that Maori health providers have requested the government to provide appropriate funding so that they can effectively recruit and retain staff in PHC services but the government has not delivered the funding to enact the PHC Strategy.
3) The barriers to change in general practice, PHO's, NGO's and DHB's (as noted in the Report to the Minister of Health from the Workforce Taskforce,

May 2008) are noted and recommendation 2: be implemented in 2009. These barriers include the small business model consuming owner-operators in service delivery rather than primary health care development, physical space, lack of capital investment for computers and equipment, possible restriction to amalgamation with other providers, disagreement between PHO's on whether nursing services should or could be provided directly from a PHO, the range of involvement in development of DHB district annual plans.

b) new service configurations:

The time limit allowed for consultation of this discussion document limited our full response on this. We suggest both national and international models are reviewed and the Ministry of Health fully support a full pilot. One such example is the nurse led minor injury / ailment walk in centre provided by the NHS in England.

c) triage services:

63. Nursing triage is not offered in some PHC settings, whether during business hours or after-hours. Nursing triage is shown to improve access and maximise the efficiency of the subsequent consultation with medical colleagues and assist appropriate referrals. Nursing triage is best located within general practice (first point of health care), and by telephone such as Healthline and NHS Direct models.

4. What (if any) are the barriers to nursing playing its role in those three settings? How can the barriers be overcome? Who should take responsibility for ensuring barriers are overcome?

64. Professional organisations and the MOH have a role in supporting change processes and buy in from all health professionals. Positive images on effective and new models of primary health care nursing are integral to implementation and outcomes.

65. A continuum of prescribing ability needs urgent attention and focus on the required developmental work and enactment needs specific resourcing by the MOH. This will include Standing Orders, Collaborative Prescribing, authorised Prescribing and Independent Prescribing.

66. Fragmentation of health services by devolution of contracts limits workforce availability and effective leadership. Not all contracts should be devolved to DHBs and to PHO's if a NGO's service provided nationally is more effective in health outcomes. For example, Plunketline has an appropriately trained and supported workforce to deliver the service which may / may not be delivered at the same level by smaller regional locations / PHO's.
67. Leadership from the MoH Chief Nursing Adviser and Nursing Council of NZ would be useful in this context. They should be proactive and supportive agents for change in the political arena, to accommodate innovative new models of healthcare in response to the changing environment.
68. Workforce availability is a key barrier. NZNO notes that there are very few NPs and even fewer in primary health care. If this model is to be effective, barriers to NP and advanced nursing need to be addressed. .
69. NZNO also notes that public expectations can be a barrier, when an outdated or muddied perception of the nursing role is held. In this regard the introduction of unregulated healthcare workers without adequate guidelines for their deployment and the ongoing confusion around the title and scope of second level nursing, exacerbated by some ill-informed decisions, has done nursing a great disservice. Unless there is a clarity around the roles of regulated nurses, public and professional confidence in the profession will will waver.

5. What are the messages, from nursing's point of view, that needs to be communicated to the public about after hours PHC services?

70. Timely advice from a trained health professional is beneficial to supporting you and your family/whanau's health care needs after hours.
71. PHC is a low priority in ED which means that waiting times can be considerable. Effective and more timely after hours care can be accessed through your usual health provider's extended service.

6. How can nursing add value to after hours PHC services?

Nursing adds value when it is involved at all levels, whether as a consultant to the process or a provider of a service.

In NZ we have small examples and evaluation of the nurse practitioner in PHC although the international evidence and value is already demonstrated. The MOH needs to fund and support various NP PHC models to replicate this value in NZ and encourage the snowball effect.

Rural Nurses

After hours is an important issue for PHC teams in rural New Zealand (NZ) and this therefore impacts on the role of advanced rural nurses. Currently, due to both workforce shortages and financial considerations, nurses are increasingly being asked to be involved in first on-call. The responses to the questions of this Ministry of Health (MOH) discussion paper below are from the advanced rural nurse perspective only.

1. What is / should be nursing's role(s) in after hours PHC services?

Appropriately trained advanced rural nurses can be part of a PHC after hours roster, specifically:

- suitable depth of nursing experience
- PRIME training
- use of locality-approved standing orders
- post-graduate education / ongoing CNE
- knowledge of locality geography and local service networks
- collegial support, i.e. GP second on – call to cover issues outside the nursing scope and / or access to local secondary medical service support
- regular access to supervision / mentor support

2. What is the role of telephone triage in PHC after hours services?

If locality-specific telephone triage is available, then it can be excellent. Unfortunately the Australian, Tasmanian example demonstrates problems that can occur when telephone triage is not locality-specific. Staff must be aware of localised support networks, isolated communication and geographical difficulties, not just possess PHC triage knowledge. Based on international research it is doubtful that nationwide telephone triage would have a place in PHC after hours in rural NZ.

