

Nurse perceptions of models of health care in New Zealand

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Executive Summary

In a rapidly evolving health environment facing significant challenges associated with an ageing population, ageing health workforce and increasing patient acuity, there is widespread agreement that current models of health care provision will struggle to meet future health need. This project sought nurse leaders' perceptions on models of care to ensure the nursing position is identified, articulated, relevant and available for use in policy development.

Method

Utilising a broad qualitative approach, the study used a two step process of data collection. An initial narrative survey was sent to lead nursing groups in New Zealand and follow-up interviews were undertaken by phone. A presentation and workshop were also undertaken at the NZNO Te Rūnanga annual general hui (AGH) in August 2013. In total, 37 narratives, obtained from nurse leaders from many practice backgrounds, were analysed seeking common themes and patterns. NViVO qualitative data analysis software was utilised to aid analysis.

Results

Analysis of the narratives identified five core themes and 15 associated sub themes. The five main themes were: people as recipients of care, health professionals, communication, health delivery and Mātauranga Māori.

Conclusions and recommendations

The findings from this study demonstrate that nurses have an in-depth knowledge of the way in which models of care can and should be developed in this country along with some of the barriers to development and implementation.

In summary, models of care in New Zealand should focus on the following key elements:

- > maintaining the person at the centre of health care;
- > ensuring the provision of quality, evidence-based health care;
- > providing mechanisms to enable interdisciplinary practice;
- > clarifying roles and responsibilities between health professionals;
- > enabling nurse-led care;
- > facilitating nurse leadership and authority across the sector;
- > ensuring health professionals have appropriate education and skills to sustain change;
- > developing effective communication strategies throughout the sector;
- > focusing on primary health care as an overriding approach to health improvement;
- > maintaining a healthy awareness of the risks associated with the business model;
- > facilitating cultural competence, biculturalism and a commitment to te Tiriti o Waitangi; and
- > enabling Māori-centred approaches to models of care.

We recommend greater involvement of nurse leaders in model of care development across the health sector. We also recommend further New Zealand specific research into many of the aspects listed above. Nurses have a clear vision for how approaches to health care can be improved and it behoves funders, providers, and policy makers to ensure this perspective is acknowledged and included.

Introduction

In a rapidly evolving health environment facing significant challenges associated with an ageing population, ageing health workforce, increasing patient acuity, and resource constraint there is widespread agreement that current models of health care will struggle to meet future health need. The term “models of care” has seen increasing usage over the past five years with frequent reference to “changing models of care” or “new models of care” in many Ministry of Health policy documents. These new models of care are destined to change the face of health care in Aotearoa New Zealand and provide a means of addressing the changing health needs of New Zealanders. However, the nursing perspective is often missing from much of this policy work, despite nurses being the largest health workforce and providing the bulk of health care in this country. This project explored the perceptions of nurse leaders regarding current and future models of care in New Zealand, to ensure the nursing position is identified, articulated and relevant for policy development.

Background

In 2011, NZNO developed a vision for nursing that outlined a future direction for nursing in a range of areas including health sector models of care (Clendon, 2011). With specific reference to models of care the vision states:

Innovative and flexible models of care that are person-centred will be developed and evaluated by nurses. Technology, enhanced communication, and new treatment modalities will be utilised to ensure that models of care are appropriate, cost effective and meet the needs of all people. People will be consulted about the models that best meet their needs and nurses will work collaboratively with other health professionals to meet these needs. The principles of whakawhanaungatanga, manaakitanga, rangatiratanga, and wairuatanga¹ will continue to guide professional nursing practice...(p. 12)

This project extends the vision by seeking nurses’ perceptions on models of care to ensure that development and implementation of models of care is based on best practice and the best available evidence as proposed in the vision statement. ‘Models of care’ is a multifaceted concept with no one definition. In essence however, a model of care describes the way in which services are designed and delivered (Queensland Health, 2000; Davidson, Halcomb, Hickman, Phillips, & Graham, 2006). A model of care should:

- have a theoretical basis;
- be underpinned by evidence;
- incorporate defined standards and principles;
- include a framework that provides a structure for implementation and evaluation (Davidson, et al 2006).

Examples of models of care in nursing include nurse-led care, family centred care, the ‘recovery model’, case management, and pre-admission clinics. Broader models of care across the health sector include primary health care as an over-riding approach to

¹ See glossary on page 32 for definitions.

health care, general practice, whānau ora, health care in hospitals or in homes, and specialist health services in major centres. While there are endless possible approaches to health service delivery, the following elements appear to be common to those models identified in the literature as most successful:

- > Interdisciplinary care (where each team member recognises and respects the knowledge and skills others bring to the care of a patient).
- > Collaborative teamwork (with the right person providing the right care at the right time at the right place to the right person).
- > Patient-centred approaches
- > Consultation and engagement with end users, clinicians, managers, and key stakeholders throughout the development and application of any model
- > Robust evaluation
- > Organisational commitment

(Cooper et al., 2012; Germain & Cummings, 2010; King et al., 2011; Kruis, et al., 2013; Mead & Bower, 2000; Munn, Tufanaru, & Aromataris, 2013; Petri, 2010; Reeves, et al., 2013; Schmied et al., 2010; Smith, Allwright, & O'Dowd, 2007; Wong & Cummings, 2007; WHO, 2008; Zwarenstein, Goldman, & Reeves, 2009).

Engaging nurses in model of care development, implementation and evaluation is clearly essential to maximising outcomes. This project sought nurse leaders' perceptions on existing and future models of care across the New Zealand health sector.

Method

Using a broad qualitative approach, this study sought to identify and understand nurses' perspectives on models of care in New Zealand to ensure the nursing position is identified, articulated and relevant for policy development. The study used a two-step process of data collection. An initial narrative survey was sent to all NZNO college and section chairs (20), members of the National Nursing Consortium (9), the two co-presidents of NZNO, and NZNO regional council chairs (11) for dissemination. This purposive sampling approach was used to target nurse leaders across New Zealand, with the dissemination email requesting the survey be forwarded to other nurses who recipients thought may be interested in the survey. Nurse leaders were targeted due to the knowledge it was anticipated this group had about models of care. It is unknown how widely the survey was disseminated beyond these groups but a total of 26 written narratives were submitted via the survey portal and a further 10 telephone interviews using the same set of questions were undertaken with those who either agreed to a request in the survey, or who were identified during initial telephone conversations. The telephone interviews were not tape recorded but comprehensive notes were taken and returned to the interviewee for checking. Interviewees were invited to make any additions or amendments. In addition, a presentation and workshop were undertaken at the NZNO Te Rūnanga AGH in August 2013. Participants were invited to consider the questions and place "post-it" notes on posters around the room with their thoughts on the questions. This data was collated into a single narrative. In total, 37 narratives were then analysed seeking common themes and patterns. NViVO qualitative data analysis software was utilised to aid analysis.

Ethics approval to undertake the study was obtained from Victoria University of Wellington's Human Ethics Committee: approval #20092.

Results

Demographics

The majority of survey and telephone interview participants were aged over 50 with this likely to reflect the purposive sampling approach that sought nurse leaders. Most were female (n=32/36), and of European ethnicity with six participants identifying as Māori. Participants came from a range of practice backgrounds. Figure one shows the broad area of practice of each participant who participated in an interview or survey. All participants at the NZNO Te Rūnanga AGH were Māori and numbered approximately 115. Participants at the hui also came from a range of backgrounds including primary health care (n=31), mental health (n=7), DHBs (n=23), aged care (n=7) and other (mostly students, n=47). Figure two shows the broad area of practice of each participant who participated at the AGH.

