



Coast Health Care

*West Coast District Health Board
PO Box 387
Greymouth*

OVERVIEW

Neighbourhood Nurses in Reefton

A Primary Health Care Nursing Innovation for a Rural Community

The NEIGHBOURHOOD NURSES innovation will address the challenge of primary health care:

Quite simply, the need has never been greater for strong primary health care to be put at the centre of our health system....

Services will be directed not just at those who seek care when they are ill, but will be there to look after the health needs of the whole population group. So primary care providers will need to know not just who is sick, but who might become sick because they are not getting access to preventative health care and health education.

We need to coordinate our primary health care professional resources far better. For example, we have 11 or more different types of primary health care nurses. We need linkages between all sorts of community care, hospital services and other key areas like social welfare, disability support, housing and local government.

We also need continuity in care, especially for the increasing number of people with complex long term health needs....

*The Honourable Annette King, Minister of Health, 30 May 2002
'Primary Focus: The Future of Primary Health Care' Address to the Primary Health Care Conference*

The NEIGHBOURHOOD NURSES innovation will give us answers to questions about the possibilities of 'generic' primary health care nursing roles:

Would nurses be willing to do such a role?

Would a more holistic approach enable them to deliver care and health promotion of the same quality as they deliver from specialist roles?

Would their clients and communities find continuity and a more comprehensive approach an improvement?

And if so, what was the learning and support that enabled the transition to a new way of working?

funded by

Primary Health Care Nursing Innovation Funding, Ministry of Health

NEIGHBOURHOOD NURSES IN REEFTON

A Nursing Innovation in Primary Health Care

Manaaki Te Wairua me Te Tinana o Te Tangata

A team of 'neighbourhood nurses' who will work in Reefton and its surrounding district with individuals, families and the community is proposed. What they offer will be described in two ways: professionally as a mix of generalist, specialist, expanded and advanced practice; but by their clients and colleagues as: "They just do what needs to be done".

Rather than engaging with clients on the basis of contracted work streams, it will be client need that directs their interactions and care. Client needs will be understood to range from those related to actual health problems, to the education and support people need take responsibility for maintaining their own health, wellness and capability.

In practice this may mean that a nurse may establish a relationship with a family 'in all kinds of trouble' through an initial contact requiring home visits to dress a grandmother's leg ulcers, but go on to support the daughter, a young solo mother, in making choices about her children's immunization, assist her in shopping for healthy meals on a limited budget, and encouraging the live-in boyfriend to take up remedial reading so that his employment prospects improve, recalling that his mate hasn't looked back after doing the ACCESS course.... In other words, these neighbourhood nurses will practice in a comprehensive and integrated way that is far removed from the disease focus or age related nursing roles that otherwise fragment nursing interactions with individuals and families.

Although initially a nurse-driven project, it will be understood as a community endeavour, as the first stage of project implementation will be a process of community consultation that shapes the project more definitely. Equally, the nurses who will be involved, the GP and other health, welfare and community service providers will determine the way the project is realized.

In line with the expectation that the innovation also advances nursing practice possibilities, those nurses recruited to the project will be attracted to it because it offers support for further formal education (e.g. Diploma in Primary Rural Health or a clinical masters) as well as good informal support through clinical supervision, coaching and team facilitation and leadership.

The 'neighbourhood nurse' team will offer from amongst its members expertise in mental health, Maori health, district, well child, public health, first response, disease state management etc without any one nurse practising exclusively in one area of responsibility.

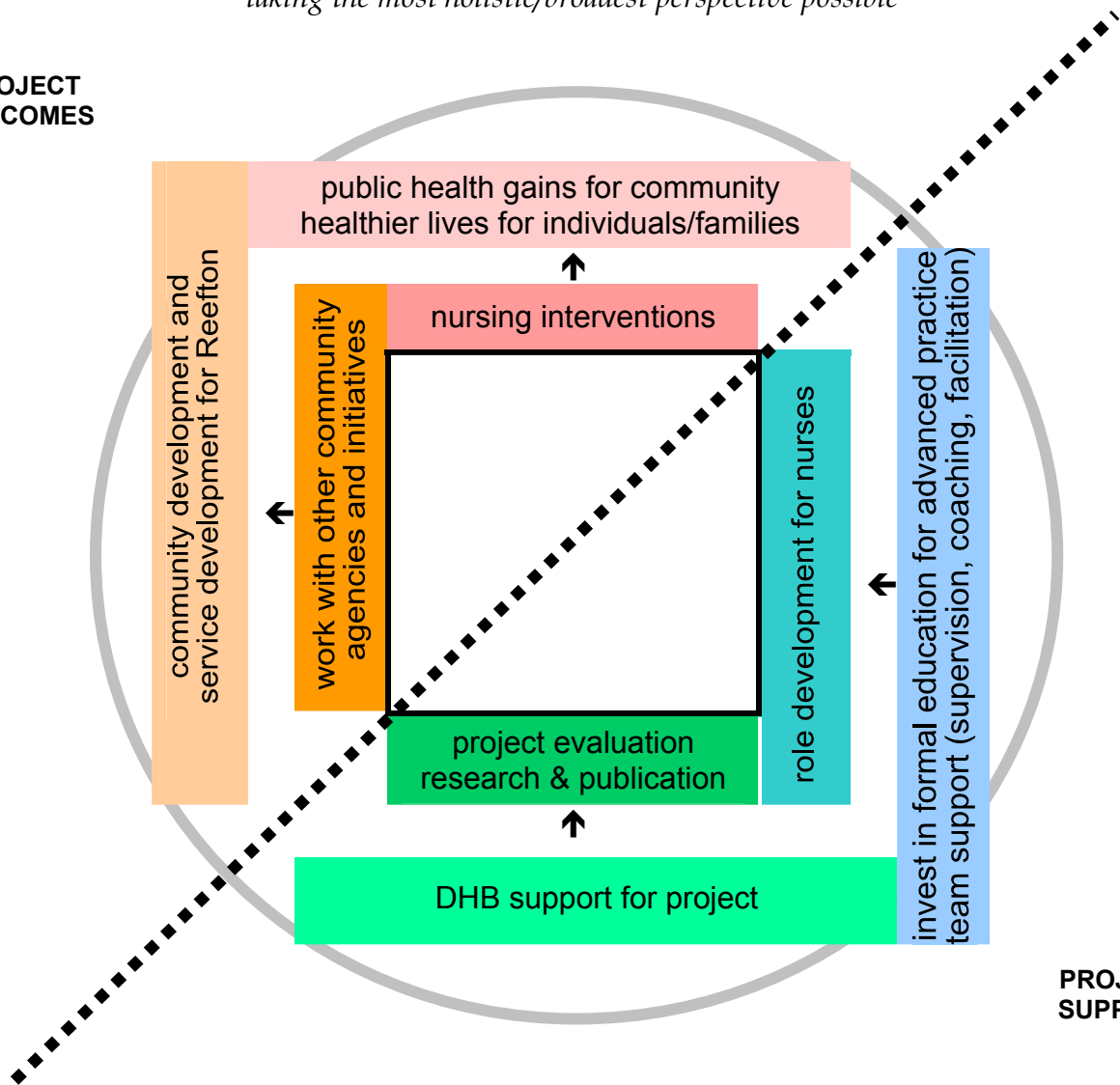
A good reference point for the 'neighbourhood nurse' concept is Coast Health Care's Rural Nurse Specialist.

