Margaret May Blackwell Travel Study Fellowship

2016/2017

Leadership in Developing Quality Nursing Initiatives in New Zealand

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Nurse Practitioner

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Acknowledgement

I would like to take this opportunity to personally thank the Margaret May Blackwell Trust and both the New Zealand Nurses Organisation and the New Zealand Nursing Education and Research Foundation. I would particularly like to express my appreciation for their ongoing understanding and support as I put aside the completion of this report to compile my Nurse Practitioner portfolio and prepare for my panel interview.

It is without hesitation that I recognize that the learnings gained from this experience significantly contributed to my Nurse Practitioner endorsement. This amazing opportunity has not only provided a wealth of knowledge to support the development of a Nurse Practitioner role within our current Well Child Tamariki Ora service, but has also made me a more thoughtful practitioner with a broader understanding of the sociopolitical influences of health.

Introduction

In 2016, I applied for and was awarded the Margaret May Blackwell Travel Study Fellowship, to explore leadership in developing quality nursing initiatives in New Zealand. The focus of this was to contribute to the development of a nurse prescribing pathway within New Zealand's current Well Child Tamariki Ora (WCTO) service delivery model. My key objective was gathering information to support the establishment of a Nurse Practitioner role within high deprivation communities to positively change the life course of some of New Zealand's most vulnerable tamariki and their whanau.

This was based on my many years of working with high needs families in high deprivation areas as a WCTO nurse for the Royal New Zealand Plunket Trust (Plunket). During this time, I noticed the impact that social chaos had on caregiver's ability to access primary health care, or to implement health promotion recommendations. These chaotic episodes included but were not limited to, parental depression/anxiety, intergenerational drug and alcohol abuse, family violence, reliance on inadequate social welfare, food insecurity and historical trauma.

Despite caregivers clearly identifying that the health and wellbeing of their Tamariki was of utmost importance, it was not uncommon for recommendations to access their primary health organization (PHO) to go unactioned. Likewise, the health of primary caregivers was often marginalized in order to meet the basic needs of their whanau. This often led to the deterioration of what was initially a minor health issue, and the over utilisation of emergency/secondary care. This regularly encountered scenario prompted me to work towards Nurse Practitioner endorsement with a goal of developing a specialised responsive service that attends to these primary health care shortfalls. This is whilst adhering to the principals of WCTO nursing, that promotes resilience and community connectivity through the development of increased health literacy.

My itinerary consisted of a mixture of in-depth clinical placements and relevant educational and networking opportunities over a six-week period. In this report I have listed them according to the country visited. These experiences have led to the formation of service specific recommendations that are listed at the end of this report.

Background

Despite making GP visits and prescriptions free for children and youth under the age of fourteen, adequate and equitable primary health care is still not being achieved in New Zealand. This is more prevalent in high deprivation communities where approximately 28% of children are living well below the poverty line (Child Poverty Action Group, 2017). Within this group, a further 8% are experiencing significant hardship, which has been strongly linked to poor health outcomes. This contradicts children's rights to optimal health as outlined in the United Nations Convention on the Rights of the Child (Expert Advisory Group on Solutions to Child Poverty, 2012).

Likewise, research conducted by the New Zealand Child and Youth Epidemiology Service confirms that hospitalisations follow a social gradient, with children living in low decile areas being two times more likely to present to an accident and emergency facility (Simpson et al). It was also found that medically based hospitalisation rates were higher for children aged 0-4 than older children, with the leading causes being poorly managed respiratory conditions, gastrointestinal and skin infections. This is reflected in an increased national ambulatory sensitive hospitalization (ASH) rate that currently accounts for 30% of all admissions (Simpson et al). Overall, ASH rates were also significantly higher for Maori than non-Maori.

One of the measures to combat these potentially preventable hospitalisations is the WCTO indicator aimed at encouraging and supporting caregivers to enroll their child with a GP by three months of age. Early engagement with primary health care has the potential to prevent unnecessary hospitalisations through robust medical management that reduces the likelihood of significant deterioration. However, recent statistics related to this indicator shows that the national target of 90% is yet to be achieved, confirming that for many infants our current system is not working for them (National Services Framework Library, 2018).

Compounding this situation is the consumer self-reported unmet need when accessing primary health care as outlined in the 2016-2017 New Zealand Health Survey (Ministry of Health, 2018). This survey found that one in five caregivers with a child aged 0-14 experienced an unmet need of some description, with one in six relating this to not being able to get an appointment with their PHO within 24hrs. Once again this was higher for Maori and Pacific children, which is concerning given that Maori are our key target population for

increasing primary health care engagement. Other less prevalent factors affecting accessibility were lack of transport and adequate childcare for siblings (Ministry of Health, 2018).

Developing an Innovative Nurse Practitioner Scope Within WCTO Nursing to Meet the Needs of High Needs Whanau.

The Nurse Practitioner scope was introduced in 2001 in response to New Zealand's increasing health complexities and an overall reduction in medically trained practitioners. It was envisaged that Nurse Practitioners would improve healthcare access to disadvantaged populations at both primary and secondary levels. Initially, the scope was open to nurses who had completed an appropriate master's degree and could demonstrate an advanced level of practice within a specific area. Applicants could apply for prescribing or non-prescribing rights, with prescribing rights being restricted to their defined area. Initially Nurse Practitioners were classed as designated prescribers who required an authorised prescriber to oversee their practice, such as a GP or consultant.

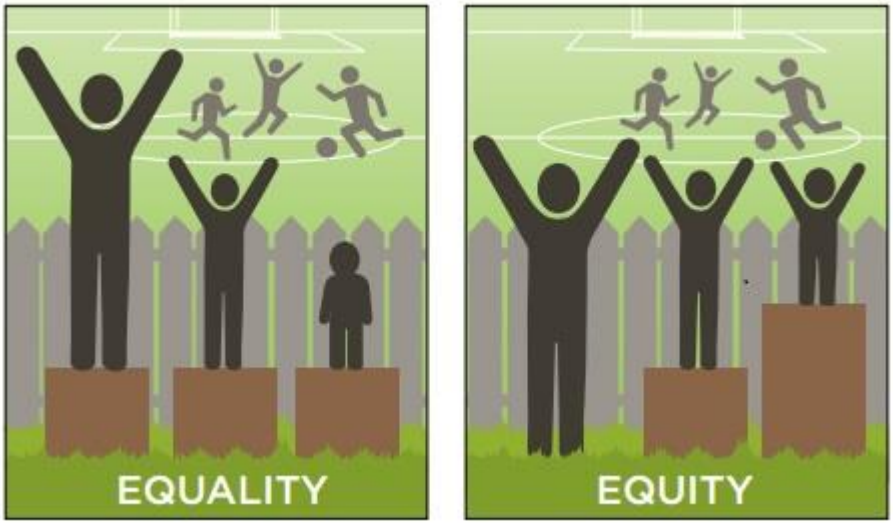
The Nurse Practitioner scope is now an authorised prescribing scope. This change means that Nurse Practitioners have greater autonomy over their practice and can adjust their area of expertise as their knowledge and clinical experience grows. This greater flexibility has enabled Nurse Practitioners to safely adjust their practice to meet the needs of the populations they serve. This has also accommodated a shift in primary health care that has seen more complex, historically secondary care clients, being managed in the community. Theoretically, Nurse Practitioners working in the community can support GP's to focus on more complex cases by effectively managing clients that fall within their area of expertise.