Figure 1. Area of practice (survey and interviews)

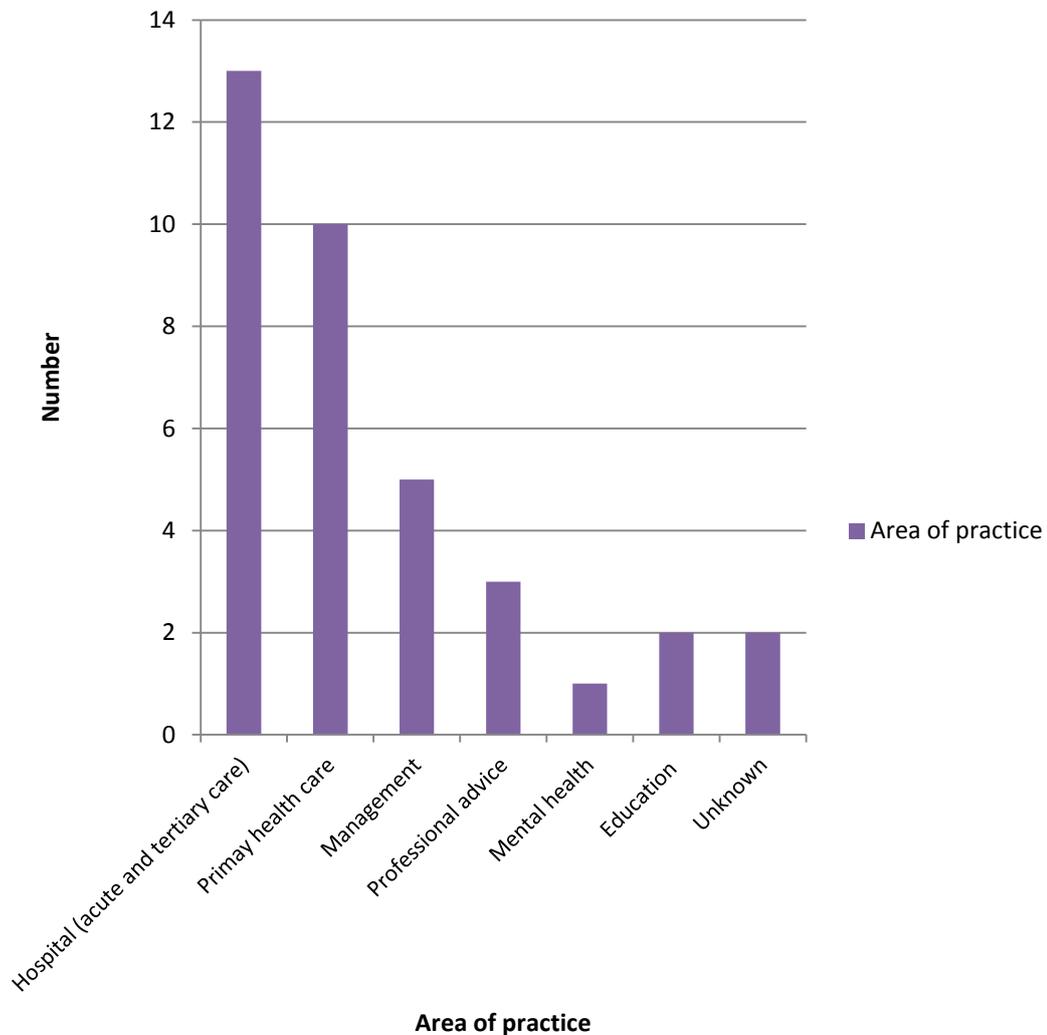
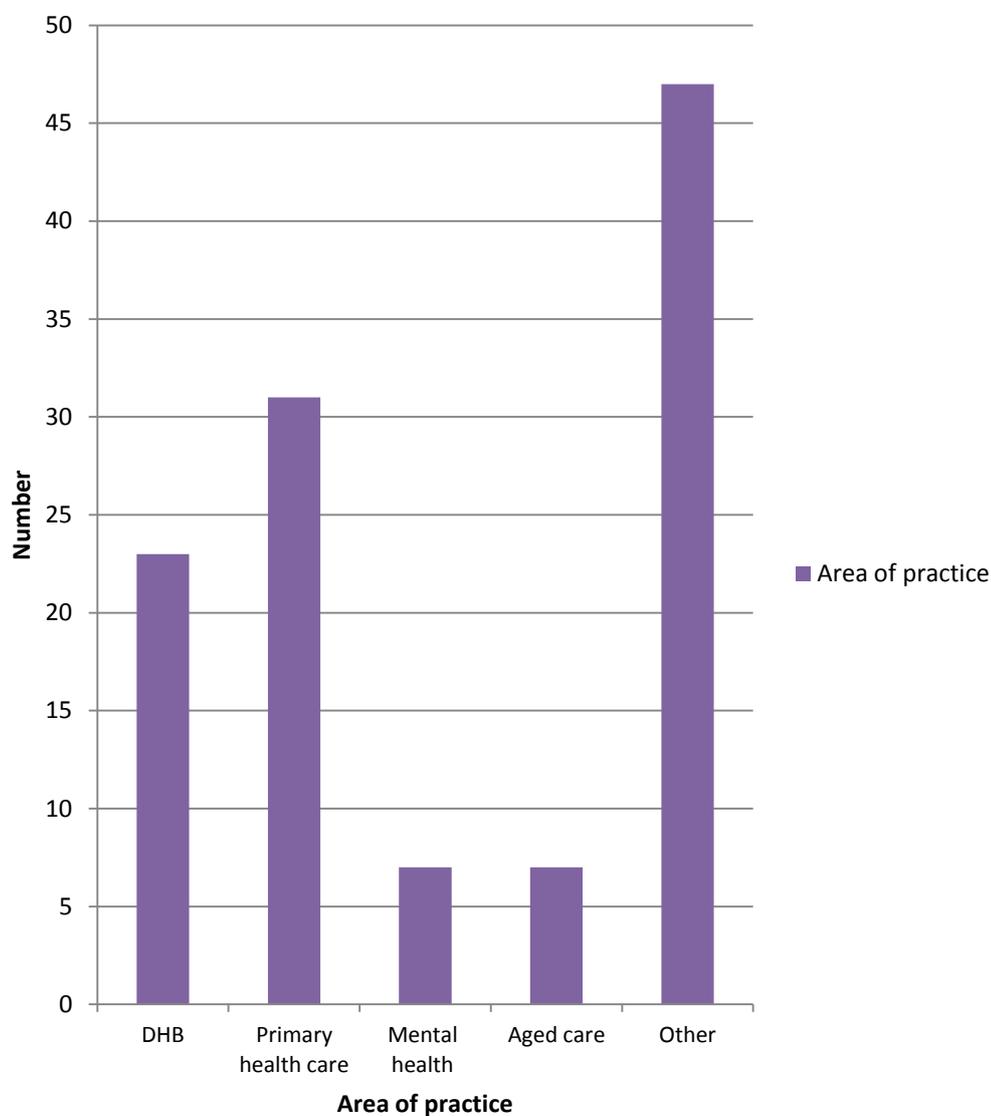


Figure 2. Area of practice (AGH)



Core themes

Analysis of the narratives identified five core themes and 15 associated sub-themes. These are outlined in table one. Each of these themes is presented in detail along with representative quotes from participants. The practice role of the participant is included by each quote.

Table 1. Themes and subthemes

Theme	Descriptor	Sub themes
People as recipients of care	In this theme, the focus is on people as recipients of care	Patient-centred care Quality
Health professionals	In this theme, the focus is on health professionals and their scopes and roles in providing care	Interdisciplinary practice Nursing Leadership and authority Education
Communication	In this theme, the focus is on the value of communication in relation to quality of care	Interpersonal communication Integrated care IT infrastructure
Health delivery	Here, broad approaches to health care are described including barriers and facilitators to quality care	Primary health care The business model Cultural competence
Mātauranga Māori	This theme focuses on approaches to health that are based around Māori ways of knowing	Traditional practices Whānau-centred care Tuakana teina

People as recipients of care

This theme focuses on people as the recipients of care and their role within models of care. Two sub-themes are captured here: patient-centred care and quality.

Patient-centred care

There was a strong belief that services needed to be patient centred and responsive to patient needs, with funding following the patient.

Services need to be wrapped around an individual – at home, in the community, with occasional forays into secondary and/or tertiary care. (Nurse adviser)

Services should be designed so that patients have choice about their health care "home" and the funding follows on that basis. The focus should be on need - at an individual and community level and then providers aligned with those needs in collaborative interdisciplinary teams. (Primary health care nurse)

Take on board consumer recommendations. (Participant – Te Rūnanga NZNO AGH)

People are central – work around their needs before health in NZ can be achieved – people must be central to health targets. (Participant – Te Rūnanga NZNO AGH)

One participant talked of a model that guided her individual practice with patients:

*CARE is the abbreviation for the following concepts:
C represents compassion, body language, voice, attitude.
A represents accountability: to the client, organisation, whānau, community, government and the nursing profession.
R represents respect, being mindful of where this person has come from and their whakapapa.
E represents enabling excellence: best practice guidelines, monitoring, preceptoring. (Primary health care nurse)*

Quality

In this sub-theme, participants talked about how important quality of care was to patient outcomes and the differing ways this could be achieved through effective models of care.