NEIGHBOURHOOD NURSES MODEL:
INTEGRATING INNOVATION WITH IMPROVEMENT
IN HEALTH STATUS AND COMMUNITY DEVELOPMENT

*Outcomes from and supports required for
the Neighbourhood Nurses in Reefton Innovation*

taking the most holistic/broadest perspective possible

**PROJECT
OUTCOMES**



**PROJECT
SUPPORT**

*thinking 'outside the square', beyond traditional nursing roles
and responsibilities to engage with clients in new ways*

Reefton Medical Centre is the partnering organisation in the innovation,
under the umbrella of the West Coast PHO.

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Background to the Neighbourhood Nurses Innovation

Primary health care is the key to improving the health status of individuals, families and communities

Primary health care has been defined as ‘...the first level of contact of individuals, the family and community with the national health system bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process’¹. Although it includes trying to cure people when they are sick, primary health care is also about promoting health and wellness, preventing illness and rehabilitating and supporting those with health problems. This means thinking about everything that impacts on health – from food safety, to housing and employment, to people taking responsibility for their own health, to having good referral systems and coordination amongst health care workers.

Obviously, promoting health and preventing illness is the area that holds the most potential for keeping people well and minimising the need for expensive and intensive hospital treatment, and this is the thinking behind the Minister of Health’s Primary Health Care Strategy (PHC Strategy).

The Ministry of Health approved funding for innovations in primary health care nursing

Nursing roles in primary health care are seen to hold great potential and at the same time, to be considerably under-utilised. In mid-2002 the Ministry of Health put up funding for innovations in primary health care, as a way to

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

Expressions of interest were invited, to be submitted through and supported by District Health Boards (DHBs). Ten innovations were to be funded over and above current service provision for three years, but at the end of that time they would need to be sustainable without the extra funding.

A team at West Coast DHB started work on an idea

The first step in the process was to submit a Registration of Interest (ROI) outlining an idea. It would be assessed against 11 criteria related to primary health care, consultation and collaboration, service priorities and the development of primary health care nurses. A small team at West Coast District Health Board (WCDHB) started work shortly before the early August deadline.

Key principles in developing the NEIGHBOURHOOD NURSES idea were:

- to link the innovations funding with real health need in a particular community with the intent of achieving health gains
- to recognise that in rural areas health service provision can be more ‘fragile’ than in larger centres
- that the project should be both manageable and relevant for WCDHB

¹ WORLD HEALTH ORGANISATION (1978) **Declaration Of Alma-Ata**, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978 www.who.int/hpr/archive/docs/almaata.html

² FEEK Colin and HUGHES Frances (June 2002) **Call for Registration of Interest: Primary Health Care Nursing Innovations Funding** Ministry of Health : Wellington

- that the project would support and develop the nurses involved, and also contribute its learning to primary health care nursing and primary health care more generally
- that the project would need support in terms of project management, change management, team and individual development.

The first three principles drew us to look at Reefton, a small rural community in the Buller District.

The essence of the idea is presented in the word picture in the frontispiece 'Neighbourhood Nurses in Reefton', and the model 'Integrating Innovation with Improvement in Health Status and Community Development', also at the front of this document. Immediate feedback from primary health care nurses in Reefton, the Reefton GP, and the Chair of the Buller Community Development Company was supportive and encouraging.

It was difficult to know how extensively to consult and what to inform people of when we didn't know ourselves

We were committed to – and required to be committed to – our final principle: to base the project on a partnership model (with the community, iwi and hapu, and with health and related providers). But at this point we felt we were in a lottery – what chance had we of winning? And would it be right to enthuse and involve everyone with a new idea when we had no idea if it would really happen? We decided that we needed to 'be in to win' and if we got somewhere, then we would have something real to be talking about.

The NEIGHBOURHOOD NURSES idea was shortlisted and a full proposal requested

We were notified mid-October 2002, that of 139 expressions of interest, NEIGHBOURHOOD NURSES was one of the 15 shortlisted. A comprehensive proposal was requested, due mid-December. The Request for Proposal (RFP) template was received and a 30 page proposal (plus appendices) developed by the team with assistance from corporate staff and others. There was further consultation with the community nurses and GP in Reefton, the WCDHB Kaiarahi (Senior Maori Health Adviser), two representatives of Nga Papatipu Runanga on the WCDHB/Te Poari Hauora a Rohe o Tai Poutini (and the Komiti of the Inangahua Manaaki Mo Te Whanau (representing Maori in Reefton, under the mandate of Kati Wai Wai). This document is based on the proposal.

Additional information was requested and supplied

In late January 2003 the shortlisted candidates were requested to submit further information in response to six specific questions for a mid-February deadline. Just ten would be selected. We pulled together another 11 pages of information, along with eight appendices.

NEIGHBOURHOOD NURSES receives funding

The Minister of Health, Annette King, formally announced 11 successful innovations at a nursing forum in late February. NEIGHBOURHOOD NURSES was successful. It was the only South Island innovation to be selected.

An idea whose time had come?

However, the proposing team has always recognised that people in Reefton had been exploring different ways of doing things long before the Innovations Funding came along. We believe that this meant that the NEIGHBOURHOOD NURSES idea was an idea whose time had come.

There were two prompts for discussions in 1998 about a 'community' nurse role – how to maximise the nurses' time in far flung house calls, and how to reduce the fragmentation of nursing services to clients. For instance, a specialised nurse may travel past three homes where nursing services are needed, on her/his way to another client. Meanwhile, one home may be visited by several nurses, each dealing with a specialised area or age group. The then Director of Nursing, Sue Wood, and Robin Williams, as Manager Community Nursing Services, discussed how to overcome these problems with nurses in district and public health nurse roles.

Another discussion along somewhat similar lines was driven by Drs Buzz Burrell and Julian James-Ashburner. The key idea in this dialogue was whether there would be benefits to the Reefton community if nursing services were coordinated by Reefton general practice, rather than through the DHB.

Then, in the context of community consultation around the introduction of Primary Healthcare Organizations (PHOs) for the West Coast, Dr Julian James-Ashburner called local health professionals together. At that time, there seemed little prospect of being able to get a second general practitioner for Reefton, and the question was how to provide a health service with a different mix of professionals. One response was that the DHB sought funding for a rural nurse specialist position for Reefton.

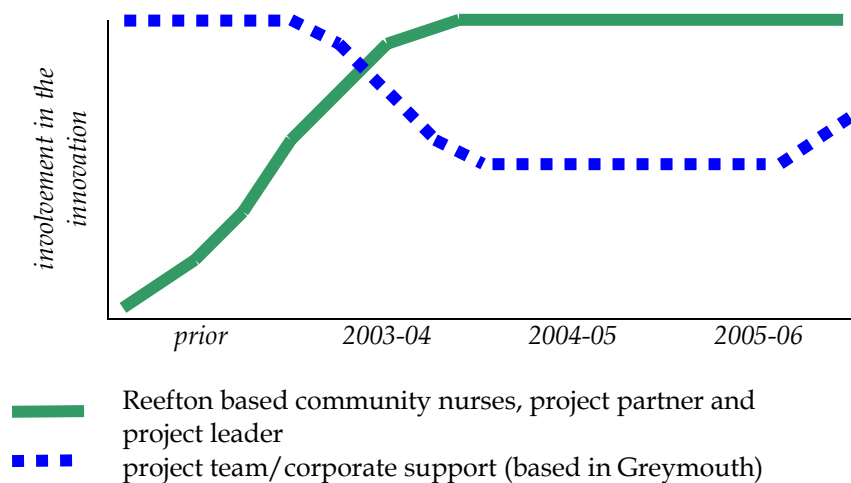
Other ongoing developments are PHO development led by Southlink Health, in which nurses are increasingly involved, and the formation of a regional primary healthcare nursing network.

Where are we at?

We'd opted for the later of two funding streams: July 2003-June 2006 to give us time to continue consultation and preparation. At the time of writing, the priority is to appoint a project leader to support the people involved in it and keep it on track according to timeline and budget.

