LONG TERM CONDITION MANAGEMENT:
HEALTH PROFESSIONALS’ PERSPECTIVES.

A thesis presented in partial fulfilment of the requirements
for the degree of

Master of Nursing
at the
Eastern Institute of Technology
Taradale, New Zealand.

Natasha Sarah Ashworth
2009
Abstract

Long term conditions are the leading cause of morbidity and mortality in New Zealand. The burden upon secondary health care services to manage the complications of long term conditions has prompted calls for primary health care to lead the way in early diagnosis, management and coordination of care for long term conditions. Nurses are in an ideal position to lead primary care initiatives for long term condition management. The aim of all involved in primary care should be to provide long term condition management that is evidence-based and culturally acceptable. This gives rise to questions such as: What is the key to successful long term condition management? How can nurses be at the forefront of this? What do central stakeholders in the planning, funding and delivery of primary care believe to be the solutions? How can we ensure that Māori needs are prioritised in delivery strategies?

This qualitative study aims to describe health professional's perspectives on long term condition management and identify barriers to future change in service delivery, by interviewing 10 health professionals in the primary care field in a geographically isolated area of New Zealand. Four General Practitioners, four nurses and two management team personnel were interviewed and the resultant data were analysed using a general inductive approach (Thomas, 2006). Thematic analysis of the interviews conducted revealed over 30 themes on the subject of long term condition management. These were categorised into five main headings: management issues; information technology, leadership, patient centred care and power.

The results highlighted that long term condition management is rated as highly important by all the participants and that they are aware of the need to change current delivery methods to improve client outcomes. However, all participants raised the issue of funding as a significant barrier to implementing innovations in long term condition management, including nurse led services. Future plans to develop Integrated Family Health Centres and increased collaboration between clinicians involved in delivering services, were hailed as potential solutions to improve long term condition management.
Acknowledgements

First and foremost I would like to thank my wonderful husband Robert. Without his love, patience, support, endless cups of tea and mastery of all household duties, this thesis would never have been completed. I would also like to thank my two beautiful children, Myles and Maddie, who lost their computer, and their mother, for a year with little complaint.

Secondly I would like to thank my principle supervisor Dr Shona Thomson for her insights and enthusiasm. Shona’s thought provoking questions helped my development as a researcher and her patience with my ungrammatical presentation was legendary. Thank you to my secondary supervisor Anne McLeland who gave prompt and valuable feedback and support all the way through the process and to all the staff at the Eastern Institute of Technology.

At Tairawhiti District Health I would like to thank Robyn Dymock, Karen Lorigan and Kate Mather, for support given in so many ways: acting as interview guinea pigs; help with typing and printing costs and patient listening. Thank you to Maaka Tibble and all at the Hauora Māori Directorate for their feedback and cultural guidance. I would also like to acknowledge the Central Training Agency funding that enables professional development for nurses.

I would like to acknowledge the help and support of Keriana Brooking and all at Turanganui Primary Health Organisation. Finally and certainly not least I would like to thank the General Practitioners, practice nurses and primary care management teams who participated in the research or who made it possible for others to participate.
# Table of Contents

## CHAPTER 1 – INTRODUCTION  

1.1 Introduction  
1.2 Background  
1.2.1 New Zealand Health Strategy
1.2.2 Primary Health Care Strategy
1.2.3 Tairawhiti Strategic Health Plan
1.2.4 Māori Health Strategy (He Korowai Oranga) and The Treaty of Waitangi (Te Tiriti o Waitangi)
1.2.5 Income inequality and socio-economic deprivation
1.3 Research question
1.4 Purpose of the research
1.5 Aims of the research
1.6 Significance of the research
1.7 Overview of the thesis

## CHAPTER 2 – REVIEW OF LITERATURE  

2.1 Introduction
2.2 Models of Long Term Condition Management
  2.2.1 Implementing Long Term Condition Models
2.3 Long Term Condition Management in Primary Care
  2.3.1 Primary Care Nursing
  2.3.2 Advanced Practice Nursing in Primary Care
2.4 Māori Health Research
2.5 Barriers to Change
2.7 Summary

## CHAPTER 3 – METHODOLOGY  

3.1 Introduction
3.2 Research and Healthcare
3.3 Quantitative Research
3.4 Qualitative Research
3.5 Research Perspective
### CHAPTER 4 - RESEARCH METHODS

4.1 Sampling
- 4.1.1 Inclusion Criteria
- 4.1.2 Exclusion Criteria
- 4.1.3 Limitations and Delimitations
- 4.1.4 Sampling Methods

4.2 Data Collection

4.3 Data Analysis

4.4 Rigour and Value

4.5 Ethics
- 4.5.1 Competency Boundaries
- 4.5.2 Informed Consent
- 4.5.3 Confidentiality
- 4.5.4 Protection from Risk and Injury
- 4.5.5 Quality
- 4.5.6 Publication and Dissemination of Findings

### CHAPTER FIVE – RESULTS AND DISCUSSION

5.1 Introduction

5.2 Management Issues
- 5.2.1 Funding
- 5.2.2 Time Management
- 5.2.3 Opportunistic versus Planned Care
- 5.2.4 Professional Development
- 5.2.5 Team Composition and Workforce Issues
- 5.2.6 Summary

5.3 Information Issues
- 5.3.1 Information Technology
- 5.3.2 Information Technology Integration
- 5.3.3 Communication
- 5.3.4 Duplication of Services
- 5.3.5 Evidence Based Guidelines
- 5.3.6 Summary

5.4 Leadership
- 5.4.1 Clinical Leadership
- 5.4.2 Nurse Led Services
- 5.4.3 Role Protectiveness
- 5.4.4 Relationship Building
- 5.4.5 Summary

5.5 Client Centered Care
- 5.5.1 Client Journey and Continuity of Care
- 5.5.2 Māori Needs
- 5.5.3 Client Outcomes
- 5.5.4 Holistic Care
Table of Figures

Figure 1: He Korowai Oranga. Source (A. King & Turia, 2002). Maori Health Strategy. Wellington. Ministry of Health. 8

Figure 2: Te Whare Tapa Wha Source (Durie, 1994). Whaiora. Maori Health Development. Oxford. Oxford University Press. 9

Figure 3: Model of the social and economic determinants of health 11

Figure 4: Profile of the Gisborne District. Source (White, et al., 2008) 12
CHAPTER 1 – INTRODUCTION

1.1 Introduction

In keeping with the majority of the industrialised world, long term ill health conditions are the leading cause of morbidity and mortality in New Zealand. The World Health Organisation produced a document entitled ‘Innovative Care for Chronic Conditions’ which states that long term conditions comprise 60% of the global disease burden and that this is set to rise exponentially (World Health Organisation, 2002). In a national survey conducted by the Australian Institute of Health and Welfare 77% of respondents identified themselves as having one or more long term health condition (Australian Bureau of Statistics, 2009). In New Zealand the 2006/7 ‘Health of the Nation Survey’ revealed that 66% of adults had been diagnosed by a doctor with a long term health condition (Ministry of Health, 2008).

The burden upon secondary care to manage the complications of long term conditions has prompted increased calls for primary care to lead the way in early diagnosis, management and coordination of care for long term conditions. Definitive, evidence-based guidelines for the management and treatment of chronic disease have been produced by the New Zealand Guidelines Group (NZGG) to aid health practitioners to deliver consistent standards of care. Despite this there is a wide divergence in the delivery of primary care long term condition services across New Zealand.

The data for Tairawhiti, the area in which this research is set, demonstrates that there is a high prevalence of long term conditions and a need for good quality management. That this need has not been met by currently provided services in primary and secondary care is made clear by the continuing rise in presentations to secondary care with chronic illnesses. This is despite some excellent health care initiatives such as the Tane Ora programme, the Kaumatua programme, community cardio and pulmonary rehabilitation programmes, disease state management nurses, whanau ora nurses, Ngati and Healthy and HealthRight - all programmes for long term condition management shared between the Primary Health Organisations and General Practices.
The district of Tairawhiti consists of two Primary Health Organisations (PHOs); Turanganui Primary Health Organisation (TPHO) and Ngati Porou Hauora (NPH). TPHO encompasses a mainly urban area with 35% of the population living in deciles 9 and 10 on the deprivation scale (Statistics New Zealand Map – Appendix i). Māori make up 35% of the total population, in the PHO, and 58% of this group live in decile 9 and 10. These figures indicate that large numbers of both Māori and non-Māori live in deciles 9 and 10 and this is linked with poor health outcomes (Meetoo, 2008). NPH encompasses a mainly rural area with 13,000 registered patients of whom 76% are Māori. There are significant funding and organisational disparities between the two PHOs mainly in response to the geographical differences. Although the challenges of long term condition management delivery in NPH are of interest, Turanganui will be the focus of this research.

1.2 Background

The following sections aim to provide an overview of the strategies developed on a national and local level with regard to health, and more specifically long term conditions, and a brief discussion of the impact of economic inequality and social deprivation on morbidity and mortality. These concepts have an impact on long term condition management as they are major determinants of the structure of health related funding, service development and public uptake of health services.

1.2.1 New Zealand Health Strategy

The New Zealand Health Strategy identifies the Government’s priority areas and gives District Health Boards (DHBs) a framework in which to operate (A. King, 2000). King (2000) acknowledges that New Zealand has fallen behind other developed countries in terms of health status and that the gap between those with best and worst health has widened. To redress these issues the Strategy outlines various principles, objectives, service delivery areas and key issues that it wishes DHBs to focus upon.

* Decile is a statistical term meaning the division into ten parts. In New Zealand socio economic terms it refers to the division of the population into bands associated with material deprivation where 1 is least deprived and 10 is most deprived.
The 13 population health objectives are:

- reduce smoking
- improve nutrition
- reduce obesity
- increase the level of physical activity
- reduce the rate of suicides and suicide attempts
- minimise harm caused by alcohol and illicit and other drug use to both individuals and the community
- reduce the incidence and impact of cancer
- reduce the incidence and impact of cardiovascular disease
- reduce the incidence and impact of diabetes
- improve oral health
- reduce violence in interpersonal relationships, families, schools and communities
- improve the health status of people with severe mental illness
- ensure access to appropriate child health care services including well child and family health care and immunisation. (A. King, 2000)

Of these 13 objectives six are directly related to reducing the impact of long term conditions. This highlights the importance of effective long term condition management at a Governmental and consequently DHB level. King (2000) goes on to identify service areas for the health sector to concentrate upon, one of which is primary care. This emphasis on long term conditions and primary care provides General Practitioners (GPs) and primary care nurses with a huge responsibility to meet Government stated objectives.

Despite the worsening picture of New Zealand health painted in the New Zealand Health Strategy (A. King, 2000) there has been an overall decrease in age standardised mortality rates in New Zealand over the past 20 years (Ministry of Health, 2009a). However, long term conditions account for 80% of all preventable deaths and are the leading cause of hospitalisations (National Health Committee, 2007). This is
demonstrated by the rise in admissions to publicly funded hospitals which has increased by 7.9% from 2001/2 to 2006/7 (Ministry of Health, 2009b). Primary care consultation rates have increased across all groups from 2001/2 to 2004/5 with the largest increase, 24%, being seen in the over 65 age group (Cumming & Gribben, 2007). These data indicate that medical treatments are resulting in increased longevity but the incidence and impact of illness, especially chronic illness, is increasing with a resultant impact on health related spending, over stretched services, and whanau/caregiver strain.

In response to the rising costs of healthcare and a global recession, the New Zealand government appointed a Ministerial Review Group (MRG) to present recommendations as to how the quality and performance of the public health system could be improved (Horn, 2009). The report contained 170 recommendations a number of which pertained to structural changes to improve client access, quality and coordination of services as well as client safety and cost saving. Other recommendations involve development of clinical leadership by formation of national programmes and holding DHBs accountable for fostering primary and secondary coordination. The report also contains recommendations pertaining to improved Information Technology for safe transferable client information and suggestions about increasing accountability of PHOs (Horn, 2009). The structure of PHOs and primary care is discussed in the report with the recommendation to develop Integrated Family Health Centres that would include General Practitioners, nurses, allied health professionals and hospital specialists. If the government chooses to implement some or all of the recommendations there will be an impact on primary care delivery of long term condition services.

1.2.2 Primary Health Care Strategy

In 2001 the then Minister of Health released the Primary Health Care Strategy (A. King, 2001). The document had been developed after extensive consultation with professionals involved in primary care and heralded the development of PHOs. The newly envisioned PHOs were charged with the responsibility of being responsive to community needs and developing inclusive health care delivery strategies that fitted the population demographic enrolled with them (A. King, 2001). An important role for the
PHO was to reduce inequalities in health that existed particularly for Māori and Pacific people.

The Primary Health Care Strategy identified several specific areas in which the Minister expected to see development, one of which was an increase in multi-disciplinary collaborative working across primary care. The strategy noted that an increase in the complexity of health meant that new models of working must be embraced (A. King, 2001). This would mean doctors and nurses examining the role they play in primary health as well as including a wider range of disciplines in care delivery.

King (2001, pg. 19) notes that long term conditions “such as diabetes, respiratory and/or cardiac may occur in primary health care settings, but with significant input and support from secondary services”. To enable a close working relationship between primary and secondary care, as well as a defined standard of clinical governance, the Strategy suggests the use of evidence based guidelines and referrals guidelines to guide care and initiatives to improve primary/secondary collaboration. King (2001) suggests that these initiatives may take five to ten years to implement and require a considerable degree of flexibility and patience to determine local application.

The Primary Care Strategy (A. King, 2001) identified the increased role that nurses would play in the new primary care structure. To enable nurses to fulfil the philosophy of the Strategy the Expert Advisory Group on Primary Care Nursing (2003) presented a report to the Ministry of Health outlining a framework for developing the primary care nursing workforce. The group developed a number of recommendations for the Ministry of Health, DHBs and PHOs. Some of these recommendations, for example supporting primary care nurses to access post-graduate education by provision of scholarships and grants have been implemented. Other recommendations such as identifying the barriers to nurse practitioners entering the primary health care setting are still work in progress. Still other recommendations, for example ensuring DHBs have a clinical career pathway in primary care have not been implemented as yet.

* Primary care refers to health care delivered in the community by health professionals based in the community. Secondary care refers to health care delivered by hospital based health professionals.
1.2.3 Tairawhiti Strategic Health Plan

The Tairawhiti District Health Board (TDH) Strategic Health Plan (Tairawhiti District Health Board, 2005) describes the population and geographical make up of the region. It is isolated and sparsely populated with nearly 30% of the population living in a rural area. 46% of the population are Māori and of this number 78% live in the highest deciles of deprivation and have almost double the unemployment rate. In Tairawhiti the mortality for Māori is higher than the national average mortality for Māori. Both Māori and non-Māori have a higher than national average incidence of ambulatory sensitive admissions, admissions for diabetes, cardiovascular disease and rheumatic heart fever (Tairawhiti District Health Board, 2005). The Ministry of Health Mortality and Demographic Data reports that Tairawhiti has the highest age-standardised rate of death of any DHB in New Zealand at 562.8/100,000 (Ministry of Health, 2009a).

Tairawhiti is geographically isolated, has a relatively small population, has limited local amenities including a small selection of high schools and a medically complex population profile. This has resulted in poor recruitment and retention of medical and nursing staff. The recent addition of a Universal College of Learning (UCOL) nurse training course based at Gisborne has relieved the nursing shortage to an extent, although experienced nurses with post graduate training have not been in plentiful supply. The struggle to recruit and retain physicians in secondary care and General Practitioners in primary care is ongoing.

The TDH Strategic Plan goes on to state that “the bulk of our chronic diseases and cancers are preventable through changes in lifestyle factors and excellent access to quality primary care” (Tairawhiti District Health Board, 2005, pg. 23). Access to quality primary care remains a key factor in improving all health but especially long term condition prevention, detection and management. However, primary care has to be delivered and structured in such a way that it delivers care that is both evidence-based and culturally acceptable to Māori and non-Māori (Durie, 2003).
1.2.4 Māori Health Strategy (He Korowai Oranga) and The Treaty of Waitangi (Te Tirirti o Waitangi)

Māori are acknowledged as the indigenous population of New Zealand having colonised an uninhabited land from as early as the 13th Century (M. King, 2003; Metge, 1990). When European colonisation occurred in the 19th Century a treaty was signed between many of the diverse Māori tribes or Iwis and the Crown of Queen Victoria. This treaty, signed in 1840 at Waitangi, is viewed as a binding legal document that serves to uphold and protect the interests of Māori.

The Ministry of Health produced the Māori Health Strategy – He Korowai Oranga (A. King & Turia, 2002) which links The Treaty of Waitangi principles of Partnership, Participation and Protection with health care improvements. The principles are applied in practice to consulting Māori with regard to strategy development, involving Māori in decision making and delivery of health care and safeguarding Māori culture and values.

He Korowai Oranga literally means ‘the cloak of wellness’. The illustration of a beautiful, hand woven cloak serves to demonstrate the numerous strands of people and resources who must all work together to provide meaningful health services for Māori. Some of those key ‘strands’ are illustrated in the triangle overleaf. The ultimate goal of whanau ora – family health, is at the top and layers of community, Governmental and individual initiatives support it.

King and Turia (2002) point out that Māori, at all educational, occupational and income levels have poorer health than non-Māori. Reasons for this are complex but the strategy promotes Primary Health Organisations as being a major contributor to reducing inequalities for Māori and expects them to work with Iwi community organisations to enhance service delivery. Durie (2003) suggests that broad governmental health strategies with good intentions are not enough if they are not backed by sufficient funding, development of Māori health workers and employment of traditional Māori healing methods (Durie, 2003).
The Treaty of Waitangi, signed by a representative of the British Government and Māori chiefs in 1840, inferred to Māori that they would retain tribal authority and Māori Chiefs believed they would enter into an authority sharing partnership with the powerful Crown that would serve to protect their interests (State Services Commission, 2005). That their interests have not been protected is undeniably evident by the position that Māori hold within society today. The vision of partnership where each culture values the rights and ideals of the other has also been often lacking. Renowned New Zealand anthropologist Joan Metge makes a powerful statement on behalf of Māori living in New Zealand:

Members of our minority groups are expected to know about and be able to act in two cultures – their own and that of the dominant majority. Adhering to their own culture adversely effects their access to resources...Members of the majority group are typically monocultural, knowing very little about the cultures of minority groups, even Māori. Most are unaware how often their way of doing things offends or disadvantages others. (Metge, 1990, pg. 3)
Durie (2003) acknowledges the differences in cultures that exist in New Zealand and highlights the importance of the use of appropriate language, culturally validated assessment protocols and outcome measures along with respect for custom in successful delivery of health care services for Māori.

Te Whare Tapa Whā model described originally by Durie in 1985 (Durie, 1994) has been widely used to express the thinking of many Māori towards well being. This model acknowledges, of equal importance, the facets of; taha wairua – spiritual health, taha tinana – physical health, taha whanau – family health and taha hinengaro – mental health. Te Whare, the house, represents this model and has often been represented as a traditional Māori meeting house as below.

*Figure 2: Te Whare Tapa Whā*
Source: [www.teiho.org/MaoriHealthPerspectives/TirohangaMaoriByMasonDurie](http://www.teiho.org/MaoriHealthPerspectives/TirohangaMaoriByMasonDurie)

These four principles have been contextualised within the added concepts of te whenua – the land we belong to, te reo – language, te ao turoa – environment, and whanaungatanga – extended family (Cram, Smith, & Johnstone, 2003).

Durie (1994, pg. 74) continues to explain that three main issues have caused Māori widespread concern:
1. Physical, biological and technical advances in medicine do not replace holistic care.
2. Māori felt alienated from health professionals, not because of lack of access or poor care, but through “lack of shared decision making and limited recognition of Māori views”.
3. Good health cannot be gauged through measurements such as weight or blood pressure. Spiritual and emotional factors are of equal importance though difficult to measure.

As the majority of healthcare in New Zealand is based on Western bio-medical models of delivery it is clear that incongruence for many Māori will exist between the way they would choose to be treated and the reality of their treatment.

1.2.5 Income inequality and socio-economic deprivation

In recent years much importance has been placed upon the role of health service delivery and individual lifestyle choices as determinants of health. Whilst it is undeniable that smoking, obesity, alcohol use and lack of exercise are risk factors for development of many chronic diseases it is naïve to ignore the wider determinants of health. Rene Dubos (1901 - 1982) the French born microbiologist, pathologist and environmentalist commented about the dramatic increase in life expectancy in the 19th century:

No medical discovery made during recent decades can compare in practical importance with the introduction of social and economic decency in the life of the average man. The greatest advances in the health of the people were probably the indirect results of better housing and working conditions, the general availability of soap, of linen for underclothing, of glass for windows and the humanitarian concerns for higher living standards.

(Public Health Advisory Committee, 2004. pg. 6)

The Public Health Advisory Committee (2004) advises a whole government, public policy, approach to make meaningful improvements to the health of the nation. This approach would firstly acknowledge and secondly tackle the wider determinants of
health such as housing, education, employment and other environmental factors. The model below demonstrates the variety of influences on health of which only age, sex and hereditary factors are unable to be affected by either individual or societal change.

Figure 3: Model of the social and economic determinants of health
Source: (Dahlgren & Whitehead, 1991)

As has been previously stated a large proportion of the population in Turanganui live in deciles 9 and 10 which are described as having the highest rating of socioeconomic deprivation in New Zealand (White, Gunstan, Salmond, Atkinson, & Crampton, 2008). Measurements of socioeconomic deprivation are complex and ever changing. White et al (2008) who are the authors of the 2006 New Zealand Atlas of Deprivation, use nine variables that are statistically weighted to give an overall score of deprivation. The categories are; income (receiving benefit and total household income), employment, home ownership, living space, qualifications, support, communication and transport. These factors are considered to give an overall scale of material deprivation that is related to access to productivity and control of resources (White, et al., 2008). The graph overleaf represents Gisborne, of which Turanganui is a part, and demonstrates the distribution of the population in each decile.
The links between socioeconomic deprivation and poor health outcomes are clear. (Barnett & Lauer, 2003; Mooney & Fuhtong, 2008; Public Health Advisory Committee, 2004; White, et al., 2008). The issues influencing poor health and premature mortality are varied and include increased violence in unequal societies, increased infant mortality from low immunisation uptake and damp and overcrowded housing leading to increased risk of infectious diseases (Mooney & Fuhtong, 2008; Public Health Advisory Committee, 2004). In addition to this the psychological stress and reduced opportunities that arise from living in poverty or material deprivation increases the prevalence of smoking, physical inactivity and poor diet (Kreindler, 2009).