Authorised prescribers can also support and train Nurse Practitioner interns and other designated nurse prescribing roles that fit within their area of expertise. This could contribute to the sustainability of a nurse led initiative that provides whanau experiencing chaos with holistic health care when they need it the most. A Nurse Practitioner integrated social response would also adhere to the principals of New Zealand's Health Strategy, that recognizes the importance of preventative care to enable New Zealanders to Live Well, Stay Well, Get Well (Ministry of Health, 2016).

Within this strategy, preventative care that incorporates the needs of the individual and whanau within the context of their environment, is accessible and promotes an intersectoral approach to maximize health outcomes, is seen as essential to maintaining a robust healthcare system (Ministry of Health). At a philosophical level, the principals of WCTO nursing align well with this approach, as WCTO nurses are trained in the importance of knowing the community and subsequent resources and how to connect whanau with these resources to maximize health outcomes.

Likewise, they are comprehensively trained to see the child within the context of their wider environment that includes but is not limited to their caregivers, extended whanau, housing conditions and the community in which they are born. Therefore, a Nurse Practitioner that carries this world view would theoretically provide a social investment approach to healthcare that encourages the Nurse Practitioner to not only diagnose the individual but to promote the health literacy of the whanau to support greater self-resilience.

The Expert Advisory Group on solutions to child poverty in New Zealand has also recommended the development of integrated service delivery models, such as Whanau Ora, to tackle the interconnected social disparities experienced by children effected by poverty (Expert Advisory Group on Solutions to Child Poverty, 2012). In their document they recommend that the government acknowledge the importance of preventative care to reduce health spending across the lifespan. In relation to preventative care they promote proportionate universalism. This approach does not eliminate universal services such as our current WCTO program, but recognises the need to allocate funding dependent on need, to ensure that everyone has an equal opportunity to reach their fullest potential (Expert Advisory Group on Solutions to Child Poverty, 2012).



This approach could be built on in our Plunket WCTO service delivery model. Currently, we have a needs-based assessment framework that enables individual practitioners to allocate additional visits dependent on the assessed needs of the whanau. Often this results in referrals or recommendations to external agencies such as GP's, pediatricians, developmental services, maternal mental health services and family planning. However, often these services are overwhelmed and unable to meet the needs of the whanau in a timely manner, and/or the service is inaccessible to the whanau due to their personal circumstances.

An example of a family needing additional specialised care is a family of five that has scabies. Complicating the situation is the fact that the mother has suspected postnatal depression and poorly managed asthma, and the older child has missed an appointment with the ophthalmology department. This family is already struggling with being reliant on social welfare and has Oranga Tamariki involvement. As a WCTO nurse it would be beneficial to be able to do parallel care with a prescribing practitioner who can attend to the immediate needs of the family and treat the scabies whilst also reviewing and managing the potential postnatal depression and asthma.

This approach would also foster rapport between the Nurse Practitioner and the family due to the face to face introduction created between the whanau and their WCTO nurse. This would allow for greater co-ordination of care such as reconnecting with secondary services, discussing contraception options and supporting the family to work alongside Oranga Tamariki to resolve any ongoing and future concerns. It could also provide a space to work on long term goals such as developing a trusting relationship with a PHO, enrolling in

appropriate early childhood education, securing appropriate housing and exploring future employment/career options. Ideally having a WCTO trained Nurse Practitioner working across services such as Oranga Tamariki, Work and Income, primary and secondary care and the education sector would ensure optimal health outcomes.

Plunket's Nurse Practitioner Scoping Document also identifies a partnership model as one of three options to developing and funding this role (Royal New Zealand Plunket Trust, 2011). Through this inter-sectoral process, the importance of prioritising child health could be maximized across all sectors including within health. Plunket's strategy also promotes the importance of having a highly skilled and motivated workforce to meet the ever-changing landscape of WCTO nursing (Royal New Zealand Plunket Trust, 2015). It is hoped that this report will add to these two documents and provide a sound argument for the development of this role to improve child health outcomes.

Australia

Remote Child Health Nursing In Western Australia:

I spent two weeks with Angela Bolstad, a Child Health Nurse working in Western Australia for Ngaanyatjarra Health Services. She had been working in this position for three years since leaving New Zealand as a WCTO nurse. This position involves providing acute and preventive care to predominantly aboriginal children aged 0-17 living on the Ngaanyatjarra lands. Geographically this encompasses a 250,000 square kilo meter radius that incorporates eleven aboriginal communities with roughly 750 children aged 0-17

The Ngaanyatjarra lands are privately owned aboriginal lands that are accessible by the great central highway between Alice Springs and Laverton. This road is wide, rough and made of the red earth, synonymous with the outback of Australia. In the Ngaanyatjarra lands access to adequate healthcare is an ongoing battle given the terrain and distance between communities, with the nearest main hospital being Kalgoorlie. However, each of the eleven communities has its own health clinic manned by Remote Area Nurses (RAN's).

RAN's provide a variety of primary health care services to their communities and help to co-ordinate specialised clinics such as renal and cardiology. They are often the only health

professionals on site as there are few permanent medical doctors working in the lands. These RANs have an incredible knowledge base and impeccable triaging skills that informs their clinical judgement. This includes knowing when a patient needs to be flown out to one of the main hospitals. They also need to be able to co-ordinate the specialty clinics, which includes being able to identify residents who need to be seen. During my time with Angela I was present for one of these clinics. This was a renal clinic where consultants from Kalgoorlie flew into the Warakurna clinic for the day. This clinic was well attended and the RAN's ensured that the consultants had access to the client information they needed.