As time goes on the project will be driven more by Reefton and less by the project team based at corporate

While the project is currently being driven by the proposing team, the balance of input and direction will alter, so that the project team are directed by the Reefton community primary health care nurses, project partner (Reefton Medical Centre) and Reefton community representatives. A high level of support will continue from the project team at corporate level, and increase at the close of the funding to assist in final evaluation and reporting.



How can you know what is happening?

Because we believe that this project is 'owned' by the wider community on the Coast, we have planned to be directed by the community and to be accountable to it, with the Reefton community being primary. Equally, we believe that the project is one that is of interest to primary health care providers and nurses in particular, and we wish to share our learning with the health service and professional community.

The Registration of Interest document and related links are available on www.westcoastdhb.org.nz under 'Neighbourhood Nurses: Background'.

This overview document and the regular six monthly reports required of the project will be posted on the website under 'District Health Board Information', and more immediate news under 'Current News'.

Overview of the Neighbourhood Nurses Innovation

Project aim and timeframe

The NEIGHBOURHOOD NURSE innovation seeks to implement an innovative primary health care nurse role in a discrete community, with the object of improving the health status of that community. A secondary goal is to explore the success factors (or otherwise) in implementing a new primary health care nursing role and new ways of working with clients, families, and colleagues.

The project funding commences July 2003 and terminates June 2006. A certain amount of preparation and consultation has taken place in the period prior to July 2003. Please refer to the Timeline, *page 20*.

Project purpose: The innovation is directed to primary health care in a rural community

The NEIGHBOURHOOD NURSE proposal was a response to the opportunity to provide an improved health service to a small relatively isolated rural community with low income and high health need, when the Reefton Medical Centre had been functioning with just one GP (where two are required) for some time, and with no definite prospect of employing another GP.

Although another GP has been appointed subsequently, the innovation proposal went far beyond assuring the sustainability of primary health care through the General Practice role, to providing a truly health-oriented primary health care service:

Services will be directed not just at those who seek care when they are ill, but will be there to look after the health needs of the whole population group. So primary care providers will need to know not just who is sick, but who might become sick because they are not getting access to preventative health care and health education³.

This orientation to 'health' is the basis of Primary Healthcare Organizations. The PHO formed for the West Coast includes the Reefton Medical Centre.

Further, the innovation is concerned with 'getting it right' for rural people through developing both the rural health workforce and community capability:

It has been said that rural health is a kind of laboratory for the whole health system – if you get it right for rural people – you get it right for everyone. This is particularly true for accessibility where many rural areas have difficulty in attracting and retaining a skilled primary health workforce and there is a long way to travel to access secondary care. As I travel around New Zealand visiting many rural areas and practices I get strong messages about the importance of communication, flexibility, skill development, and support⁴.

Please refer to the Registration of Interest document **Neighbourhood Nurses in Reefton: A Nursing Innovation for a Community with Low Income and High Health Need**⁵ for further background to the innovation proposal.

³ The Honourable Annette King, Minister of Health, 30 May 2002, 'Primary Focus: The Future of Primary Health Care' Address to the Primary Health Care Conference

⁴ Hon Damien O'Connor, Associate, Minister of Health, 25 November 2002, address to AGM of Clinical Leaders Association of New Zealand

⁵ Hanson, Jones, Ross and Williams (2002) **Neighbourhood Nurses in Reefton: A Nursing Innovation for a Community with Low Income and High Health Need** (Registration of Interest), Coast Health Care

**Primary Health Care
Nurse defined**

The NEIGHBOURHOOD NURSE innovation is referenced to the definition of primary health care nurses as

Primary health care nurses are registered nurses with knowledge and expertise in primary health care practice. Primary health care nurses work autonomously and collaboratively to promote, improve, maintain and restore health. Primary health care nursing encompasses population health, health promotion, disease prevention, wellness care, first-point-of-contact care and disease management across the lifespan. The setting and the ethnic and cultural grouping of the people determine models of practice. Partnership with people – individuals, whanau, communities and populations – to achieve the shared goal of health for all, is central to primary health care nursing.⁶

This definition translates through the concept of the NEIGHBOURHOOD NURSE to the word picture in the *frontispiece*.

**Project team for the
innovation**

Project Sponsor

Robin Williams
Director of Nursing/General Manager Primary Care Services
Coast Health Care

Project Leader

(to be appointed/seconded)

Project Consultant

Shelley Jones
Consultant to Coast Health Care

Project Partners

Reefton Medical Centre
Community based nurses in Reefton.

Advisors and external resource people with expertise in the following will be contracted for the project as required:

- project management
- change management
- primary health care nursing
- rural nursing
- family nursing
- nursing models
- programme evaluation
- community development
- research and publication.

Respective roles and responsibilities are outlined in Project Support: Roles and Responsibilities, *Appendix 1*.

Additionally, access to the resource people and support normally available to Coast Health Care employees will continue.

⁶ Expert Advisory Group on Primary Health Care Nursing (2002) *Investing in Health: Whakatohutia te Oranga Tangata. A framework for activating primary health care nursing in New Zealand*, page 9.

Services Offered by Neighbourhood Nurses

SERVICES CURRENTLY DELIVERED AND GAPS TO BE ADDRESSED

Services currently delivered will be continued as the innovation will encompass current primary health nursing staffing and service provision

Reefton currently has six Registered Nurses regularly employed in primary health care roles⁷:

setting/role	nurses	FTE
practice	2	1.5
public health well child immunization coordination	2	1.4
district nursing	2	1.4
total	6	4.3

Services provided by the NEIGHBOURHOOD NURSE team will include those currently provided by these nurses, i.e.:

- Pregnancy and Parenting Education
- Well Child Immunization
- Well Child Care Services
- Health Promoting Schools
- Pre School and School Health Services
- Palliative Care (Community)
- Specialist Community Nursing Services
- ACC Community Home Based Nursing
- Wound Management
- Continence Services
- Clinic-based Practice Nurse Services.

They will also continue to refer to and consult with the following services:

- Oncology Service and Palliative Care Coordination
- Health Protection and Health Promotion Services
- Meals on Wheels
- Home Support Services
- AT & R Service
- Smoking Cessation
- Home O₂ Therapy
- Respiratory Services
- Stomal Therapy
- Continence Resource Nurses
- Specialist Community Allied Health Services
- Sexual Health and Family Planning
- Cervical Screening
- Breast Screening
- Mental Health
- Drug and Alcohol Service
- Maori Health
- Te Waka Hauora
- Child Dental.

⁷ A seventh nurse is available for practice nursing on a relieving basis. Note that only two of these nurses work exclusively in one of the four possible work contexts in Reefton - practice, public health, district and hospital. Additionally, an Operations Manager and 4.2 FTE Registered Nurses work in Reefton Hospital (five continuing care beds, and five medical) and Ziman House (an attached geriatric facility of 20 beds).

Location, setting and hours of operation may change

The nursing team based in Reefton currently delivers a clinic-based and mobile service. In the NEIGHBOURHOOD NURSE innovation, nursing services will be offered where the community can access them most conveniently. Locations may include private homes and school/church/community halls.

Equally, while nursing services are currently available 8 am to 5pm Monday to Friday (with a minimal weekend service for district nursing), the innovation will explore with the community the most suitable ways services can be delivered. The possibility that nursing services may be available over a seven day period directs thinking to new ways of service delivery such as providing a Reefton-based nurse-led telephone triage/health advisory service and weekend and after hours nursing services.

Service gaps and potentials will be addressed

There are some gaps and potentials for development in current primary health care services, including:

- Men's health issues
- Women's health issues
- Maternal health
- Well elderly
- Mental health
- Adolescent health
- Drug and alcohol
- Maori special health needs
- PI special health needs
- Occupational health
- Volunteer driver service
- Healthy lifestyles (e.g. eating breakfast, 'push-play', green prescriptions).