Knowledge of this information adds to the responsibilities of health professionals in areas such as Tairawhiti to consider the health of clients within the wider context of social and economic determinants of health. Whilst this research has not been designed to specifically investigate this matter it will be interesting to note if it is an issue acknowledged by the participants.
1.3 Research Question

The aim of all involved in primary care should be to provide long term condition management that is evidence-based and culturally acceptable. Attempts to find the best way to accomplish this, however, gives rise to many questions. What is the key to successful long term condition management? How can nurses be at the forefront of this? What do the central stakeholders in the planning, funding and delivery of primary care believe to be the solutions? How can we, health care providers, ensure that the needs of all, Māori and non-Māori, are included in our delivery strategies? This research was undertaken to find answers to those questions. While it is primarily relevant for Turanganui, it has wider application to other areas facing similar long term condition issues. The research question is:

What are health professionals’ perspectives on the management of long term conditions in the Turanganui area?

1.4 Purpose of the research

Medicine and nursing are professions that never remain static; they evolve and grow according to the development of new technologies, the acquisition of new knowledge, or in response to changing needs of the population. To enable nursing to evolve there is a need to reflect on current practice and critically analyse ways to move forward. It is hoped that this research can lead to relevant stakeholders in Tairawhiti using the data as a means of critically examining the current level of primary care long term condition management and reflecting on the participants suggestions for ways to move forward.

This research could contribute to the development of a strategic framework to manage long term conditions in Tairawhiti. The development of a strategic plan for long term conditions is part of the recommendations from the National Health Committee of New Zealand (National Health Committee, 2007).

This study sets out to encourage other nurses considering carrying out research to believe that it is a process in which they can also engage. The final aim of the study is a
personal desire to grow professionally as a result of the research process and reflection on the data collected.

1.5 Aims of the Research

Setting aims for the study enables the researcher to limit the topic to a manageable but still meaningful level. To this end, the research has the following three aims:

1. To describe nurse perspectives on long term condition management.
2. To describe General Practitioner perspectives on long term condition management.
3. To identify barriers to future change in the delivery of long term condition services.

1.6 Significance of the research

Little has been published about the specific issues faced by primary care practitioners in Turanganui on the subject of chronic illness. A multitude of initiatives designed for primary care has been developed in the area, some continue but many have since been abandoned. There is a need to discover what makes a successful initiative by consulting with the people involved in the delivery of services and those responsible for planning and funding the services. This research aims to accomplish that objective.

There is a burgeoning volume of research taking place about long term medical conditions in New Zealand at the current time, much of it having a broad national focus. This research will add local depth to an existing body of literature and as such will be a valuable resource to clinicians and planning and funding teams in service delivery and development.
1.7 Overview of the Thesis

Chapter One: Introduction
This chapter introduces the purpose, aims and significance of the research as well as the research question. It has also provided a geographical, economic and social background to the area involved in the research. In addition information has been provided on relevant New Zealand Health strategies and Te Tiriti o Waitangi.

Chapter Two: Review of Literature
This chapter comprises a review of literature on the subject of long term ill health condition management. A variety of terms were used to search for literature including; chronic conditions, long term conditions, primary care, nurse led and others. The aim of the literature review is to present current research in relevant areas which can then be utilised in the development of this study and the analysis of data gathered.

Chapter Three: Research Design
Chapter three comprises a theoretical discussion of research design with a justification for the design chosen in this study. A consideration of the background to quantitative and qualitative research aids understanding of the approach used in the research.

Chapter Four: Research Methodology
This chapter presents details of the research methodology used in the study including; participant selection, data collection method, and ethical considerations. A justification of the data analysis method, general inductive analysis (Thomas, 2006) is included.

Chapter Five: Results and Discussion
In this chapter the five main themes revealed in the analysis of the data are discussed: management issues, information, leadership, client centred care and power. Using Sandelowski’s (2000) qualitative descriptive approach the voices of the participants are allowed to tell their own story.

Chapter Six: Conclusion
Finally, the researcher’s suggestions for the application of the data are presented along with implications for nursing practice. and a proposal for a future research project.
CHAPTER 2 – REVIEW OF LITERATURE

2.1 Introduction

Defining long term health conditions can be a challenge due to the variety of terminology used in this field that include, chronic illness, chronic disease, and chronic conditions. Chronic conditions have been described as “health problems that require ongoing management over a period of years or decades” (World Health Organisation, 2002. pg. 11). O’Hallaron, Miller and Britt (2004) reviewed the literature to examine characteristics of long term conditions and followed this with a systems analysis of these characteristics to determine their significance. They found that the characteristics for defining long term conditions were duration of at least six months, reoccurrence or deterioration, poor prognosis, and significant sequelae (O'Hallaron, Miller, & Britt, 2004). These definitions encompass a vast array of health and disability related issues and are not all necessarily relevant to a discussion on primary care long term conditions management. A report from the National Health Committee (National Health Committee, 2007) on long term conditions reports that the most common conditions in New Zealand are, neck or back problems, mental illness, asthma, arthritis and heart disease. However, the Ministry of Health (A. King, 2000) has placed emphasis on long term conditions that are the leading causes of mortality and health care spending. These include cancer, cardiovascular disease (including stroke and ischaemic heart disease), chronic respiratory disease and diabetes (Meetoo, 2008).

To find the most relevant data on the subject of nurse involvement in long term condition management, searches were conducted in the following databases; CINAHL, ProQuest, Medline, Cochrane Collaboration, and MDConsult, as well as individual journal databases for the New Zealand Medical Journal, British Medical Journal and Nursing Praxis. The internet was also searched for policy statements from government groups around the world. The key words used to search were: long term conditions; chronic disease and/or management; chronic illness; chronic conditions; models of chronic disease; Māori health; primary care; general practitioner; practice nurse; nurse practitioner and nurse-led. Literature was also drawn from the references in relevant
articles. Data that featured secondary care initiatives, shared care, paediatric care, mental health, substance abuse and population based initiatives were excluded. 150 articles discussing relevant aspects of nurse involvement in chronic disease management were identified and they were reviewed to reveal the main themes and specific results from each study.

The study design included experimental, quasi experimental, longitudinal, observational and various qualitative methodologies. When analysing the validity of any research the reader needs to be capable of determining if the study design employed was suitable for the subject under investigation (Dodd, 2008). Therefore, as well as giving an overview of the research conclusions there is an analysis of the soundness of the research process, as far as it is possible to determine from the information given in each case.

Recent studies from both quantitative and qualitative perspectives will be examined alongside established long term condition models, as well as comparison to Māori health models, to provide a platform for the research study. These will offer insights into primary care long term condition management, the involvement of nursing, and future direction for service delivery. The following sections cover a selection of the most relevant research studies or respected commentaries on long term condition management. They have been presented under the following headings:

Models of Long Term Condition Management. Under this heading are the most influential national and international models that have been used in recent years to inform service design and delivery in the field of long term conditions. Following this research studies investigating the practical application of these models are examined.

Long Term Condition Management in Primary Care. This section encompasses views on the delivery and design of long term condition services in primary care.

Māori Health Research. In this section is research that specifically targets Māori experiences of long term condition management or the application of generic models to Māori populations.
Primary Care Nursing. Presented here is literature that reviews the position of nursing within primary care, the skills and attributes that nurses possess and how that relates to long term conditions, followed by research studies examining the role of nurses in primary care within the field of long term condition management.

Barriers to Change. This section encompasses research studies that present some of the difficulties encountered when implementing long term condition models. Some studies attempt to quantify why the barriers exist and present solutions with varying degrees of success.

2.2 Models of Long Term Condition Management

Wagner (1998, cited in Wagner et al., 2005) is responsible for the most influential model of long term condition management. After conducting a review of chronic illness interventions, which was validated by a Cochrane Collaboration, Wagner developed a model called the Chronic Care Model consisting of six primary areas that led to improvement in patient outcomes. These are patient self-management, delivery system redesign, provider decision support, clinical information systems, effective health system leadership and linkages to community resources. A more recent article (Coleman, Austin, Brach, & Wagner, 2009) reports that the model has been widely adopted by national and international groups responsible for quality improvements and validated by numerous trials and studies. There is no doubt that the literature strongly supports Wagner’s model and many of the six areas can be identified as themes from quantitative and qualitative research undertaken over the past ten years.

The WHO (2002) ‘Innovative Care for Chronic Conditions’ report suggests eight essential elements to improve care, based on extensive literature review. They are: support a paradigm shift; manage the political environment; build integrated health care; align sectoral policies for health; use healthcare personnel more effectively; centre care on the patient and family; support patients in their communities; and emphasise prevention. There are similarities between these two models and none more so than at the starting point for development of a model, which is necessary for a complete paradigm shift in delivery of healthcare. The starting point for both models is the acknowledgement that healthcare planning, funding, and system of delivery have been
developed to manage acute illness, infectious disease and injury, by medical practitioners who dictated treatment (World Health Organisation, 2002). As already stated long term conditions now absorb the majority of healthcare resources and time and these cannot successfully be managed with existing acute focused strategies.

The National Health Committee’s (NHC) 2007 report on managing long term conditions acknowledges the need to use a chronic care model to organise the elements needed for successful change but also recommends a disease management programme consisting of three levels, self-management, care management and care coordination. The committee advises that each area develops a framework to manage long term conditions. The NHC acknowledges that work is being carried out in many District Health Boards (DHB) and PHOs, but that this is fragmented and recommends national action to coordinate chronic care model implementation and manage workforce and information system issues.

2.2.1 Implementing Long Term Condition Models

A variety of evidence exists around the value of disease specific or general chronic disease interventions. Renders et al. (2000) conducted a review of research studies involving interventions to improve diabetes care in primary, outpatient and community settings (Renders, et al., 2000). Organisational level interventions such as computerised patient tracking systems were seen to improve process outcomes but few studies related these changes to patient outcomes. In examining the findings relating to revision of professional roles the review concluded that nurse replacement of physician resulted in a positive impact on glycaemic control. However, many of the studies reviewed had short follow up durations which limited their usefulness. There were also problems with variations in the methods and reference values used to assess blood glucose levels which could affect the conclusions drawn in relation to glycaemic control. Many of the studies were conducted in North America and this does have implications on generalising the results for New Zealand due to differences in healthcare structure.

In Australia a systematic review of a variety of quantitative studies investigating primary care chronic disease management was undertaken (Dennis, et al., 2008). The purpose was to inform policy development. The review was based on the principles of the
Chronic Care Model and discussed findings for each of the six areas identified by Wagner *(1998).

Dennis et al. (2008) found that studies researching patient self-management programmes reported them to be effective in improving process outcomes and patient outcomes. No comment was made on whether these self-management programmes had been studied in indigenous people. It was felt that the education of the health professional directing the self-management programme was an important factor in its success.

Delivery system design studies focused on increased use of the multi-disciplinary team, in particular practice nurses (Dennis, et al., 2008). The results showed positive effects on provider behaviour and some patient outcomes in selected disease groups. The authors highlighted that in the current Australian primary care system funding was a key issue in the increased employment of practice nurse and other team members and this had been aided by government initiatives. This issue would be applicable in New Zealand as current funding for General Practitioners does not reimburse many practice nurse consultations. Dennis et al. (2008) discussed the subject of the variation in levels of post graduate training of practice nurses. A study from the UK also investigated this issue, the results showed little correlation between the level of practice nurse involvement in chronic disease management and level of post graduate training (Baird, 2003). It must be acknowledged that Baird’s (2003) study was weak methodologically and had made no formal statistical analysis of the findings. It should therefore be treated cautiously. A New Zealand study (Hoare, Steele, Ram, & Arroll, 2008) to determine practice nurse use of evidence-based guidelines found that over half of the nurses who responded to the survey did not use any guidelines and a third had never heard of the NZGG. This study was well designed and had a validated questionnaire, large sample size and a good return rate. There was no data collected on age, experience or post graduate education to determine if these factors influenced the use of clinical guidelines, but completion of formal training would greatly increase the likelihood of knowledge of evidence-based guidelines.

* For an overview of Wagner’s Model see pg. 16
Decision support tools such as evidence-based guidelines have been hailed as a valuable resource although use of them has been varied with reasons including: lack of awareness; lack of familiarity; lack of agreement; low expectancy of favourable outcomes and perceived external uncontrollable barriers (Grol & Wensing, 2004).

Dennis et al (2008) go on to report studies on clinical information systems. Improvements in data systems were found to be helpful to increase clinician compliance with evidence-based guidelines and had some impact on patient outcomes. Interestingly, the education level of health professionals alone did not improve patient outcomes but good databases for audit, call and recall, and clinical decision software combined with education were beneficial (Dennis, et al., 2008). Health professional education to improve patient self-management in chronic disease care was the subject of a UK study by Russell, Thille, Hogg, and Lemelin (2008). A randomised controlled trial was conducted with the intervention group being given patient centred consultations, a written information booklet, self-management action plans and open access to specialist physicians. The physicians had been trained in patient centred communication and self management techniques but surprisingly no improvement to patient satisfaction or quality of life scores was found in the intervention group. A further qualitative study to interview the physicians and participants revealed that the training had made little difference to the way the physicians conducted the consultations or how they felt about patient involvement in chronic disease management (Russell, Thille, Hogg, & Lemelin, 2008). Therefore, any local initiatives to alter chronic disease services would be reliant on the individual application of the health professionals involved and this would impact on research outcomes also.

The relationship of clinical information systems to improved patient outcomes is of particular interest to this study, as the gathering, ownership and sharing of data around chronic disease is a subject to which no local solutions have been found. Each practice maintains as much or little in the way of disease registers as it decides and there is strong feeling against databases that contain DHB level information on patients. There is also little ability for information to be shared between primary and secondary care. The evidence suggests that screening, call and recall, as well as audit and benchmarking aid in delivery of high quality clinical care, so there are indications that
Tairawhiti must find a solution to the current problems with software compatibility and ownership of data.

In the areas of community support and health care organisation Dennis et al. (2008) report little research has been generated. This is a huge gap in the literature as without changes to health care funding and structure it is hard to innovate or maintain quality care improvements (Coleman, et al., 2009). Community involvement in long term conditions can refer to the individuals family/whanau, extended support networks, and community based programmes or initiatives. This group of activities is important for Māori who relate health to the broader concept of whanau and for whom Māori health workers and programmes are often more acceptable (Durie, 2003; Ellison-Loschmann & Pearce, 2006; McPherson, Harwood, & McNaughton, 2003).

The application of chronic care models on a local level appears to have been less successful than implementation on national levels. Many of the aspects of a chronic care model involve high level system changes and without national strategic changes to accommodate this there is the risk that the model becomes another layer on the top of existing structures. There was little research that sought the opinions of planning and funding personnel, but these are the very people deciding the strategic direction for a locality.

### 2.3 Long Term Condition Management in Primary Care

Primary Care is globally viewed as the hub for management of long term conditions (May, Montori, & Mair, 2009; Mohammed, Philip, Richard, & Brenda, 2007; Russell, et al., 2008; Wellingham, Tracey, Rea, & Gribben, 2003). As discussed previously Primary Care was originally designed to meet the needs of acute presentations with illnesses or injuries that could be “cured”. This model has resulted in a system featuring short consultation times with an emphasis on diagnosis and normalisation of aberrant physiological measures (Cumbie, Conley, & Burman, 2004). With the increasing complexity of patients and a wide range of treatments this model will no longer fulfil the needs of the majority who present to Primary Care.
The landscape of Primary Care in New Zealand has changed frequently over the preceding decades resulting from a series of governmental funding changes and initiatives. The fee for service system was officially replaced by capitation funding in 2001 but, in reality, access to funding is a complicated process and is often task or fee for service based (Pullon, 2008). The single handed General Practitioner model has evolved into larger practices housing a number of General Practitioners, many of whom maintain separate patient lists and act for all intents and purposes as single handed General Practitioners who share a building and out of hours cover with other single handed General Practitioners.

Independent Practitioner Associations (IPAs) were formed and served to act as business support agencies for General Practitioners. These were then replaced by Primary Health Organisations (PHOs) after the release of the 2001 New Zealand Primary Health Strategy (Docherty, Sheridan, & Kenealy, 2008). The intention was for greater involvement in the governance of PHOs by a range of primary care health professionals with the hope that this would result in increased clinician involvement in planning and funding decision making (Ministry of Health, 2001). However, this has proven unsuccessful in several ways. Whilst some GPs have appeared on the Boards of PHOs there has been little or no practice nurse representation (Docherty, et al., 2008). Board representation has also proven to be too far removed from the real decision making to have much influence on planning service delivery.

General Practitioners have always viewed themselves as holistic practitioners, developing a lifelong relationship with clients and whole whanau (Pullon, 2008). However, primary care has come to involve more than merely individual acute or ongoing management. It has come to involve preventative care, health education and population health initiatives and this has resulted in the need for General Practitioners to include a team approach to care delivery (Pullon, 2008). The development of the practice nurse role within general practice has been haphazard and largely dependant on the employing GP rather than a national framework (Docherty, et al., 2008).
2.3.1 Primary Care Nursing

Nurses are in an ideal position to be involved in and even to lead primary care initiatives for long term condition management. There is a growing acknowledgement that medical interventions for chronic illness make up a small part of successful treatment, whilst the key to good clinical outcomes is related to a knowledgeable, empowered patient (Wagner, et al., 2005). Nursing is inextricably linked to caring and holism (Bowden, 1997; Cumbie, et al., 2004; Edwards, 2001) and has at its core the ability to translate the nursing process, a scientific method of assessment, problem identification, goal setting, implementation and evaluation, to a holistic, therapeutic relationship (Arnold & Boggs, 1995; Walsh, 1991, 1997).

Whilst the ability to form caring relationships with patients is not unique to nursing it is certainly the only profession that has care as one of its central tenets combined with independence and individual choice (Bowden, 1997; Cumbie, et al., 2004). Early nursing theorists such as Henderson (1966, cited in Walsh, 1997, pg. 4) recognise that an essential part of nursing is to "improve the patient's level of understanding and, by doing so, improve the patient’s health".

In primary care in the United States advanced practice nurses are often employed for their advanced clinical competencies alongside an ability to build therapeutic relationship, deliver professional leadership and possession of an evidence based approach (Cumbie, et al., 2004). In the UK practice nurses have for many years received increased training to take on the management and coordination of the majority of long term condition care (Branson & Badger, 2008). This has been credited to a change in GP contracting, where financial incentives were offered for employing practice nurses (Patterson, Muenchberger, & Kendall, 2007).

A similar situation in Australia and New Zealand has been slower to evolve. Despite the Practice Nurse Subsidy Scheme introduced in 1974, where GPs were remunerated to employ a nurse to act as an assistant, little structure was put around developing that workforce, monitoring it or linking it to patient needs (Docherty, et al., 2008). Practice nursing has been seen as a refuge for older nurses or those seeking office hours and this combined with practice nurses often taking on reception duties has tended to give
the profession a perception of low status (Gibson & Heartfield, 2005). General Practitioners are the employers of practice nurses and as such they have often utilised their services from the basis of perceived business need rather than for their clinical skills.

Secondary care has often been the environment where nurses have been able to develop an advanced role in long term condition management but this has led to specialisation of health services and ultimately fragmented care where the specialist nurse may focus on a specific disease instead of on the individual, which can lead to clients disengaging (Chang & Johnson, 2008). Strengthening the nursing role in primary care long term condition management appears to make sense if the nurse is viewed as an educator and health promoter who has the ability to make long term relationships with patients, encourage self-management and apply mentoring, coaching and motivating strategies (Cumbie, et al., 2004; Hayes & Kalmakis, 2007; Redman, 2005).

### 2.3.2 Advanced Practice Nursing in Primary Care

One of the purposes of this research is to discover health professional's views on the development of the primary care nursing workforce to deliver long term condition management. The involvement of nurses in managing chronic health problems has been well established in other countries and some areas of New Zealand. The research suggests that, due to the fact that General Practitioners are business owners and the employers of most primary care nurses, the implementation of advanced nursing roles has been varied and highly individualistic (Pullon, 2008).

A Cochrane review (Laurant, et al., 2004) examined 16 studies, all before and after, randomised or quasi – randomised controlled trials, researching the replacement of doctors with nurses in primary care. The nursing roles varied in the studies and included first consultations and follow up with all patients, urgent consultations, out of hours consultations, and chronic disease management. In all cases the control group was doctors providing the same service. Studies looking at the first three areas found very little difference in costs, process, patient outcomes or satisfaction between the two groups. However, in the studies looking at chronic disease management, statistically significant improvements were found in the patient satisfaction and patient knowledge
components in the nurse led groups, although the number of studies involved was small and all had methodological problems including a lack of ability to confer statistical significance. This data is useful as it suggests that nurses can take on doctors' roles safely in many areas with little or no compromise in patient outcomes and, in fact, can impact positively on patient outcomes in chronic disease management. The studies reviewed came from Canada, the United States of America and the United Kingdom which raises further questions as to their ability to be generalised to the New Zealand health system. There is no data on the level of nurse education or support from colleagues but these would be important factors in the safety and success of nurse led services. It is worth noting that under research conditions the normal working practice of the nurses may have been altered to fit the study design and this impacts on the generalisability of the results (Iliffe, 2000).

There has been a growing attempt in Australia to increase the role of practice nurses and several research studies have been undertaken to examine the benefits and barriers to practice nurse role extension. One study (Halcomb, Davidson, Griffiths, & Daly, 2008) used a postal questionnaire to survey practice nurse opinion on the subject of nurse involvement in cardiovascular disease management. The survey tool was self designed by the researchers and sent to a convenience sample of practice nurses with a random sample of returned questionnaires being selected for follow up telephone interview. The barriers to an extended nurse role were seen to be: concern over legal implications; lack of physical consulting space; role limitations from poor remuneration; education and workload and General Practitioner attitudes. Some facilitating factors were identified the most significant of which was General Practitioner collaboration, followed by access to education and performing primary care nursing to the benefit of the community. These data indicate that the General Practitioner/nurse relationship is viewed as being the most valuable asset or deficit in providing chronic disease services by nurses (Halcomb, et al., 2008). This is important to the research undertaken here as it indicates that the opinions expressed will vary according to the characteristics of the general practice. However, Halcomb et al.'s (2008) study used a survey tool that was not validated and the selection process was not random which could have lead to response bias or area bias. The authors felt that the returned questionnaires were from a diverse location and background of nurses and therefore they were representative of Australian practice nurses.
A UK study (A. Wilson, Pearson, & Hassey, 2002) looked at the barriers to advanced nursing practice in primary care by interviewing General Practitioners in focus groups. A structured framework was used in the focus groups and analysis of the content was carried out separately by two assessors. Inter-rater reliability was excellent. The General Practitioners expressed concern over loss of role, particularly around the nurse having all the straightforward patients and leaving the General Practitioners with the very complex patients. The threat to role also entailed the General Practitioners questioning the value of their own training if nurses were capable of doing their job. The subject of nurse training and skills elicited strong opinions from the General Practitioners who were concerned about their own accountability for the nurses’ actions. Some had a lack of confidence in nurse training or intelligence, but most were in agreement that trust could be developed in advanced practice nurses. One practice had a nurse practitioner working in it and expressed satisfaction with the role but the study revealed difficulties for nurses in accessing training, funding and role development. The consensus was that these issues needed to be handled at a Health Authority level. On the subject of system barriers the General Practitioners uniformly identified finances as being the biggest problem. Practices were not funded for the additional salary of a nurse practitioner and doctors were reluctant to share the practice profits with nurses. The General Practitioners held strong views that in the majority of cases patient preference would be to see a doctor rather than a nurse.