A model of care that ensures that health care for the New Zealand people is accessible and of a high standard is important and imperative if New Zealand is to be affiliated with countries who are leaders in healthcare delivery. (Clinical nurse specialist)

Whatever is derived by the process it has to meet a standard of criteria; has to be cost effective (within budget); efficient (meet defined goals & outputs); meet standard employee contractual agreements; is research based if research exists; if deviates from other current known models of accepted norm the research & reasoning is clearly defined (in which case a review period is instigated to ensure objectives are met); is robust & allows for service & staffing needs; follows a robust change process to ensure staff participation & engagement. (Charge nurse manager)

Health professionals

This theme focuses on health professionals and their role in providing care and developing models of care. Four sub-themes capture the various elements of this theme. These are: interdisciplinary practice, nursing, leadership, and education.

Interdisciplinary practice

Participants strongly believed that interdisciplinary practice was essential and, although not all practitioners functioned in this way, many workplaces were moving toward this model. Tied up with interdisciplinary practice were accountability for practice, partnership with other health professionals, and effective practice with health care assistants (HCAs) and other ancillary team members.

[There are] not many health practitioners who wouldn't work collaboratively. There are lots of examples of where doctors work closely with nurses. It's often the people not on the ground who don't see that collaboration is actually going on. Some places collaboration is interdisciplinary, some it is multidisciplinary. Often it is the system that does not allow interdisciplinary practice. Pendulum is swinging more toward interdisciplinary. (Nurse Practitioner)

Teamwork, collaborative practice, interdisciplinary team work – this is essential. If a nurse can't work in this way, then they put that person at risk...Nurses need to be mindful of their own accountability but need to be mindful of who they can collaborate with. (Nurse adviser)

A focus on health rather than illness. Efficient and timely referrals made to appropriate clinicians, using the skills and knowledge of all health professionals [is essential]. (Care co-ordinator)

Relationships and collaborative practice – there has to be a level of communication and respect between practitioners – equity of employment has been an issue. There are new and younger doctors now starting to come into practice who have a better understanding of nursing practice. (Primary health care nurse)

Current model is individualistic and compartmentalised. Healthcare should involve as many people as may be affected by an individual's diagnosis as long as that person consents to this approach. (Manager)

Barriers need to be broken down between nurses and doctors although I do feel in rural areas this has already happened due to necessity. Specialists in tertiary hospitals need to respect and value the nurses ability who are working in rural areas. This can be achieved by meeting and working with the teams in their environments so they get a good picture of the environment they are working in. (Charge nurse manager)

Participants' comments on HCAs suggest there is support for this model but there is significant work to be done to achieve optimal conditions for improved patient outcomes.

RNs are confused – they still think they are 'caring for' but need to switch to 'caring about'. They should have the primary relationship with the patient and demand accountability from the EN and HCA. RNs believe they are not as important as CNS, but need to do more than ENs and HCAs, and can't articulate this difference. The RN needs to think about who the patient is, what the whole package of care is for that person and the best way to give that care. (Educator)

...predicted nursing shortages may mean that nurse assistants are going to be utilized more for some aspects of care. (Clinical Nurse Educator)

Nursing

There were a number of elements associated with this sub-theme, in particular a strong belief in nurse-led care as an effective approach to care provision (although much greater funding and a reconsideration of education priorities were noted as being required to roll this out). Some of the types of nurse-led care mentioned by participants included: having a greater role in clinics and small, rural emergency departments; nurse-led clinics in long-term conditions' management, schools, and communities; nurse prescribing; patient management in specialty areas; higher numbers of nurses at the bedside managing the patient pathway; more and better use of nurse practitioners (NPs); nurses as business partners and owners in primary health care; and nurse-led discharge with community follow-up and care.

Entry to PHC and mental health services would probably be via a nurse or perhaps a pharmacist who would triage and either treat/discharge or refer/admit...Nursing would manage predictable long term conditions referring as required. Nursing would also take on a significant role in wellness management and promotion and to enable this to happen funding streams for this work will be required to incentivise its development. [With regard to] acute inpatient provision - some further services will shift into PHC with flying squad types of arrangements; nurse led discharge will be adopted nationally; nursing team models will be used to provide nursing services with a skill mix of 80/20 RN/EN depending on the clinical unit. Aged care - residential facilities will have NPs servicing 2-3 facilities to provide health services. Nursing and personal care delivery models will have an enriched skill mix of RN/EN/HCA to enable sound quality care. (Manager)

The potential of the nurse practitioner role has not yet been realised. (Clinical nurse educator)

[Nurses should have] a greater role in clinics and small rural emergency departments with the support of telemedicine. (Charge nurse manager)

More nurse led clinics and specialist practitioners in place to support the medical team & ease some of the pressures which leads to communication breakdowns, delayed treatment for patients and reduced access to timely healthcare for some patients. (Care co-ordinator)

There was a sense there needed to be greater clarity between what generalist and specialist nurses do and, as mentioned above, what HCAs do. Where some called for the nurses to be largely generalist, others felt this should not be at the expense of specialist nurses.

[Nurses should be] everywhere but cognisant of people as part of families as part of communities – generalists with specialist back up. The many, few, some model. The role of regulated and non-regulated personnel needs to be considered. (Nurse adviser)

We need to understand each others roles in terms of generalist or specialist. Generalist can often think it is not their role as there is a specialist who will do it. Generalist sits back and waits for the specialist to tell them what to do. (Clinical nurse educator)

Need some serious thought about the best deployment of RNs and we need to clarify their relationship to what CNS's do and what HCAs and ENs do. (Educator)

Leadership and authority

Participants strongly believed nurses needed to step up and take on stronger leadership roles across the sector, if change was to be achieved. There was concern that, although there were nurse leaders within most organisations, sometimes their voice lacked authority and the voice of the clinical nurse was largely absent. Where opportunities had been present to speak up, change was successful.

There is the barrier of the environment not hearing what nursing can offer. Nurse leaders in organisations are sometimes afraid because they see it as a professional or clinical risk to speak up. (Nurse adviser)

Clinical nursing experts do not have the power of influence compared to operational nursing leaders. Medicine get their mana from being a clinical expert. E.g. 0.5 clinician, 0.5 medical director. This person is respected because they are as a physician. In nursing and nursing leadership it is operational. Leadership documents come out wanting to strengthen clinical leadership – but it is all about charge nurse managers and directors of nursing – the voice of clinical experts of nursing is often absent. (Nurse practitioner)

The Charge Nurse role needs strengthening with more control over budgets and model of care. Often the model of care is inflicted from outside by managers who have no clear idea of the needs and resources of the communities or their organisation. The standard view is that the CNM are too close to have the wider overview which may not be the case if given the chance to step back with their teams to review, reflect and research. Our experience has been provision of the latter which has seen an innovative, cost effective, robust model open to review and change according to clinical and community needs. (Charge nurse manager)

There was also a sense among some participants that current leadership models (whether nursing or not) are often based around the individual personality of the leader (which could be a barrier or a facilitator), rather than the evidence. For example, where good evidence exists of excellence in models of care, these models of care were often not rolled out to other areas, with roll out reliant on an individual's decision-making.

Why are the innovations not rolled out elsewhere e.g. Christchurch shared care model – we need less personality and more change management across the sector. Need to get more KPIs at a higher level so that those at the top see the importance of PHC. Individual personality can limit culture of a workplace but this should not be the case. (Nurse practitioner)

...with advanced nursing practice – this still relies on individual leaders within nursing to drive change and not the evidence... (Nurse adviser)

There were a number of suggestions for approaches that could improve leadership and authority including more effective mentorship and preceptorship.

Talk language of success, not 'what if' but 'we are'. Identify and groom the next lot of leadership from year one. Nurture year one and give opportunity to apply skills to nurture and support so by year 3 they can fly. (Participant – Te Rūnanga NZNO AGH)

If you give [nurses] a good preceptoring you will have that person for life, but if you get a dicey preceptor or there is no mentoring then people just lose their way. There are so many solo positions and this makes it more challenging – people are going for the cheaper option so they get the less experienced nurse who may not have the skills. It's not good for our profession to not provide the support these nurses need and we lose them. (Primary health care nurse)

Tuakana teina – safety, awhi, communication, networks – Ngā Manukura o Āpōpō, mentorship, being strategic in planning. (Participant – Te Rūnanga NZNO AGH)

Education

Participants made significant comments on developments that needed to occur in nursing practice and education so nurses could work within new models of care and achieve better health outcomes for recipients of care. Business skills, greater understanding of nurses' role in relation to others and the need for effective supervision and delegation, better use of information technology in managing the patient journey, and better understanding of the influence of funding, contracts, legislation and the policy cycle on nursing practice were all identified as areas needing development.