As a Child Health Nurse, Angela works closely with the RAN's. She is based out of the community of Warburton and attempts to visit each individual community regularly via a 4x4 vehicle. This often involves a two to three-night stay away to accommodate for travel. For example, during my time with Angela we drove to Cosmo Newberry, her furthest community. This was an 840km round trip that took over 6hrs to travel one way. Angela explained that she only visited this community two to three times a year due to its remoteness, which makes providing the Child Health Program for 0-5 year olds challenging.

The Western Australia Community Child Health Program is like New Zealand's WCTO schedule. It is based on a universal service model made up of six core visits and is aimed at assessing infant growth and development, whilst also supporting caregivers to grow their confidence and build resilience through increased health literacy. Angela also provides the targeted Enhanced Aboriginal Child Health Schedule (EACHS) to her families that identify as Aboriginal. EACHS provided additional contacts aimed at improving health outcomes. The expectation is that a minimum of fourteen contacts will be achieved for every eligible child within their first five years of life. This targeted approach is aimed at reducing the health inequalities experienced by Aboriginals.

These health inequalities, like many indigenous populations, are related in part to a split between traditional ways of being and a rapid exposure to western traditions and diseases. This has had a major impact on the social determinates of health experienced by Aboriginals that are negatively geared in these communities and include poor housing, sanitation, unemployment, reduced health literacy, gambling and drug and alcohol addiction. In her role, Angela co-ordinates care between a variety of social services through a memorandum of understanding (MOU) that is aimed at protecting the health and wellbeing of children and youth under the age of eighteen.

This co-ordinated care also involves other sectors, including education and corrections, as well as responding to gaps between primary and secondary healthcare. Supporting this gap between primary and secondary care is the use of standing orders that allow both Child Health Nurses and RANS to provide clients with much needed medication in a timely manner. These standing orders are supported by the carpa manuals, which are a set of easy to follow procedures that help clinicians identify and manage conditions that may lead to poor health outcomes.

Some of the key services that Angela provides the families she visits, that are aligned with her standing orders and are outlined in the carpa manual are:

- Anaemia identification and management. Aboriginal children are at increased risk of iron deficient anaemia due to reduced maternal iron stores, poor nutrition and an increased risk of helminths infestations.
- Immunisations
- Fungal infections prevention and treatment
- Impetigo prevention and treatment
- Sore throat management
- Eczema management
- Asthma management
- Head lice
- General first aid
- Contraception

Other conditions and services that Angela co-ordinates and manages are:

Fluoride varnishing.

Like New Zealand, poor oral health in children is increasing with many children requiring extractions. The residents of the Ngaanyatjarra lands have access to a dental service that visits each community at set times and is dependent on location and population. However, this is not enough to combat the ongoing decay that occurs between visits. Angela has completed additional training that is overseen by the Dental Association of Australia. This gives her the ability to apply fluoride varnish bi-annually to the teeth of children with identified carries. She is also training Aboriginal Health workers to learn the technique, which is having a positive roll on effect for both the community and the Aboriginal Health Workers. Angela has noticed that this procedure has significantly improved the oral health of most of the children who receive the treatment with further decay being prevented.

Tympanic membrane photographing, monitoring and management of acute and chronic otitis media with or without effusion.

An increased risk of otitis media is common within indigenous populations and is certainly an issue for Aboriginal children. This forms a large part of Angela's role involving the regular monitoring of each child's ears, acute treatment of otitis media under standing orders as outlined in the carpa manual, and co-ordination of Ear Nose and Throat specialty trips to the Ngaanyatjarra lands. She also supports the planning for children who are needing surgery for otitis media with effusion to be flown out to larger hospitals such as Kalgoorlie.

Nurse Practitioner- Pharmacology and Prescribing Conference Brisbane 27-28th March 2017

The inclusion of this conference into my itinerary was aimed at networking with Nurse Practitioners who may work in similar areas to WCTO nursing. Unfortunately, none of the Nurse Practitioners attending this conference were, or knew of anyone within this field, although a few were working with paediatric populations within a general practice setting. However, it was very clear that those in attendance found the conference incredibly important as it addressed scope specific professional development issues.

Nurse Practitioners attending also viewed it as an excellent opportunity to network with others in similar roles, as it provided collegial support that was often missing in their work areas. In New Zealand, Nurse Practitioners must complete 40hrs of professional development under their Annual Practicing Certificate. This is essential in ensuring that their practice remains relevant and safe under the Health Practitioner Competency Assurance Act. The need for robust professional development plans is also reflected in the fact that Nurse Practitioners must complete double the requirements of the Registered Nurse scope.

The New Zealand Nurse Practitioner Education Evaluation Report also identified that newly endorsed Nurse Practitioners considered access to allocated professional development funding and collegial support as essential to ensuring a safe and effective practice (Malaest International, 2018). It was also seen as crucial to enhancing the transition from trainee to qualified provider. However, inconsistencies between employers did exist. For example, the Auckland District Health Board (DHB) allocates $6,000.00 of professional development funding to each Nurse Practitioner that can accumulate over three years to a total of $18,000.00. This contrasts with other DHB's and PHO's that allocate little or no funding (Malaest International, 2018).

Another consideration employers need to factor in when assigning professional development funding is the removal of specific area of practice to any newly registered Nurse Practitioner under the new competency framework. This is because the role is seen as an advanced level of practice where individual practitioners are trusted to work within their area of competence based on their evolving clinical experience and knowledge. Employers therefore need to trust that these advanced practitioners will base their professional development on the needs of the populations they serve in order adapt to their changing health care needs.

United States of America

International Meeting on Indigenous Child Health 2017, Denver

I also attended the 2017 International Meeting on Indigenous Child Health in Denver, to once again network and gain knowledge that would contribute to the safe and effective development of a Nurse Practitioner role, within our current WCTO service. This was predominantly attended by services and consumers associated with First Nation people from America and Canada, although a handful of presenters originated from Australia and New Zealand. Unfortunately, there were no Nurse Practitioners present, although some service providers described being aware of Nurse Practitioners working in remote areas of Canada.