This study (A. Wilson, et al., 2002) found little discordance in the doctors’ views except for the practice that had a nurse practitioner working with them. The practices involved were all large training practices and this could have influenced the opinions expressed as they would be more likely to have good collegial support and may therefore have less need of advanced nursing roles to support their practice management. However, the consensus of the views expressed does suggest that the findings could be generalised to other General Practices of similar size and the issues raised are all ones currently facing the New Zealand primary health system.

An interesting four year study carried out in the UK by Branson and Badger (2008) examined patient, professional and management perspectives on community nurses roles. They started with focus groups and interviews, the results of which were used to
formulate a questionnaire, which was sent to 278 primary care professionals in the area, and a group of patients randomly sampled from General Practice lists. 28% of patients responded giving a sample size of 241. Data analysis was of highly replicable standard. There was strong consensus from all groups on the need for expanding the practice nurse role, but other community nurses including nurse practitioners, were hardly mentioned. Managers mentioned their satisfaction with practice nurses as an integral part of the team who were able to offer more cost-effective chronic disease management.

There were some differences in the tasks that patients and General Practitioners were comfortable to have delegated to nurses. Patients were happier to have minor ailments and repeat prescribing delegated to nurses but less keen for chronic disease care, particularly cardiovascular disease management as this was seen as ‘life threatening’. Most General Practitioners had already delegated chronic disease management to nurses but were more reluctant to hand over repeat prescribing as it was not seen to be a nurse role (Branson & Badger, 2008).

These differences in opinion are very interesting and serve to highlight the trust that patients have in their primary care physician and the level of importance chronic illness treatment has in their minds. Patients do not see long term condition management as a task that can be handed off to any member of the team when it is seen as cost-effective to do so, to replace doctors’ time with nurse time. It is an issue of paramount concern to patients and needs to be handled by the most appropriate, skilled member of the team. With appropriate training that team member can be the nurse but it cannot be assumed that all practice nurses are capable of delivering long term condition care just because they are employed in General Practice. Branson and Badger (2008) also found that whilst patients appreciated the longer consultation times with nurses they did not agree that it was easier to talk to nurses and revealed that a lack of continuity in nursing staff made the General Practitioner relationship more valuable. This again points to the paramount importance of the relationship people make with their health care provider.

Several reports on pilots of integrated nurse teams in long term condition management from Canada, Australia and the USA, showed significant improvements in patient outcomes and satisfaction (Grimmer-Somers, Dolejs, Atkinson, & Worley, 2008; Litaker,
et al., 2003; Senior, MacNair, & Jindal, 2008). The most commonly expressed problems were around system issues and funding for treatment.

A valuable New Zealand study in 2006 was conducted by nurse researchers at Massey University (Carryer, Snell, Perry, Hunt, & Blake, 2008). This study used qualitative methodology and inductive, thematic analysis, to analyse data from semi-structured interviews with 32 participants. The participants were a sub-sample of a larger cohort of respondents to a survey on primary care nursing and long term condition management. The 32 were purposively chosen to represent a variety of ethnicities and disease conditions. Three main themes arose from the interviews: “patients’ desire for personal connection and guidance; General Practice as an accessible but reactive service; and limited awareness of the nurse’s role in general practice settings” (Carryer et al., 2008, pg. 320). The data described patients as consistently identifying a need for nursing type services but never recognising that nurses could deliver those services. The participants described the General Practitioner consultation as rushed and felt that it often lacked comprehensiveness and an acknowledgement of the connection between their condition and the rest of their lives. They also identified nurses as being exceptionally busy but often connected this to carrying out General Practitioner directions and reception work, rather than linking it to service delivery.

Carryer et al. (2008) discussed the potential of practice nurses to deliver long term condition management services that promoted patient self-efficacy and modelled a partnership approach. However, they acknowledged that the practice nurse employer, usually a General Practitioner, determined the contribution of the nurse to the practice, which was normally bound by a medical model approach to service delivery. The researchers highlight other issues that limit practice nurse development. These include: devolvement of traditional nursing tasks; access to post graduate education; increased professional development; reorientation of primary care services to a multi-discipline approach; and altering public perception of practice nursing.

Carryer et al.’s (2008) study does have some limitations, particularly in application to the Tairawhiti/Turanganui region. Only four Māori were included in the study. This would lead to an inaccurate representation of the needs of an area such as Tairawhiti as the views expressed would be overwhelmingly non-Māori. The research also lacked
input from General Practitioners and practice nurses themselves as to the perceived barriers to long term condition management and practice nurse involvement in this.

Research in Tairawhiti therefore, needs to canvas the opinions of health professionals on the role of nurses in primary care to evaluate to what extent primary care nursing is currently utilised in long term condition management and whether it is seen as a valuable resource in delivering improved patient care.

2.4 Māori Health Research

As discussed earlier the Māori perspective on long term condition management is essential for any project in New Zealand and of even greater importance in Tairawhiti due to the high percentage of the population that identifies themselves as being of Māori descent. A 2006 study (Sanson-Fisher, Campbell, Perkins, Blunden, & Davis, 2006), commented that the amount of research that exists on a subject can be used as a simple measure to judge the impact of that subject on health policy and health outcomes. The study went on to examine the number and nature of research publications on indigenous people’s health including Māori. A variety of literature types was included by the authors such as: research; reviews; programme descriptors; case reports and discussion papers. In the period between 2001 and 2003 only 32 pieces of literature regarding Māori health were found and of these 27 (84%) were descriptive. This was a reduction in literature produced from previous years. These data reflect the dearth of good quality research around Māori health which could reflect a lack of impact on health policy and health outcomes for Māori (Sanson-Fisher, et al., 2006).

Research that examines disparities in health between Māori and non-Māori often focuses on long term conditions. A 2007 study (Riddell, Jackson, Wells, Broad, & Banninck, 2007) used a software package to gather data from a large primary health population and analyse the level of cardiovascular disease (CVD) care given to Māori and non-Māori. The data showed that although Māori were more likely to be smokers, have diabetes or a family history of CVD, factors that increase their CVD risk, they were also more likely to be receiving and taking guideline recommended pharmacotherapy. This resulted in comparable blood pressure and cholesterol profiles between Māori and
non-Māori. However, less than half of all patients with high CVD risk were receiving management advice and guideline recommended pharmacotherapy. The most disturbing data were around revascularisation rates. Māori were found to have approximately half the revascularisation rate of non-Māori. The lack of risk management advice may be a reflection on the General Practitioner consultation style, which tends to be less educational and more problem focused, or it could simply reflect lack of time to document advice and discussion that took place at the consultation. It may be beneficial to interview General Practitioners, to determine the importance they place on giving risk management advice and the time they have to accomplish it. The data around revascularisation procedures is less easily explained but includes the following issues: racism of health professionals; disease severity at presentation; transport to appointments; scheduling of appointments; and lack of trust and engagement (Harris, et al., 2006; Jansen, Bacal, & Crengle, 2008; D. Wilson, 2008).

For Māori the reasons behind the high prevalence of long term conditions go beyond biomedical risk factors. Harris et al. (2006) carried out a well designed survey to ascertain if a link between racism and deprivation to poor health could be found. The large scale survey found that Māori were significantly more likely to experience racial discrimination in all circumstances and in the specific instance of choosing housing they were 13 times more likely. Housing is an important determinant of health, consequently discrimination when choosing housing could result in Māori having unhealthy homes and poor health outcomes. The study concluded that racism and deprivation were inextricably linked to poor health. As the data was self-reported there is accuracy and suggestion bias which the authors felt would lead to under reporting of racism.

A qualitative study by D. Wilson (D. Wilson, 2008) used semi-structured interviews to develop grounded theory regarding a Māori centred approach to health. Wilson interviewed 38 Māori women to elicit their views on health and wellbeing and their experiences in accessing mainstream services. The women were purposefully selected by a network approach and the research aimed to be beneficial to Māori. Amongst the experiences revealed by the research were the important themes of victim blaming, inappropriate services and cultural competence of health professionals. The syndrome of victim blaming is alarmingly widespread in the domain of health. It becomes easier to look for a deficit in the patient, when treatment or outcomes are not as successful as
desired, than to find alternatives. The women interviewed felt that the services provided were a ‘one size fits all’ approach that did not address the actual issues affecting them. Wilson commented:

Continued access and use of health services is dependent upon, and optimized by the development of effective relationships with nurses and other health care providers – a powerful indicator of the nature of future access and use of health services. (D. Wilson, 2008, pg. 180)

Whilst this study is not generalisable to all Māori, as those from other geographical locations may have divergent views on and experiences of health care, it is a valuable piece of research for nurses. It encourages nurses to be reflexive, culturally competent practitioners who are constantly working to build therapeutic relationships with patients and seek culturally acceptable health care solutions.

A similar study conducted in 2003 by Cram et al. used semi-structured interviews and a Kaupapa Māori approach to thematically analyse the data gathered. The 28 participants were recruited from local marae-based health programmes as they had been exposed to mainstream and Māori health services. Some themes that emerged were around the complexities of separating the root causes of poor health from individual, whanau and societal difficulties. Many felt that the decline of the whanau was connected to poor health outcomes. When discussing their encounters with mainstream services many participants expressed suspicion of treatment outcomes due to bad experiences of whanau and felt this would stop them from accessing services when needed. However, the participants strongly linked rapport with their health provider as a determinant of their interaction successes (Cram, et al., 2003). The age range of Māori interviewed was broad (17-75) and the analysis method valid for the study. The data has value as it once again highlights that individuals within a health care system can do much to improve access and health outcomes for Māori, by showing knowledge of and respect for cultural beliefs.

The NHC (2007) made recommendations around building culturally competent long term conditions services that included evaluation tools that recognize cultural needs, a
person centered approach and further research in areas that are important to indigenous people. Mauri Ora Associates is a Māori owned business designed to provide training, research, audit and cultural competency tools for health professionals. A recent Mauri Ora study had the objectives of providing an insight into Māori experiences with health and disability services and developing a culturally appropriate tool for surveying Māori (Jansen, Bacal & Crengle, 2008). The study utilised a kaupapa Māori approach which was appropriate to fulfill the research objectives. A series of focus groups were undertaken with 86 Māori, the data from which guided the development of a survey tool. The tool was then employed as a telephone survey with 601 Māori and face to face with 50 deaf Māori. The results from the focus groups revealed four barriers for Māori accessing health and disability services: organisational barriers; cost barriers; health provider barriers and cultural barriers. Māori spoke of the importance of building good relationships with providers of health care and related this to a greater impetus to present earlier with health concerns. A strong message was that previous bad experiences with health care workers were a significant barrier to accessing care. The subject of access was mentioned frequently with cost of attending appointment, distance to travel and inflexibility of appointment times cited as barriers. Another barrier alluded to by the participants was the fear of being patronised by the health professional. The survey results showed that on the whole Māori were satisfied with the health and disability services that they had experienced in the previous six months. However Jansen et al (2008, pg.12) noted that the younger Māori participants tended to be more critical of health care services and commented that the health sector may have to “up it’s game” to fulfill the needs of these consumers.

The information reported above influences this study on the future of long term condition management as it is important to discover if individuals involved with health service planning or delivery are actively considering the impact of racism and social factors, on health and wellbeing of Māori and to what extent this influences decision making. As the majority of health professionals are of European descent how valid will be their consideration of Māori health needs? It would also be valuable to include Māori health organisation nurses working in the community in my research as these health professionals could be expected to have a closer link to Māori in the community and be able to convey the real health needs.
2.5 Barriers to Change

It is helpful to identify acknowledged barriers to change in primary care long term condition management to inform future development and allow for provision to be made for problems that are expected. Hroscikoski et al. (2006) conducted a qualitative study to examine the challenges of implementing the Chronic Care Model in a 600 physician multispeciality group, organised into 18 clinics, in the USA. They acknowledged that there are no definite steps for implementing the model therefore it is open to the interpretation of each health organisation. The changes involved multidisciplinary team formation, electronic database roll out, systematic process development and emphasis on self-management. To evaluate the change process the authors randomly selected 5 clinics and interviewed 53 personnel including physicians, managers, change leaders, nurses and administrators. The interviews were semi-structured and immersion crystallisation and iterative consensus techniques were used to analyse the data, with triangulation of multiple informant views to reduce recall bias. The participants revealed that the new team structure gave the practices a greater feeling of unity and improved work place stress levels. Difficulties around getting the team together for meetings were common due to shifts, staffing or geographical constraints. The software systems that were to improve patient registries, call and recall and preparation for patient consultations were found to be hard to implement. Only practices with administrators who had computer know-how were able to adapt the programme to be useful to the clinical staff and two practices did not use the database at all due to implementation problems. Some of the chief barriers were around physician attitudes. Lack of physician support, understanding of the care process or willingness to change were cited as key issues. There is some suggestion that part of this inertia was due to limited expectations of improved patient outcomes from the change process and a continuing belief in the patient being the root cause of their own poor health. Even in practices that were successfully implementing the care model change occurred around the physician role. However, strong nurse leadership of the change process was associated with positive outcomes (Hroscikoski, et al., 2006).

The study was conducted by a strong research team with experience in Chronic Care Model implementation and physician behaviour change as well as a cultural anthropological perspective. Obviously, the practices selected were all from the same
geographical region and belonged to a large organisational structure which limited the specific generalisability of the results. However, one theme that emerged is useful for all teams in all areas: change must be managed in a step wise approach as implementation of multiple factors simultaneously can result in failure of all areas.

A study by Grol and Wensing (2004) analysed the research around barriers to adopting evidence based guidelines and arrived at six levels where problems can occur; the innovation itself, the individual professional, the patient, the social context, the organisational context, and the economic and political context. Reflection on these areas allows thought about local issues that could affect engagement in change. The age and background of the primary care physicians, opinions about Māori health and patient blame, the structure of individual practices and primary health organisations, the current economic recession and recent changes to government could all influence change acceptability (Grol & Wensing, 2004).

A New Zealand perspective on implementing a long term condition model can be found in the work carried out in Counties Manakau (Wellingham, et al., 2003). A Plan, Do, Study, Act approach was used to trial a variety of chronic disease initiatives and arrive at a final generic chronic disease management process. Several projects resulted in significant improvements to patient outcomes and reduction in secondary care use, others were less successful and revealed some barriers including time out for clinicians to accomplish planning and development aspects of the programme, longer consultation times needed which has further financial implications, and primary and secondary ‘silo thinking’. The key message from the authors was that application of even simple changes requires “excellence in planning, change management and implementation” (Wellingham, et al., 2003, pg. 5). This study encompassed such a variety of initiatives across divergent areas of the healthcare system that it is hard to estimate the generalisability of the results. It is also important to note that due to the configuration of the New Zealand primary healthcare system differences exist from DHB to DHB as well as PHO to PHO that result in hugely different structures and make application of models from other areas problematic.

One study looked at the attributes of practices that were successful in implementing parts of the chronic care model (Cloutier, et al., 2009). This study has some
methodological problems involved with the questionnaire implementation, which was carried out after a lunchtime training session with incentives for completion. Extra questionnaires were left for staff that did not attend. The questionnaire was designed to examine individual practice characteristics and does not take into account the important role of system changes, funding or information technology. Despite these issues there are some interesting conclusions from the questionnaire data. The four most significant characteristics associated with programme success were communication timeliness with the practice, the perception that the practice met patient needs, responsibility for decision making and job satisfaction. This indicates that even without large scale system changes it is possible to improve long term condition management by enhancing aspects of the practice team.

2.7 Summary

The analysis of the literature on long term condition management has revealed some themes that will inform the present research and some gaps in research that it is hoped will be filled. This research study will ask management team personnel, General Practitioners, practice nurses and community nurses a series of questions in one to one interviews. The questions will be based on the issues revealed by the literature review in the following areas:

- Information technology development.
- Evidence-based guideline use.
- Nurse led long term condition management.
- Māori long term condition needs.
- Community nurse/Māori health organisation long term condition management.
- Funding for long term condition services.
- General practice team composition.
- Involvement in decision making process for future of primary care.

There has been little New Zealand based research on primary care long term condition management particularly comparing the range of health professionals that are the focus of this study. There has also been little research that focuses on the needs of Māori, which is essential for any part of New Zealand and Tairawhiti in particular. As the
researcher of this study is non-Māori, her ability to determine if the views expressed in interview adequately represent Māori health needs will be limited. However, every endeavour has been made to refer back to Māori authors on health care to evaluate the data and it has been presented to the Māori Health Directorate at the DHB. It is hoped that the research will have local and national value as it is designed to reveal a variety of views on long term condition management some of which may serve to inform policy development or at the least facilitate practice innovation.
Chapter 3 – METHODOLOGY

3.1 Introduction

The previous chapter explored the literature on long term condition management with particular emphasis on nurse involvement in service delivery and practical application of theoretical models of chronic disease management. This chapter provides a theoretical overview of the place of research in healthcare and the two major research paradigms, quantitative and qualitative. There is also justification of the methodological framework used to answer the research question. What are health professionals’ perspectives on the management of long term conditions in the Turanganui area?

3.2 Research and Healthcare

Modern nursing involves combining its core tenet of caring with providing high quality, evidence based treatment (Brockopp & Hastings-Tolsma, 1995). It is easy to think of examples of previously accepted day to day practice that have now become outdated, even deemed unsafe. Health professionals are required by their governing bodies to spend a prerequisite amount of time each year in reading scholarly journals and attending conferences or study days, all with the aim of keeping practice up to date. The only credible foundation on which to base a change in practice is research. Research can be described as the process of discovering new knowledge through a specified process governed by set principles (Cormack, 1996).

Research has been historically thought of as occurring in laboratories, or as a process that measures variables to compare outcomes. It has an embedded association with pharmaceutical companies manufacturing drugs or scientists discovering “cures” for diseases. However, with long term conditions, as inferred by the nomenclature, there are no medicinal cures. There are instead individuals with values, opinions, behaviours, and emotions who are struggling to live day to day with their symptoms. For these individuals research has to be able to deliver something more existential than a pill.
In today’s healthcare environment there are many demands on research and researchers. Treatment has to be cost-effective, it has to match the increasing demands of consumer expectation and it must be acceptable to a diverse group of cultures (Brockopp & Hastings-Tolsma, 1995). It is more important than ever that research follows a specified process to ensure high quality outcomes, but it also has to encompass more depth of knowledge about the human condition and humans as multifaceted beings.

Research methods can be broadly delineated into two main categories; quantitative and qualitative, and the decision about which of these approaches is most appropriate for any study is largely dependent on the subject to be investigated. Following is a brief outline of the key elements of each perspective and an explanation for the approach chosen for this study.

### 3.3 Quantitative Research

The terms empirical and scientific are often used in conjunction with quantitative research. Quantitative methods involve the formation of a hypothesis and construction of a well controlled environment to test that hypothesis with measurable outcomes that are able to be replicated with great accuracy many times over (Bowling & Ebrahim, 2005; Cormack, 1996; Hott & Budin, 1999; Schneider, Whitehead, Elliott, Lobiondo-Wood, & Haber, 2007). In terms of quantitative design three basic types of study exist; experimental, quasi-experimental and observational. Experimental and quasi-experimental are designs that aim to allow the researcher to attribute causality. To achieve validity and replicability in these designs a multitude of factors must be considered including:

- **Target population** – a set of individuals with the appropriate characteristics needed to answer the research question or hypothesis (Cormack, 1996)
- **Sample size** – a selected group that is representative of the target population. A small sample size can lead to a loss of power in the data analysis (Schneider, et al., 2007).
- **Experimental group** – a sample group that receives the experimental care/treatment or faces investigation.
• Control group – a comparison group that receives usual care/treatment instead of the experimental care/treatment (Schneider, et al., 2007)

• Randomisation – ensures that any group being studied has an equal distribution of confounding characteristics that could influence treatment outcomes (Bowling & Ebrahim, 2005)

• Measuring instruments – these must be well validated tools that are capable of accurately and consistently measuring the chosen elements of the study (Schneider, et al., 2007).

• Statistical analysis – an accurate and appropriate method of statistical analysis must be chosen to enable inferences to be made from the data about the population (Bowling & Ebrahim, 2005).

Therefore, if this study was based on a hypothesis about a particular type of long term condition service, and there was the time and resources to set up the service to run parallel to existing services, patients could be randomly selected to each service and baseline tests run on the two groups. The tests would then be repeated after the groups received the service to reveal if the hypothesis was correct. However, the purpose of this research is not to test a new service but to find out information about existing services.

Observational studies are useful to gather data about a situation and use that data to infer relationships between variables. Demographic data is often gathered and this enables a level of generalisability to be determined. However, causation cannot be accurately inferred from observational studies as variables are not isolated and manipulated (Schneider, et al., 2007). The observations are represented by numbers that can subsequently be statistically analysed (Brockopp & Hastings-Tolsma, 1995). Sample size is important in quantitative research as even if causation cannot be inferred then generalisations are expected. To enable generalisations to be made the sample size has to be carefully calculated and randomisation of the sample is important (Bowling & Ebrahim, 2005). This type of research design could be used to investigate the subject of long term conditions in primary care. A data collection tool designed to gather information on General Practice size, geographical location, and team composition, as well as health professional age, educational background and level of long term condition service provision, could have been utilised with subsequent
statistical analysis of the data obtained. There are a number of difficulties in using this research perspective and these will be discussed in section 3.5.

### 3.4 Qualitative Research

In qualitative research there is no formation of a prior hypothesis when approaching the subject matter. The purpose of qualitative research is to provide understanding into the universe of the research participants and do this by studying them in their own environment (Pope & Mays, 2006). Qualitative research has become increasingly popular in healthcare (Bowling & Ebrahim, 2005). This could be due in part to the diverse nature of qualitative research which can, on a simple level, use textual rather than numerical data or, on a more complex level, employ theoretical methodologies to deconstruct specific phenomenon (Holloway, 2005).

Schneider et al (2007) point out that qualitative research has been useful to nursing and midwifery as both professions are concerned with individuals and their relationships to healthcare. Qualitative research is not simply a tool for gaining understanding of a phenomenon or behaviour but the information can be used to develop policy (Holloway, 2005). Policy for healthcare is most effective if it is based on knowledge of the reasons why professionals involved in its delivery act and behave in certain circumstances. This knowledge can best be gained from qualitative research.