3. How and where should nurse-led / nurse only services and / or nursing in general, fit into the following three settings: a. current service configurations? b. new service configurations? c. triage services?

In rural NZ the emphasis needs to be on PHC teams. Obviously some of these are nurse-led / nurse only as these are the only PHC local services. Local rural nurses in these rural teams would already have knowledge of their patient populations / support systems, appropriate medical support and geography. As answered in question 1 the nurses need to be appropriately trained and collegially supported.

4. What (if any) are the barriers to nursing playing its role in those three settings? How can the barriers be overcome? Who should take responsibility for ensuring barriers are overcome?

Specific barriers that advanced rural nurses encounter in NZ and internationally are:

- Medical practitioners, who have no working relationship nor knowledge of the nurse-on-call's competence and generalist scope of practice, are inclined to be insecure in their decision-making on the basis of a nursing assessment and tend to ask for the patient(s) to be transferred when there is no clinical indication. This is frustrating and time consuming for the patient and undermines his/her confidence in the nursing after-hours service.
- This can be overcome by locality specific teamwork, nurses working together with doctors who know and trust their practice. By networking, mutual recognition between the two professions will occur with time and practical experience.
- The MOH / DHB can take responsibility by supporting the local PHC teams to enable them to provide accessible and sustainable after hours services. The medical and nursing professional bodies need to look at ways where ongoing education can be team-based to support integration.
- Standing orders that are not locally relevant and endorsed by the doctors within the localized teams, i.e. nationalized ones are often too broad (without depth) and yet sometimes inappropriate for isolated nurses (restrictive; necessitating patient transfers that are lengthy and costly).
- This can be overcome by locality-specific standing orders.

- The MOH could provide several acceptable standing order models that are evidence-based and regularly updated. These can then be modified by the PHC teams to be locally relevant.

- Lack of diagnostic / treatment equipment for the nurses to access.

- This could be overcome by a similar system to PRIME where each site has suitable emergency equipment available, likewise the nurses who are not providing after hour services from ordained health centres could receive a basic kit for this purpose.

5. What are the messages, from nursing's point of view, that need to be communicated to the public about after hours PHC services?

That the services are team-based and staffed by experienced nurses and doctors who understand the locality (nursing research identifies that rural people seek help from those 'known' to them and avoid 'outsiders').

6. How can nursing add value to after hours PHC services?

The nursing model provides clinical care that is holistic and whanau / family based.

Often after hours illness / accidents can have a profound effect on family dynamics creating dislocation in rural communities; nursing skills and communication and liaison between services are important in these situations to prevent further disruption.

It is important to stress that nursing skills differ from medical skills and that nurses cannot be viewed merely as cheap or replacement doctors providing a second rate service. As a profession, nurses have an important role to play as part of the PHC after hours team supporting their colleagues to care for rural communities .

The **New Zealand College of Practice Nurses** *NZNO*

1) What is/ should nursing's role (s) in after hours PHC services?

- ✓ Dependent on competence, skill level, education base.
- ✓ Consider protocol based care with proficient/expert endorsed PHC nurse
- ✓ EBG/Best Practice guided care approaches
- ✓ LTC management strategies need to be more robust
- ✓ Links with MDTeam especially GP's needs to be defined, structure and within a supportive framework.
- ✓ As an aspect of a PHC team approach
- ✓ As in rural areas currently may be on call (PRIME trained)
- ✓ As an essential element of afterhours care delivery

2) What is the role of telephone triage in PHC after hours services?

- ✓ Consider direct links with Healthline re triage, how much more funding/energy can we put in to this service to make it more robust and take it forward towards next 10 years;

  Consider:

  - ➢ Progressing this service via investment out of health budget and create an even better service.
  - ➢ More central service centres
  - ➢ Anonymity for nurses to tap in to local GP/Dr from nearest DHB to discuss plan of action for a specific patient in that located area. This will mitigate reluctance to collaborate and liaise with nursing staff.
  - ➢ Consider training, review UK NHS direct LTC tele programme as a long term potential investment.
  - ➢ Utilize standing orders, decision support software

3) How and where should nurse-led/ nurse only services and /or nursing in general, fit into the following 3 setting:

a. current service configurations?