Additional areas may be identified in community consultation.

It is intended that the NEIGHBOURHOOD NURSE team develop skills, access resource people or establish referral relationships to provide these services where possible and appropriate. They will work with other primary health care providers, agencies and the community.

Therefore the service programme is as broadly outlined

The Timeline (*see page 20*) gives the following service outline along with project, development and reporting aspects:

six month period	priorities
Jan–Jun 2003 <i>prior to funding</i>	<ul style="list-style-type: none"> • consultation and preparation • deliver existing services
Jul- Dec 2003	<ul style="list-style-type: none"> • continue consultation and preparation • bring on new team members • planning and upskilling • deliver existing services • begin to deliver Maori specific services
Jan–Jun 2004	<ul style="list-style-type: none"> • deliver existing services through new model integrated with Maori specific services
Jul- Dec 2004	<ul style="list-style-type: none"> • plus develop new services to address gaps and potentials as identified
Jan–Jun 2005	<ul style="list-style-type: none"> • refine services to ensure integration, continuity and seamlessness
Jul- Dec 2005	<ul style="list-style-type: none"> • consolidation
Jan–Jun 2006	<ul style="list-style-type: none"> • further refinement and consolidation as final review takes place

SPECIAL HEALTH NEEDS OF MAORI

How NEIGHBOURHOOD NURSES will meet special health needs of Maori

Our ROI noted a '...somewhat lower proportion of Maori in comparison to the rest of New Zealand, but most importantly, a population characterized by low income' (Hanson *et al* 2002:3), and the analysis reported below suggests that Maori in Reefton (which is in the Buller District) may be subject to a 'double whammy':

The Buller Territorial Authority consistently shows the highest levels of deprivation, which is further exacerbated by its rural isolation, transport and communication difficulties, and a lack of health services.

Two main groups are identified as having high health needs in the West Coast region, those of relatively low socioeconomic status and Maori. While there is interaction and overlap between these two groups, a focus on one alone would miss a large group with high health needs. For example, most people of low socioeconomic status are not Maori, and the health status of Maori is still relatively poor compared to non-Maori, even after controlling for socioeconomic status...

The situation of Maori on the West Coast, with respect to some demographic statistics (such as life expectancy, housing and income) and health statistics (such as avoidable hospitalization - for example for injuries, smoking prevalence, cardiovascular disease, suicides, and breast screening rate), appears to be generally better than for Maori in New Zealand as a whole. Some of the apparent reduced disparity of Maori with non-Maori, however, is a consequence of the generally lower life expectancy, high levels of deprivation, low incomes, low property prices, and high levels of health needs seen in the total West Coast population⁸.

Given that the innovation is directed to a community with low income and high health need, it will specifically address the special health needs of Maori. The broad holistic perspective on health that is a foundation of this innovation is particularly relevant when aspects of culture and low income combine.

Consultation and partnership processes

Preliminary discussion with WCDHB's Kaiarahi (Senior Maori Adviser) towards a partnership approach outlined our intention to address Maori health needs in two ways:

1. To include in the NEIGHBOURHOOD NURSE team a nurse with specific expertise in Maori health. As this nurse will need to be acceptable to the Maori community she/he serves, we expect that Maori will be involved in the selection process and supporting his/her practice.
2. To address any learning needs or skill deficits amongst the NEIGHBOURHOOD NURSE team, so that any nurse will be able to offer high quality care and health promotion that is appropriate and safe for Maori.

Iwi representatives will be involved in defining this position and appointment. In the event that a local nurse could be appointed, and is otherwise acceptable to the employer and iwi but without fully developed expertise in Maori health, then the required educational support and mentoring would be part of the employment package.

⁸ Public Health Consultancy, Wellington School of Medicine and Health Sciences (2001) **An assessment of Health Needs in the West Coast District Health Board Regions: Te Tirohanga Hauora O Tai Poutini**, West Coast DHB, pp 1-2

SPECIAL HEALTH NEEDS OF PACIFIC ISLAND PEOPLE

How NEIGHBOURHOOD NURSES will meet special health needs of Pacific Island people

There is on the West Coast ‘...a very small but growing Pacific peoples population’⁹, however, we have not been able to establish the Pacific Island population in Reefton.

We would consult with Pacific Island people through the DHB’s established relationships and expect to address any learning needs or skill deficits amongst the NEIGHBOURHOOD NURSE team, so that any nurse will be able to offer high quality care and health promotion that is appropriate and safe for Pacific Island clients and families. It may also be appropriate to obtain Pacific Island nursing or primary health care referrals or consultancy to meet particular cultural needs.

BENEFITS TO REEFTON COMMUNITY

The Reefton community will benefit through the improvements offered in an expanded nursing perspective and increased emphasis on health

Assuming the requisite supports identified in the next section are supplied to the project (i.e. business planning, project management, team facilitation, advanced education and coaching), we anticipate the NEIGHBOURHOOD NURSE innovation to have impacts in all of the following areas because the nurses’ expanded perspectives means that every encounter with a client, family or group holds potential for engagement in the following ways:

- better access to care
- risk assessment
- life style planning
- health promotion activities
- disease prevention and minimization activities
- disease management
- early interventions and treatments
- case management or care co-ordination
- and improved Maori health outcomes.

Qualitative differences in approach and emphasis will result in better coordinated and more complete care, and in longer term improvements to health status

Specifically, what clients will notice as different is

- a more continuous relationship with one or two nurses and their coordination of services and consultation of nursing and other colleagues for expert advice
- an emphasis on understanding their current or potential health problems in terms of lifestyle and personal health patterns and practices (e.g. diet, smoking and exercise)
- a shift from ‘getting fixed up’ by the health professional to taking responsibility for lifestyle and personal health patterns and practices, and being supported to make such changes
- a sense of being in charge of their own health care, and the possibility of holding their own record
- a mobilization and organization of capability within the community that reduces problems of access and enhances and extends health professional’s inputs, for example, a roster of drivers to pick up and deliver clients to distant appointments
- for Maori clients and whanau, nursing care delivered by a nurse with a specialty focus on Maori health/disease state management.

⁹ Ibid p 1

The service will be reviewed to ensure improvements and responsiveness

The innovation is intended to enhance the personalised and responsive service already offered, and as it will be directed in its development by the Reefton community (including Maori) through a 'guardian/kaitiaki' group (*see next section*), it is expected to be experienced by consumers as being appropriate and effective.

Indicators to be reviewed prior to the innovation, midway and at its conclusion include:

- client satisfaction with services
- compliance with Treaty principles
- compliance with Code of Health and Disability Services Consumers' Rights.

The baseline findings will indicate any reorientation and new approaches required, which will be attended to through team learning, coaching and systems redesign. The effectiveness of such interventions will be monitored in the midway and summative reporting.

Structures and Processes to Manage Quality

The structures and processes planned are based on assumptions about properly supporting and monitoring an innovation

We have planned six broad programmes of support and monitoring to assure service delivery quality and develop lasting enhancements in capability in nursing team members and the community, as well as ensure that what is learned in the innovation is reported and disseminated:

1. community involvement and professional oversight of the innovation
2. project management
3. support for team and role development
4. individual professional development
5. evaluation
6. reporting, dissemination and publication.

COMMUNITY INVOLVEMENT AND PROFESSIONAL OVERSIGHT OF THE INNOVATION

Community involvement with the innovation through a 'guardian/kaitiaki' group and...

Once we have held a briefing with other primary health providers, a letter drop will invite the community to a public meeting in Reefton (or one of a series of meetings in outlying areas). Specific invitation will be made to key representatives of the stakeholder groups identified earlier.