Nurses are fundamental to the health of New Zealanders however we can be our own worst enemies. We need to get smarter and wiser about the business environment and how to work this to our advantage. We often clamour about lack of funding and access, but have failed to develop business skills which would allow us to position ourselves well. (Manager)

Greying of the faculty is of concern. Change must start with the faculty in terms of what their understanding is of nursing practice at the ward level and the importance of delegation and supervision. (Educator)

We need to be talking constantly to the nurse education institutions to make sure their ideas and our ideas are on the same page. Need to ensure nurses are

getting the right education in IT and communication skills. (Clinical nurse educator)

Students don't understand fully the legislation and policy that frames the health care sector e.g. Vote Health and how these impact on the care that is provided. In primary care the need to consider the other determinants of health e.g. cost of a dressing, type of dressing so a person can manage this in terms of their personal circumstances, appears to be lacking. We need significantly greater focus on primary health care and what this is and how the structures work to fund and access services for people. This seems to be missing. The school of nursing when talked to about this seemed to be really uninterested in providing this information. We need our younger nurses to be knowledgeable and a bit 'bolshie'. They need to have the information to be able to make change in primary care – need to know where funding comes from and where it goes. Many in the secondary sector don't understand the planning and funding cycle either – nurses need to know this stuff. (Manager)

Some felt that the nurse entry-to-practice (NEtP) programme was not sufficiently focused on clinical practice.

Too much emphasis being put on post graduate study in the NEtP year without there being enough focus on how they are practicing and what accountability of practice looks like. The NEtP year should be the highest level of clinical scrutiny the nurse should face and yet those nurses who need more support are often not getting it. (Nurse adviser)

Give trainee nurses more clinical time! NEtP was supposed to address the inadequate training that nurses arrive on the wards with. Instead students are given another poxy uni paper to do! I find that so moronic. (Staff nurse)

Participants also believed the focus of nursing care may need to change from complete hands-on care to overseeing the patient journey and ensuring all care is compassionate, of high quality and completed in a timely and appropriate manner.

I suspect the BN needs major overhaul to increase focus on PHC strongly and to clarify that what RNs need to do in hospitals is plan, assess and evaluate care through skilled supervision and delegation of so called basic care. Understand the importance of RNs talking to/assessing patients and of participating in ward rounds and multi disciplinary meetings. At the moment they are meant to do everything and failing at all of it. Hence their misery. (Educator)

Ownership of the 'relationship' between nurse and patient can be problematic - why do nurses not own the relationship and the care pathway of the patient. Greater need to add up the different aspects of a picture of a patient to make decisions and follow up – we need to understand our nursing role in more detail – include the psycho-social elements of nursing care but we don't articulate this well. Not sure why? (Clinical nurse educator)

Nurses have a central role but all [must be] working to top of scope. Nurses will need to work out what care they are going to let go in order to take on more of the higher level roles eg personal cares etc. (Manager)

When you look at undergrad nursing training we have a good comprehensive undergrad program where the student nurse is exposed to a broad array of experiences... Then you go into the MN where they typically have a single mentorship model. The nurses are typically in employment and are expected to find mentorship themselves. It is a flawed model that is not equipping nurses to

have a high level preparation for portable advanced knowledge and skills across specialities... If you are going to be a PHC NP you don't just do your time in the general practice where you are going to practice, you spend time in ED, in other settings. At present the model is based on good will and the ability of the nurse to establish placements and mentorship. If you have the single mentorship model as we do, then it is very difficult to get buy in from other professionals. We need to set it up in the same way as the undergrad or registrar programmes with rotational placements. (Nurse practitioner)

I feel there needs to be shift up for those nurses working in roles normally done by junior house surgeons in rural areas. They need to be recognised for their ability, this will help with recruitment and retention to these areas. Education funds need to be increased in line with doctors so appropriate training programs are not only available but also well attended for those working at higher levels. (Charge nurse manager)

Communication

In this theme the focus was on the value of effective communication in relation to quality of care. Three sub-themes comprise this category: interpersonal communication, integrated care and IT infrastructure.

Interpersonal communication

Interpersonal communication skills were seen as essential to everyday practice. This included the ability to communicate in a common language with medical colleagues, managers, and others within the health care team. Without these skills, nurses would not be heard in clinical, management or policy arenas, and achieving effective interdisciplinary practice and teamwork was considered unlikely.

Nurses need time to communicate and it's not given enough credibility in the clinical environment. You need to be trusted, credible, have your practice reviewed and scrutinised and respected by peers before you can communicate successfully. If you don't know the person you are communicating with then it will be a very different communication than if you know the person. With teams changing consistently then we need tools to manage communication and nurses need to know and understand these tools to use them effectively. Across, up and down the hierarchy people need to listen and hear what nurses are saying. Submissions are usually sound and well reasoned but there is insufficient weight given to this sometimes. (Nurse adviser)

We use a range of approaches to maximise access for targeted populations. We may never get it right for everyone but there is a difference between perceived need and actual need. How do we balance between those who are the 'worried well' and those that truly need to be there and are not coming. We need better communication about where people need to present. We need to educate the community better about where they can access care – don't always need to come into a general practice – can use pharmacy, nurse triage after hours – patients often need reassurance and they don't need to come in to see the nurse or doctor. (Primary health care nurse)

Nurses need to start communicating in a common language with their colleagues. We need to be smart about how we present and communicate with others. We need to present ourselves as a little less 'fluffy'. If we do that then we will have fewer problems with our medical colleagues. (Manager)

Ensuring that our voices are heard. Senior Māori nurses need to speak up. Be a voice, become engaged in making change. (Participant, Te Rūnanga NZNO AGH)

Integrated care

Integrated care was identified as a core element of future models of care and good communication was essential for this to be achieved.

Communication between primary, secondary and tertiary care needs to be much better – if notes would all link, people don't miss out. (Clinical nurse educator)

COMMUNICATION and sharing of information. Chronic Disease Management but sharing the responsibility of the patient across all services and the patient active in their own health care outcomes. There would be no line between PC and acute it would all be seamless. (Clinical specialty nurse)

We need health care provider teams to match the needs of the patients and the population – the local population. So we need appropriately trained health care providers at various levels so the patient can see the person they need to see when they need to see them. We need a system that communicates effectively throughout the patient's journey, and we need to move away from the primary, secondary, tertiary split. (Nurse practitioner)

There should be enough flexibility in the funding model that if we get the model right we should be able to get the funding in the right place. Being smarter about how funding is distributed at the DHB level. DHB funding and planning managers should have more authority to move the funding around the system more. Every time come up with a new approach, the barrier is at the DHB level. Always a concern about fitting things into a budget – might be better communication and better contracting or both. Need to be more flexible. Need a more integrated system that you can move funding around more flexibly. (Nurse practitioner)

The ever-changing ways out in the community you have to be a bit of a juggler. We're not that integrated between secondary and primary – everything is held in secondary but the bulk of their care is out in the community. Have the right person leading it, better integration can happen. (Primary health care nurse).

Although there was a strong belief integrated care was the way forward, participants noted that simple devolution of services from secondary to primary care would not necessarily result in better integrated care. Funding, support, appropriate care pathways and information technology were all considered essential to achieving effective integrated care and reducing fragmentation of the system.

Funders need to understand that the people providing service have worked together to a philosophy or vision or objective so if you take out the people aspect where the service will be modified you will lose the people who have been leading and doing in those areas. Getting nursing expertise in areas takes time and a lot of it is reliant on the individual nurse being self-aware, professionally aware and aiming toward that target. [Devolution] needs a more systematic approach with mentoring and support for all nurses to enable the system to achieve longer term outcomes. (Nurse adviser)

Care in NZ is fragmented and sometimes isolated. Contracts are business orientated therefore do not reflect how the clinician should implement care. (Primary health care nurse)

Information technology infrastructure

Participants clearly identified the importance of effective information technology (IT) to improve models of care. This included shared patient records, improved IT knowledge so nurses can use it effectively and share information with patients knowledgeable and appropriately, and the use of telehealth – particularly in rural areas.