Qualitative research is often described as inductive in that the data gathered drives the direction of the research and conclusions drawn from it (Schneider, et al., 2007). Some qualitative approaches have a precise methodological structure attached to them determined by their ontological basis. The most commonly used approaches in nursing are:

- **Phenomenology** – an in depth exploration of the world inhabited by an individual (usually a client). It attempts to provide a holistic view of the lived experience (Holloway & Wheeler, 1996).
- **Grounded Theory** – explains human actions and interactions in terms of the relative social background and constructs of the participants involved (Schneider, et al., 2007).
• Ethnography – seeks to understand behaviour within the context of culture, often by immersion in the culture, where culture represents a set of shared, learnt customs and beliefs (Hott & Budin, 1999).

Schneider et al (2007, pg. 117) comment that a growing trend in nursing research is for the researcher to employ a general descriptive exploratory methodology, which allows them to “stay close to the data”. In this instance the data collection and analysis tools become important in maintaining validity of the data.

3.5 Research Perspective

Both quantitative and qualitative methods could be used successfully to investigate the subject of chronic disease management. At first a quantitative approach was chosen as there is value in being able to identify certain characteristics of individuals, groups or practices that may be linked with a particular barrier to or facilitator of long term condition service delivery. Nevertheless there were some problems with this methodological approach. The potential sample pool in Tairawhiti is small and, allowing for a normal response rate, this would lead to a loss of power in the data analysis. There is also a risk that the study results may appear to be critical of certain groups of individuals or practices and the purpose of the research is not to highlight individual weaknesses but to encourage thinking about future service design.

In addition, the qualitative studies reported in the literature review had been exceptionally insightful in identifying the challenges other areas had faced when developing long term condition services and this would be of value to Tairawhiti. One of the key factors in qualitative research is that it enables the reader to identify with the research and often motivates personal growth or action (Smythe & Giddings, 2007). As previously stated qualitative research can be very useful in developing healthcare policy and a long term conditions policy is due to be developed in Tairawhiti in line with national directives. In light of this it was felt that a qualitative approach would be most useful in this circumstance.
The research question lent itself to a general descriptive exploratory approach to reveal truth as it is experienced by the participants involved (Schneider, et al., 2007; Struebert & Ribaldi - Carpenter, 1995). This approach is validated by research theorists who acknowledge that the reality of research in health care does not always allow for a strict methodological theory to be applied (Pope & Mays, 2006). Some authors warn that practitioner based research can often fail to utilise correct data collection and analysis techniques to reflect the theoretical framework, or that the theoretical framework is absent (Dodd, 2008; T. Wilson, 2000). To counteract a lack of methodological focus this research uses a qualitative descriptive approach in the interpretation of the data (Sandelowski, 2000). Qualitative descriptive research is described as remaining close to the data gathered and using a “low-inference” style of interpretation that allows the data to be presented in the language of the participants (Sandelowski, 2000, pg. 335). This has an advantage over other more prescriptive methodology as the data is not subjected to undue or elaborate construal and is therefore conveyed to the reader as accurately as possible.
Chapter 4 - RESEARCH METHODS

4.1 Sampling

Identifying the target population for any research study is a key component to the success and usefulness of the research. In qualitative research the sampling of participants is very different to quantitative research. In quantitative terms the ability to truly randomly select the sample increases the value of the study in terms of its generalisability (Schneider, et al., 2007). However, the aims of qualitative research are often very different: there is the desire to deeply understand one individual or a specific group of individuals intentions, ideas and experiences (Roberts & Taylor, 2002). The data gathered is not meant to be generalised to the wider population but rather to reveal dense information about the issue from the point of view of the participants (Struebert & Ribaldi - Carpenter, 1995). Nevertheless there is still the need for rigour in sampling so that the data that emerges genuinely reflects the phenomenon being researched. Polit, Beck, and Hungler (2001. pg. 246) describe the qualitative researcher as asking questions of themself before sampling such as: “Who would be an information rich data source for my study? Whom should I talk to first…to maximise my understanding of the phenomenon?” To this end a combination of purposive and convenience sampling was utilised to gather data for the study. Purposive sampling is the identification of individuals who would have the required knowledge to be ideal participants and convenience sampling is the utilisation of people who meet predetermined criteria and are easily accessible to the researcher (Schneider, et al., 2007).

It was necessary to gain consent from a range of organisations for the research and the following were approached:

- Tairawhiti District Health Board
- Tairawhiti Planning and Funding Department
- Tairawhiti Māori Health Directorate
- Turanganui Primary Health Organisation
- Pinnacle
- Turanga Health
The letter sent to these organisations is included in Appendix ii.

4.1.1 Inclusion Criteria

The literature review showed that successful long term condition services combined changes on many levels, including funding, organisational design, practitioners, and the multi-disciplinary team. Therefore, it was important that the sample population for this study included individuals involved with service management and delivery. Individuals from the following areas were included:

- Tairawhiti DHB planning and funding management team – primary care.
- Turanganui PHO management team and Pinnacle General Practice management team.
- Nurse practitioner in Turanganui PHO.
- Community nurses – Māori health organisation.
- General practitioners.
- Practice nurses.

4.1.2 Exclusion Criteria

The primary care structure of Tairawhiti consists of two primary health organisations (PHO). To keep the project manageable and to reduce any dissonance in the data resulting from differing PHO structures, General Practitioners and other primary care health professionals from the Ngati Porou Hauroa PHO were excluded. Also excluded were nurses working in the community but not involved in the delivery of adult long term condition services.

4.1.3 Limitations and Delimitations

Several decisions regarding the scope and design of this research must be acknowledged at this juncture. Long term mental health conditions have not been included in the scope of the research for reasons that include the researcher’s lack of knowledge and experience in mental health service design and delivery. Child long term health conditions have been similarly omitted.
It is also acknowledged that a greater depth and understanding to the research would have come from involving key informants from the general public. Recipients of health care services or their whanau/family would be ideally placed to give their perception of long term condition management. This would also have served to inform future service development with greater meaning. However, within the scope of a Masters research thesis it would not have been feasible to find, contact and form relationships with members of the public and analyse the volume of complex data that would have been obtained.

A further limitation must be conceded in that as a non-Māori the researcher is limited as to the conclusions she can draw about long term condition management from a Māori perspective. To lessen the impact of this, Māori informants have been included in the research wherever possible. The research proposal was discussed with the Hauora Māori Directorate at Tairawhiti District Health, Turanga Health and Turanganui Primary Health Organisation and approval was gained for the research (See Appendices iii – v). Māori health professionals were also engaged to provide peer review during the process of the research.

4.1.4 Sampling Methods

The informants interviewed for this research were purposively sampled. Gathering knowledge from the management team of Tairawhiti DHB and Turanganui PHO required selecting specific individuals in the primary care domain and these people were deliberately approached due to the roles they hold. The same approach was required of the community nursing team who are a small group of nurses with only a select few being directly involved with long term condition management. With regard to the selection of General Practitioners and practice nurses, these were purposively selected from practices with differing compositions to gain a broad view of the issues facing primary care teams. Hence individuals from large practices as well as smaller or single handed practices were invited to participate.

Ten individuals were interviewed in total. This was made up of a predetermined number of people from each category: four nurses, four General Practitioners and two members of management teams. Many researchers advise continuation of interviews until data
saturation is reached (Polit, Beck, & Hungler, 2001; Schneider, et al., 2007; Struebert & Ribaldi - Carpenter, 1995). Data saturation is described as the point where no new themes are emerging from the informants, instead there is repetition and confirmation of previously collected data (Struebert & Ribaldi - Carpenter, 1995). In this research some groups were so small that it was not feasible to test for saturation, to counteract this the information contained within the data was thoroughly examined.

A letter was sent to the selected individuals explaining the purpose of the research and giving an overview of the interview process, duration and possible locations along with the information for research participants sheet. The invitees were then given the option to participate. The letter explained that they would be contacted by telephone some days later to ascertain if they would be willing to be involved and, if they agreed, the interview time and location was set. (For letter see Appendix vi for Information Sheet see Appendix vii). This method gave the individual the opportunity to reflect on the offer and the follow up phone call increased the chance of their involvement. Care was taken to use encouragement to be involved in the research as opposed to coercion or ‘emotional blackmail’ as a reluctant participant would be unlikely to provide quality data as well as making them feel unsafe (Smythe & Giddings, 2007).

4.2 Data Collection

The interviews were conducted in a semi-structured manner, using the themes from the literature to steer the topics of conversation but also allowing the participant the freedom to elucidate the issues that they felt were pertinent (Roberts & Taylor, 2002). The interviews were conducted face-to-face, allowing the researcher to use human interaction to enhance meaning from oral narrative and body language (Schneider, et al., 2007). The schedule of interview questions is included in Appendix viii.

The location of the interviews was important as participants needed to feel comfortable and relaxed to enable them to express themselves without the barriers of time constraints, lack of privacy or physical discomfort (Roberts & Taylor, 2002; Schneider, et al., 2007). Participants were offered the choice of location such as their home, the researcher’s home or a location of their choice. Refreshments were supplied by the
interviewer to make the experience feel more like a conversation between colleagues than a formal process.

Interviewing is a technique that requires some skill on the part of the researcher. As an experienced interviewer the researcher relied upon communication skills to gain a rapport with the participant and elicit meaningful data. Communication skills such as active listening, paraphrasing, reflection, body language and validation are essential for the interview process (Arnold & Boggs, 1995). The formation of therapeutic interpersonal relationships is an integral part of the nursing process. The relationship with the participant, therefore, is similar to that of nurse and client as there is the necessity to gain trust and remove the barrier of power from the dynamic.

The interviews took place in the Tairawhiti region during July and August 2009. The time they took ranged from one to two hours. Each interview was audio taped and then transcribed verbatim. While it would have been advantageous for the researcher to have carried out the transcription herself, as this process contributes to increased familiarity with the data (Holloway & Wheeler, 1996), the time required to transcribe the amount of raw data proved prohibitive and a third party was employed. This person was a medical typist at Tairawhiti DHB and was familiar with the language being used as well as already working in a setting that required absolute confidentiality. Regardless, a separate Confidentiality Agreement was signed for the purpose of this research (See Appendix ix).

Concomitant with audio taping the interviews field notes were kept to record any non-verbal cues from the participants or impressions garnered at the time of the interview (Schneider, et al., 2007). Opinion is divided as to whether these notes should be written during the interview process or immediately afterwards. Some researchers are adamant that writing at the time of the interview is distracting to the interviewee and results in key information being missed (Holloway & Wheeler, 1996). Others point out that waiting until after the interview will undoubtedly lead to some data being forgotten (Pope & Mays, 2006). In this case the researcher carried a notebook which served a positive purpose. From the pilot interview with a colleague the researcher learned that it is difficult to convey acute interest in the participant’s opinions without staring directly at them throughout the interview. By note taking the interviewer is able to show that they
are interested in what is being said without holding constant eye contact, which can appear disconcerting or even threatening.

### 4.3 Data Analysis

The method of analysis of collected data is often dependent upon the theoretical standpoint of the research. For example if the methodological approach was from a grounded theory perspective a set of guidelines exists to inform data analysis (Schneider, et al., 2007). As this research was conducted with a qualitative descriptive approach with the goal of providing a “comprehensive summary” of the participants perceptions then the analysis must allow for the development of themes from the data (Sandelowski, 2000, pg.336). In qualitative research there is the ability to be adaptable in the analysis process to move “backwards and forwards between the original data and the emerging interpretations” (Pope & Mays, 2006, pg. 67). This allows the researcher to discover further insights and re-evaluate the data from the standpoint of these new perceptions (Schneider, et al., 2007). This is an inductive approach to data analysis.

Thomas (2006, pg.238) expands upon the general inductive approach to data analysis and delineates some primary purposes: accurate condensing of extensive raw data; establishment of transparent and defensible links between the research objectives and findings; and development of a model or theory about the experiences revealed in the data. This extends the analysis from a simple identification of themes present to a more sophisticated process involving coding of subjects, formation of categories and linking categories to underpinning literature or within a theory framework (Pope & Mays, 2006; Thomas, 2006). To this end a general inductive approach was used as a guide to the detailed thematic analysis of the data. The raw data was read over and over to build familiarity with the nuances in the text. Themes that emerged were labelled with a colour coding and key segments identified that summed up the theme.

Thomas (2006) then advises the researcher to categorise these themes and start to refine them which reduces overlap. At this point discernable groups of themes began to emerge and these were collected together to form categories of ideas. The original set of nearly 30 themes were grouped together to form five major categories:

- Management issues
During this process the original data were critically examined to ensure that the themes and quotations were not being taken out of context or key areas missed. At this point the researcher’s supervisors cross checked the coding themes to ensure rigour. Finally, the resultant categories were examined within two contexts: firstly their relationship to the themes from the literature review, and secondly the areas of consonance or dissonance between groups or individuals. The aim was to provide valid interpretation of the analysed data (Roberts & Taylor, 2002).

4.4 Rigour and Value

Rigour in quantitative research has been associated with ensuring the reliability of empirical data, whereas in qualitative terms the concepts of integrity and competence are more relevant (de Witt & Ploeg, 2006). If the research process is designed well and carried out scrupulously it adds to the rigour of the data results (McBrien, 2008; Polit, et al., 2001; Roberts & Taylor, 2002). However, much debate continues with regard to the specifics of how to ensure rigour in qualitative research. Often the standards used would be dependent on the methodological perspective of the research (Roberts & Taylor, 2002). For example, a feminist researcher may want to ensure the rigour of her research by checking the relevance of the research to women’s issues or the use of terminology that reflects women’s concepts and views. These standards would be of little relevance for researchers using a different theoretical stance.

McBrien (2008) suggests several broad concepts that can be utilised to check the rigour of the research process, namely member checking, peer debriefing, audit trail, reflexivity, and triangulation. Member checking can be used during the interview process by paraphrasing the participants answers back to them and checking their agreement with your interpretation and after the interview process by asking the participant to check the transcript or the research findings as you have interpreted them. There are some difficulties with this as the participant may not agree with the
conclusions you have drawn from their views and this can compromise the value of the research (McBrien, 2008).

Peer debriefing is profound discussion of the research with other experienced researchers or people with knowledge of the research subject (Polit, et al., 2001). This can be useful to enhance the credibility of the work although McBrien (2008) does warn that an independent reviewer can never have the same degree of familiarity with the data as the researcher and so may lack insight into the interpretations drawn.

An audit trail is a vital tool to a qualitative researcher as it generates a discernable process for decision making in the research and could theoretically lead to another researcher following the same approach to arrive at similar conclusions (Roberts & Taylor, 2002). Polit et al (2001) suggest that the audit trail should consist of raw data, data analysis products, process notes, personal notes, instrument development information, and data drafts.

Reflexivity is an ongoing process of self-critique and self-appraisal (McBrien, 2008). The researcher constantly examines themselves and the research for bias, assumptions and neutrality to enable the research to be truthful. Keeping a journal or log of the development of ideas and feelings during the research process can aid the researcher to examine their progress honestly.

Triangulation is the confirmation of data by several means. Data source triangulation is the comparison of a variety of key informants' views on the same subject. Investigator triangulation is the use of a second researcher to analyse the data. Theory triangulation is the use of differing theoretical perspectives to interpret data and methodological triangulation is the use of more than one data collection method (McBrien, 2008; Polit, et al., 2001; Roberts & Taylor, 2002).

To ensure trustworthiness of this research member checks of the transcripts were used as well as paraphrasing during the interview process and peer debriefing with supervisors. The data has also been presented to key members of the Māori Heath Directorate and the Primary Health Organisation in which the research was based for feedback to enhance the validity of the work for the region of Tairawhiti. A research
journal was kept which was examined regularly to help check for impartiality. This journal also contributes to the safe treatment of the data and enables an audit trail to be developed. Finally, data source triangulation, namely the interviewing of nurses, doctors and management personnel, will help the conclusions drawn from the participants to be viewed as reliable.

4.5 Ethics

History is littered with examples of abuses of human rights through medical experimentation and research. The Nuremburg trial, held as a result of the Nazi experimentations on prisoners in the concentration camps during the 1930’s and 1940’s, resulted in the first code of ethics relating to legitimate research (Roberts & Taylor, 2002; Schneider, et al., 2007). The Nuremburg Code outlined some basic principles to govern researchers and these have been used as the basis for many national and organisational ethical codes. The New Zealand Nurses Organisation (NZNO) released a statement on “Ethics of Nursing Research” which outlines several areas that must be considered by nurse researchers. They are competency boundaries, informed consent, confidentiality, protection from risk and injury, quality, and publication and dissemination of findings (Nursing Research Section New Zealand Nurses Organisation, 2007).

4.5.1 Competency Boundaries

A nurse must constantly question whether he or she is working within the limits of their competence, which is to say working in a level or in a domain for which they are sufficiently skilled, qualified or experienced. The same principle holds true for nurse researchers who would be unwise to be involved in research in an area of which they have little knowledge or experience.

The researcher of this study has worked for nine years in the area of long term condition management in a variety of situations. For the past five years she has practiced in New Zealand in the following settings: the set up and running of a new complex long term condition service for an Iwi provider; the delivery of long term
condition management in General Practice; as a Clinical Nurse Specialist in respiratory disease in secondary care; and currently in project management of a long term condition facility to span primary and secondary care. Concurrently with this she has studied for a post graduate degree to expand clinical knowledge. The combination of amassed education and experience contributes to an appropriate background and competence for this research project.

4.5.2 Informed Consent

Informed consent is closely related to autonomy, which is an individuals right to make decisions about their future based upon their own set of values and beliefs (Schneider, et al., 2007; Tschudin, 1992). An individual’s ability to give informed consent for involvement in a research project is dependent upon the clarity of the information given to them about the project, their competence to understand that information and their perceived freedom to refuse involvement. If any element is missing true informed consent cannot be given.

The interview group for this study comprised experienced health professionals who would certainly have the competence to understand the purpose of the research and the implications of their involvement in it. The information for research participants and consent forms are attached as Appendices vii and x. These forms use language that clearly states the research format and aims and gives the participant the right to withdraw at any point until the research has been finalised and is ready for submission.

As the participants were not involved in a direct working relationship with the researcher and are on a similar professional level there were few concerns that they would feel unable to refuse involvement because of an existing power differential. However, due to the characteristics of qualitative research the actual outcome of the research can sometimes end up being quite different to that which is expected because of the information collected (Roberts & Taylor, 2002). This does impact to a degree on the issue of informed consent, but the participants were offered the opportunity to read the completed work before any of the findings were published so that they were able to see the conclusions reached from the data collected.
4.5.3 Confidentiality

There are two key aspects to confidentiality in research. The first is ensuring that the information provided by an individual cannot be linked to them in the text (Schneider, et al., 2007). Polit et al. (2001) point out that this can be a challenge in qualitative research due to the small number of participants and the depth of data collected. They suggest that more is needed than simply using a pseudonym to obscure a participant’s identity. It may be necessary to omit or change demographic information to achieve confidentiality. This is particularly applicable where groups from which participants are drawn are small numbers. The sole nurse practitioner in Tairawhiti, for example, could be very easy to identify. Therefore, care has been scrupulously taken to ensure that no identifying comments or data are contained in the research results.

The second aspect to confidentiality is secure storage of data collected. Paper copies of the data transcripts are kept in a locked filing cabinet at the researcher’s home. Any electronic data is stored in password protected files on a personal computer. The person who carried out the data transcription was aware of the need for confidentiality of the data and signed a data protection form.

4.5.4 Protection from Risk and Injury

The principle of non-maleficence or ‘doing no harm’ is central to medical and nursing research. This ensures that the human research participants are free from physical, psychological, emotional, social or financial harm or exploitation (Roberts & Taylor, 2002). Whilst this research is qualitative and therefore unlikely to physically endanger those who participated, there was a need to carefully consider how to protect them from other kinds of harm. The subject matter was not such that it was necessary for individuals to reveal personal or private details about themselves and therefore the risk of psychological or emotional harm was relatively low. The subject areas to be discussed were not intended to be accusatory of existing service delivery agencies or employers but it was possible that participants might express opinions that were critical of others. To remove the risk of damage to professional relationships or loss of employment strict confidentiality was maintained to ensure that if any such opinions
were relevant to the research and therefore included in the data analysis it was impossible to link them to any individual.

4.5.5 Quality

Ensuring the quality of research is vital and to this end ethics committees at tertiary education provider, regional and national level have been established. The job of these committees is to monitor research that is to be undertaken and ensure it is well designed, well thought out and of benefit to the community. The research proposal was submitted to and approved by the Research Approvals Committee at the Eastern Institute of Technology (EIT) and to the Northern Y Regional Ethics Committee (see Appendices xi and xii).

4.5.6 Publication and Dissemination of Findings

Dissemination of the findings can be accomplished on several scales. In the first instance the participants would be invited to view the completed research to add to reliability of the data and give value to the sample group. The findings will be presented to nurse colleagues at peer review sessions and to wider local groups. Relevant conferences will be another forum pursued to disseminate the findings and add value to the research. By publishing a research study the researcher allows peers to examine the process and the findings, by which the work is more likely to add to the pool of nursing knowledge. It is intended that these research findings will be submitted to a nursing journal and primary care journals.
Chapter Five – Results and Discussion

5.1 Introduction

This chapter presents the qualitative results from the interviews conducted with selected healthcare informants in Turanganui PHO between August and September 2009. When reporting research findings gained from a general inductive analysis of data the use of the categories as main headings serves to present the data in a logical way (Thomas, 2006). The categories identified from the analysis and therefore used as headings in this section are:

- Management issues
- Information
- Leadership
- Client centred care
- Power

These headings are used to group together the key themes that the interviewed health professionals indicated were important issues for the management of long term conditions in Turanganui PHO in the Tairawhiti area. Their responses are quoted anonymously but an identifying letter indicates the professional position from which they are speaking (N = Nurses, GP = General Practitioner and M = Management team).