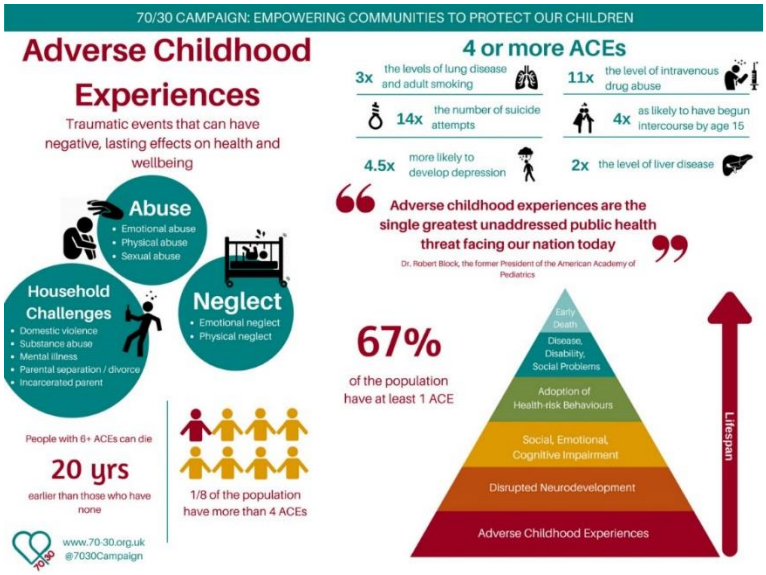
However, one of my key learnings from this conference that is fundamental to the establishment of any health role is the importance of being trauma informed and responsive. This is particularly true when working with indigenous populations where intergenerational trauma related to colonisation is present. This conference provided a greater understanding of the social determinantes of health, and how upstream factors can impact on individual life course trajectories.

It also provided solutions to complex social issues such as the culturally-based intergrated early childhood education care and development program running out of British Columbia in Canada, that was described by Professor Jessica Ball. This intersectorial approach to supporting wellness, culture and community cohession was founded on viewing the child holistically within the context of his or her family and community. It also recognised the

importance of consulting with indegenouse populations to ensure that their needs are being met, and that the service is culturaly appropriate.

Another powerful life course approach to the social determinates of health discussed at this conference, was the impact of Adverse Childhood Experiences (ACE). ACEs are based on ten life situations that can lead to significant health disparities. These ten AECs are related to abuse, neglect and household challenges. A person with four or more ACE's has a significantly higher chance of being obese, having a drug and alcohol addiction, suffering from depression and developing heart disease. There is also research being conducted that is looking into the intergenerational transmition of epigenetic gene expression changes that are related to social advantage/disadvantage. These changes can have a positive or negative flow on effect to offspring, that is dependent on the lived experience of his or her parents.

The impact of these neurodevelopmental changes highlighted the importance of providing trauma sensitive support. This involves informing caregivers in a non-judgmental way about the impact of ACEs on their lives, and the lives of their children. It also involves being able to connect the family into culturally appropriate services, and providing practicle advice and support that will enable the family to develop resilliance through self awareness, and self regulation.



Sheridan Youth Health Services, Denver

I spent a couple of days at the Sheridan Youth Health Centre, with Nurse Practitioner Neva Jarvis. The Sheridan Youth Health Centre is one of two nurse-led clinics operating in the low socioeconomic area of Sheridan. Both clinics are federally qualified health centres, that receive funding under the Public Health Services Act, to provide affordable healthcare to disadvantaged populations. This is regardless of their medical insurance status. Clients accessing these services are generally allegeable for Medicaid, which is reserved for American citizens with limited resources to obtain health insurance. However, a large majority of clients have no insurance. This is often due to nationally reduced Medicaid funding, or immigration status that interferes with employer allocated medical insurance.

For these uninsured clients both the Sheridan Family Health Centre, and the Sheridan Youth Health Centre provide a sliding scale payment scheme. This is based on income to ensure that every client receives the care they require. Both clinics are also overseen by the University of Colorado, who have established them as teaching clinics for Nurse Practitioner candidates. Although it also caters for those training to be Doctors, Dentists and Pharmacists.

I was particularly interested in the supportive, and safe environment that has been developed for Nurse Practitioner candidates when completing their 500 preregistration clinical hours. Nurse Practitioner candidates working at these centres, are provided with the time to complete full or focused health assessments, that include developing diagnostic and treatment plans under the direct, or indirect supervision of their Nurse Practitioner mentor.

They are also provided with additional time to research and reflect on individual cases, and share these with their colleagues in both formal, and informal settings. This model of professional sustainability, that is safe and supportive could be incorporated into the development of Nurse Prescribing pathways within our current WCTO service delivery model.

As a facility, the Sheridan Youth Health Centre provides a wide range of clinic based services. These include, general visits for acute care such as skin infections, upper and lower respiratory complications, gastroenteritis and allergy-based reactions. They also provide long-term management of chronic conditions such as eczema, asthma, diabetes and renal disease. Preventative care also forms part of this service delivery model, and includes immunisations, and well child health checks. Neva also shared that oral health is a major issue in Sheridan, which they have been successfully managing through their onsite low-cost dental service.

During my time at the Sheridan Youth Health Centre, I had an opportunity to observe a well child health check being conducted by a Nurse Practitioner candidate. Like New Zealand, the check took a holistic approach that incorporated family centred parental coaching to improve health outcomes. A screening tool like New Zealand's Parents Evaluation of Developmental Status (PEDS) was also completed by the caregiver while waiting to be seen. Unlike New Zealand's paper-based form, this one was completed on a tablet and was incredible user friendly and fun for the caregiver to fill out. This type of approach could increase the overall usability of the PEDS screening tool within New Zealand's WCTO package, which would ultimately enhance the quality of the service being provided.

The advantage of the Nurse Practitioner candidate completing this well child health check was outlined when his mother shared that the family had "nits". Because of her supervised prescribing capacity, the Nurse Practitioner candidate was able to provide her with a script to treat the infestation. Another benefit of the Sheridan service model was their low-cost pharmacy service, and the fact that scripts are sent directly to the pharmacy, preventing them from getting lost along the way.

Neva also highlighted how an integrated social response approach was being implemented within the clinic. This was reflected in the recent appointment of a behavioural psychologist, to manage the increase in neurodevelopmental cases being identified within their 0-5 population group. This is on top of the social worker and counselling services already being offered. Overall, Neva felt that both Sheridan Health Services responded well to the needs of the community.

England

Health Visiting, London

Unfortunately, the Health Visitor I was meant to go home visiting with was unable to take me. However, I did manage to talk to a couple of other health visitors during my stay. I also met with Professor Viv Bennett who is England's Public Health Chief Nurse and Lead for the Health Visitors and School Nurse programs. This was during a presentation she was giving at the Maternal Child and Family Health Nurses Conference in Melbourne, Australia.

Health Visitors are equivalent to New Zealand's WCTO nurses, and delivery England's Healthy Child Programme. Like WCTO nurses, they undergo a year of additional training on top of their Bachelor of Nursing degree. Unlike New Zealand, this course contains a Community Practitioner Nurse Prescribing module, that enables them to prescribe from the community practitioners formulary for nurse prescribers. This formulary consists mainly of dressings and skin care preparations, such as emollients and antifungal creams, and is aimed at reducing barriers to treatments for simple medical issues such as candida albicans, head lice and eczema.