The key is the shared health care record – it is essential we get that right. We need to have every health practitioner seeing the information they need to see. We need to move beyond the privacy issues and the record needs to be seen where the patient is. We need a well connected patient record system. If we get that right then we will see huge improvements in communication. (Nurse practitioner)

Information technology – need to talk more to patients about websites – we need to have more knowledge about websites to be able to safely refer patients. Smartphones, tablets, snatches of information not huge information sheets. The future will look quite different. (Clinical nurse educator)

Health promotion in primary care relies or is starting to rely on social media moving toward electronic forms. But not all people have access to these things. Still going to need the personnel to deliver healthcare – telehealth care or e-health platforms will not meet the needs of all people. (Nurse adviser)

Current model very fragmented with lots of repetition of information even if repeated admission into hospital. Information should be able to transfer between different areas when people relocate. The system should be able to build an holistic patient profile which is added to as needed (Charge nurse manager)

We need a national co-ordinated approach to telehealth similar to that in Queensland and shared records throughout New Zealand. It is not sustainable to offer full services to the entire rural population but a co-ordinated national approach could ameliorate some of these issues. But, we need to increase the resources – it's not good enough to call somewhere and be told 'ring the registrar'. (Charge nurse manager)

If we focus on patient information systems some nurses find IT systems a real challenge therefore more on the job support for the utilisation of IT systems would be useful for nurses on the floor. For a truly integrated system to work staff would need to be able to access, input and maintain the data on individual patients to a high and accurate standard. (Charge nurse manager)

Health delivery

Participants had a range of suggestions on how models of care should develop and this theme captures the broad approaches to health care, including barriers and facilitators to quality care identified by participants. Sub-themes include primary health care, the business model and cultural competence.

Primary health care

Many participants identified a primary health care approach to improving health outcomes as a foundation model of care, yet one that needs to be more fully developed and implemented across all sectors. A primary health care approach was not simply limited to the community, but all practitioners needed to be cognisant of why people were unwell, what was needed to support them to become well, and how to put in place the appropriate supports and interventions to achieve this.

The current model is the ambulance at bottom of cliff but we want the ambulance at the top of cliff with the patient in control – the wise patient. This makes the best use of everybody's skills. We focus on an illness model and therefore worry about the skills of general practitioners when this may not be the priority – we need best use of skill. (Nurse adviser)

There is not enough emphasis on health education and health promotion – even before that we need to take a population approach at an early age – antenatal care, peri-natal care – need to focus on primary health care at the earliest stage. Services need to be wrapped around an individual – at home, in the community, with occasional forays into secondary and/or tertiary care. (Nurse adviser)

What are patients getting in hospital – hospital nurses need to look more broadly at why the patient is there and what they will need when they get discharged. (Nurse practitioner)

A primary health care approach – a general idea. I've only ever worked in hospitals, but even from the inside we don't take the opportunity to build people's health. Although we ask about immunisation etc we don't take the opportunities for health promotion in that setting. We want good immunisation and no smoking etc but obesity, lack of exercise are obvious even in a hospital and we need to work harder on this in acute settings. We don't value the opportunities we have when families come to see us – we could do a lot of health promotion. (Clinical nurse educator)

Age, poverty, child health, these problems are still there and we need to work out systems to approach them. (Nurse adviser)

Better primary care, prevention of hospital admissions, wellness and health promotion programmes from birth through to death. A focus on health rather than illness. Efficient and timely referrals made to appropriate clinicians, using the skills and knowledge of all health professionals. A model of care that embraces all cultures that are prominent in New Zealand and reflects the health needs of all. (Care co-ordinator)

More government funded family medicine centres in primary care with a heavy emphasis on nurse led clinics. Nurses reach more people and spend more time in educating and following up individuals. If we are to keep more people in their own homes as they age or indeed go into villages, more home visiting is needed. Ensuring people are understood and care is delivered in a timely manner which is individualised. (Clinical nurse specialist)

Move a large percentage of funding from health to social care, and invest in the social determinants of health - education, jobs, decent housing. Reverse the access costs from free secondary to free primary, with safeguards for those who need it, and an emphasis of really supporting those with LTC in the community and on health promotion. More nurse led LTC clinics and nurse prescribing for chronic stable conditions. More accessible community focused integrated health centres, with doctor support by telemedicine in the hard to staff rural areas. (Nurse manager)

If we can address the issues of an unhealthy society, we are then better resourced to address actual health issues, diseases, genetic disorders etc. Nurses will still be needed in hospitals and communities. We can't prevent all accidents, we can't stop ageing and we have a long way to go to address all the genetic anomalies and disease, but at least by preventing the social illnesses we

are making a huge difference. Nurses will also be needed in education and health promotion. Once the population has some self worth, we can then start to address the issues of obesity, fitness and disease prevention. (Primary health care nurse)

New models need to reflect needs of our Māori patients, barriers are mainstream not understanding Māori world views – not wanting to try new models (Māori) – look at different strategies, policies and processes that reflect the needs of inequalities and disparities identified by the Ministry of Health. (Participant – Te Rūnanga NZNO AGH)

The business model

In this sub-theme, the business model is broadly defined as an approach to health care that integrates business ownership, targets, productivity, and fiscal prudence. This was the most contentious area in the study, where views diverged substantially. Whereas some thought the business model produced opportunities for nurses, improvements in health, and managed demand, others felt the model limited nurses' ability to actively meet population health needs. Inconsistency in the application of the business model was identified as problematic.

You are not incentivising services if you are not having some kind of cost – cost attaches value to the service for people. You need to have some mechanism to target funding to those groups that need it most and minimise access issues for them most. Those who can afford a co-payment can pay. (Primary health care nurse)

Some services offer cost efficient, excellent care with a high degree of attention paid to cost benefit in terms of quality of life. Within the same hospital another service (another budget) will charge ahead with eg cardiac surgery just to get the contracted numbers through. (Staff nurse)

Care in NZ is fragmented and sometimes isolated. Contracts are business orientated therefore do not reflect how the clinician should implement care. In primary care, models of care are not regarded as important; collecting outstanding fees is a priority. In community facilities if the managers are not clinical, models of care are not spoken about, frame-works are used but there are no pathways to make it happen. Pathways exist but need to be implemented into contracts and competencies. (Primary health care nurse)

There is a trend for constant change for change sake when the apparent need for change is not articulated or known. New managers seem programmed to stamp their mark with change. Often & mostly it is to save money or sometimes efficiency but change costs & it is debateable whether the investment is wise or worth it. It seems to me that a wiser move is an investment in altering performance of individuals by investing in them the resources required or replacing if this is not possible. (Charge nurse manager)

Too much time in primary health is taken up with chasing targets rather than providing good care to our patients. (Primary health care nurse)

Ongoing PHC provision would continue through a general practice/PHC service however these would be developed into more interdisciplinary PHC services with either a joint ownership/shareholding model. The owner operator model of GP services has been a barrier to nursing development in many instances. (Manager)

We have significant conflicts between public and private medicine. Sometimes when you are confronted with a barrier it is not about you or the service, it is about the public private business that is going on. Sometimes it is in the specialist's best interest to have long waiting lists. This is the elephant in the room and is not talked about at any level. When you are in the DHB, this issue is never put up there – it is never discussed. This is something you see in surgical not medical. Hospital leaders won't even discuss it. Can cut back on cleaning staff but will not face up to the waste occurring with the public private system. It is so taboo that now people don't even think about it. People will purposely put patients back on a waiting list for a follow up check that is totally unnecessary – this ties up the waiting list and it grows further – the specialists are growing their own practices, when a nurse or GP could easily do a follow up check. Or the specialist wants another practitioner so keeps the waiting lists high – this is a way they lobby...It's when specialists work in both private and public that conflict occurs. Get rid of the private public divide or manage it better so that there is no conflict. (Nurse practitioner)

Cultural Competence

This sub-theme describes participants' belief that approaches to health delivery should be founded on cultural competence, biculturalism and commitment to the principles of te Tiriti o Waitangi. Participants believed these elements should be embedded in all health care practice.