5.2 Management Issues

Management issues relate to operational elements of General Practice such as: funding; time management; opportunistic versus planned care; professional development and team composition and workforce issues. These operational elements are key determinant of who delivers long term condition management and how it is delivered. When relating back to Wagner’s 1998 model of Chronic Care we can identify many of these themes as belonging in the category of delivery system redesign (Wagner, et al., 2005). What follows are the participants perspectives on those areas.
5.2.1 Funding

A recurrent theme amongst all participants was that of funding and issues regarding operating General Practice, in particular long term condition management, under the current financial structure. In most cases the General Practitioners interviewed were very concerned about the subject of funding and if featured continuously throughout the discussion, as one practice nurse explained:

Well, I think, as a business model, in my practice, funding is a big thing for the GPs, being business minded first. N 4

Like the owner of any small business General Practitioners have to ensure their revenue meets their expenditure. However, unlike any other small business owner they have complete accountability for the well being of their ‘customers’ and a moral responsibility to provide care that is of the highest quality in an ever changing environment. This puts pressure on the General Practitioner to go out looking for extra revenue to meet increased demand and this does not meet with the expectations of many as to their role. As one General Practitioner explained:

Family medicine is so complicated in its structure of funding and it annoys me when you have specific targets which only then attached to money, and I just find them irksome really because we’re not really keen (on) looking at trying to maximise funding streams. GP 1

Some participants reported a proactive approach to gaining funding which resulted in an ability to deliver extra services. For example:

(We) approached TPHO about targeting patients who weren’t presenting, who…had lifestyles that could be changed to better their heart health and (we were) granted…(funding for) checks and that was only to our practice. N 1
The current funding structure was described by many as being a “fee for service” model, which one General Practitioner described in the following way:

Most of general practice long term condition care is still, unfortunately, based on a fee for service GP model where the contact is initiated by the patient when they perceive there is a problem that the GP can solve. GP 4

One of the first problems with this funding structure, as highlighted by the participants, was that it inhibited the use of nurses to led clinics. One General Practitioner when asked about nurse led services replied:

Sadly, we haven’t been able to develop it fully because the funding stream demands that I actually see the patient and if I don’t see the patient then the funding actually is poor. GP 1

One nurse acknowledged that many nursing tasks did not attract a funding stream:

I think we’re getting more and more conscious that the nurse needs to generate a part income for their salary whereas a lot of the work that we do is not funded like check blood pressures, check weights…sorts of things…the doctors aren’t being paid a fee for. N 1

However, others expressed the view that a lack of specific funding streams for nurse tasks was not a barrier:

If the service is being delivered, it doesn’t really matter who delivers the service, providing the quality and outcomes are the same. GP 2
So, for the people who say that there isn’t enough funding it’s because they’re still operating on the process that we only get billed for the people we see, when that’s actually not true. They get paid for you and I, and, I mean, I’m a gift because I haven’t been to the doctor since 2006. M 2

Some nurse services do attract a funding stream of their own, such as diabetes annual reviews, but many expressed frustration with trying to balance the narrow definition of who could be seen and who would generate income with those who should be seen in order to provide good care. One nurse’s role was described by a General Practitioner as follows:

She does the diabetes annual reviews, that’s got a funding stream attached to it. But we use her to do the new diabetics and our pre diabetics and they all see her and there’s no funding stream for that. Which to me, that’s a service that we choose to do... it’s very easy to say “well actually we not getting paid for that so we won’t do it”. We’ve chosen not to say that. GP 3

Another nurse pointed out that even if funding was fully maximised by the General Practitioner seeing every client who presented, it still left a shortfall:

You get paid X amount of dollars per patient and we are meant to be capitated, it’s meant to be that that pool of funding that comes for patients covers everything, but in fact the cost of running a clinic, employing people, having all the gear, keeping up to date (shrugs). N 2

A management representative expressed the view that more funding was unlikely to be forthcoming:

They’re not going to get any more funding. I mean people need to accept that the amount of funding we’ve got is
probably the best funding we’re going to get for a long
time, and we may in fact get less. M 2

A strong impression from the participants was that funding was attached to specific
types of clients or specific problems and this specificity was an issue when trying to
keep pace with evidence based care provision. As General Practitioner 3 explained:

Silos of funding don’t work. They just don’t. They inhibit
good care. And fee for service models of care don’t work
either…I mean, they provide perverse incentives or they
inhibit innovation. GP 3

The lack of continuity in the revenue streams was cause for much frustration amongst
the participants. The impression was that the types of services funded had been
changed relatively frequently and this caused problems for primary care clinicians:

We’ve tried different thing(s), or the PHO have tried
different things, and then a year later that funding’s gone
and suddenly nobody’s interested in it any more and it’s a
sad thing to say. N 3

They actually put people off in the end because you get
yourself organised to do something and by the time you’ve
actually got it running and it’s built into your system, the
funding’s gone. GP 3

Some suggestions for alternative methods of funding General Practice were made by
several participants. Some felt that changes were already being planned and that these
could potentially improve service delivery. One management representative opined:

Oh there’s lots of discussion at the moment around the
current funding structure. Primary care are saying…“why
don’t you give us a bucket of money and in return we
agree some targets like up to 95%, diabetes annual
reviews and we have to deliver on those” and I think it’s probably going to happen. M 1

A second management participant described how new services could be developed. Instead of finishing one service completely and funding an entirely new service the suggestion was made that a ‘stock take’ of current health needs and services would lead to the following decision making process:

Here’s what needs to be fixed and we’re going to do X of a new service and half of a current service and that’s going to equal this result. Those people (the ones with the greatest need) are going to get better care, (some) people are going to get less care than they are receiving currently, but that’s OK because that’s probably about the optimum care that they should get. M 2

One participant suggested that by looking at models of primary care from other countries a more meaningful service could be developed, especially in terms of long term conditions:

In the long run, if PHOs salaried the GPs and the nurses, and I have had good examples of this, where the whole structure of the primary health care set up has been altered to promote good team work. N 2

However, M 2 commented that a salaried model had been found to be unsuccessful:

Some people would say that it’s that it would be all better if we moved to a salaried model of care although (names organisations) are both salaried models of care and you wouldn’t necessarily say that either of them are, you know, the nirvana way of doing things. M 2
It was common for the participants to look overseas for models of workable primary care. GP 2 commented for example:

There should be incentivised goals and it worked very well in the UK with diabetes where they said, “okay guys you know you’re currently running at an average of HbA1c of 8.7. If you get down to dot dot dot we’ll give you this much money”. That’s a really good way of getting GPs on board. GP 2

A note of caution on overseas models, however, was expressed by M 2:

Some are not at all transferable to New Zealand, not at all transferable to Gisborne...look at America and they spend twice as much of GDP (on health) as we do and yet they still have 40 million Americans with no health cover at all. M 2

Frustrations with the funding structure led other clinicians to comment:

It doesn’t work, the way it’s structured doesn’t work well for us. Partly because we’re doing quite a lot of stuff already and the way I see it as being structured round...something which was separate from day to day life. GP 3

I think we’re trying to fix up a system that is flawed and it seems to me that no one’s brave enough to say we have to actually do a quantum leap... and so we tinker, and so, from our perspective, spending a lot of time and energy tinkering with a system that is essentially dead isn’t useful. GP 1

Amongst the participants there was consensus on the necessity for a significant change in the current model. However, it became clear that various groups differed in their
expectations. Some expressed the need to reduce primary healthcare spending, for example:

The current rate of funding for things such as very low cost access can’t continue… that’s probably going to go and that’s quite a major bit of money for TPHO, so the way the funding’s structured and the amount of funding, the government is saying is not sustainable, so we have to do something different, we’re going to be forced to do something different. M1

Whereas others expressed an opinion that reduced costs and quality healthcare could not coexist:

There are issues regarding funding that it depends politically what you believe they achieve, and I think politically sometimes there’s a perception that it might be cheaper but in fact it’s not cheaper. We should do this because it’s better, but it’s not cheaper, it’s like all good chronic care or preventative care, we don’t save money we spend money in order to do it better. GP4

The issue of long term condition service funding generated much diverse discussion. The majority of clinical participants viewed lack of funding as the most significant barrier to improved service delivery. Whereas, management participants viewed current funding to be sufficient and suggested that an attitudinal change was needed on the part of primary care clinicians. Whilst it was clear that models of funding were going to change in the near future no consensus existed as to the structure that would fulfil local need.

**5.2.2 Time Management**

All of the participants raised time constraints as an issue that impacted on their ability to provide long term condition management. This was apparent as a problem across
many aspects of primary care activity and, according to the participants, contributed to reduced quality of care delivery. Those involved with nurse led long term condition management described how long they would need to see a client. For example:

The minimum time I would spend doing a health right assessment is 45 minutes to an hour and even that is having to put an awful lot of stuff in to that short time frame. And that’s an absolute luxury in primary care. They don’t have an hour appointments, that’s what the people need, and you need it as a clinician, to fit all the pieces together. N 2

With General Practitioners running clinics based on 10-15 minute consultations, the issue was how much long term condition care it was possible to handle in that time. All felt that this was not long enough but they had differing views on whether or not this was a real problem. One nurse stated:

When (they’re) seeing patients every 10 minutes and a really busy practice…they just don't have that time. N 1

Whereas the General Practitioners’ perspective was:

I guess the model that GPs use is not necessarily of a whole lot of time at that one point but an accumulation of small increments of time. GP 4

Because the thing about chronic care is that it’s not that it is chronic (but) that it is about chipping away. GP 2

Another General Practitioner pointed out that, due to an increasing volume of patients presenting, there was pressure to reduce consultation times:

We’ve practiced 15 minute consultations which is basically plenty of time… there is a tendency for people to even
move down to 12 minutes. That's five patients an hour that will impact on things…in fact we should be moving from 25 to 20 consultations a day not moving from 30 to 35. GP 1

The clinician’s availability and time constraints were not the only issues that were raised. The client’s availability and ability to afford lengthy consultations was also seen to be a problem:

Most of these problems require more time to be applied to them. The GPs, they require more time than that patient can probably afford or that that practitioner can provide for them because of the pressures of the other acute problems. GP 4

Direct client time is of course not the only pressured function of primary care life. Time is also needed for learning of new skills in the areas of Information Technology, guidelines and evidence based practice and clinical techniques, as well as time for innovation of current working methods. Participants reported this also was hard to fit into the busy working day:

But again, the work we do is now so pressured, relatively, that we really just haven’t got time and energy to expand what we do in any useful way. GP 1

This lack of time can result in clinicians finding it hard to keep up with changes in clinical or practice management:

When you’re busy you don’t have time to search for something new. Again it’s all about behavioural change and if you don’t have the time and support to actually try something new and get given the extra time you need to fluff around with it and get confident with it, you automatically refer to old habits, especially if you are under
stress and short staffed, there is no way it’s going to happen. N 2

Complex clients present other time management issues, such as reported by N 3:

That’s what we don’t have time for, we don’t have time to sit on a phone a) because most of the time you haven’t got phones and b) just the resources to keep chasing DNAs (Do Not Attends) and you know, keep at them.

You’ve just got to keep plugging away at it really and that’s what I mean by education, you can’t do it in one hit… it takes a long, long time. N 3

The time pressures identified did not end at the finish of the working day. Participants from various professionals positions explained how their ability to be involved in planning and funding decision making or professional development was hindered by afterhours demands. One nurse said:

It is hard work and it’s all that whole thing you know endless meetings and it’s after hours stuff and you know it’s tough on everybody to try and keep it all together and see what happens. N 3

And another:

Trying to get out to do some out of work time… is difficult for us because we’re pretty full on or full time. N 4

This was echoed by a General Practitioner:

Part of that’s our fault, I mean there are opportunities to be involved in things, but it’s time. GP 3
These comments paint a picture of busy clinicians who have a strong desire to spend more time with clients with long term conditions and be more involved in the planning of services but who are struggling to juggle the demands on their time. Some solutions and positive messages, however, came through from a few individuals. N 2 suggested adopting a model in which technology is utilised to free up clinician time:

The whole structure of the Primary Health Care set up has been altered to promote good team work, give a lot more extended face to face consultation time, a lot more interview, review stuff happening over the phone, on the internet, and this is talking from the States, it frees up an awful lot of time for the GPs to work. N 2

GP 3, however, described adding long term condition management to a normal consultation:

You know it doesn’t take very long, just a tape measure or a linear set of scales and it takes a minute to do their bloods and so treating cardiovascular risk like measuring blood pressure so it’s just part of day to day life. GP 3

These two diverse opinions show that changes can be made. Whether it is on a small scale, within the bounds of ‘business as usual’ practice, by an attitudinal change as to what normal procedure for a client consultation should involve. Alternatively, a big picture idea that involves the use of extended information technology and changes to team composition to bring about improved client care. The comments from the participants on the subject of time management show that, due to an increasing volume of consultation demands as well as afterhours demands, time will become increasingly pressured. This will in turn necessitate changes in the structure of primary care, which will influence long term condition management.
5.2.3 Opportunistic versus Planned Care

As previously noted in Chapter 2, primary care has been evolving from a system based around acute presentations to a more proactive planned care environment. Opportunistic care describes the approach of allowing the client to present for an acute issue and using the occasion to screen for other diseases or risk factors for diseases or to review ongoing treatment. Planned care involves identifying all those with an existing condition and calling for regular review and education as well as having a system for screening the practice population for undiagnosed conditions. Planned care is a central tenet of evidence based long term condition management. However, many in primary care still see acute presentations as an effective way of managing long term conditions:

I see chronic care as being the sort of thing I’m doing all the time. GP 1

Certainly, in this practice, a lot of the chronic care management takes place either opportunistically or by crisis. GP 2

One participant explained how the demographic of the client group in their practice determined the way they delivered services:

With an older practice a lot of it is just care that you want to do every day. GP 3

Some participants felt an opportunistic approach was more effective as planned appointments for long term condition management had not been successful in the past:

They’re doing special clinics and special events which people had to go to. People don’t go and so I know that at other practices they were sitting and waiting for, you know, for the half a dozen no shows. GP 3
I really find the respiratory people are very good at coming in acutely but they are very difficult to engage in the long term. Until, of course, they’re getting really end stage which is (the same) with a lot of these chronic conditions. N 3

Whilst there are important and often frustrating problems related to planned care, some practitioners have managed to find solutions. These solutions may involve a change in administrative systems as well as using a wider range of team members to deliver care. As one nurse explains:

If I’ve got a set clinic and they’ve missed an appointment I might give them a call and say, “well did you forget”, and sometimes we get the receptionist to ring them and remind them... (we) don’t really have too many DNA’s because usually once they’ve got their letter, they’ve rung up, we’ve given them an appointment as soon as possible... (and we) give them a call on the morning as well. N 4

In the above example the nurse leads the clinic and the reception and nursing staff are involved in sending letters, telephoning to remind clients about appointments and follow up of DNAs to determine barriers to attendance. Although this may appear to present an increased workload, one General Practitioner commented on the risks of not having a system of planned long term condition care:

If other acute problems raise their head during that time the most acute problem will always be the one that is dealt with first. The danger is that problems that are insipient but never become acute are not adequately dealt with. GP 4

This concern is echoed by two nurses who comment on lack of screening in General Practice:
Quite often those ones you know that aren't presenting are probably the ones that really do need the service. N 1

I still would like to see more done, actually, on the screening end, to not shut the door after the horse has bolted. I think there are a lot of services for people when they have all these overwhelming things happening but it would be nice to capture them earlier and that's always been difficult. N 3

Participants described how in some practices a combination approach of planned long term condition clinics and opportunistic screening so as to catch hard to reach patients worked well. Two examples follow:

We opportunistically have to do diabetic checks on some patients who just don’t come in with the recall, so when they come in to see the GP about something, for prescriptions, we try and work with them before they actually see the GP. N 3

With men, particularly Māori men, young Māori men, we don’t see them unless they’re injured or broken so a lot of our case finding, if you like, hypertension, diabetes etc, cardiovascular risk assessment, is done when somebody presents with an injury. GP 2

For this approach to work each clinician has to be clear about their role in the practice, be able to work as a team and also be aware of every opportunity to screen for long term conditions or review ongoing care. Whilst there is reluctance from some clinicians to adopt planned long term condition management due to past failed attempts or a perception that it would not work for particular client demographics, participants gave good examples of successful systems.
5.2.4 Professional Development

For nurses to take a lead in primary care they need to have a strong system of professional development to enhance their knowledge base, skills and confidence. This has sometimes been a challenge in the primary care environment. All members of the primary care team need ongoing training and development, as one doctor pointed out:

It’s an issue for all of us. It’s not just for nurses, it’s an issue for primary care GPs because they fund themselves so there are real pressures on them not to fund that, and because the breadth of their required expertise is so wide’ it’s hard to know which part, so there’s a large element of under education there. GP 4

Primary care clinicians are expected to be knowledgeable across a breadth of areas, which can result in individuals feeling as though they are a ‘jack of all trades and a master of none’. General Practitioners self fund their professional development, therefore, their choice of education would most likely focus on their areas of interest.

I mean the doctors say they always enjoy the CME sessions, particularly the ones where they get out of town physicians, speaking about sleep apnoea or skin or whatever they like, and they find them very interesting but they’re not particularly going to launch forward and do anything further than that. M 2

Recently ‘ring fenced’ DHB and PHO funding has been extended to primary care nurses to increase their opportunities to develop advanced nursing skills. However, there are still differences in the way nurses feel about accessing training and the location of it:

You always have to go out of the area, there’s not too much coming into the area. N 4
Yep we’re well supported in that way… And if that needs for us to go out of town we’re supported in doing that. N 3

One participant reported that the relevance of professional development to primary care nurses has improved:

There’s a lot more specific, like, really good study days for primary health care nurses than there used to be. N 1

However, despite an increased quantity and quality of nurse focused education, two participants pointed out those barriers that still exist:

The business mind of our GPs and their approach…to what professional development they want for us is the big one, probably, ’cause it has to be something that they can see is going to work for their advantage… sometimes I think it’s a barrier to what professional development we want to do and it’s a bit limiting at times. N 4

If you’re in those smaller practices it is a reasonable sacrifice for the rest of the workforce in that practice, if you are five days (away) doing the diabetes course. M 2

These comments indicate that access to professional development is still quite variable from practice to practice and is an issue for both doctors and nurses in primary care. One solution to improve access to professional development was suggested:

I participated the week before last in Ministry of Education run training for Board of Trustees in my office, a web based teleconferencing kind of thing, which had a whole lot of experts in. They ran a session for an hour and broke every 10 minutes so you could actually type your questions in and people could put them back. I think we’re probably
gonna have to head toward that kind of style of learning.

M 2

Use of advanced information technology to access training is certainly a time and cost saving exercise but, as will be seen from comments in later sections, health professionals access to and understanding of information technology is varied. The participants did not indicate that they felt unable to manage long term conditions due to lack of professional development opportunities, but they did indicate that access to training is not always equitable across practices. In addition the comments suggested that there is an issue with getting cover for absences from work when accessing professional development.

5.2.5 Team Composition and Workforce Issues

In the early days of General Practice a doctor would often be the sole health carer. Even reception or administration duties were handled by the doctor or a partner if there was one. In more recent years a practice team has evolved but with unclear role boundaries, such as nurses who are also receptionists and administrators, receptionists who are practice managers and so on. The value of Allied Health roles such as physiotherapy, pharmacy and psychology has also been recently acknowledged. Locally these services have sat outside of General Practice, but two General Practitioners explain how these services can compliment their practice:

Obviously with smoking cessation services through (names local provider) and the Green Prescription staff, and the social workers, we can sort of plug into those bits. GP 3

Health Right service, they’ve got a relatively broad service base. They’ve got the social worker input, they’ve got kaiawhina input, they’ve got their people with the exercise thing and all of that sort of stuff and that’s all useful. GP 4
All participants expressed satisfaction with their ability to access these additional services and with the quality of care provided. Some, however, questioned the value of additional roles:

I would love to have greater access to a dietitian, although lots of patients will tell you that they haven’t really been that helpful, but I think a dietitian would be great. N 3

The number of physical therapists serving a more active population 30 years ago was probably a tenth of what it is now...Now I can’t believe that we’re actually 10 times better off. GP 1

Whilst these concerns are legitimate, the general consensus is that there is value in the extended team roles. Some discussed whether some of these roles could be based within the General Practice:

They had a physician, a couple of nurse specialists, a psychologist, a dietitian, a physio, I mean it was just, you know, a Rolls Royce version of healthcare. But it costs an absolute fortune to do that. N 2

I think we’re going to see some changes in the way that we do things as well, to manage that kind of thing and that involves more access into services more quickly and a broader team approach. GP 3

Once again funding and the structure of primary care appear to be a factor when deciding on team composition. Along similar lines the subject of workforce issues was mentioned by the participants, with the doctor role as being of primary concern. One doctor simply said:

There won’t be enough of us to do the work the way we use to do it. GP 1
Others commented on the difference between the primary care nursing workforce and General Practitioners:

At the moment our big problem is we haven’t got enough doctors…Nurses we’re fine and we retain them really well…and the right staffing too. N 3

The lack of a permanent, fully staffed General Practitioner workforce is seen to have an impact on client outcomes. As one nurse explains:

There’s always new practitioners and locums so it’s just giving it continuity of records too, because there are so many different practices now, so many different practitioners now compared to even 10 years ago. N 2

When asked how the clients felt about the volume of locums and new practitioners the same participant stated:

They hate it. They really feel that their care is very disjointed. N 2

Reasons for and solutions to the diminishing General Practitioner workforce were identified by two participants:

The way I see things going, particularly with the demographics of the GP workforce, is about GP consultant nurse chronic care type thing. GP 2

I mean especially in these days of diminishing workforce and aging workforce, if your health professionals then deal at the upper end and people take more responsibility, because they have more information and more access to their health professional. There’s no other way to do it. M 1
The suggestions mooted here are around using nurses to handle some roles previously held by General Practitioners and about using Information Technology to increase client access to health professionals and other data. These concepts are developed further in later categories.

A further barrier to doctors entering the General Practice workforce was identified as well as a potential solution:

The new wave of professionals don’t want to work in solo practices. They consider that to be very unsafe and not particularly fun and so we design facilities in a way that enables that greater group of professionals to work together. M 2

On the whole the participants expressed a readiness for change in the structure of primary care system design. What was not always so harmonious was the way that this should be accomplished.

5.2.6 Summary

The management issues category was the most prevalent of all the themes raised by the participants. All felt that the sub themes in this category were significant barriers to improving long term condition management. Interestingly, there was evidence that many participants had already given thought to how these barriers could be overcome, as they were ready with suggestions for change or international examples of models of service delivery. Some of the suggestions for improving long term condition management could be applied at the level of individual clinician or General Practice. For example, GP 3 suggested including cardiovascular risk assessment as part of a standard consultation and Nurse 4 explained how the practice she works in combines planned and opportunistic management by increased team work. However, some suggestions would need to be applied at DHB planning and funding level. For example, M 2 discussed building integrated family health centers to increase space for clinicians and attract General Practitioners to work in a safe environment and M 1 talked about
changing the delivery of funding to General Practice. Importantly, these suggestions are being discussed at DHB level. In a later section the issue of primary care clinician involvement in planning and funding discussions will be examined.