However, it has been widely recognised that many Health Visitors choose not to prescribe due to a lack of confidence and continued professional development in clinical prescribing. This was certainly the case for the Health Visitors I spoke to, who felt they needed additional training and support. One also felt it would be beneficial to be linked to other medical and non-medical prescribers for additional guidance when needed. These nurses did however recognise the positive effect nurse prescribing could have on the health outcomes of the families they see.

For example, one nurse working in a high immigrant area of London where health literacy is particularly low, shared how getting a more confident colleague to prescribe when she has been concerned about a family has prevented the situation from deteriorating further. The benefits of nurse prescribing were also shared by Professor Viv Bennett, who sees great potential for increasing accesses to primary health care within the Health Visitor role.

During her presentation of the newly introduced 4-5-6 Healthy Child Programme, Professor Viv Bennett outlined how Health Visitors are instrumental to achieving the six health impact areas. These six health impact areas include preventing and managing minor illnesses and accidents, which has been promoted as an area that can be enhanced by nurse prescribing (Public Health England, 2018). Ultimately, the 4-5-6 Healthy Child Programme has been designed to improve child health outcomes, through increased intersectoral collaboration. It also promotes the importance of establishing strong links between the 0-5 and 5-19 year old health programs.

The 4-5-6 Healthy Child Program is based on proportionate universalisms as outlined in the "levels of service" listed below. In this model, there is a real focus on Health Visitors connecting with, and developing community-based services and resources that meet the requirements of individual communities. This includes having robust consultation and feedback process, to ensure the needs of the community are being met. The Universal Healthy Child Programme contributes to this sense of community, and is offered to all caregivers. It consists of five visits that includes an antenatal appointment at around 28 weeks gestation. This antenatal appointment allows for caregivers to prepare for the arrival of their child, and includes topics such as smoking cessation, bonding and attachment and safety.

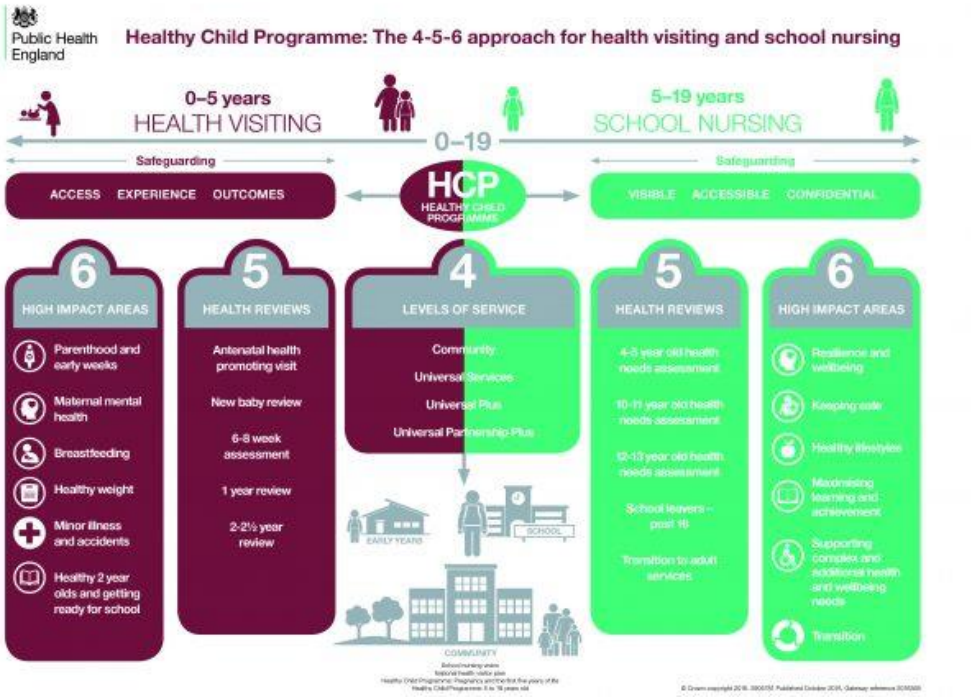
Health Visitors can also provide caregivers with additional advice and support such as attending to breastfeeding and sleep issues through the Universal Plus Program. The final level of care is the Universal Partnership Plus program, which is aimed at providing client focused intersectoral support to vulnerable families. This approach is supported through the Sure Start Children Centres that are already established throughout England, as they provide a space to enable professionals with different backgrounds to co-ordinate care.

Ultimately, each Sure Start Children's Centre should have its own designated Health Visitor and Social Worker. Many of these centres also have links to midwifery, and child protection services through the National Society for Prevention of Cruelty to Children (NSPCC). However, these centres are more than meeting places for professionals to co-ordinate care, but also provide support services that are dependent on the needs of the community. These include, but are not limited to:

- Mental health services
- Drug and alcohol addiction services

- Learning through play and speech and language services
- Smoking cessation supports
- Breastfeeding support services
- Integrated early education and child care
- Links to training and employment opportunities for caregivers

However, there is concerns around the sustainability of this model due to reduced funding at a local authority level. Regardless of this, New Zealand's WCTO program could benefit from adopting a robust multi-agency approach to care delivery, when working with at risk families. This could reduce the ineffective siloed approach to healthcare, whilst improving health outcomes for whanau through increased collaboration and accountability. This approach could also prevent at risk children going undetected, as it would further reduce the barriers that continue to prevent individual services from sharing concerns under the Vulnerable Children's Act.



Ireland

Nurture Programme-Infant Health and Wellbeing & Public Health Nursing, Dublin

In Dublin I spent time with Francis Chance, a social worker for the Katherine Howard Foundation. Frances works there as a program manager for the Nurture Program. The Katherine Howard Foundation strives to improve the lives of young children and their families, and the nurture program is one of its main vehicles to support this vision. Like New Zealand's WCTO service, the Nurture Programme recognises that conception through to three years of age is critical for enhancing individual potential and life course trajectories.

Ultimately, the Nurture Programme aims to work alongside the Health Service Executive (HSE), which is Irelands equivalent to New Zealand's Ministry of Health (MOH). It aims to improve health outcomes by ensuring that all healthcare providers involved in the delivery of Ireland's Child Health Programme, are well trained and can provide relevant evidence-based information. This is whilst keeping caregivers at the heart of the service. Part of this process involves reviewing the current Public Health Nurse (PHN) role, as PHN's are the main provider of Irelands Child Health Programme.