The formation of a 'guardian/kaitiaki' group is anticipated, in order to have a group of community representatives to act as a reference and advisory group to the innovation, through a programme of regular meetings for consultation and advice.

It is expected to have a stance of 'guardianship' over both the community and the nurses as the NEIGHBOURHOOD NURSE innovation is developed, implemented and evaluated. However, it should be noted that the Reefton community is locally respected for its tradition of ready and committed community involvement and it will be appropriate to follow what emerges from the initial community consultation.

... a parallel process of professional oversight through a network of 'friends'

As we wish to have a parallel process of concerned and supportive watchfulness for the professional aspect of this primary health care nursing innovation, we are inviting a group of respected New Zealand nurses to be Friends of the NEIGHBOURHOOD NURSES project for the three years that it runs.

We hope that the Friends, as nurses with an interest in primary health care nursing and professional development, would have been interested in this project in any event. The Friends will receive the six monthly reports, and will be asked for their insights and critique in response to the plans for the next six months. We may, from time to time, ask a specific question of a particular Friend.

PROJECT MANAGEMENT

Project management through appointment of a project leader

While day-to-day operational coordination and management of the NEIGHBOURHOOD NURSE team will be provided from within the team and the Clinical Nurse Leader role, the wider scope of an innovation requires project management.

At the time of writing, a 0.5 position for a project leader is being advertised. The Reefton community nurses will be involved in the selection process. The position will be disestablished at the conclusion of the funding.

Identification of the competencies required in the role and a learning needs analysis will be undertaken with the individual appointed to the role in order to plan appropriate learning experiences, coaching and mentoring. The project

management capability this individual develops will be able to be applied to other initiatives within the DHB, and the involvement with the NEIGHBOURHOOD NURSE innovation critically useful to introducing the NEIGHBOURHOOD NURSE model to other primary health care nursing roles should it prove effective.

SUPPORT FOR TEAM AND ROLE DEVELOPMENT

Supporting the NEIGHBOURHOOD NURSE team

As noted in the ROI, the NEIGHBOURHOOD NURSE innovation is likely to require a reorientation and reinterpretation of role for the nurses involved (and their immediate colleagues)¹⁰. Although the Reefton nurses have already begun to 'try on' new perspectives, support for team and role development are seen as important inputs for an effective innovation.

Attention to change management is also critical to the success of improvements in health services¹¹. A considerable investment will be made in this area, and may include accessing specific external expertise.

Specific inputs anticipated are

- identification of NEIGHBOURHOOD NURSE role competencies
- supporting and facilitating new ways of working with clients and colleagues
- group upskilling through an action learning process¹²
- group/team facilitation in planning and problem solving
- site visits to or from other primary health services with instructive models of practice.

Staffing has been increased (by 1.0 FTE in Years 1 and 3, and 0.5 FTE in Year 2) to cover the time planned for team and role development (denoted as 'relief' under direct labour costs in the budget). Many of the developmental activities and processes planned will be open to not only the NEIGHBOURHOOD NURSES but also other nurses in the Reefton area and other disciplines as appropriate.

In a long-term view, the investment 'pays off' not only in the success of the innovation, but also in the increased capability of West Coast health professionals (and it should be noted here that the nursing staff are a particularly stable group – some are fifth generation 'Reeftonites').

We recognise that the concept involves a broadening of the scope of practice to a more generalist role...

In the final stage of the proposal assessment we were asked to:

- address a question about nurses working over broad health areas and consequent concern that some may work outside of their scope of practice
- discuss with Nursing Council the competencies NEIGHBOURHOOD NURSES would be required to meet
- identify and explain the competencies and how nursing staff would be supported to meet them.

¹⁰ See, for instance, CARR Susan M (2001) Nursing in the community – impact of context on the practice agenda **Journal of Clinical Nursing** 10: 330-336.

¹¹ See foreword by George Salmond, discussion by Shelley Jones, and commentaries by Ashley Bloomfield and Sam Denny in **Effective Leadership and Change Management: Leaders' Personal Journeys** in Learning Resources at www.clanz.org.nz

¹² 'Action learning' is a particular approach (as described by Reg Revans and others) requiring a small group of people to commit to learning together in a self-directed and facilitated process on a problem or topic of joint concern or interest. This approach is also referred to as 'learning sets'.

We acknowledged that as

implementation of the Primary Health Care Strategy will challenge the traditional roles of GPs, nurses and managers [and will also mean that] nurses will have the opportunity to take on wider scopes of practice...¹³,

the NEIGHBOURHOOD NURSE project is part of this challenge and opportunity. It proposes a change from the status quo - especially in nurses' roles - and any change generates anxiety and uncertainty. We reiterated that the project itself would deliver a set of specific competencies for the NEIGHBOURHOOD NURSE.

We referred to the scope defined for primary health care nursing (*as given on page 4*) and confirmed with the Registration Advisor at Nursing Council that this was the appropriate scope for the NEIGHBOURHOOD NURSE project. Additionally, we identified five resources from which to build NEIGHBOURHOOD NURSE competencies (including work by the Centre for Rural Health¹⁴), the likely parameters of the competencies and the specific expertise in developing competency statements held by the proposing team¹⁵.

... and the retention of specialities

We anticipate NEIGHBOURHOOD NURSE team members each carrying a geographically appropriate case load of individuals, families and other groups (as does Coast Health Care's Rural Nurse Specialist with a particular community), and also holding a number of 'portfolios' related to their current specialties and expertise, i.e. for which they have demonstrated competence. Carrying a portfolio means being available to the other nurses (and other health professionals) for consultation and clinical coaching, referral of clients or coordination and oversight of a given health programme.

This plan takes into account the readiness of the Reefton nurses for a new role

Nurses will move into carrying a caseload as they develop the competencies that enable them to do so. As we are familiar with the educational preparation and experience of the nurses concerned we believe that most of them are close to already having or attaining the competencies for a primary health care role which is more generalist and more holistic than their current somewhat more specialized roles. This assessment was confirmed by an analysis of the qualifications, educational preparation and current roles of the community and practice based nurses in Reefton, and a tentative matching of the portfolios they might carry in the NEIGHBOURHOOD NURSE team, along with an indication of what might be the change in focus required.

We aim to keep the expertise held in traditionally focused roles while gaining the advantage of a more holistic and integrated approach

In essence, we hope to provide through the NEIGHBOURHOOD NURSE team the benefits of continuity and integrated nursing care without losing specialized knowledge. For instance, the proposal included the appointment to the NEIGHBOURHOOD NURSE team a nurse with specific expertise in Maori health. This nurse will likely carry a significant caseload of Maori clients/families but may not deliver all nursing services required by Maori. She/he would therefore be available to other team members as a consultant on Maori health needs and cultural safety when nursing

¹³ Health Workforce Advisory Committee (2002) **The New Zealand Health Workforce: Framing Future Directions Discussion Document**, p 22.

¹⁴ For instance 'Distinctively Rural' Competencies in Jones & Ross (2003) **Competency Framework for Developing Rural Nursing** Centre for Rural Health : Christchurch *see Appendix 3*.

¹⁵ Barber, Bygate, Jones, Williams (2003) **Neighbourhood Nurses in Reefton: A Nursing Innovation for a Community with Low Income and High Health Need** (Additional Information), Coast Health Care

Maori, and for referral when appropriate. Another example: the NEIGHBOURHOOD NURSE will immunize children in the course of a more holistic and integrated interaction with the families in her caseload, but the coordination of the programme will remain with the nurse currently in the Public Health Nurse role.