...we need to have a model that is inclusive of a bicultural focus, and one that focuses on cultural competencies being essential for high quality health care delivery and services. (Participant – Te Rūnanga NZNO AGH)

A model of care that embraces all cultures that are prominent in New Zealand and reflects the health needs of all...Improved interpretation services & cultural support workers for all major cultural groups, Pacific, Māori and Asian for example, to enable practitioners to understand the needs of the patients and ensure engagement from the patients in their care. (Care coordinator)

New models need to reflect needs of our Māori patients, barriers are mainstream not understanding Māori world views... (Participant – Te Rūnanga NZNO AGH)

Mainstream need to value Māori ideas and tikanga and ensure equal partnership, participation and protection – ensure implementation of te Tiriti o Waitangi. (Participant – Te Rūnanga NZNO AGH)

Mātauranga Māori

This theme focuses on approaches to health based around Māori ways of knowing. Participants who identified as Māori – including those who were interviewed, filled in surveys, or participated in the workshop held at the Te Rūnanga NZNO AGH – spoke of the importance of Māori-centred approaches to health care and the role of Māori nurses throughout the health sector. Along with the themes previously outlined, participants also wanted Māori cultural practices incorporated into models of care for Māori. These included traditional practices and learning, more marae-based facilities and initiatives, more kaumātua input, whānau-centred care and whānau ora, greater leadership from Māori, Māori models of preceptorship, mentorship and professional development (tuakana teina, Ngā Manukura o Āpōpō), and being an active and equal partner in developing, designing and leading models of care for both Māori and non-Māori.

Speak up speak out, Mana, Tika, Pono Aroha, Wairua, Tū Kaha - remain united and continue to speak your mind – leadership (Participant – Te Rūnanga NZNO AGH)

Pilot and collect data to show evidence that Māori models and difference concepts work (evidence). (Participant – Te Rūnanga NZNO AGH)

New models need to reflect needs of our Māori patients, barriers are mainstream not understanding Māori world views – not wanting to try new models (Māori) – look at different strategies, policies and processes that reflect the needs of inequalities and disparities identified by MOH. (Participant – Te Rūnanga NZNO AGH)

Lack of Māori at the development table. No Māori influence or weak Māori influence, strengthen tikanga in skills and knowledge. (Participant – Te Rūnanga NZNO Annual General Hui). [Nurses must] utilise their role to empower selves, whānau, iwi, hapu tauwiwi, work colleagues to promote goal setting and to accomplish achievements to improve health and well being of all. Reduce inequalities! (Participant – Te Rūnanga NZNO AGH)

To see the health services being delivered are being implemented by passionate Māori nurses working with Māori whānau and nurses passionate about Māori. (Primary health care nurse)

Discussion

The nurses taking part in this study had clear views of what role they have or could have in improving health outcomes. A focus on people as recipients of care, the role of the health professional, the value of communication, and the types of approaches that could be used were the primary themes identified in this study. Here I will consider each in light of existing literature and evidence, finishing with a set of recommendations for policy development.

People as recipients of care

The premise that people should be at the heart of health care was strongly identified by participants in this study. Participants believed people's opinions must be heard and respected, needs must be identified, and services and funding must wrap around the client. In addition, services must be of high quality, easily accessible and evidence-based. Patient-centred care has become an increasingly important component of health care since it was first conceptualised in the late 1960s (Mead & Bower, 2000). It is also a primary component of a primary health care approach to care (WHO, 2008). As a concept, patient-centred care is widely understood to contribute to improved patient-reported outcomes, improved communication, greater satisfaction with care, and improved biomedical outcomes (Cooper et al., 2012; Jayadevappa & Chhatre, 2011; Wilson, 2008). Yet despite these attributed benefits, definition of the term varies and barriers to implementation exist. With regard to nursing, Teekman argues that despite a desire to undertake comprehensive health assessment and provide patient-centred care, the introduction of generic management principles and continuous restructuring have reduced nurses' autonomy to practise in this way (Teekman, 2012). Further, Teekman argues it is the ward environment and imposition of standardised, documented processes that do not support nurses to give the care their education prepares them to provide. It will be important for nurses to consider ways in which these types of barriers can be overcome, if patient-centred, quality care is to become a reality in future models of care.

Quality care is inextricably linked with patient outcomes and is achieved when patients, providers, health professionals and systems work in harmony to ensure optimal health outcomes at all stages of a patient's journey through the health system. In New Zealand, the Health Quality and Safety Commission (HQSC) oversees quality of care in the health sector and is mandated by legislation to regularly publish a set of quality indicators (HQSC, 2012). The "Triple Aim" outcomes summarise the goals of the New Zealand health sector: improved quality, safety and experience of health care; improved health and equity for all populations; and best value from public health system resources (HQSC, 2012). Achieving quality is a continuous process and nurses have a core role at all levels – whether at the system, individual or community level. Falls' prevention, hospital-acquired infections, reducing perioperative harm, and reducing medication errors were the four priority areas of the HQSC in 2013 (HQSC, 2013). While addressing these areas is essential and will improve quality in these particular areas, quality improvement should be an overarching goal of all nursing practice and was clearly a priority for model of care development for the nurses in this study.

Health professionals

Health professionals are what make health systems and models of care work. The way in which health professionals work together, the leadership required to facilitate this, nursing-specific approaches to models of care, and the education required to achieve new approaches to health care were all identified as essential to current and future models of care development. Each of these are intertwined, and an examination of the literature in relation to the approaches described by participants situates the findings in relation to the evidence underpinning each.

Participants strongly identified interdisciplinary practice as a core element of future models of care. Interdisciplinary practice (also known as interdisciplinary collaboration) is described as an interpersonal process characterised by health-care professionals from multiple disciplines with shared objectives, decision-making, responsibility and power, working together to solve patient care problems (Petri, 2010). Each professional brings to the practice setting knowledge grounded within their own discipline but with sufficient knowledge and awareness of the other disciplines in the group to recognise and respect where interventions can be shared, delegated, transferred or retained to obtain maximum benefit for the patient. For interdisciplinary practice to be effective, interprofessional education, interpersonal relationship skills, role awareness and institutional support must be present (Petri, 2010). Interdisciplinary practice has been identified as one of the most effective approaches to chronic condition management (Boult et al., 2009), and as a contributor to improvements in patient care and decreased length and cost of hospital stays (Zwarenstein, Goldman & Reeves, 2009).

The participants in this study also noted there needed to be greater clarity between the respective roles of HCAs/practice assistants, clinical nurse specialists and the generalist nurse within teams – particularly, although not exclusively, in acute care. This observation is also reflected in the literature, with effective interdisciplinary practice more likely to be achieved where teams with varying skill mix have spent time learning together as a team and have a clear understanding of the roles and responsibilities of each practitioner (Munn, Tufanaru & Aromatis, 2013). With regard to HCAs, there is some evidence the addition of specialist support staff trained in specific interventions (eg dietary interventions) may have an important impact on patient outcomes, including a reduction in mortality (Butler, et al., 2011). However, a lack of formal policies and protocols regarding communication between HCAs and nurses affects patient safety and HCAs are often asked to do tasks outside their knowledge and skill level, without education or monitoring by a regulated health professional (Spilsbury & Meyer, 2004). Clearly, substantial work is required in practice settings to ensure effective

communication, delegation and direction is occurring between respective team members to ensure improved patient safety and outcomes. As noted by the participants in this study, as the use of HCAs in all settings increases RNs must be very aware of the differences between their respective roles, with RNs taking responsibility for the patient journey and ensuring the right practitioner is doing the right intervention with the right patient at the right time. As one participant noted, RNs need to move their focus from “caring for” to “caring about” patients.

Participants also noted inconsistency in the relationship between clinical nurse specialists (CNS) and generalist RNs in wards, with some observing that the two frequently work in parallel rather than with the common goal of improved patient outcomes. There is good evidence supporting the use of CNS– a systematic review examining the employment of masters-prepared specialist nurses in a variety of specialties (eg mental health, diabetes and cardiac care) found evidence of reduced length of stay and reduced frequency of pressure ulcers, although no differences in readmission rates, mortality or attendance at the emergency department (Butler, et al., 2011). However, as is the case with HCAs, roles and relationships between CNS and RNs clearly need greater clarification, if these improved outcomes are to be observed and maintained.

Schmied et al (2010) describe a continuum in the way in which health services are provided: co-existence (services provided independently and may be fragmented); cooperation (formal and informal communication where sharing is ad hoc rather than planned); coordination (degree of shared commitment and coordinated decision-making); and integration and co-ownership (formal arrangements based on common values, where there is no differentiation between services). While this is a useful analogy in relation to integrated care (discussed later), it is also useful to consider in relation to the way individuals interact to provide care. Where teams and individuals sit on this continuum may help identify what more needs to be achieved in terms of teamwork, training and integration.