Currently in Ireland, PHN's provide a cradle to grave service. This means that they may visit a mother with a new born in the morning, then provide palliative care in the afternoon. However, there is a push to develop a specialised child health role, that supports the development of highly trained professionals, who can meet the complex needs of families.

During my time with Frances, I was able to share my experience as a WCTO nurse at the HSE Child Health Group Meeting. This was an amazing opportunity to show case the uniqueness and benefits of New Zealand's WCTO nursing role.

Francis also organised several other visits, that included going out with Jacqui Austin. Jacqui is a PHN working in the geographical area of Tallaght. As a PHN, Jacqui described many of the social issues present in Ireland that I was seeing regularly as a WCTO nurse in New Zealand. These included an increase in social anxiety, a disconnect between families and communities, and lack of affordable housing that is warm and dry. Like myself, Jackie believes in a social investment approach to tackling these issues, and the importance of everyone being socially responsive.

One of the highlights of my time with Jacqui was visiting Ancosan. Ancosan is a community-based learning centre situated in the high deprivation area of Jobstown. It is a bright, warm and welcoming facility, that is open to anyone in need of support. When I arrived, the smell of freshly baked scones that the centre is famous for were awaiting anyone in need of a pick me up, in the communal eating area. This contributed to the sense that the centre is an inclusive, friendly place for all.

Overal, Ancosan offers a variety of courses to increase the confidence and professional growth of individuals, whilst catering for their social-emotional needs. This is achieved by providing wellness classes, and a counselling service. I was shown around the centre by Anne Genockey, who is Ancosan Chief Operating Manager. She shared how it is a real hub within the community, and often seen as a haven for residents experiencing significant hardship. As a PHN Jacqui shared how she often supports clients to access this service to improve their personal circumstances.

As a WCTO nurse, this facility gave me a glimpse of what a purpose-built facility, that promotes intersectoral collaboration could look like. Although Ancosan did not routinely co-ordinate clients with health care providers, Anne recognised the importance of working with health professionals such as PHN. Anne also felt that developing beautiful spaces in high needs areas, that promote inclusiveness and pride is extremely important for promoting individual self-worth and enhancing a person's perspective.

Anette Cuddy, Health Services Executive Assistant Director of Nursing and Midwifery (Prescribing), Dublin

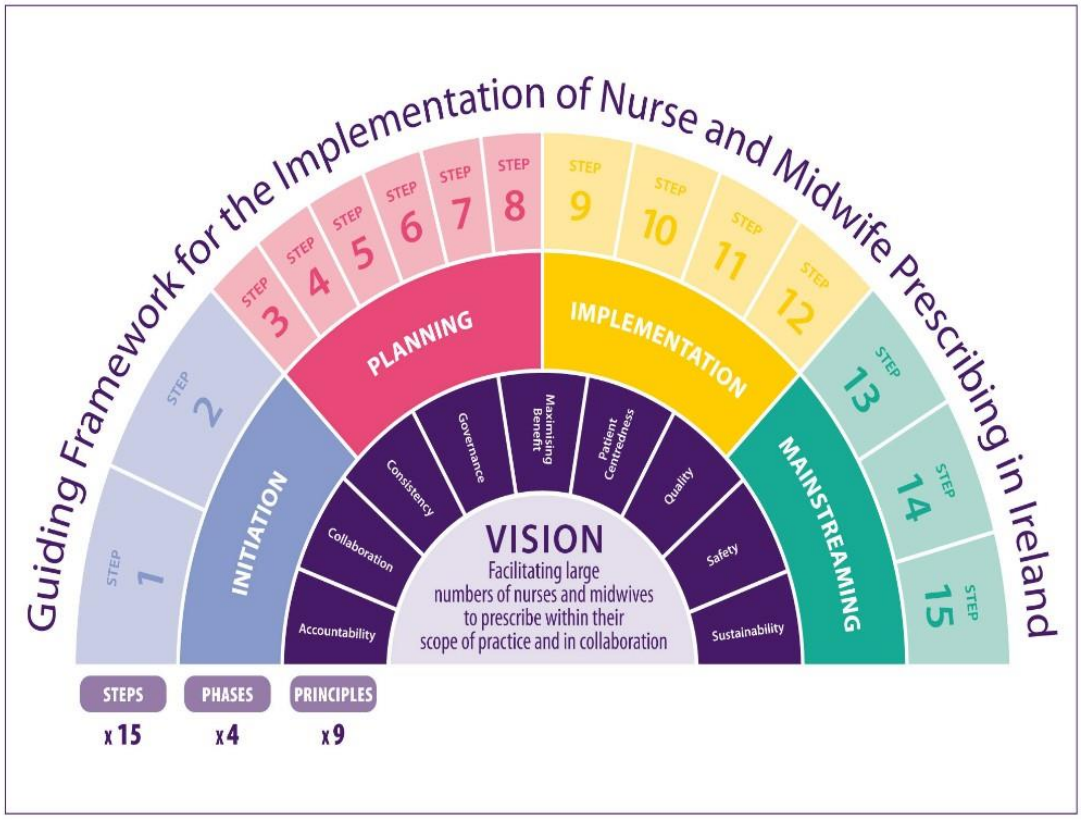
I also spent time with Anette Cuddy, Irelands HSE Assistant Director of Nursing and Midwifery Prescribing. She provided an overview of nurse prescribing in Ireland and shared some of the resources they have developed to ensure the safe and effective implementation of the scope. In Ireland, there are no authorised Nurse Practitioner pathways like those established in New Zealand, instead they have Registered Nurse Prescribers (RNP). Nurses wishing to become a RNP in Ireland must first complete a 6mth prescribing course, with the support of their employer.

During this time, the nurse in conjunction with the employer must appoint a mentor who will support the candidate through the designated prescribing component of the course. Likewise, after the completion of the course, the employer and the prospective RNP must create an individualised Collaborative Practice Agreement (CPA). The CPA outlines the conditions in which the RNP can work, such as outlining the target population and referral processes. It also contains a list of the medical products that the RNP can dispense.