Appropriate expectations for development of Nurse Practitioners in conjunction with the NEIGHBOURHOOD NURSE project

Because we are committed to the community served by the West Coast DHBs and the PHOs under development, we must recognise that nursing services in this area will firstly be staffed from people who live in the area, which is remote and without local tertiary educational institutions. Coast Health Care has made a significant investment in upskilling nurses to function effectively in expanded and advanced roles, notably the Rural Nurse Specialist roles. This commitment will continue in relation to Nurse Practitioner development.

The project will strongly encourage and fund further professional development amongst those in the NEIGHBOURHOOD NURSE team, and it should be noted that most Reefton community nurses have already gained a postgraduate qualification, or have a BN.

While application for Nurse Practitioner status with Nursing Council can be made on the basis of 'equivalence' (i.e. providing evidence of advanced nursing practice) and if appropriate we would support a nurse applicant through this process, but we also would expect to support at least one or two nurses through an approved programme in the course of individually appropriate career plans.

Equally, as the NEIGHBOURHOOD NURSE project is an innovation of national importance, we believe it possible that nurses from outside the area may apply to join the team for a period of time (e.g. two years) as a working member for the experience offered and to be supported in their development towards Nurse Practitioner.

INDIVIDUAL PROFESSIONAL DEVELOPMENT AND UPSKILLING

Individual professional development and upskilling begins with identification of learning needs

Each nurse will review her learning needs in relation to NEIGHBOURHOOD NURSE role expectations and more general professional development, using tools already designed for this purpose¹⁶. This process will be facilitated with each nurse by an external nursing adviser and/or WCDHB clinical educator and/or project leader, and an individual development plan agreed.

Individual development plans may include the following elements, some of which are likely to be funded independently of the innovation funding:

development/learning	funded from
clinical supervision	innovation budget
how to use journaling for learning and reflection	innovation budget
action learning	innovation budget
sector specific training e.g. for forecasted national roll out of meningococcal vaccination programme	MOH (2004)

¹⁶ JONES Shelley & ROSS Jean (2003) **Competency Framework for Developing Rural Nursing** Centre for Rural Health : Christchurch, and JONES Shelley & ROSS Jean (2003) **Career Development Framework for Rural Nurses** Centre for Rural Health : Christchurch

development/learning (<i>cont'd</i>)	funded from
relevant post graduate clinical nursing courses at NZQA level 8 or above (e.g. PG Certificates in Palliative Care, Child and Family Health)	CTA
postgraduate nursing courses in primary health care at NZQA level 8 or above (postgraduate certificates, postgraduate diplomas, masters and PhD degrees)	primary health care nursing scholarships (MOH)

The NEIGHBOURHOOD NURSES will be encouraged to choose or set questions and projects in their coursework that are directly related to the innovation or aspects of client/community care.

EVALUATION

Overall evaluation of the innovation

A number of indicators will be specifically reviewed prior to the innovation, midway and at its conclusion to enable evaluative assessment of the effectiveness of the innovation:

- client satisfaction with services
- service utilisation
- specific measures of Maori health outcomes
- compliance with Treaty principles
- compliance with Code of Health and Disability Services Consumers' Rights
- community and health status profile
- nursing/medical perceptions of role and health service effectiveness.

A study will be designed midway through the innovation, ethical approval sought and participants sought for a retrospective review of their experience in the new model.

Provision for monitoring specific service quality and compliance for consumers

In the final stage of the proposal assessment we were also asked to supply more detail on

- how you will ensure your service works towards addressing the special health needs of Maori
- how you would ensure the service will comply with the principles of the Treaty of Waitangi and the Code of Health and Disability Consumers' Rights.
- what performance indicators you will use to measure health outcomes for consumers
- the steps you have taken/will take to ensure that your service becomes part of a PHO.

A schedule of 'Performance Indicators and Quality Measures' was drawn up in response to the last two points. The policies and standards used in ongoing DHB auditing would be applied in relation to compliance with Treaty principles and Consumer Rights.

In terms of evaluating the extent to which the service addresses the special health needs of Maori, we reiterated our expectation of appointing a nurse with specific expertise in Maori health. We suggested that Maori health outcomes could be measured as below, but recognise that further consultation may refine these suggestions:

- increased number of patients seen by or referred to appropriate services

- the provision of a more comprehensive service (through whanau central health promotion, education, assessment and early detection and planning while simultaneously developing the skills and knowledge of whanau)
- Maori clients feel safe and their opinion valued
- improved quality of life for Maori in the Reefton and surrounding area through appropriate primary and or secondary care for their level of need.

Development of performance indicators for the structures and processes to manage quality

Specific performance indicators will be developed for each of the six programmes of support and monitoring. In some instances, it will be appropriate that those involved identify indicators – for instance, part of the shared learning that supports the team process of the NEIGHBOURHOOD NURSES is to facilitate their awareness and objectives (e.g. ‘How will you know that care is better coordinated?’).

Community involvement and professional oversight of the innovation

The community consultation process will be designed to surface the community’s perception of both strengths and areas for improvement in current primary health care service provision, but it may need to incorporate an educative aspect emphasizing wellness and disease prevention as goals of primary healthcare (in contrast to disease management).

Therefore, performance indicators may include:

- the extent to which the community felt informed about the innovation and what it meant
- the extent to which the community felt it could direct and influence the innovation
- the extent to which the innovation met community defined objectives
- the quality of the relationship and interaction between a community nominated ‘guardian/kaitiaki’ group (or other similar group) and the NEIGHBOURHOOD NURSES.

The professional oversight process is intended to expand the knowledge and networks of the project on professional aspects of primary health care nursing. Therefore, indicators of the usefulness of the network of ‘friends’ could include

- number of references and contacts supplied
- number and nature of insights and reflections offered on project progress
- the extent to which the ‘friends’ felt it was an interesting innovation and worth their involvement.

Project management

Performance indicators will include:

- the extent to which the appointed project leader felt prepared for and supported in that role
- the extent to which the project ran according to timeframe and budget
- the alacrity and appropriateness with which deviations from timeframe and budget were managed.

Support for team and role development

Performance indicators will include:

- attendance and participation in team development events and team meetings
- the extent to which team members felt supported through and in control of the change process required in the innovation

- ❑ the extent to which team members develop their own group facilitation and problem solving skills
- ❑ an record of the topics and problems addressed in action learning, and the outcomes of learning transferred to practice
- ❑ the development of a set of competencies for the NEIGHBOURHOOD NURSE role
- ❑ nurse identified outcomes of visits to similar services
- ❑ nurse, colleague and client identified developments in practice.

Individual professional development

Performance indicators will include:

- ❑ a register of individual development plans completed, their yearly update/review, and an audit of the completion of learning objectives
- ❑ an audit of qualifications gained and in progress prior to the innovation, and at its completion, by the NEIGHBOURHOOD NURSES
- ❑ nurse-identified outcomes of journaling and clinical supervision.

The choice and consent implications of this aspect of evaluation have been raised with the nurses involved and will be explored further.

Evaluation

Performance indicators will include:

- ❑ an assessment of utilisation of extant data and established data gathering systems
- ❑ a review of the appropriateness, usefulness and effectiveness of evaluation tools developed specific to the innovation
- ❑ the extent to which evaluation findings influence planning and provision, and are acted on appropriately.

Reporting, dissemination and publication

Performance indicators will include:

- ❑ structured feedback on the timeliness, completeness and usefulness of the six monthly reports to the innovation's sponsor, 'guardian/kaitiaki' group, network of 'friends' and MOH
- ❑ a record of the number of hits on the web-based reports
- ❑ a record of presentations and publications related to the innovation made by the NEIGHBOURHOOD NURSES, their colleagues, and the project team.