Although participants clearly identified the need to work more carefully on developing the interdisciplinary team and enhancing relationships between team members, participants also strongly believed in nursing and nurse-led care as a core element in future models of care. Collaborative, interdisciplinary approaches were also strong features of nurse-led care. There is now substantial evidence to support the safety and efficacy of nurse-led care in both primary and secondary health care.. An early review that evaluated the impact of doctor-nurse substitution in primary care found appropriately trained nurses produce as high quality care as primary care doctors and achieve as good health outcomes for patients. This Cochrane review was updated in 2009 with no changes to the conclusions (Laurant et al 2004/2009). Since 2004, numerous other systematic reviews and meta-syntheses have continued to expand the evidence on nurse-led care (see for example: Boulton, et al., 2009; Glynn, et al., 2010; Griffiths, et al., 2007; Kuethe, et al., 2013; Parker, et al., 2012; Schadewalt & Schultz, 2010). In addition, recent evaluations of new and innovative nurse roles in New Zealand show demonstrable improvements in health outcomes for recipients of care and in nurses' job satisfaction (see, for example, King, Boyd, Carver, & Dagley, 2011; Peri, Boyd, Foster, & Stillwell, 2013; Wilkinson, Carryer, Adams & Chaning-Pearce, 2011). There is little doubt nurse-led care is successful in a range of differing ways and models of excellence should be rolled out across the country. However, participants in this study were concerned that frequently, roll out was hindered by a lack of nursing and managerial leadership.

Participants identified nursing leadership and authority as prerequisites for the development of future models of care. Leadership and authority were required to ensure roll out of effective models of nurse-led care, input into the wider development of models and at policy and strategic levels. Participants expressed concern that

nurses were still struggling to have a voice at the decision-making table in some areas and that change was more likely where nurses were respected for their clinical expertise and given the time to review, reflect and research effective models. Participants suggested effective mentorship programmes were still needed to develop and support leaders. Nursing leadership is considered "...critical for implementing evidence-based, ethical practice and promoting optimal patient outcomes" (Davidson & Sindhu, 2014, p.234). A systematic review examining the relationship between nursing leadership and patient outcomes found a range of positive outcomes associated with effective nursing leadership, including: improved patient outcomes; significantly reduced patient adverse events and complications; an association between leadership and mortality rates, eg through retention of greater staff expertise; and increased patient satisfaction where positive leadership behaviours were present (Wong & Cummings, 2007). There is also strong evidence that effective nursing leadership improves nurses' workplace productivity and performance (Germain & Cummings, 2010) and contributes significantly to a positive working environment (Tomey, 2009). This link to a positive working environment is particularly important, as research has clearly demonstrated that such an environment is strongly associated with lower patient mortality and failure to rescue in acute care (Aiken et al., 2008). Clearly there is strong evidence for the development of effective nursing leadership to improve patient outcomes. Mentorship and leadership development programmes, along with good role modelling for early career nurses, are possible approaches for improving nursing leadership across the sector. Nurses require greater access to leadership programmes, including recognition by funders of leadership and management education pathways.

Participants believed a number of changes needed to occur in nursing education to ensure effective implementation of future models of care. Key points included the need to refocus education on teaching nurses how to manage the whole patient journey with a strong focus on delegation and direction of care, reworking the master of nursing degree to include rotational clinical experience during practical courses, improving knowledge and understanding of business models and nurses' role within these models, and improving student understanding of how policy, strategy and funding intertwine to impact on health service delivery. NZNO published a policy framework on nursing education in 2013 identifying a range of future directions for nursing education, some of which touched on similar areas (Clendon & Trim, 2013). The policy framework specifically identified the importance of interprofessional education (IPE) and improved IT teaching as priorities – both, along with the importance of integrated care, identified by the participants in this study under the overarching theme of communication.

Communication

Participants saw effective communication between health professionals, with patients and across services as crucial to developing and implementing future models of care. The specific areas identified under this theme included interpersonal communication, integrated care and IT. Effective communication is essential for achieving interdisciplinary practice, integrated care and improved health outcomes (Sargeant, MacLeod & Murray, 2011). Formal training through IPE can improve the communication skills of health practitioners and outcomes for patients and should be considered an appropriate intervention for improving communication skills (Reeves et al., 2013; Sargeant et al., 2011).

Integrated care was identified by participants as essential for improving health outcomes in New Zealand, yet participants identified there was still significant work to be done to achieve this, particularly in relation to the need for appropriate funding, support, care pathways and IT infrastructure. Integrated care is a type of service delivery that ensures seamless transition for users between services, along with co-ordinated care between providers involved in the care of the user (Cumming, 2011). Providers may include not only health services but also housing, income, justice and

social services as well, with the ultimate goals of true integration across sectors and inter-sectoral collaboration. Within health, integrated care frequently refers to ensuring primary, secondary and tertiary services are better linked to ensure the patient journey is quick, easy and efficient (Graham-Smith & Clendon, 2013). To achieve integrated care, methods and models of funding, planning, administration and clinical services must be coherent to ensure collaboration and co-operation between the varying elements, yet this has frequently been absent in New Zealand, leading to poor clinical outcomes (Cumming, 2011). Cumming argues that although integration between funding and planning has now been achieved, this has resulted in little tangible improvement for the end user. In addition, change has been “slow and patchy” and frequently occurs at the local level, with little evidence of innovations being evaluated or expanded (Cumming, 2011, p.9).

There is evidence of some success in integrated care in New Zealand. The Canterbury District Health Board (DHB) has undertaken significant work toward developing and implementing a health service plan focused on integrating care across sectors. As noted, while there has been no formal evaluation of the Canterbury Initiative, as it is known, Canterbury DHB can demonstrate it has low rates for acute medical admissions compared to other DHBs, its average length of stay for medical cases is not the lowest in New Zealand, but it is low, and its acute readmission rate is also low (Timmins & Ham, 2013). One of the primary elements of the Canterbury approach is the recognition that clinicians are at the core of the initiative. This has improved engagement with those who are using and implementing the various elements of the initiative. Internationally, integrated care models show improved outcomes for people with chronic disease (Kruis et al., 2013), however, similar to Cumming’s (2011) above, other studies suggest integrated care underperforms without sufficient engagement from health professionals, substantial start up funding, and appropriate service configuration (Calciolari & Ilinca, 2011; Coupe, 2013; Smith, Allwright & O’Dowd, 2007). Clearly the issues identified by participants in this study are recognised as issues elsewhere and further work must be done to address these. Care pathways were supported by some participants in this study and there is evidence these pathways reduce in-hospital complications, decrease length of stay and reduce hospital costs (Rotter et al., 2010).

Participants also noted the growing importance of telehealth, IT, and, in particular, shared records. Telehealth or telemedicine is the use of telecommunications technology for medical diagnosis and care (Currell et al., 2000) and is noted as particularly useful in rural contexts (Moffatt & Eley, 2010). There is growing evidence of the usefulness of telehealth, with reports that usage improves access to health care for patients and improved professional development for health professionals (Moffatt & Eley, 2010). In addition, IT is increasingly used as a health intervention, with examples such as online cognitive behavioural therapy and mindfulness training for young people showing good outcomes (Merry et al., 2012; Monshat et al., 2011). There is strong support across New Zealand for some type of system that allows shared access to medical records (UMR Research, 2009). However, similar to the concerns of participants in this study, unease regarding cost, privacy and incompatible systems across the sector remain (UMR Research, 2009).

Health delivery

While participants had a range of suggestions for how models of care should be developed, primary health care and the business model were primarily identified as two broad approaches that warranted comment. Primary health care encapsulated participants’ ideas around the importance of addressing the social determinants of health if health gain, health promotion, self-management, preventative care and health literacy are to be achieved. Participants believed that a primary health care approach should not be limited to community settings but was an approach that could and should be used in all settings to support patients and their families lead healthy lives. The

literature strongly supports this approach, with the World Health Organisation (WHO) originally proposing primary health care as key to improving population health with the signing of the Declaration of Alma Ata in 1978. In 2008, the WHO reiterated the importance of primary health care as an overriding strategy and approach to improving health (WHO, 2008). The Canadian Nurses Association (CNA) also supports models founded on a primary health care approach. The CNA argues for models to put individuals, families and communities first, implement primary health care for all, pay attention to Canadians at risk of falling behind, and invest strategically to improve the factors that determine health (National Expert Commission, 2012). In addition, the CNA recommends the need for ensuring a focus on health in all policies, safety and quality in health care, preparing providers educationally and using technology to its fullest. Nurses have an essential role in improving health outcomes through primary health care (King, 2001) and it is clear the study participants recognise this role and wish to see funding and models prioritised to support primary health care approaches.