Supporting this process is the Guiding Framework for the Implementation of Nurse and Midwifery Prescribing in Ireland (Health Services Executive,2018). This framework provides a step by step guideline that individual service providers can follow to support the implementation of a RNP into their business model. This framework is based on an overarching vision, that is supported by nine interconnected principals. These principals help to guide the four phases related to the successful development of an RNP pathway. These phases are:

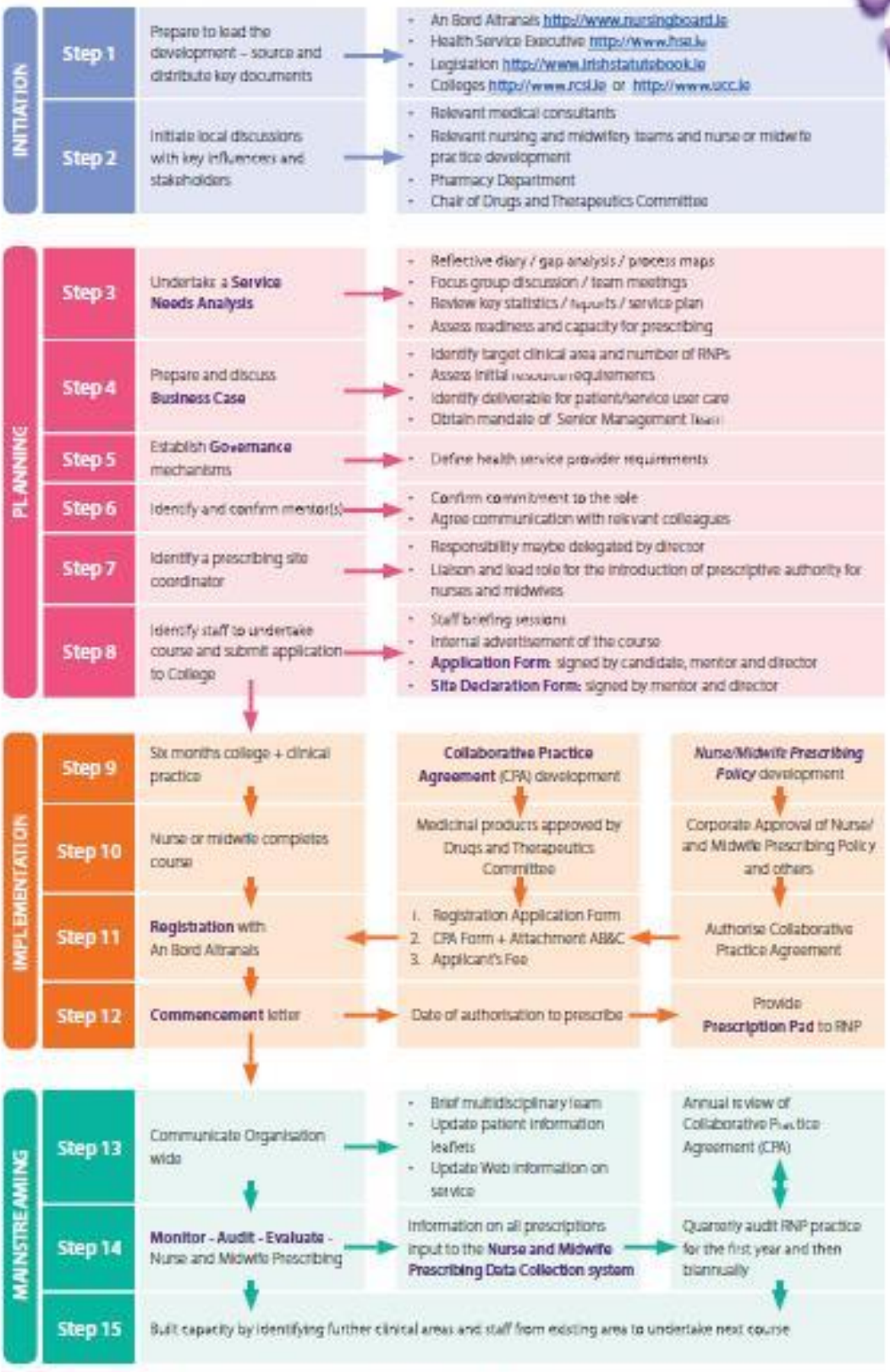
- Initiation
- Planning
- Implementation
- Mainstreaming

The achievement of these phases is based on following the fifteen steps outlined below. This framework could provide Plunket with the basis to formally develop a Nurse Practitioner, and other nurse prescribing pathways safety and effectively. It would however have to be adapted to accommodate the training and scope requirements that underpin the New Zealand's Nurse Practitioner scope.



Source: Office of the Nursing Services Director, HR Directorate, Health Service Executive (2008)

Figure 2.3: The 15 Steps to the Introduction of Nurse and Midwife Prescribing



Source: Office of the Nursing Services Director, HR Directorate, Health Service Executive (2008)

Recommendations

Recommendation One:

"Adapt Irelands Nurse Prescribing Implementation Framework to fit within New Zealand's Well Child Tamariki Ora context and current nurse prescribing scopes."

As observed in Western Australia, Denver and London nurses can step up to meet the demands of at risk, isolated and deprived populations. As an organisation, Plunket is in a unique position to be able to utilise the capacity of its workforce to fill the primary health care gaps that currently exist. This service delivery model could capitalise on the privileged position of WCTO nursing that enables them to visit whanau in their home. This would allow for the development of robust care plans based on individual social determinates of health. However, it could also include a clinic approach, such as the one developed in Denver.

This model needs to be built on the recommendations of the Expert Advisory Group on solutions to child poverty, that supports proportionate universalism. This can be achieved by establishing these expert roles in geographical areas with the greatest barriers to primary health care.

Adaption of this framework will also enable staff to advance their practice to meet the needs of the populations they work alongside, using a structured approach that promotes evidence-based practice. This approach would uphold Plunket's commitment to developing high performance Plunket people, as outlined in their strategy. It will also show a real commitment to acknowledging the value clinical staff bring to Plunket, by providing clearly defined advanced clinical pathways. This would also combat the current migration of well-trained staff who are wanting to advance their practice, into managerial roles and/or other areas of nursing.

Recommendation Two:

"Ensure that the service needs analysis within the Nurse Prescribing Implementation Framework is robust, aligns with current population health needs and is culturally appropriate."

Learnings from the International Meeting on Indigenous Child Health has further highlighted the importance of ensuring that any initiative meets health consumers' expectations. This involves clearly identifying the rationale behind the initiative, and the proposed outcomes. This includes completing a robust and inclusive consultation process, that utilises a variety of forums to maximum participation.

When developing services aimed at reducing health inequalities experienced by Maori it is very important that the principals of Te Tiriti o Waitangi are upheld. As with First Nation peoples, adopting a holistic approach to developing a culturally appropriate service is essential to optimising health outcomes. This requires seeing the child within the context of the whanau, and acknowledging that supporting the health and wellbeing of the family is just as important as supporting the health and wellbeing of the child.

Recommendation Three:

"Focus on the sustainability of Nurse Prescribing roles within the context of Well Child Tamariki Ora nursing."