REPORTING, DISSEMINATION AND PUBLICATION

A set of six monthly reports will be provided

A programme of six monthly reports to the DHB sponsor, 'guardian/kaitiaki' and 'friends' groups and Ministry is scheduled:

- June 2003 (reports preparation prior to innovation funding)
- Dec 2003
- June 2004
- Dec 2004
- June 2005
- Dec 2005
- June 2006 (final report, jointly written by NEIGHBOURHOOD NURSES).

An edited version of each report will be available on the WCDHB website. The NEIGHBOURHOOD NURSES will be encouraged to present their experiences at relevant forums, and individual and team coaching will support them in presenting and publishing any work completed for course work requirements and related to the innovation.

The NEIGHBOURHOOD NURSE team will be coached in written reporting through the six monthly reporting on the innovation, and be joint authors of the final report.

Reporting will focus on service delivery, the effectiveness of support to the innovation and evaluation findings

The first report will cover the period between announcement of being awarded the funding and the funding beginning, and will therefore detail consultation processes, the preparation of the project manager and the NEIGHBOURHOOD NURSE team.

A description of services delivered in this six month period will provide a baseline prior to the innovation. Thereafter, six monthly reports will follow a template that includes service delivery reporting as well as

- an indication that progress is as expected per the timeframe or an explanation of any variation
- inputs and outcomes for each of the following:
 1. community involvement and oversight of the innovation
 2. project management
 3. support for team and role development
 4. individual professional development
 5. evaluation
 6. reporting, dissemination and publication.

A specific annual report will focus on referral to secondary services

A short analysis of the impact of the service on any reductions/improvements to the referral rate of the Reefton region residents to secondary services (particularly to A&E and inpatient admissions to hospital) will be provided annually.

A final report will crystallize the learning in the innovation so that it can inform other developments

The final report will be authored by the NEIGHBOURHOOD NURSES and project team. It will detail the innovation and present our learning.

Questions about the possibilities of 'generic' primary health care nursing roles will be addressed in this report:

Would nurses be willing to do such a role?

Would a more holistic approach enable them to deliver care and health promotion of the same quality as they deliver from specialist roles?

Would their clients and communities find continuity and a more comprehensive approach an improvement?

And if so, what was the learning and support that enabled the transition to a new way of working?

Additionally, the final report will specifically summarise (from the six monthly reports) what has happened over the three years on the following points:

- *The process and implementation of the service/model*
- *The improvements that the service/model is making to the practice of health professionals in the team*
- *The improvements that are occurring for consumers*
- *The progress you are making towards joining a PHO.*

It is expected that the discussion of our experiences – the project team, the NEIGHBOURHOOD NURSE team, the stakeholders and the community – will be invaluable to progressing and strengthening primary health care through nursing roles.

Relationships

Relationship with the Reefton Medical Centre

The proposers of the NEIGHBOURHOOD NURSE innovation have consolidated their good relationship the project partner, i.e. with Reefton's (then) only GP, Dr Julian James-Ashburner of Reefton Medical Centre on the following basis:

- the ROI was developed in close consultation with him and the practice nurses
- completion of this proposal was preceded by a meeting between him and members of the proposer team at the Reefton Medical Centre to exchange perspectives and confirm his support
- gaining an assurance from him that any future GP partner would need to understand and be actively supportive of the NEIGHBOURHOOD NURSE innovation¹⁷.

Further, as required for the proposal, a disputes process has been outlined and agreed between the two parties.

Relationships with other primary care providers

Other primary care providers for Reefton have been notified of the NEIGHBOURHOOD NURSE innovation and invited to a briefing of Reefton health professionals/service providers in early July 2003. We anticipate involving the physiotherapist, occupational therapist and social worker amongst others.

Relationships with other agencies and stakeholders

Equally, other agencies whose remit impacts on or overlaps with health in its broadest sense will be specifically invited to a community briefing and consultation mid-2003.

We anticipate involving the personal help services available to Coasters (as listed in the West Coast and Buller telephone book) and

- Buller District Council
- Buller Community Development Company
- Work and Income New Zealand
- Representatives from local schools, police and fire services
- Rural Women.

Since the community consultation is intended to recruit the guardian/kaitiaki group for the innovation, it is hoped that some of its members will represent these agencies as much as provide community perspectives.

PHO establishment progress and its relationship with the NEIGHBOURHOOD NURSE innovation

The West Coast PHO has been announced by the Minister of Health, Annette King. The PHO Manager at the time of the NEIGHBOURHOOD NURSE proposal submission was fully aware and supportive of it, having being involved in it since development of the ROI. He briefed the PHO Trustees about the proposal, and the project team will schedule a presentation with the Trustees.

The following points summarise the state of the PHO's development:

- Presently an interim 12 member Board to 30 June 2003, is taking the PHO establishment to its next phase.

¹⁷ With an enrolment of 2430, it is a two GP practice, but has run with one GP since February 2002, until May 2003, when another GP was appointed. Please refer to pp 4-5 of the ROI for a discussion of problems of sustainability.

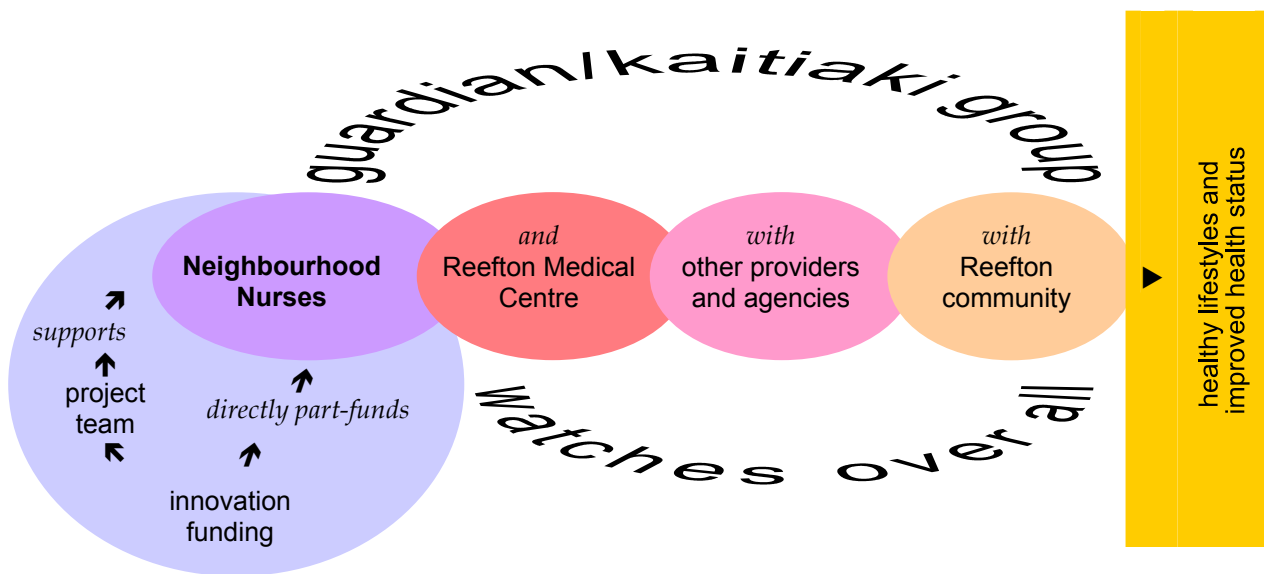
- Southlink Health IPA have agreed in principle to being the appointing body of the West Coast PHO and is going through the process of contracting with the DHB and at the same time preparing a replacement board from 1 July 2003.
- The West Coast GP Primary Care Providers have been funded by the PHO Funding formula since 1 October 2002.
- The Community Nursing Service section of the DHB provider arm, (Coast Healthcare), being funded via a contracting system.
- Until the permanent PHO Board is established the relationship between the Primary Healthcare Providers, within the PHO and the Coast Healthcare Community Nursing Group, will continue to enjoy the current collaborative professional relationship.
- Through the development of a Memorandum of Understanding (MOU), the geographically defined Healthcare team's approach to delivery of Primary Healthcare services, will have goals and objectives bedded down in the West Coast District Health Board DAP. Including also Primary Healthcare Strategy, Maori Health Strategy and other relevant strategies that will be recognised as the PHO develops.