5.3 Information Issues

Information issues cover a range of subjects from individual level communication to systems level communication. In terms of Wagner’s 1998 model this category relates to the areas of clinical information systems and provider decision support (Wagner, et al., 2005). Wagner et al. (2005) point out that research shows that enhancing clinical information systems can improve client outcomes, client satisfaction and processes of care in long term condition management. The following themes will be discussed in this section: Information Technology (IT); IT integration; communication; duplication of services and evidence based guidelines.

5.3.1 Information Technology

In TPHO all General Practices use the same electronic patient management system. Within these IT systems there are various programmes to aid in the management of clients with long term conditions. However, each practice utilises these programmes in an individualised way and are, to a greater or lesser extent, dependent upon a practitioner’s computer literacy. This can range from the experience of General Practitioner who said:

And I’m not a good e-mailer so, you know, the modern IT systems are not designed for people like me. GP 1

To that of a nurse who described a client support software package:

It is easy to use and it does have a lot of information that you can print out while you’ve got the patient there…and we enter data in. N 4
Other sectors of primary care involved in a client’s health also have IT systems but these do not always link in with the General Practice. For example, one nurse explained:

A lot of the ‘NGO’s aren’t on computer record like a patient management system. They may use a computer to keep data but it’s not a patient management system. N 2

The same nurse continued to talk about the issues Iwi providers have with access to IT:

Their hands are tied a little bit because they don’t always get the full information. For instance like the nurses can’t access lab results or anything unless it’s been specifically ‘cc’d to them. N 2

IT developments designed to improve client care and access to information have been presented as ways to improve long term condition management but in the Tairawhiti area access and literacy cannot be guaranteed. As the following two participants explained:

Someone can poke their finger in a gadget that sits on their kitchen table, once a week or once a day…and it can tell you their INR, their BP, their HR…(They can) access help to a dedicated call centre where they will have registered nurses and social workers…and then, what happens on the East Coast, where, you know, “Welcome to rural health”. No broadband, no staff. But anyway…a lot of people aren’t even computer literate. N 2

So it could be electronically being able to set your own appointments, check your lab results, engage with the

* Non-government organisations. Health related organisations such as Arthritis New Zealand or the Cancer Society.
* carbon copy or courtesy copy.
nurse or doctor by email. Some of that is going to work for...the future...that’s not going to work for Doris Lulu living with her 92 cats. M 2

With every IT system technical problems arise:

The actual computer based programme, ohh it’s been a nightmare actually...if you haven’t got one little thing it won’t let you go any further on it so you have to have every single blood test, weight, you know, all the information, and if you’re missing one little link it doesn’t let you go any further so it can be a little bit frustrating. N 3

Improved IT systems appear to be a way of enhancing long term condition management but there are concerns over client access and practitioner competency. A less fragmented development of IT across primary care is a consistent message and this is developed further in the following section.

5.3.2 Information Technology Integration

General Practice is set up as a business and therefore, historically, there have been limited IT linkages between practices. In addition, secondary care runs a completely separate patient management system and clinical database. Recently some electronic exchange of information between secondary and primary care has become possible in the way of referrals and results, As N 3 explained:

As far as just referral goes we’ve got an electronic Healthlink referral process which, they can, you know, it can be both ways. N 3

Whilst an electronic referral and results system is an improvement, for many this still is not working well enough:
I mean, now the doctors can access the lab and x-ray which has been good but the letters are still coming hard copy and then they’ve got to be scanned, so there’s a delay in that because we actually have a problem getting them scanned in, so often we have been known to be up to a couple of weeks behind. N 3

We can access them by looking up the labs on the computer but the stuff that the hospital does, like, they do an HbA1c, unless they send a copy to us we don’t know that it’s been done unless we go and have a look in there, in the labs and so on, it doesn’t come through to our system. GP 3

The participants were unanimous in their views about a solution to the poor exchange of client information:

Without doubt if we’re going to be more effective we’re going to need to be coordinating from the same centre…and the delivery of the service will need to be from the same hub…Using the same set of notes and in closer association. GP 1

We should be operating from the same data base in primary care but we don’t, so people communicate with phone calls, with bits of paper that are faxed and the bits of information that are unwieldy and are only part of that patient’s record. GP 4

That a shared database should extend to secondary care was the view of many participants:
I mean in terms of chronic care primary care integration is only one step in it. I think there needs to be the integration, with secondary care as well, I mean, and it can work. M 1

It would be wonderful if the link between the hospital, if the hospital’s computer and primary health care computers talked the same language and kept the records in the same manner. That would just make life so much easier. N 2

Whilst it sounds relatively simple to integrate IT systems, especially in primary care where the General Practices and community health organisations are using the same practice management database, some important issues need to be considered when contemplating giving a wider set of health workers, such as secondary care, access to client information. As GP 4 cautioned:

It will improve care but there’s real issues around confidentiality…most of the staff there they will have GPs and they will have confidential patient records which other people can then access, and how happy are they about that? GP 4

The issue of wide access to confidential information is of real concern when planning integrated IT systems. One participant suggested a compromise:

But if you were a person with a long term condition it would seem to me that there would be a set of precursors that should follow you around that aren’t sensitive…a set of data points that should be available to either a primary or secondary clinician at any given time. That’s different than whole scale, you know, being able to look through everything. M 2
The participants were unanimous in wanting to improve the integration of IT systems across primary and secondary care. The only barriers identified were confidentiality of client information and the management team interviewees spoke of personality clashes in previous attempts to integrate systems. In terms of long term condition management two of the key problems that result from poor information sharing are communication difficulties and duplication of care.

5.3.3 Communication

Communication is the cornerstone to good client care. In long term condition management, good communication is vitally important due to the amount of clinicians that are involved in an individual client’s care. At an organisational level accounts of good communication between sectors were reported. For example:

We met last week the PHOs and (names an NGO) to actually agree on the referral pathway and what was required by way of information when the client is discharged. M 1

I think we have good communication with nurses at (names a community health organisation) and at the PHO so I’ve found it to be good lines of communication. N 4

Others, however, felt that little real information filtered back to the core General Practice team particularly from a planning and funding level. One General Practitioner explained:

There’s no feedback. You just know that they’re sort of out there somewhere doing whatever they do and deciding things in whatever way they do. GP 3

GP 4 felt that individuals were ready to communicate but that system design did not match that desire:
There is a real desire to communicate and integrate but it works despite the systems and the systems aren’t designed to integrate. GP 4

Improved communication at an organisational level is a positive step but is only part of the picture. Participants reported communication problems between clinicians, even within the same General Practice:

Communication sometimes isn’t the greatest thing because we’re all so busy doing things and people think they’ve told people things. N 3

I don’t think that there is…sufficient working as a team within each general practice to actually ensure continuity. M 1

Some participants reported a lack of communication between clinicians in primary and secondary care when involved with clients with long term conditions:

No we (primary and secondary care) don’t talk about a particular patient in terms of planning care and that sort of thing. GP 3

We don’t do handover well. There’s sometimes valuable information that get lost on either side. M 2

The objective of enhanced communication is to improve client care, especially for those with complex long term conditions. As GP 2 explained:

There should be trust and communication between the two sectors such that, if a primary care practitioner…is having difficulty with…the management of a patient that can’t be sorted out in the primary sector it needs to go to the secondary care service…and have a tune up and
management plan and discharge rather than a, ‘you keep coming back to us as well as trying to go back to your General Practitioner’. GP 2

The participants pointed out that communication between the client and the health professional is a complex issue:

I’m still fascinated hearing what some people think I’ve said…but that’s what they’ve interpreted. So it’s powerful stuff some of the things we say and we, you know, as professionals we all need to be singing from the same tune which is difficult cause we all do have a different slant on things…and listening to them I still don’t think we’re as good listeners as we could be. N 3

We try not to bombard them with too much information and we can always recall them. I guess when I’m interviewing a client I can sort of tell how much information is enough for them. N 4

However, one participant highlighted that sometimes we expect too much in terms of communication from the client to the health professional:

So they go and see their general practitioner after they’ve been discharged, if the discharge hasn’t managed to make its way back into the patient’s file you’re asking a patient to tell the doctor what happened and I just think that’s a nonsense. M 2

A number of participants bought up the subject of Integrated Family Health Centres which are a new proposal to combine service delivery in primary care. Some felt that this concept would serve to improve communication and, by extension, client care. M 1 described the concept:
(It would) be an increased and more real team environment where case discussions hopefully will occur in a much more structured way and it won’t be just the GPs having their CME∗ discussion it will be the team talking about the more complex people. M 1

Integrated Family Health Centres have already been set up in the USA and GP 3 commented on their success:

And then they actually plan out the chronic care stuff. So they’ll say, you know, there’s ten patients coming in today who’ve got, you know, this list of problems and so they’ll look at who’s actually going to be involved in each of these, actually plan for it as part of the day.

In some practices a system of real communication exists that enhances client care and service innovation. N 1 described formal and informal examples of this:

We have a monthly evening meeting which all staff attend, the whole practice. We have dinner provided for us…we have an agenda, set things that we talk about every month and then we have our general meeting and that’s all minuted.

Then we might feed back…opportunistically we quite often have a cup of tea together like often we are able to all finish at the same time …so you just sort of bring it up.

Whilst this is the ideal it is clear that it is far from commonplace. The participants described several areas in which communication could be improved: between clinicians in the same practice; between clinicians in different practices; between clients and clinicians; between planning and funding and clinicians and between primary and

∗ CME is Continuing Medical Education.
secondary. A resultant phenomenon from poor communication is duplication of services and this subject is discussed in the following section.

### 5.3.4 Duplication of Services

Many participants reported that clients were having the same or similar services performed for them by different health professionals. They blamed this duplication on a lack of coordination within the healthcare structure. Two General Practitioners explained:

> There’s so many people doing the same thing and what they do doesn’t actually impact greatly on what I do. Sadly there’s no co-ordination and that is the fault of the structure. GP 1

> Sometimes there’s duplication and triplication. So you may get, for example, a Māori person who has who sees the Hauora, who also has a Health Right contact, who also comes to their GP and you may get three elements sort of doing the same thing so there’s a co-ordination aspect there. GP 2

It was perceived that this lack of coordination impacted directly on the client:

> For the diabetics that are on CAPD* so they’ve got the renal nurses, they’ve got visiting physicians, they’ve, you know, got the cardiac nurse, they’ve got us on their back and sometimes it’s just a bit overwhelming for them. N 3

And on service delivery:

---

* CAPD is Continuous Ambulatory Peritoneal Dialysis a form of treatment for kidney disease.
I think there’s a lot of double handling, a lot of stuff done at one place and the patient will go to another vendor and have a similar thing repeated and some fabulous work gets done but nobody gets to know about it. The patient knows but it doesn’t get shared between practitioners as best as it could. N 2

One major issue that arises when several agencies are involved in delivering care to a client is that of accountability. One nurse described the client journey:

They tend to go under specialist care and sometimes I think well who is actually managing…I think occasionally (things) slip through the cracks because it is difficult for the GPs. If they haven’t requested the blood tests, who’s responsible for them? N 3

One General Practitioner described two ways of reducing service duplication:

Having a really deep understanding of the individual roles of the other people. GP 4

Communication between the two (secondary and primary) and bridging that gap so that you’re supporting each other not doing the same thing. GP 4

As GP 4 explains, by having a thorough knowledge of what services are being delivered by other providers and increasing communication between providers, duplication of care would be reduced.

As reported in the opening chapter of this study, health services are becoming overwhelmed by presentations to both primary and secondary care. Therefore, if services are being duplicated many times over for many clients, it makes sound economic sense to improve coordination. This would also improve continuity of care for
the client. By integrating IT systems as described earlier, much of this duplication could be resolved.

5.3.5 Evidence Based Guidelines

To improve the management of long term conditions, sets of guidelines based on a review of the latest international research have been developed in most OECD\(^*\) nations. These guidelines have now been incorporated into practice management systems in New Zealand and are readily available during primary care consultations. Participants had positive comments about such guidelines:

You've got to kept up to date and, in this day and age, having some academics pour through thousands of clinical trials and things like Cochrane and best practice guidelines…they give you a good idea of where to start from and where to head to. N 2

The guidelines have helped a bit because you've got some things to actually try and aim for, you know, in terms of control, which helps sort of give you the incentive to actually keep working away on it. GP 3

Participants indicated that accessibility to the guidelines was not a problem. One nurse referred to the latest cardiac guidelines and said:

They've just been brought out and they're easy to work with. N 3

Another commented:

I quite like using the guideline there in the practice and I always have the guideline booklets available in the

\(^*\) Organisation for Economic Cooperation and Development. Formed in 1948 and often used as a comparative group for New Zealand to measure itself against.
practice so that I can refer to them if I’m needing to look up anything. N 4

Non clinical personnel working on service development also reported finding the guidelines useful:

So from a planning and funding perspective in primary care whenever we’re looking at a new programme we do look to the guidelines. M 2

Despite an overall positive feeling towards guidelines most participants also highlighted that the clinician still needed to use their skills in the application of the guidelines:

Guidelines are exactly what they say. There’s a difference between a protocol and a guideline…a guideline to me tells you if you exclude other factors, if that’s the sole thing that you’re looking at, that that’s the best way to manage it. GP 2

Individualising guidelines was mentioned by several participants:

They do need to be adapted for every person that comes through sometimes you’ve got to individualise the care. N 2

You’ve still got to individualise it, you know. I mean they have a generic that should fit well with everybody but it’s a guideline. N 3

Two doctors spoke about the “art” of practicing family medicine in terms of guidelines use. They intimated that General Practice is a very different world from secondary care where a clinician can focus on a particular specialty and the use of strict guidelines may work more effectively. They spoke about the holistic nature of primary care practice which will be discussed in more detail in future sections. A cautionary note about guidelines was raised by one participant:
And guidelines are apt to change...and then, low and behold, you find that the real evidence isn't there for this change. GP 1

The balance between working with the client to set achievable, personalised goals and working to the targets recommended in evidence based guidelines is an issue that the participants raised. GP 3 gave an example of several clinics that delivered cystic fibrosis management. One clinic had much better client outcomes than the others and the difference was their strict application of the guidelines “not accepting near enough” to a target. However, N 3 described that strict application of guidelines can have a negative impact on clients:

So I think, all that information’s out there, putting it in reality usually means the person sitting in front of you is going to end up on more pills, so you have to weigh all that up with the person too. I mean, they have to be involved. N 3

One participant raised the issue of governance, of ensuring that clinicians were utilising the clinical guidelines. M 2 described the ideal situation:

(I would like) to ensure that they’re being implemented systematically across primary care and community care and secondary care, because at the moment there’s no methodical way of ensuring that guidelines are being used. M 2

The majority of participants reported actively using the guidelines in practice, in direct client care and in service planning. Having electronic versions of the guidelines was useful to some but not all participants indicating that IT access or literacy is an issue. Whilst clinicians indicated that guidelines have to be adapted for each client, some comments indicated that stricter application of the guidelines might be needed to improve client outcomes.
5.3.6 Summary

Clearly, integrated IT systems have contributed to bridging the divide between sectors of healthcare but equally clearly, further progress is needed to remove the remaining barriers to coordinated long term condition management. Improving IT literacy and consistent access to IT would generate enhanced long term condition management. Along with improving IT integration other methods of information exchange were highlighted by the participants as a barrier to good care delivery. Communication between clinicians was identified as a barrier, which often resulted in duplication of services. Poor communication and duplication of services were acknowledged to result in frustration for clinicians and reduced quality of care for clients. Evidence based guidelines are designed to improve quality of care but it was suggested that a methodical system of clinical governance to ensure their application in practice was necessary.

5.4 Leadership

One of the six components in Wagner’s 1998 model was effective clinical leadership (Wagner, et al., 2005). During the interviews participants often referred, directly or indirectly, to components of clinical leadership. The comments had application to leadership within practice teams and at wider PHO or DHB level. Also encompassed in this category are the themes of: nurse led services; role protectiveness; relationship building and accountability.

5.4.1 Clinical Leadership

There was widespread acknowledgement amongst the participants that leadership was needed in the primary care environment, both at a management level and in General Practice. M 1 spoke about developing nurse led services and commented:

So I think it will need some change management and it would need a champion. M 1
N 3 spoke about the need for clinical leadership at a General Practice level:

I've always thought it would be really nice to have somebody mentoring, you know, if there was enough staff ...just like an overall mentor if you’re not sure about something, just somebody else you can go to. N 3

Some comments suggested that leadership in healthcare was not forthcoming:

I think, from my professional group, I don’t think there’s been a real intent to want to do it differently either. GP 4

Unfortunately we haven’t got a nurse liaison here in Gisborne anymore. Our Pinnacle Nurse liaison role wasn’t filled. N 1

Nevertheless, there was a feeling, from a management perspective, that clinical leadership improvements had been made:

I think having...a GP liaison person has made significant difference, having the primary care nurse role...is making primary care nurses more visible. M 1

The Primary Care participants, however, did not perceive that these roles had as yet made significant differences to them and felt under represented at DHB level:

So there isn’t a primary care voice actively working in primary care. GP 3

I think there is a lack of leadership...both clinical and management leadership...Nobody seems to have the overview of what kind of population we’re dealing with, what works, what doesn’t. GP 2
There were some positive examples of good clinical leadership existing within practices. One nurse explained how the nurse team and the General Practitioner developed long term condition protocols together, which were available on the computer for all to use. Two nurses described the support they had received from senior nurses:

Initially some of the nurses who weren’t quite sure what they were doing with the patient but now that we’re doing it seems to be flowing quite well and we have had a lot of input from (names senior nurse) when we get a little bit stuck. N 4

It’s been really good in some ways having (names senior nurse) who comes in to the practice. N 3

The participants indicated that they believed that an organised system of clinical leadership was lacking throughout the DHB structure, from secondary through to primary, and they would welcome change in this area.

5.4.2 Nurse Led Services

The literature review showed that there is considerable evidence of the value of nurse led long term condition management services in primary care. In Turanganui PHO the utilisation of nurse time varied from practice to practice:

I understand some of the nurses actually have portfolios in terms of long term conditions whereas in other (practices) nurses seem to be hand maidens. M 1

The participants regularly referred to ‘practice nurse duties’ and ‘clinic nurse duties’ separately. Varying degrees of autonomy and responsibility between these roles are described by the nurse participants. Some described a support role:

I’m getting patients in to see the doctors. We’re keeping them flowing we’re doing the blood pressures and heights,
weights and waist circumference and doing a bit of education. N 4

It used to be that we would see each patient before the doctor saw them. N 1

Whereas others described a more autonomous role:

I’m updating the docs on the assessment injuries, ACC claims that I might put in place, immunisations that I’ve given, care plans that we’ve worked out. N 2

The skill base of nurses was highlighted by many as making them suitable to lead long term condition services. Two General Practitioners commented:

The nurses on the HealthRight thing are very good at doing the stuff which the docs are less good, which is about dotting the i’s and crossing the t’s and making sure that you haven’t forgotten that and all of that kind of stuff. GP 2

Nurses bring a different perspective of care from what we do and I think they are complementary...often the nurses are much more diligent and may have a better relationship with that patient in order to fulfill the requirements of managing that chronic condition. GP 4

Nurse participants also saw themselves as having additional skills to offer, different from the General Practitioners, particularly in terms of supporting client self management:

You can only try and help the person self-manage a variety of their lifestyle aspects, their medications, accessing appointments, regular monitoring, making sure things are
happening for them. And that’s definitely a place for nursing with advanced skills. N2

(As) nurses we can continually reinforce what (the GPs) are doing. We can show them that it is making a change, like whether it's supporting them through stopping smoking or weight change, blood pressure, medication compliance and, I think, the brief interventions along the way are really valuable. N1

One participant felt that nurses’ motivation was different from that of General Practitioners:

I mean, ultimately, I think for the nurses it’s not about the money it’s about how we can help the patients. N4

Other reasons for using nurses to lead long term condition services were mentioned by the participants and include, rural health service cover, diminishing General Practitioner workforce and reduced costs to the practice and the client. One comment indicated that careful consideration needs to be paid to the type of roles devolved to nurses so that each clinician works to their skill set strengths and within their scope of practice:

And then there are nurse triage models, do they work? And the conclusion we came to was that it may be better, safer all round, for more of the chronic care to be nurse led and nurse driven and so that leaves us to focus on the acute triage stuff. GP2

With widespread acknowledgement of the value of nurse led long term condition services, the participants offered some suggestions as to why these services were not more universally implemented. An initial focus was on the nurses themselves for not having the desire to extend their roles:
I think nurses need to take some responsibility as well... a lot of nurses don’t assert themselves, don’t take that extra step. M 1

Some nurses possibly don’t have the desire to work in that role, in a clinic role. N 4

Other suggestions highlighted lack of nurse representation at a strategic level and lack of professional development of nurses. M 1 described a recent consultation process around out of hours services:

We had a meeting a couple of nights ago, one night last week, just to review it. Again that was GPs, PHO management and TDH. You’re going to say where are the nurses? They’re not there yet. M 1

One General Practitioner described the skill set needed by nurses taking on extended roles:

You need multi-skilled nurses to start with...whatever comes you need to have the flexibility to be able to do that...I think nurses replacing doctors isn’t really the answer either: GP 3

One participant noted that system barriers were often a reason for poor use of nurse skills:

In the management of long term conditions there’s nothing that I see that couldn’t be done by the nurses, that is not done by the nurses at the moment only because of regulatory things that are preventing them from doing that. M 2
The participants identified that nurse led services for long term conditions were not utilised uniformly across Turanganui PHO. Lack of nurse motivation, lack of representation at a DHB level and training were identified as barriers to nurse led services. Another significant barrier as identified by the participants was role protectiveness.