Mainstreaming is an important phase within the Nurse Prescribing Implementation Framework, aimed at enhancing work force capacity. This section needs to be adjusted to accommodate New Zealand's context, and the subsequent key objectives of the Nurse Practitioner scope. This will help to establish the legitimacy of the role, whilst supporting the roll out of the pathway within the organisation.

Measurable and Non-Measurable health outcomes that could be linked to the establishment of advanced nursing roles such as a Nurse Practitioner could be:

1) Narratives
2) Case Studies
3) Prescribing audits
2) Reduced ASH rates
3) Reduced DNA (did not attend) at DHB outpatient facilities
4) Reduced smoking rates
5) Decreased unmet need when accessing primary health care

As outlined in the Nurse Prescribing Implementation Framework, developing pathways that enable internal and external stakeholders to be aware of the success of the service would also contribute to the mainstreaming of these pathways within our WCTO service delivery model.

It would also be beneficial to develop a training model like the Sheridan Youth Health Service, where Nurse Practitioner Interns are able to develop their practice in a supportive and safe environment. This could also cater for up and coming scope developments, such as the Community Nurse Prescriber that needs to be overseen by an authorised prescriber.

Recommendation Four:

"Ensure that these advanced clinical pathways are based on an intersectoral approach to improving health and wellbeing outcomes for tamariki."

Nurses working in the remote areas of Western Australia demonstrated the importance of working collaboratively with other services, and agencies to improve health outcomes. This was particularly true when managing client's health between primary and secondary care. Likewise, having a memorandum of understanding between health and social services helped to safe guard at risk children, whilst also providing families with co-ordinated care aimed at building resilience.

The need for a more co-ordinated approach to support at risk families was also reflected in England's Universal Partnership Plus program, that forms part of the NHS 4-5-6 Healthy Child Programme. A partnership approach to funding a Nurse Practitioner role within high need vulnerable populations could see individual Nurse Practitioners co-ordinating care between DHB, PHO, Orange Tamariki, Tamariki Ora services as well as through Plunket staff. This mixed model approach would lead to greater transparency and the prevention of at-risk children going undetected.

Recommendation Five:

"Provide advanced clinical pathways with access to role specific resources and professional development funding."

Recent changes to the Nurse Practitioner scope means they can adjust their area of expertise to match the changing health care demands of their targeted population. This reflects their training and years of clinical experience that underpins their advance practice, and enables them to recognise local changing demographics against population health targets. This is also underpinned by the 40+ hours of professional development they must complete each year, to maintain a safe and effective practice.

Likewise, they often have differing professional development needs to their colleagues. This would be particularly true for a Nurse Practitioner working within a WCTO setting. It is therefore fitting that a Nurse Practitioner working in this area should have allocated annual professional development funding. Considering the findings by Malatest International who recently evaluated the Nurse Practitioner education process, it is recommended that this professional development budget sit between 3-6 thousand dollar per annum. This should allow for a maximum accumulated balance of 9-18 thousand dollars over a three-year period.

As mentioned above an intersectoral approach to service delivery would also ensure that Nurse Practitioners had access to applicable resources, professional development, and collegial support such as electronic health pathway programs, peer groups and Bpac referral systems, that may otherwise not be available to them.

Recommendation six:

"Ensure that this advanced clinical nurse pathway has a solid foundation in trauma sensitive support."

Trauma sensitive support was identified at the International Meeting on Indigenous Child Health, as essential to supporting individuals and families who have been affected by Adverse Childhood Experiences. Being able to recognise and support caregivers to acknowledge the impact that these past experiences have had on the health and wellbeing of their offspring's will be essential when working with at risk families. Appropriate training will also enable individual practitioners to recognise when caregivers need additional support and reassurance, and when they require supportive challenging to improve health outcomes.

Conclusion

WCTO nurses are in privileged positions to go into homes and develop a deep understanding of what life is really like for whanau. They often share in the triumphs and tears that surround bringing a new life into the world, and work towards developing whanau-based resilience that will enable this new life to thrive. WCTO nurses working within high need populations regularly encounter opportunities where families are needing advanced primary health care, that is beyond their current scope. It is within these moments that an opportunity to further highlight the importance of selfcare is lost.

Statistics show that for some families the structure of our health care system is not working. We need to create innovate collaborative services, that enable families to engage in primary health care in a meaningful, and timely manner. It therefore makes sense to utilise the already established home visiting capacity of the WCTO nurse to reach and support these families. Through these positive experiences, that are aimed at addressing both the health and social concerns that exist it is anticipated that families will be better positioned to value the importance of managing and maintaining their health in the long-term.

Reference List

Child Poverty Action Group. (2017). *Facts about child poverty*. Retrieved from https://www.cpag.org.nz/assets/170925%20Facts%20about%20CP.pdf

Expert Advisory Group on Solutions to Child Poverty. (2012). *Solutions to child poverty in New Zealand: evidence to action.* Wellington: Expert Advisory on Solutions to Child Poverty

Health Service Executive. (2008). *Guiding framework for the implementation of nurse and midwifery prescribing in Ireland*. Dublin: Health Services Executive.

Malatest International. (2018). *The New Zealand's Nurse Practitioner Education Evaluation Report.* Retrived from: https://www.health.govt.nz/system/files/documents/

publications/evaluation-nurse-practitioner-education-programme-feb18.pdf

Ministry of Health. (2018). New Zealand Health Survey. Retrieved from https://minhealthnz .shinyapps.io/nz-health-survey-2016-17-annual-data-explorer/_w_6e30bb90 /#!/home

Minister of Health. (2016). *New Zealand health strategy: future direction*. Wellington: Ministry of Health

National Services Framework Library. (2018). *Well Child / Tamariki Ora Quality Improvement Framework*. Retrieved from https://nsfl.health.govt.nz/dhb-planning-package/well-child-tamariki-ora-quality-improvement-framework

Public Health England. (2018). *Early years high impact area 5: Managing minor illnesses and reducing accidents (improving health literacy). Health visitors leading the Healthy Child Programme.* London: Public Health England.

Royal New Zealand Plunket Trust. (2015). *Plunket strategy 2016-2020 the journey towards generational change*. Wellington: Royal New Zealand Plunket Trust

Royal New Zealand Plunket Trust. (2011). *Nurse practitioner scoping document*. Wellington: Royal New Zealand Plunket Trust

Simpson J, Duncanson M, Oben G, Adams J, Wicken A, Butchard M, Pierson M, Lilley R. and Gallagher S. (2016*). The Health Status of Children and Young People in New Zealand 2015.* Dunedin: New Zealand Child and Youth Epidemiology Service, University of Otago