Both the West Coast PHO and the NEIGHBOURHOOD NURSE proposal are two new initiatives on the West Coast and will need time to be established and work together.

An additive effect of positive relationships applies

We believe one of the keys to the success of the innovation lies in giving attention to the relationships between all the parties involved, and having the support and direction of the community in this endeavour, as shown in the diagram below.

Relationships in the Reefton Neighbourhood Nurses Innovation: An Additive Effect for a Healthy Community



Timeline for Neighbourhood Nurses Innovation

funding	DHB underwrites preparation for project				project aspects are MOH funded								
	Jan-Jul 2003	Jul-Sep	2003/2004 Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	2004/2005 Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	2005/2006 Oct-Dec	Jan-Mar	Apr-Jun
Service provision	existing	existing (plus explore new ways of working) plus Maori specific services (new team member)	Neighbourhood Nursing model implemented (delivers existing and Maori health services)	Neighbourhood Nurses develop new programmes in partnership with other providers and community to address gaps and potentials	Neighbourhood Nurses refine services to ensure integration, continuity and seamlessness	Neighbourhood Nurses consolidate services	Neighbourhood Nurses involved in reviewing services for summative report						
Partnering organisations and other providers for Reefton	formal agreement with partner; direction-setting meeting with all providers	joint planning	implementation	ongoing communication	ongoing communication	ongoing communication	shared review						
Community consultation and oversight	letter drop, initial consultations and public meeting; establish guardian/kaitiaki group	six monthly reporting/meeting	six monthly reporting/meeting	six monthly reporting/meeting	six monthly reporting/meeting	six monthly reporting/meeting	shared review						
Project management	appoint (and upskill) project leader	ongoing support/coaching for ProjLdr; project management	ongoing support/coaching for ProjLdr; project management	ongoing support/coaching for ProjLdr; project management	ongoing support/coaching for ProjLdr; project management	ongoing support/coaching for ProjLdr; project management	ongoing support/coaching for ProjLdr; project management						
Support for team and role development	identify development needs and other models	weekly afternoon team meeting for planning, problem solving and action learning (1 FTE cover); site visits to/from other models; identify NN role competencies		fortnightly afternoon team meeting for problem solving and action learning (0.5 FTE cover)		weekly afternoon team meeting for problem solving, action learning and reporting/final evaluation (1 FTE cover)							
Individual professional development	individual learning plans begun (scholarship applications due Nov)	individuals undertake learning according to plans agreed with project manager and team coordinator; study in postgraduate programmes, students complete assignments on innovation and service related questions where possible		individuals undertake learning according to plans agreed with project manager and team coordinator; study in postgraduate programmes, students complete assignments on innovation and service related questions where possible		individuals undertake learning according to plans agreed with project manager and team coordinator; study in postgraduate programmes, students complete assignments on innovation and service related questions where possible							
Evaluation	develop community and health status profile; establish baselines for consumer satisfaction; primary service utilisation; secondary service utilisation; audit compliance with TOW principles, HDC Code; explore nursing/medical perceptions of role effectiveness			midway: evaluation of consumer satisfaction; audit compliance with TOW principles, HDC Code; exploration nursing/medical perceptions of role effectiveness	design study to ascertain client experience of new model, seek ethical approval	identify clients/families to approach for retrospective study via chart audit and interview; begin study	complete study to ascertain client experience of new model; final: evaluation of consumer satisfaction; audit compliance with TOW principles, HDC Code; exploration nursing/medical perceptions of role effectiveness						
Reporting	baseline report	six monthly report to project sponsor, kaitiaki group and MOH (includes project progress and service reporting per Appendix 8 of Additional Information)	six monthly report to project sponsor, kaitiaki group and MOH; annual report on secondary service utilisation	six monthly report to project sponsor, kaitiaki group and MOH	six monthly report to project sponsor, kaitiaki group and MOH; annual report on secondary service utilisation	six monthly report to project sponsor, kaitiaki group and MOH	six monthly and final summative report to project sponsor, kaitiaki group and MOH; annual report on secondary service utilisation						

Authors and Acknowledgements

AUTHORS

The proposing team has had the following members, who should be referenced as the authors of this Overview Document:

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Jenny Hanson	Clinical Educator Coast Health Care
Shelley Jones	Nurse Consultant to Coast Health Care

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Mark Bowen	Quality, Privacy, Risk Manager WCDHB
Deb Hughes	Practice Nurse (Dobson) Coast Health Care
Peter McIntosh	Research and Planning Officer WCDHB
Shona Nivan	Clerical Support Hospital Administration Coast Health Care
Vicki Piner	Personal Assistant to Chief Executive WCDHB
Jean Ross	<i>formerly</i> Lecturer in Rural Health Department of Public Health and General Practice University of Otago
Graeme Savage	<i>formerly</i> General Manager Planning and Funding WCDHB

We also wish to acknowledge nurses in Reefton for their involvement and comments in discussions prior to the finalisation of the Proposal:

Susan Barnet	Public Health Nurse/Practice Nurse
Marlene Boyd	Operations Manager, Reefton Hospital
Betty Gilsean	Public Health Nurse
Margaret Prince	District Nurse
Paula Smith	District Nurse/Reefton Hospital Nurse
Betty Thomas	Practice Nurse/Reefton Hospital Nurse

Appendix

PROJECT SUPPORT: ROLES AND RESPONSIBILITIES

<i>Project Sponsor</i>	The Sponsor has overall responsibility and accountability for the project and its budget. She reports to the CEO and Board of WCDHB on project progress, and also ensures that the requirements for reporting to the Ministry of Health are met. The Project Sponsor and Leader liaise with project partners and Reefton community representatives, including iwi representatives.
<i>Project Leader</i>	The Project Leader 0.5 reports to the Sponsor, and is responsible for the operational implementation of the project, supporting the team of nurses and other providers involved in the innovation, and ensuring the project runs on time and on budget. The Project Sponsor and Leader liaise with project partners and Reefton community representatives, including iwi representatives.
<i>Project Consultant</i>	The Project Consultant reports to the Sponsor and works closely with the Project Leader, and participating primary health care nurses at the direction of the Sponsor or Leader. Her primary function is to support the project's implementation, evaluation and reporting, especially through development of the team and individuals.
<i>Project Contractors</i>	A number of experts will be contracted for specific inputs. The Project Leader may seek advice from the Consultant and others to develop contractual arrangements as required, to be signed off by the Sponsor, and then managed by the Leader.
<i>Guardian/Kai Tiaki group</i>	This group of local iwi and Reefton community members and will form itself out of the process, already begun, of community consultation. It is possible that there might be a Maori caucus within this group or alongside it. The Guardian/Kai Tiaki group will determine its own role, but may act as a reference and advisory group through a programmed of regular meetings for consultation and advice. It's focus is the guardianship over the Reefton people involved in doing the project and the Reefton community being cared for.
<i>Friends of Neighbourhood Nurses</i>	This group of five or six respected nurses, each with an interest in primary health care nursing and/or professional development, will offer a parallel process of concerned and supportive watchfulness for the professional aspects of primary health care nursing. They will be asked for their comment on each six monthly report and for their insights and critique in response to the plans for the next six months.