- After hours still GP led, although healthline has removed some of the burden
- Direct links to GP/Dr support to engage in collaboration is crucial
- Prescribing an issue and Nurse Practitioner pathway, but standing orders would need to become more widely used and universal.
- LTC management guidelines to be established - huge burden nationally-structure needed and community nursing options need further exploring.
- Currently sketchy, varied, ill defined, non uniform.

b. new service configurations?

Strategic direction therefore for LTC management

- Protocol options need exploring
- Standing orders EB and collaboratively formulated with annual review.
- Consider rostering of day nurses
- Caution here not to develop even more of a dependency on health services .
- Public self management needs to be driven from the start.

c. triage services?

- Consider grading of nurses
- Educational and experiential skill
- As a key role of PHC nurse currently especially within general practice settings
- Look to International models UK Gloucestershire PCT for example.

4) What (if any) are the barriers to nursing playing its role in those three settings? How can barriers be overcome? Who should take responsibility for ensuring any barriers are overcome?

- Historical perception of the nurse's role from public and Dr viewpoint, evolving role will be embraced by some but stifled by others and this could negate role efficacy**.**
- Current role and scope of some PHC nurses as defined by employer
- Lack of current mechanisms to ensure ongoing competence
- Lack of current clinical governance at PHO level around who actually define the PHC nurse role within the general practice setting

- Variable PHO perspective of role of PHC nurse
- Current funding allocation i.e capitation seen as direct reduction for copayment to GP, whereas creativity could be utilized
- Workforce/age
- Education
- Pay Parity

How to overcome barriers

- Effective clinical governance at PHO and individual practice level
- Marketing of role of PHC nurse in varying settings. i.e general practice, outreach, PHO based etc.
- Build business cases to demonstrate innovative and pragmatic solutions to funding constraints
- Strong MDT links and medical acceptance (NZCGP/NZMA) need to look to the positives in this potential paradigm shift rather than oppose on grounds of pride and fiction.

Who is responsible?

- PHC nursing professional bodies- re marketing and ensuring effective support mechanisms and tools are available and marketed effectively
- PHC teams: should be regularly scoping skills and competence within entire team of providers, to ensure the necessary skills exist to meet clients needs in an acceptable, timely manner
- PHO- to scope modes of service delivery, current provider statistics, competencies and roles in after hour's eservice provision. Costing of pragmatic approaches to care delivery.

5) What are the messages, from nursing's point of view, that need to be communicated to the public about after hours PHC services?

- Option in need not for convenience
- Health-line if a more robust service can offer advice and save a trip.
- Who is the appropriate point of contact- fridge magnets at PHO level
- General messages around when to seek care after hours

- Clear messages re expectations of need for after hours care

6) How can nursing add value to after hours PHC services?

- Clear, comprehensive and sound assessment of patient problems
- Clear, focused LTC management assessment
- Partnered planning and implementation of care needs.
- Acute presentation, assessment and management of accident care (ACC funding review re nurse payments need consideration**).**
- Articulate clearly the scope of an RN in after hours care as described earlier- proficient/ expert level practitioners as evidenced.
- NP/ advanced nursing roles- is this where the opportunity exists to sanction/ create/ support a level of advance nursing in the community that is not NP level, such as the Clinical Nurse Specialist role in the acute environment.

Rachael Calverley
National Committee
NZCPN

CONCLUSION

72. In conclusion, NZNO recommends that you:

- **agree** that the short consultation timeframe has been inadequate;
- **note** that this submission is preliminary as a consequence**;**
- **agree** that $9 million is an inadequate amount to address concerns around the provision of after hours PHC service;
- **Agree** that MoH should adequately resource after hours PHC care in a manner consstent with athe pHC strategy;
- **note** the afterhours discussion paper released by MoH on the 27th November regarding nursing's role afterhours primary care services may influence outcomes;
- **note** our comments on primary healthcare nursing workforce development and a the need to expand advanced nursing roles in NZ; .
- **note** our previous submissions namely *Seeking a system capable of delivering an ideal interface between the public requiring urgent health care and the health*

system: A process and sorting tool to assist people to access the most appropriate health care, (NZNO, 2008a) and *NZNO Submission to the working group for achieving quality in emergency departments*(NZNO, 2008b)

- **note** NZNO expects that there will be further opportunities for engagement on the matters raised in this document, as they will impact on the professional practise of primary health care nurses and their conditions of employment

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