### 5.4.3 Role Protectiveness

As identified in earlier chapters, there is increasing pressure on primary care due to escalating volumes of clients with complex long term condition needs and a depleted General Practitioner workforce. Due to these factors primary care teams have had to examine how and who delivers care to clients so as to meet the demand for services. Both General Practitioners and nurses can find it hard to change the roles that they have always been used to performing in, as the following comments explain:

> Tradition, custom...when the doctor is a doctor is a doctor... a lot of nurses don't assert themselves, don't take that extra step. M 1

> That's what people do they default back into their usual operating mode. GP 2

The management participants reported that health professionals often struggled to see the value of other team members. They suggested:

> There are still some GPs who believe...that they are best to provide smoking cessation advice. Whereas there are people who are trained to do it and they can do it just as well as a GP. (Then the) GP can get on and do GP business that can't be done by a smoking cessation (provider). M 1

> (There may be) functions they may be doing currently now but we should be perhaps looking at whether or not there’s
anybody else in the practice that could be doing that now. For some of the nurses that might be a little bit of letting go as with some of the doctors. M 2

One General Practitioner explained why they felt it was difficult for clinicians to change their role or practice:

The relative conservativism of the individual professional groups. Everybody gets tied into the idea of this is the way I do it, therefore this must be the best way to do it, otherwise I wouldn't keep doing it this way. GP 4

N 1 perceived a potential barrier to doctors allowing nurses to manage specific client groups:

I think sometimes some doctors like to see their patients all the time. N 1

The solution to the issue of role protectiveness is not straightforward. It involves an attitudinal change on the part of professionals whom have been working in particular ways for many years and this involves doing some higher level thinking, at DHB level, about roles. According to M 2, the questions that need to be addressed include:

What are the skills and functions that are required to deliver this service, and who has the current competency to deliver them, and who could have the potential competency to deliver them, and what skills and functions don’t make sense for the people who are currently doing them to continue to do them even if they’ve always done them. M 2

One GP did acknowledge that it is easier to relinquish some of the role when the value of the alternative service has been proven:
I think it’s getting roles which are overlapping or complementary or very specialist like the (names specialist nurse) position comes in. That’s great, it works really well. It works well for us because (they) know a lot and in a way that is different from a physician knowing it. GP 3

Future plans for integrated health centres were also mentioned as a possible way to reduce role protectiveness:

And then when they (clients) come along they get whatever it takes. So it might be half and hour with the doctor and half an hour with the nurse and quarter of an hour with the pharmacist… probably less often each visit but more intensive and a whole lot of other stuff. GP 3

Role protectiveness was identified by the participants as a barrier to delivering improved long term condition services. Each clinician clings to their current role, or method of practice, because it is comfortable and familiar or because they believe it is the best way of practicing. Therefore, for any changes to be made in the delivery long term condition management a process of attitudinal adjustment needs to be undertaken with each group.

5.4.4 Relationship Building

Good leadership enhances relationship building at every step of healthcare provision. The participants all described the importance of good relationships in a variety of settings. One described relationships between organisations and the results this can bring:

We’re lucky actually we have a good relationship with TPHO… the relationship has certainly improved and we are developing services together. M 1
The participants also described the importance of relationship building between clinicians and gave examples of good working relationships:

I can’t speak for other practices but there is a lot of mutual respect of competencies that goes on here. GP 2

I think we have a good rapport with other nurses up at the hospital. N 3

You have to, again, alter that to suit each different practice (they) have their own way of functioning so you have to be mindful of what works for one won’t work for another... I’ve got a fairly good working knowledge of who does what which way. N 2

Others reported difficulties when relationships have not been developed:

One of the interesting and difficult things about medicine when you share care, one person might say “this is my target” and another person says “well it might be a target but I think it’s unrealistic” and so that creates tension. GP 1

Relationship building with clients was described as one of the most vital aspects in delivering long term conditions management. From the nurses’ perspective:

I guess part of the reason why what I’ve done…has been reasonably successful is because I have been the same face for six years and so they know me. N 2

And the biggest one, I think, is rapport building with the patients, to get them comfortable so that they will discuss their health with you. N 4
The relationship between client and clinician was described as being vital if behaviour change was needed as is so often in the management of long term conditions. GP 2 commented:

Even before any chronic care can be delivered it’s about relationship building.

People will come back and your best shot at modifying their behaviour is on the basis of trust and relationships.

Relationship building between clinicians is vital in long term condition management as clients will often have multiple clinicians and agencies delivering aspects of their care. Without effective communication and trust information will be missed and care will be disjointed. The participants identified that within General Practice the relationships are strong but that there is sometimes a gap between secondary and primary care clinicians, which often results from a lack of shared client goals. Participants also stressed the importance of the relationship between the client and the clinician in delivering long term condition management and this will be discussed further in future themes.

5.4.5 Summary

In summary, clinical leadership has been described as vital to developing strong working relationships throughout primary care and in developing nurse led services. If nurses are to become more instrumental in delivering long term condition management then trust must be present on the part of doctors to enable role handover. Nurses too have to be willing to let go of some roles that they have traditionally undertaken in order to increase their involvement in long term condition management. That nurses were ideally suited to deliver long term condition care was agreed by the majority of participants, but barriers to this have been identified in previous sections, such as funding, space, and time. Management team participants felt that current clinical leadership would serve to improve the visibility of primary care clinicians at a DHB level, but this confidence was not reflected by the clinical participants. Overall, relationship
building between clinicians and then between clients and clinicians was seen as instrumental to good long term condition management.

5.5 Client Centered Care

The term client centered care refers to the concepts of: client journey and continuity of care; Māori needs; client outcomes; holistic care and client self-management. These elements are vital in the delivery of any health service but particularly so in long term condition management. In terms of Wagner’s 1998 model this category can be equated to the concepts of patient self management and linkages to community resources (Wagner, et al., 2005).

5.5.1 Client Journey and Continuity of Care

Many of the participants expressed their commitment to endeavoring to provide services in a manner that fits the client’s needs rather than those of the health professional. Describing an Iwi health provider, M 1 states:

(They are) now delivering clinics at both the Work and Income sites to the staff and clients down there. M 1

A nurse described another initiative:

There is a project that runs out at (names a large employer)…It’s a primary health care based treatment. N 2

Improved continuity of care brings benefits to the clients and positive outcomes such as reduced DNA rates are reported:

You’ll be dealing with one nurse, like the letter that goes out goes from me and then the appointments made for me and then I see if they don’t turn up, but generally it’s very seldom. N 1
I think they're certainly reaching out to the communities and I think that's really important to get out where the people are and not always expect people to come to you. N 2

By necessity many of these services being delivered in the community are not directly related to General Practice, but General Practice remains the core provider of care. Some participants described the difficulties that result from that situation:

We try and practice patient centered medicine in the primary care environment, (it) is often confusing, bewildering and it occurs at multiple locations with multiple providers each with their own calendar or appointment slots. GP 2

I'm hoping that they (community organisations) actually don’t just sit on the information. I'm hoping they forward that back to whichever GP the person belongs to. N 2

One participant commented on the lack of clinical accountability that can result from informal health delivery situations:

OK, you can go to a Marae and take someone’s blood sugar every time you go there, but if they're not diabetic you're probably over testing them and what are you doing with the result. N 2

Participants report that a lack in continuity can affect the client adversely:

They really feel that…nobody’s really interested, they don’t know who they are going to see, it’s a different face every time. They didn’t want to tell their story over and over. They really don’t like it, they want to see a consistent face. N 2
To fully participate in that network of care is extremely demanding on patients and so they get labeled as non-compliant patients. GP 2

One nurse commented on how the client journey could be disrupted:

We do try and refer them to services …there’s always gonna be those who fall through the net or for some reason aren’t being followed up. N 4

A further impact on continuity of care, as noted by participants, is the funding of health services attached to a particular condition:

I would like to see the money attached to the patient’s journey of health. N 2

Care Plus (funding). These are things that, you know, sort of don’t sit that well with me as a General Practitioner, particularly because I don’t differentiate between conditions. GP 1

One nurse, however, pointed out that most practices have chosen to use the system in a way that enhances their service delivery:

Currently the Healthright Program… each practice runs it slightly differently to suit themselves and what best fits their patient population. N 2

N 4 reported recent positive changes, as clinicians come together to discuss clients under their care:

We alert the doctor and say “hey, you know, their blood pressure is high, what’s happening with their medication?”
or “they’re on medication, but perhaps it needs to be increased” or we do add our comments and refer them back to the GP as well.

With diabetes we've got the (Diabetes Physician)...and the Diabetes Specialist Nurse to come into the practice, so they're available, which is really good 'cause it's difficult for us to get out to see them.

The participants reported recent initiatives designed to improve the client journey by delivering services in a manner or location more suitable to the client. However, these services are often delivered by community health organisations and the participants were concerned about the communication of clinical information back to General Practice. Poor communication of information leads to poor continuity of care. Participants recognised that the client is often being asked to participate in a demanding network of care. Working in a coordinated manner improves the client journey and outcomes. But the needs of all clients are not always able to be met in the same manner.

5.5.2 Māori Needs

All participants recognised the health inequalities that exist for Māori*: A key issue in the planning and funding of services, as highlighted by some participants, was around the dichotomy of measurable outcomes within the framework of Māori models of health. As M 1 explained:

Clinical outcomes are only part of how we see our service, there are non-tangible non-visible ones and somehow we need to marry up those two but also take a bit of a leap in faith too. M 1

---

* Only two participants were Māori. Therefore the opinions are not entirely representative of Māori need but are valid as an example of existing health professional thinking
M 1 continued to talk about the difficulties faced by Iwi organisations when delivering long term condition services:

They want to deliver a Kaupapa Māori service, Whanau Ora which is the whole whanau, and the public health system is saying we’ve got to be more targeted in order to make sure our dollars get to the right people at the right time in the right way. M 1

Many participants spoke positively of the relationship between General Practice and Iwi Health Organisations. For example:

We have access to patients in different ways and different bits of geography and different scenarios and they approach from different ways, and I mean there’s a number of things where it’s worked. GP 4

Actually you know, Kaumatua programmes, that sort of thing, they are hugely participated in and you talk to the people who are involved and they love it, well they’re capturing lots of different things. N 3

Many participants commented that even within their own practice, they are attempting to use Māori models to deliver long term condition care:

Illness and wellness, particularly again in Māori populations, occurs in a family context. So when (a client)…comes here with her daughter, and meanwhile the kids are getting their immunisations and she feels comfortable here, and then you start trying to get behaviour change going on the basis of pre-existing trust…that’s when you can actually make some traction. GP 2
GP 2 continued:

Particularly for groups of Māori people often...you don’t get sick by yourself you don’t stay well by yourself it’s all about the whanau type concept and a lot of learning is done by having a big bunch of people with (some) up the front asking the questions and the rest of the people up the back, kind of it digesting and reflecting. GP 2

Two other General Practitioners expressed opinion about the reasons for the existing inequalities in health between Māori and non-Māori:

If you’re Māori you are much less likely to get a cardiac intervention... if you are pakeha* and lived in Gisborne you were less likely to get a cardiac intervention either. Except if you were Māori you were even less likely. GP 3

There’s a whole lot of places that we don’t access, like, middle aged Māori males for instance, very hard for us to access. Or youth, young people between 15 and 20. There’s a group that I don’t know who provides them with good care but I don’t think anybody really does. GP 4

Access to services was identified as one reason for inequities but cultural behaviour was also felt to be a barrier:

A lot of (Māori) are not realising or not acting soon enough to get early intervention and even when they know they’re unwell its not always their priority in their day to actually access care until things have turned to such a state that they can’t ignore it any longer. N 2

* Māori word for non-Māori.
As a result, N 2 pointed out that health professionals have a responsibility to alter their style of intervention to improve the situation:

The clinician has to be reasonably onto it to ask a question more than just a straight up yes or no answer, to be a little more delving in the way you approach things, to actually listen to what they are not saying rather than just what they’re saying, to pick up what’s really missing out of their care. N 2

However, an alternative view was expressed by one participant:

Māori are presenting at the same (time) as non-Māori but the course of treatment and the options that are offered to them are not the same. M 2

Along with recognition of inequalities in health, a few participants offered ideas on how to meet some of the recognised needs:

If you have rigid appointment slots that just sets people up to fail…there’s an actual fundamental cultural difference there, that people will rock up when it’s right and go away when it’s right and that just doesn’t fit into the sausage slots of how largely pakeha health care professionals function. GP 2

Again, I think what happens is that we want something really instantly and that just doesn’t work that way. I think that there’s this group attitudinal change…you know out there in the community people talk to each other…So for any one sort of issue you get enough critical mass, suddenly people are interested in it, thinking about it, seeing what they can do about it. GP 3
Raising community awareness of issues and encouraging people to access appropriate health care can be a joint project where Iwi health providers can provide significant help. As M 2 suggested:

They (Iwi health providers) have a role to play in championing why health services are important, why people should be actually availing themselves of them and that’s not just about being an advocate for the patient but it’s actually about selling the health sector to the patients in such a way that they accept that their health condition status requires them to be more participatory in what’s going. M 2

The participants also suggested that by asking Māori and listening to their opinions delivery of long term condition services could be improved:

I was just thinking the other day that I should be doing some more surveys on the patients that I see, Māori and non-Māori, just to see how they’re finding...the nurse clinics. So I’m going to be doing that. N 4

We need to be able to listen to patients voices more and be seen that we have heard what they have to say and that we know what the issue is even if we can’t fix it right now...There’s those things that, I think, you know, about the caring side of health, that I think we don’t listen to so much. M 2

The idea of increased consultation with Māori to determine if service delivery is working is a positive solution. Added to this the participants raised the concepts of less rigid appointment systems and community engagement to raise awareness of issues and acceptability of treatments. However, the participants also raised an important issue, that Māori are under represented in certain treatment modalities and under referred for secondary or tertiary interventions.
5.5.3 Client Outcomes

Due to the increase in clients with complex long term conditions and the increasing financial burden this places on the health service, there has been pressure from health managers to prove the benefit of treatment modalities by measuring client outcomes. As mentioned in the previous section measurable outcomes can be hard to quantify yet they are an integral part of service planning and funding:

How do you measure? These are people with chronic conditions, how do you measure whether our intervention is actually making a real and sustainable difference? M 1

Using measurable outcomes can also be part of clinical governance and improving quality of care. N 1 described an attempt to do this:

We’ve been talking as a practice we’re very keen to get a really simple tool to do, say, a monthly audit as to where we’re at, like, how many of the total target population have been seen and how many that have been seen are in the high risk, low risk, middle.

However, one participant pointed out that an outcome based system leaves certain long term conditions with poor funding or service delivery attached to them:

If a disease is common and has things which you can measure and there is maybe a political aspect to it then it’ll be that’ll be well provided for. GP 4

This General Practitioner continued:

Chronic pain doesn’t lend itself well to the model in the sense that there are no measurable parameters and…people with chronic pain either start with or end with substantial social and psychological dysfunction. GP 4
A nurse participant made the point that a good outcome for a client may not be one that is measurable:

I think if you get so hung up on being inside that square box, is that person in the end having a good outcome? A good outcome for me is that the patient is reasonably stable. They’re enjoying their life, they can do what they want and do their daily life skills with enjoyment and a good range of ability. N 2

The participants identified that services provided for clients with long term conditions can be dependent on the measurability of a particular condition. Therefore, some conditions will have better service provision than others. A number of participants described that good client outcomes in terms of improved quality of life were not easily measurable. The next section will explore further the elements of long term condition management that are outside of the boundaries of measurable outcomes.

5.5.4 Holistic Care

Both General Practitioners and practice nurses strongly identify with delivering holistic care (Ministry of Health, 2005; Pullon, 2008). As identified earlier, Māori health authors clearly recommended a holistic approach to health service delivery (Durie, 1994). In long term condition management a holistic approach is essential, as the individual will often have numerous co-morbidities as well as social and psychological issues. The participants identified several areas in which they felt that current long term conditions services did not provide holistic care. One key area was disease specific funding. One General Practitioner and one nurse described how they tried to avoid providing care of the condition instead of care of the client:

GP4s in general practice provide long term care for patients who have long term conditions, but not necessarily modeled on the care of that condition, but that patient with the condition. GP 4
So we are concentrating on people with known CVD risk reduction or diabetes or both. But again, those people are all individuals and all have their own combinations of long term conditions. N 2

One GP discussed an example where a whole team approach to long term conditions had improved quality of care:

(There was) a young lady who wasn’t taking her medications all the time…they (doctors, nurses, social workers) basically just figured out what the barriers were….it was her boyfriend and a whole lot of social issues, (they) sorted the social issues out and she’s taking her medication again. GP 3

A whole team approach has been adopted in TPHO:

The Health Right model...has a wider range of support services the Social Worker the lifestyle coach and hopefully they can get a dietitian. They attempted to have some pharmacist services hooked in as well. M 1

Despite the holistic nature of this initiative one General Practitioner explained why they have not engaged fully with it:

There’s been services to improve access and there’s been this project and this project...you don’t quite know where it is, so do you invest in it and gear up to do this thing, or is it going to disappear again. GP 3

The other team members, such as the social worker and the lifestyle coach, are not based in General Practice and GP 1 saw this as a barrier to good care:
The workers are not working with us so they can't stop us in the corridor and say “what about so and so”. You actually have to find somebody.

N 4 discussed how to provide a truly holistic long term condition service and identified the value of increased training and use of advanced interviewing techniques:

I heard about the Flinders Model* and how it’s used interviewing patients and how useful a tool it was, so I think we need definitely need more tools in primary health care with patients with chronic conditions.

When providing holistic long term condition management, GP 2 explained that the client may have different priorities to the clinician:

It’s a question of individualising the person in the chair. Some of the people we see their priorities are getting their Sickness Benefit form signed or wondering whether they’re gonna be able to feed the kids. GP 2

In recognition of these differing priorities two nurses described how they have tried to incorporate a holistic approach into their every day practice:

They’re not even going to be interested in all that if they can’t manage, you know, the power bills and the food and the moko’s playing up. You sort of really do have to get down to the nitty gritty of what’s really important for them and what you can actually help with before they even focus on their own health. N 3

* The Flinders Model is a set of generic tools and processes to enable clinicians working with clients with long term conditions to develop care plans based on self management, problem identification and goal setting. It is developed by the Flinders University in Australia.
It could be anything from stress to smoking to a partner is not well, so we try and focus on those things and then I talk about where I can help them with their chronic conditions, basically. N4

Providing meaningful, holistic interventions such as the ones described by the participants obviously requires time for consultations and relationship building as has been discussed in previous sections. The participants expressed a desire to provide holistic long term condition management, but described perceived barriers as condition specific funding, a lack of useful interviewing tools and fragmentation of service provision due to the geographic separation of team members involved in delivering care.

5.5.5 Client Self Management

There has been a recent increase in literature promulgating the importance of client self management, including the New Zealand NHC report ‘Meeting the Needs of People with Chronic Conditions’ (National Health Committee, 2007). The participants of this research expressed divergent views on what client self management encompassed and its value for people in TPHO. Many participants saw themselves as a support mechanism for the client supplying tools to encourage self management. For example:

You can’t cure things with a long term condition generally. You can only try and help the person self-manage a variety of their lifestyle aspects, their medications, accessing appointments, regular monitoring, making sure things are happening for them. N2

I think a lot of patients look for that support when they’re making big lifestyle changes. N1

An alternative view expressed was that by our interventions we create a culture of dependence and remove the ability to self manage from the clients. One General Practitioner stated:
We underestimate the resourcefulness of humans to fix themselves and...we're taking away people's ability to actually be independent and competent soles. GP 1

Some participants described strategies they used to improve client self management such as involving the client in decisions about their treatment, setting goals and providing a written care plan negotiated with the client. N 4 explained:

When I interview patients I...ask them what they see as being their biggest health concern at the time. And so we'll work on that. N 4

A number of participants identified strategies that could be developed in the future to increase the client's ability to self manage their long term condition:

If you want to quit smoking and you've got a negative urine (test) at six months we'll give you three grand...but an incentivised population metabolic goals would actually make a big difference. GP 2

Ensure that actually patients can access their own information. People take more responsibility because they have more information. M 1

A cautionary note was struck by one General Practitioner on the subject of increasing information given to clients:

Specialists often would say this is my guideline but they wouldn't say it to the patient, they would send it in a letter to the doctor...Now there's a tendency for people to say “Ooh goodness is your blood pressure that.” And it creates quite a dilemma for patients really 'cause they think it's an uncertain world. GP 1
A further warning from one participant was around health professional assumptions of the level of understanding clients have about their health and the ability of health professionals to convey that information in a meaningful way:

\[
\text{We're making assumptions that people know enough about their physiology to know when to come and that means that if they're a diabetic and they're saying "well actually I feel really fine and the last three diabetes annual reviews I went to didn't say anything so I don't think I need to go to this one"...some health professionals are very good with the language that they use and some people are quite appalling with the language that they use. M 2}
\]

Several of the participants described ways in which they currently encourage clients to self manage their long term condition, making decisions jointly, providing negotiated goals and care plans. Others made suggestions for the future to increase self management, incentivising metabolic goals and increasing client access to their own health information. However, as M 2 pointed out, clients may lack enough insight into their complex health condition to truly self manage and GP 1 warned that by our over management of conditions we could be removing the clients ability to be independent rather than enhancing it.

\[5.5.6 \text{Summary}\]

In terms of improving long term condition management in primary care, delivering client centred care was seen to be an important factor. The participants in this research expressed similar sentiments to those from the literature review, namely, the relationship between clinician and client is one of the most important factors in delivering effective long term condition management. The participants generally felt that a whole team approach to delivering care was important. Some felt that locating the whole team together in one physical location would further enhance care. Whilst there has been great emphasis from the New Zealand Ministry of Health on client self
management of long term conditions, the participants had some reservations about the amount of actual self management clients could undertake.

A genuine desire was expressed amongst the participants to ensure client care was delivered in a more holistic manner designed to increase access and accountability. However, certain circumstances made them feel relatively powerless to initiate large scale changes. These power relationships will be discussed in the following section.

### 5.6 Power

The subject of power in human relationships has often been discussed in the context of healthcare. It was not a theme that emerged overtly from the literature review but it did emerge strongly from the interviews with the participants of this research. As the participants were from various parts of the primary health care setting their awareness of power relationships was expressed as a hierarchical structure, with those in each stratum expressing feelings of powerlessness to those in the next strata above them. This feeling of powerlessness was a barrier to implementing change in long term condition management. The relationships that will be discussed in the following sections are: Management and the Ministry of Health; General Practice and Management and Nurse and General Practitioner.

In the context of this discussion both TPHO and the DHB management teams are discussed jointly as the participants seemed to make little differentiation between these two organisations in their interviews.