The business model sub-theme captured participants' thoughts on business ownership, targets, productivity and fiscal prudence. While participants strongly supported improving nurses' education on the business model, including business skills and understanding of business processes, others felt the business model limited nurses' ability to practise effectively with clients. Indeed, conflict also exists in the literature regarding business approaches to health. For example, offering incentives in primary health care has limited efficacy in improving health outcomes (Scott et al., 2011) and yet the productive ward approach has been shown to have a positive impact in terms of patient and staff experience, increased direct care time, and improved patient safety (Wright & McSherry, 2013; Schaefer, 2010). In addition, the programme was also found to contribute to considerable cost savings across the National Health Service (NHS) (Wright & McSherry, 2013). The greatest risk of a business approach is a failure to place the patient at the centre of health care. Evidence from the Mid Staffordshire Inquiry (Francis, 2013) and locally (Matheson, 2012) suggests there is a fine balance between the business model and improved patient outcomes and where the balance is incorrect, patients will suffer. Regardless of the perspective, the business model is the predominant model in health at the present time and this is likely to continue. Despite misgivings regarding this approach, as participants noted, nurses need the skills to work and thrive in this environment.

For a number of participants there was a strong belief that New Zealand is in an ideal position to develop models of care founded on cultural competence, biculturalism and commitment to te Tiriti o Waitangi. Participants believed this approach would benefit both Māori and non-Māori alike and should be embedded in health care delivery systems. Culturally competent health systems acknowledge diversity, provide culturally appropriate care, enable self-determination and reciprocity, hold governments and health planners accountable for meeting the needs of all cultures, base care on a culturally competent evidence-base and recognise the need for cultural competence training (McMurray & Clendon, in press). Culturally competent care is about the health practitioner or organisation's capacity to improve health status by integrating culture into the clinical context (Durie, 2001). For an organisation to achieve cultural competence in New Zealand, it must be acknowledged that most people receive care from mainstream providers and have a right to receive culturally safe care in this environment. There must also be a commitment to biculturalism and implementing te Tiriti o Waitangi.

Biculturalism can be understood as two distinct cultures in some form of co-existence. In New Zealand, this can be understood and enacted as a Māori-Pākehā (non-Māori New Zealander) partnership (Jones & Creed 2011). This partnership is considered equal, not a case of majority membership – thus although Māori may constitute 15 per cent of the population of New Zealand, a true bicultural partnership does not see 15 per cent of governance held by Māori, but 50per cent. In essence, a bicultural

organisation is one that recognises the ideal of equal partnership in governance. Te Tiriti o Waitangi provides the foundation for biculturalism in New Zealand and sets the parameters around partnership, participation and protection for Māori at all levels. New Zealand government policy has called for organisations to develop bicultural policies as a means of demonstrating commitment to te Tiriti but many organisations have still to develop true bicultural policies and the road to biculturalism can be challenging.

Mātauranga Māori

Study participants who identified as Māori strongly believed in the importance of including Māori cultural practices in models of care, and in Māori leading Māori health services. By Māori, for Māori health services, along with mainstreamed kaupapa Māori health services, are strongly supported in the literature as a means of addressing disparities in Māori health status. Such Māori-focused health services recognise and implement a Māori-centered approach to health care (kaupapa Māori services), and have been demonstrated as effective in reaching Māori whānau (Hamerton, et al., 2012; Ministry of Health, 2006; Oda & Rameka, 2012). These services also address the need for holistic approaches based on Māori ways of knowing (Mātauranga Māori) and are responsive to the primary health care principle of intersectoral collaboration, providing access to a breadth of services spanning housing, research, crime prevention, education, welfare and health (Oda & Rameka, 2012). Kaupapa Māori health providers not only improve access to affordable and accessible health care for Māori, they also contribute to the economic well-being of Māori communities and the Māori workforce (Ministry of Health, 2009).

Limitations

There are a number of limitations to this study that need to be recognised. Firstly, focusing on nurse leaders limited the potential pool of respondents and consequently there may be some bias in the findings. However, the findings presented here do not seek to represent the views of all nurses, simply those who took part in the study. It is hoped that the findings provide direction for policy makers and planners in terms of nurses' expectations and beliefs regarding models of care in New Zealand.

Conclusion and recommendations

Models of care is an extensive topic. This study has sought to understand nurse leaders' perspectives on models of care to ensure the nursing position on models of care is identified, articulated and relevant for policy development. The findings suggest nurses have an in-depth knowledge of the way in which models of care can and should be developed in this country, along with some of the barriers to development and implementation.

In summary, models of care in New Zealand should focus on the following key elements:

- > maintaining the person at the centre of health care;
- > ensuring the provision of quality, evidence-based health care;
- > providing mechanisms for enabling interdisciplinary practice;
- > clarifying roles and responsibilities between health professionals;
- > enabling the provision of nurse-led care;
- > facilitating nurse leadership and authority across the sector;

- > ensuring health professionals have appropriate education and skills to sustain change;
- > developing effective communication strategies throughout the sector;
- > focusing on primary health care as an overriding approach to health improvement;
- > maintaining a healthy awareness of the risks associated with the business model;
- > facilitating cultural competence, biculturalism and a commitment to te Tiriti o Waitangi; and
- > enabling Māori-centred approaches to models of care.

NZNO recommends nurse leaders should be more involved in developing models of care across the health sector. NZNO also recommends further New Zealand-specific research into many of the aspects listed above. Nurses have a clear vision for how approaches to health care can be improved and it behoves funders, providers, and policy makers to ensure this perspective is acknowledged and included.

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Glossary

Aroha	empathy and compassion
Awahi	To embrace or cherish
Hapū	Sub tribe
Iwi	Tribe
Kaumātua	Elder – either male or female
Kaupapa Māori	Māori ideology - a philosophical doctrine, incorporating the knowledge, skills, attitudes and values of Māori society.
Mana	Respect, honour, prestige, integrity
Manaakitanga	Goodwill - a commitment to working together within an environment of trust, respect and generosity towards each other. Recognising

	and understanding the capabilities and constraints each party brings to the relationship (Te Puni Kokiri, 2006)
Mātauranga Māori	Māori knowledge and the body of knowledge originating from Māori concepts including the Māori world view and perspectives, Māori creativity and cultural practices, including language and traditional and environmental knowledge.
Ngā Manukura o Āpōpō	Māori nursing and midwifery professional development programme – see www.ngamanukura.co.nz
Pono	integrity, doing the right thing, honesty
Rangatiratanga	Sovereignty, right to exercise authority, leadership
Tauīwi	Non-Māori, foreigner, European
Te Rūnanga	The national and regional body to represent the needs, concerns and interests of Māori members, and to lead NZNO on the development of processes Māori within NZNO.
Tika	just, fair or true
Tikanga	Correct procedures, customs, habits, lore
Tuakana teina	Refers to a reciprocal relationship between an older (tuakana) person and a younger (teina) person and is specific to teaching and learning in the Māori context. Arapera Royal Tangaere (1997) refers to a strategy of learning that is significant to Māori: that of tuakana and teina, where the more skilled peer, or tuakana, scaffolds the less competent child, or teina, to a higher level of understanding and knowing.
Tūkaha	To strengthen or building on our strengths
Wairua	Spirit, soul, attitude, spiritual (Ngā Pae o te Māramatanga academic journal website: review.mai.ac/info/glossary) To some, the <i>wairua</i> resides in the heart or mind of someone while others believe it is part of the whole person and is not located at any particular part of the body (Māori dictionary website: Māoridictionary.co.nz).
Wairuatanga	Spirituality, recognition and valuing of spirituality

Whakapapa	Genealogy, ancestry, familial relationships, whakapapa crosses ancestral boundaries between people and other inhabitants in the natural world (Ngā Pae o te Māramatanga academic journal website: review.mai.ac/info/glossary).
Whakawhanaungatanga	Process of establishing relationships
Whānau-centred care	Family-centred care
Whānau ora	An inclusive interagency approach to providing health and social services to build the capacity of all New Zealand families in need. It empowers whānau as a whole rather than focusing separately on individual family members and their problems (http://www.tpk.govt.nz/en/in-focus/whanau-ora/).

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Mission statement

NZNO is committed to the representation of members and the promotion of nursing and midwifery. NZNO embraces Te Tiriti o Waitangi and works to improve the health status of all peoples of Aotearoa/ New Zealand through participation in health and social policy development.

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