#### 5.6.1 Management Teams and the Ministry of Health

The power of the Ministry of Health was considered optimal. Two participants described how the Ministry of Health would make nationwide decisions that impacted on them locally. For example:

We got an email (from the ministry) saying that the very low cost access …that’s probably going to go…so we have
to do something different, we’re going to be forced to do something different. M 1

There are drivers that come from the Ministry which are sort of very national and don’t necessarily meet local needs. GP 3

When discussing the idea of giving General Practices more control of their budget one participant felt the Ministry would not support this:

That’s just a repeat of what we did with the HealthRight model so...I know just from the fights we had with the ministry over that, it’s perceived as DHBs losing control. M 1

Whilst having described “fights” with the Ministry of Health over the funding of various initiatives, the management teams were very much dependent on the current thinking and initiatives arising from government level:

The minister has asked for expressions of interest in terms of looking at integrated family health centres and there’s going to be a wave of them and we are hopeful that we can be in one of the first waves. M 1

Whilst the Ministry of Health was seen as holding the ultimate power and therefore making decisions regarding how long term conditions would be managed, management teams did reveal that on occasions they had been successful in negotiating their own initiatives. GP 3 felt that nationwide initiatives were often unsuited to local application. The next type of power relationship that was revealed in the research was between General Practice and management teams.
5.6.2 General Practice and Management Teams

Several of the General Practitioners spoke of not having enough involvement in planning and funding decisions. They expressed their perceptions of powerlessness in these ways:

I think it’s clear that we’re not involved at the critical political and funding decisions and that, when there is an attempt made at discussion, generally the decisions have already been made. GP 4

A lot of the sort of groups that meet, there’s actually an underlying agenda that’s running behind the scenes, that means that whatever you decide to do doesn’t happen anyway and whatever was destined to happen in the first place does happen. GP 3

Despite this, those in management teams felt that General Practitioners had adequate involvement in the processes:

Any planning we do involves PHO management, the PHO board and there are docs sitting on that. M1

In fact, one participant expressed the opinion that the management teams had limited power over the General Practice teams:

It’s very hard for the PHO to actually influence things when all the practices are actually individually owned or set up…I don’t have the right to go into a practice and tell them how to run their business, it’s run how they see what fits them best. N 2

One nurse described how some practitioners had taken control and approached management teams with initiatives that were successful in receiving funding:
A few years ago (we) approached TPHO about targeting patients who weren’t presenting or had lifestyles that could be changed to better their heart health and (it) was granted, and that was only to our practice… it finished in end of June but we found it was really good…and so we wrote to TPHO regarding continuing that funding so they granted it to us again. N 1

Despite the feeling of powerlessness that most General Practitioners expressed some had obviously not seen it as a barrier to commencing new long term condition related initiatives at a practice level. However, when attempting to structure General Practitioner representation at management or planning level a further barrier was seen to exist in terms of the disparities between each practice and each practitioner:

You could talk to the 24 GPs that are in Turanganui PHO you can get 16 of them and talk to them about something you were going to do and the 8 that you’ve not talked to will show you something you haven’t even thought of. Because their practice, and that’s not their scope of practice, the way they practice, whether it’s from a business perspective or a professional perspective, is so completely different. M 2

How to ensure each voice is heard at management level is a challenge for management teams and General Practitioners alike. General Practitioners felt that decisions about long term condition service delivery were made at management level and that even when they made the effort to be involved they had little power over the ultimate course decided upon. One management participant felt that as each General Practitioner held such different business and professional perspectives it would be very difficult to satisfy all needs. The next strata in the primary care hierarchy was the nurses.
5.6.3 Nurse and General Practitioner

Many of the participants spoke positively about the relationship between nurses and doctors in General Practice but often the language used portrayed the nurse as someone placed to help the doctor rather than an expert in their own field. A nurse explained:

We see a lot of patients as well and try and...help them as much as we can before the GP comes in because he's only got 15 minutes or so to work with them. So if we can work with them and shorten the time for the doctor or get things done while he's about to come and see them it works really well. N 4

One participant observed:

I think it’s an unspoken dynamic. They would probably say “we have a wonderful relationship GPs and nurses”, as long, and I think that the underlying statement is, as long as we both stay in our respective places. M 1

Some participants pointed out system flaws that reinforced the power dynamic between doctors and nurses, such as the way blood test results and specialist letters come into the practice as well as ordering rights for tests:

Again we depend on the doctor relaying that information cause it comes in to him and it’s not generally copied to us, which I can appreciate. N 1

We’ve got a nurse practitioner who, as you know, is leading nurse led services out in certain industries. But she’s frustrated, she can prescribe but she can’t refer directly for radiology for diagnostics. M 1
A simple example of power imbalance is that of space:

Our problem here actually is physicality…normally as nurses we actually don’t have a room we can use. N 3

As noted previously many of the participants described a lack of clinical leadership. Despite this there seemed to be an assumption by some that nurses would be able to take on extended roles:

Hopefully nurses will step up and lead a lot of the services. M 1

Some of the nurse participants felt that General Practitioners had influence at the planning and funding level, despite the General Practitioners unanimously declaring that they felt they had no influence:

I guess GPs have more input into what happens in the DHB but I always feel that, the PHO and the DHB, you know, the big head honchos, have got all the say and they’re not always consulting with those who are actually doing the work. N 4

When asked about primary care clinician’s involvement in planning and funding one nurse stated:

I’m not sure and I’m probably not the right one to ask either because communication sometimes isn’t the greatest thing because we’re all so busy doing things. N 3

The assumption seemed to be that this level of decision making would be left to the doctors. Some General Practitioners were positive that the relationship between doctors and nurses in primary care was a complementary one:

There’s a lot of intuitive working together that goes on between GP and practice nurse…I think in this practice
we’ve got a very experienced, very low turn over, core of nursing staff who do their own thing, you know, develop their own competencies. GP 2

Although one participant pointed to an example which highlighted a lack of power:

General Practice is so (busy) at the moment that they will pause all of the nurse led clinics that don’t have anything to do with acute because they need a free nurse to do triage and support the doctor in the acute situations. So do you feel, as a nurse, like you’ve really got the power to be a nurse in a nurse led clinic? Well you have, only on the benevolence of what the business is considered important at that time. M 2

The same participant suggested an alternative mode of practice to increase nurses’ power:

I always thought that nurses could start some kind of entity of their own, where they remove themselves out of direct employment relationships and are contracted back in to any, including general practices, and we’re collaborators in the delivery of services in this facility and here’s the terms in which we choose to work. M 2

However, one General Practitioner expressed concern about devolving control to nurses:

There are also issues regarding fragmentation...by having more people involved we also lose something in terms of relationships. I mean you gain something because they all contribute something but. GP 4

Management team participants were aware of the lack of power nurses held. However, in general the nurses’ comments reflect that they were, in some cases, unaware of and
in other cases accepting of their lack of power in the primary care structure. However, if long term condition management is going to be devolved to nurses an attitudinal shift and good clinical leadership will be needed.

5.6.4 Summary

A perceived lack of power was a significant factor in determining the extent of innovation in managing long term conditions. One participant spoke about engaging in a power struggle so as to be able to instigate separate initiatives to those determined by the Ministry of Health. Another participant described taking the initiative to apply funding to a different demographic of client so as to meet their practice population needs. However, on the whole most participants saw themselves as relatively unable to influence directives from the stratum above them. When clinicians feel powerless to influence decision making processes they will often disengage from the process and become resistant to changes imposed upon them from above. They key to empowered and active participants in change is meaningful engagement in the decision making and implementation process.
Chapter Six – Conclusion

The aims of this research were to present the perspectives of health professionals within Turanganui PHO with regard to long term condition management and identify possible barriers to improved service delivery. The four nurses, four General Practitioners and two management team personnel who were interviewed were a source of rich data which can be used to begin identifying a way forward with long term condition management within the PHO.

The strongest theme revealed was that of funding. All the groups of participants spoke about funding to one degree or another. For the General Practitioners it appeared to be a significant barrier to delivery of services, the nurses acknowledged it was a barrier but were less connected to it as they were often uninvolved in the process of generating income and decisions as to the use of funds. Data from the management personnel revealed two important pieces of information regarding funding. Firstly, that there was not going to be an increase in funding for the foreseeable future and secondly, that moving to a system of lump sum funding was a strong possibility.

Several General Practitioners gave the impression that lump sum funding would be a welcome alternative, as it would give them increased autonomy in the management of service delivery for their client group. They indicated that each General Practice has a different client group and therefore has differing health needs or requires an alternative approach in managing those health needs. Due to these differences, they felt that individualised management would be more successful than a local or national service structure and would enable them to provide client focused rather than disease focused care. However, with increased autonomy there would be increased accountability. The management participants spoke extensively about reporting on outcomes to the Ministry of Health and this responsibility would, in turn, be passed on to General Practice, a consequence of which could be increased reporting, target and performance driven payment schedules and greater planning and funding involvement. Some participants expressed that they currently could not find the time for reporting and planning of practice activities, therefore any extra responsibilities may not be achievable.
The literature review confirmed that long term conditions were going to be an increasing burden on primary care (Wagner, et al., 2005; World Health Organisation, 2002) and as no increased funding can be expected, logically General Practice cannot cope with an increased workload by continuing in the same manner of working with the same personnel in the same roles. Successful practices reported an increased utilisation of nursing and administration roles. Participants, in the main, acknowledged that role protectiveness was a significant barrier to changing service delivery. By examining the skill set of each member of the General Practice team and utilising them in the area for which they are most qualified a greater and more constructive volume of work can be accomplished. Some participants had already begun to realise this but were struggling to accomplish a complete change due to lack of space, system impediments or perhaps a lack of time out of clinical work to plan thoroughly.

Several participants commented that General Practitioners and nurses have differing and complementary skill sets. One suggestion made was that General Practitioners should handle the telephone triage of morning patients. This could result in a reduction of acute appointments necessary during the day and allow for nurse led sessions for clients with long term conditions. Doctors are skilled diagnosticians and are the ‘best fit’ for acute triage decisions.

The literature review revealed that nurse led services for long term conditions were as successful as doctor led services and in fact resulted in improved outcomes for clients in some areas (Grimmer-Somers, et al., 2008; Laurant, et al., 2004; Litaker, et al., 2003; Senior, et al., 2008). To increase the use of nurse led clinics the participants identified that nursing needed a stronger voice at service planning level and increased leadership across primary care. The research highlighted that duplication of services exists across this relatively small PHO, with Iwi organisations, the PHO and secondary care all delivering similar nursing services to primary care. By increasing the cooperation and communication across these groups it would be possible to develop a meaningful framework for delivery of services where each group is clear about their core business and as a collective they fulfil the recognised needs of the area. For example, the participants reported great satisfaction with a local Iwi organisation that had the ability to use the marae’s and other venues to target at risk people who would not present to primary care. Along with home visits for those unable to attend primary care this would
appear to be valuable core business. The participants suggested that Iwi organisation health professionals are in the best position to raise the community profile of health services and develop further strategies to target identified hard to reach groups.

The participants spoke of the worth of specialist nursing services from secondary care as they were able to add value to highly complex client groups and form links between primary care and ongoing secondary involvement. To increase the value of these services the integration of IT systems was highlighted as an area for continued development. It was suggested that whilst there is a need for primary care to have access to a majority of secondary care information there is only the need for a defined data set of primary care information to be viewed at secondary level due to privacy issues and sheer volume of data. Whilst progress on this has already been made locally one participant suggested that by leaving aside personal agendas and by continued involvement from key individuals at a primary and secondary level it could result in greatly enhanced continuity of care.

The PHO also offers some nursing services and the value of these was identified by some participants in both a ‘hands on’ and leadership role. Whilst some practices may need a ‘hands on’ approach in the development of nurse led services, to avoid disempowerment and future reliance on outside sources, a strategic leadership role would be of value for the future. Some nurse participants still identified access to professional development and education as an issue, as well as revealing their relatively powerless place in the hierarchy of some General Practices. The PHO would be well placed to offer a coordinated approach to primary care education including nursing cover for time out of General Practice. This would lead naturally to the development of clinical leadership in a nursing context. One participant raised the suggestion of using advanced technology to enhance communication such as ‘webinars’. These virtual meetings are relatively easy to use with a workable computer system and enable people to interact without leaving their office, thus drastically reducing the time spent in meetings. While clients may not be ready for these advances yet, health professionals are well placed to use such methods to improve coordination of service delivery. Monthly virtual meetings between nurses involved in primary care, to reduce duplication and improve strategies for service delivery as well as providing
peer support and professional development, would be valuable and could be developed from a PHO level.

General Practitioners interviewed also identified the need for “a voice” at service development level. Whilst measures have been taken to improve clinical leadership the participants raised doubt as to whether these measures were fulfilling current need. Due to differences in structure of each General Practice, as outlined earlier, this is a hard group to represent. General Practitioners also expressed doubts as to the value of their involvement in higher level planning and funding activities as they believed that the real decisions had already been made prior to their attendance. As a result trust needs to be developed between the groups involved. As seen from the literature review (Branson & Badger, 2008; A. Wilson, et al., 2002) and expressed by some of the participants, the usefulness of a way of working needs to be demonstrated and then commitment will follow. The General Practitioners need to feel as though the sacrifice of their time and effort to be involved in planning and funding strategies will be rewarded with real power and involvement in decision making. The management teams, on the other hand, need to feel as though the General Practitioners will work more as a collective rather than individuals. Again the development of trusted clinical leadership, as recommended by the MRG committee (Horn, 2009), will enable this process.

Whilst funding was seen as a significant barrier in delivery of long term condition services other practical considerations were raised by the participants. One such issue was physical space for consultations. Nurses were often particularly vulnerable to losing consulting space as General Practitioner consultations were seen as a priority. One solution, as suggested by the participants, was a future plan to develop Integrated Family Health Centres. These centres would be designed to house a range of health professionals with consulting space in plentiful supply. The development of larger health centres is a long term solution but in the shorter term other areas have found success by staggering the time of clinics throughout a longer working day. In this way the afternoon session could be utilised for nurse long term condition clinics and an evening session for General Practitioner consultations. Some participants expressed that DNAs were a problem in long term condition clinics and it is conceivable that daytime appointments are not always convenient, especially for clients with mild to moderate disease who may still be in employment.
The subject of DNAs was raised by some participants as being a barrier for their practice in implementing planned long term condition care. Other practices described how a system of client centred appointments and client reminders had alleviated the problem of DNAs. One participant suggested that the relationship developed between the nurse and the client mitigated DNAs. Relationships between the client and the health professional involved in long term condition management were seen to be of paramount importance from the literature review (Branson & Badger, 2008; Cram, et al., 2003; D. Wilson, 2008). In fact, the research showed that whether a doctor or nurse delivered the service was less important than the continuity and relationship between the client and the health professional.

The Horn report (2009) recommended increased cooperation across primary and secondary care and some participants highlighted this as an issue locally. Clinicians spoke about their desire for increased collegial support in the management of clients with complex long term conditions. Virtual clinics were one of the Horn report (2009) recommendations and have been commenced locally in the management of diabetes. By increasing the use of virtual clinics and continuing to improve the communication between secondary and primary care clinicians, clients can be managed in primary care rather than by referral to secondary care.

The majority of the participants reported good utilisation of evidence based guidelines with most using computer aided decision support tools. The literature review indicated that computer aided programmes improved use of guidelines and this appears to be reflected locally (Dennis et al., 2008). However, the participants did express that the guidelines have to be individualised to each client and therefore could result in varied application between clients or clinicians. One participant opined that some health professionals make decisions about the client’s ability to fulfil guideline recommendations or comply with treatment regimes without discussion with the client. This kind of paternalistic action can be more prevalent towards Māori clients and goes some way towards explaining the inequalities in health for Māori (Jansen, 2009; Riddell, et al., 2007). Nevertheless, the majority of participants acknowledged the social determinants of health and both doctors and nurses demonstrated that they utilised strategies to engage clients in investing in their health by addressing those needs.
Turanganui PHO encompasses a demographic with some of the worst health outcomes in New Zealand and long term conditions contribute significantly to the morbidity and mortality of the population. Primary care clinicians were aware of their responsibility to improve long term condition management but often felt disempowered to change the structure of health care in General Practice. Oncoming directives from the Ministry of Health could serve to provide the change in structure desired by many participants but for nurses to evolve into leaders of long term condition services further changes are needed. General Practitioners have to believe that nurse led services would actually improve the delivery of care to clients in their practice and nurses have to grow in skill set and confidence to encompass these new roles. The PHO and DHB management teams play a large part in the potential success or failure of upcoming changes and need to be responsible for continuing to encourage the development of meaningful clinical leadership structures and improved communication between secondary and primary care.

The research question ‘what are health professionals’ perspectives on the management of long term conditions in the Turanganui area?’ has been well answered by the participants interviewed. This study has shown that health professionals have a desire to improve long term condition management but often feel powerless to effect the large scale changes necessary. The participants felt that current service structure was compromised by fragmented funding and poor communication between care providers. They felt that barriers to future service development were a lack of clinician involvement in management level decisions and the role protectiveness of clinicians in primary care.

**Implications for Nursing Practice**

As highlighted in the literature review, primary care nursing is going through a period of change. Internationally primary care nurses have taken on increasingly autonomous roles in the management of long term conditions. The New Zealand Primary Health Care Strategy (Ministry of Health, 2001) recognises an increased need for primary care nurses with a wide range of skills and the Framework for Activating Primary Healthcare Nursing in New Zealand (Expert Advisory Group on Primary Care Nursing, 2003) urges primary care nurses to use the implementation of the Strategy as an opportunity to develop new ways of working. Nurses within TPHO have these same opportunities.
However, significant barriers to expanding nursing roles within TPHO exist. As yet funding streams, or the interpretation of funding streams, do not reflect the contribution of nurses in long term condition management and inhibit the remuneration expected for advanced practice nurse roles. The pressure of acute presentations and lack of physical consulting space serve to reduce the continuity of nurse led clinics and highlight the relatively low value placed upon these clinics. PHO and DHB clinical nurse leadership is needed to raise the profile of primary care nurses work and to support innovations for long term condition management. The most significant barrier for nurses is their own lack of awareness that nursing can play a pivotal role in reducing inequalities and delivering excellent long term condition management.

**Implications for Future Research**

As mentioned previously this research would be strengthened by the addition of a consumer voice. Health professionals’ perspectives on long term condition management are important but the healthcare consumer perspectives’ would be invaluable. This research is a useful starting point and the researcher hopes to return to the subject at a later time to investigate public perceptions. It would then be possible to compare findings from this first study to future work with the general public.
REFERENCES


Smythe, L., & Giddings, L. (2007). From experience to definition: Addressing the question 'What is qualitative research?'. *Nursing Praxis in New Zealand, 23*(1), 37-57.


Appendix i

NZ Deprivation Index 2006
Tairawhiti DHB
Appendix ii
Letter for Organisational Consent

7th May 2009

(Name of Organisation)

(Name of CEO or Board Chair)

The Northern Regional Ethics Committee has given approval to a research study that I will be undertaking. The research is entitled “Chronic Disease Management: What are Health Professionals Perspectives?” and will be conducted between June and August 2009 in the area of Turanganui Primary Health Organisation.

I intend to invite General Practitioners and Primary Care Nurses including, Practice Nurses, Disease State Management Nurses and Nurse Practitioners, to be interviewed on the subject of chronic disease management delivery. I would also like to interview members of the strategic management teams about chronic disease service planning.

I would gratefully ask for the consent of your organisation to proceed with this research. If you have any questions please feel free to telephone me on, 8690500 Ext 8522 or 0275798800.

Yours faithfully

Natasha S Ashworth
15th July 2009

Tena Koutou nga Rangatira o te Ao. Tenei te mihi nui kia Koutou kei roto e tenei ao hurihurui. No reira, tena Koutou katoa.

Ko Puketapu te Maunga
Ko Te Arai te Awa
Ko Epeha te tupuna Whare
Ko Manutuke te Marae
Ko Rongowhakaata te Iwi, Mauri Ora
it e whe Ao it e Ao Marama
Tihei Mauri Ora.

Ko John Pomana Reverend o te Haahi Wairua Tapu’ O Te Ringatu for 15 years, Kaiawhina and team leader of Tane Hauora for Turanga Hauora for 5 years.

I believe the project that Natasha is undertaking is research that would benefit Maori Men and whanau particularly in this area; in our discussions together about the project I would be happy to say that she is and would be suitable to research this project.

No reira, ka nui te mihi kia Natasha

Na John Pomana
15 July 2009

Northern Y Regional Ethics committee

To Whom It May Concern

Tena koe. Tuatahi, ka mihi atu ki nga Atua e hamara nei i a tatou. Ka tika me whakaaronga ratou ma kua rito ki tua. Ka hoki mai ki a tatou te hunga ora, tiheimauriora.

Re: Support of Natasha Ashworth’s Masters Research.

Having reviewed Natasha’s research proposal, in my capacity as Kaiwhakahaere Hauora Maori (GM Maori Health Tairawhiti District Health, TDH) and mandated by whanau, hapu of Tairawhiti, her research proposal is supported.

In discussions with Natasha it has been agreed that she will seek out an appropriate Maori Health professional to review progress and support. The culmination being for her to present orally to myself and other suitable kuia and korouato to ensure cultural safety and appropriateness is assured.

Thank you for your positive response to this research project which I feel sure will ultimately be of benefit to our people of Tairawhiti.

Naka noa na

Maaka T Tibble MNZM
Kaiwhakahaere Hauora Maori
Tairawhiti District Health
(06) 8690500 x 8401
maakat@tdh.org.nz
Appendix v

12 July 2009

To: Northern Regional Ethics Committee

From: Keriana Brooking
Chief Executive
Turanganui PHO
Gisborne

This memo is to confirm that I have met with Natasha Ashworth several times over the course of her Masters Research topic development to specifically discuss with her the impact of her research topic on Maori within Tairawhiti at a service deliverer, service user and community level.

If you have any further questions I am happy to be contacted at kerianab@tpho.org.nz or 0275 901 378

Keriana Brooking
Appendix vi

Letter to invite interview participants

7th May 2009

(Name of invitee)

The Northern Regional Ethics Committee has given approval to a research study that I will be undertaking. The research is entitled “Chronic Disease Management: What are Health Professional’s Perspectives?” and will be conducted between June and August 2009 in the area of Turanganui Primary Health Organisation, in fulfilment of a Master of Nursing qualification.

I would like to interview General Practitioners and Primary Care Nurses (or Strategic Management Team Members) on the subject of chronic disease service design and delivery. The aims of the research are as follows:

1. To describe nurse perspectives on chronic disease management.
2. To describe General Practitioner perspectives on chronic disease management.
3. To identify barriers to future change in the delivery of chronic disease services.

You are invited to participate in the research. The interview will be approximately an hour long and can be carried out at a venue of your choice. I would suggest that an environment free from distractions and time pressures would be preferable and I can offer my home or office or alternatively a venue of your choosing.

If you have any questions about the research please feel free to contact me on 8632643 or 0275798800.

Kind regards

Natasha S Ashworth
Appendix vii

Information for Research Participants

Project Title: Chronic Disease Management: What are Health Professionals Perspectives?

To:

Researcher(s): Natasha Ashworth

Affiliation: EIT – Hawkes Bay

Description of the research:
A qualitative study to describe the perspectives of key groups of health professionals in Turanganui Primary Health Organisation with regard to chronic disease management.

What will participating in the research involve?
I would like to interview you at a location of your choice. The interview should last approximately one hour and refreshments will be provided. With your permission I would like to audiotape the interview and I will be asking your opinions on a range of subjects that pertain to chronic disease management in Turanganui.

What are the benefits and possible risks to you in participating in this research?
This research will aid reflection on practice. It may also contribute towards development of a long term conditions strategy for the district.
There should be no exposure to risk from participation in this research.

Your rights:
• You do not have to participate in this research if you do not wish to.
• If you are a student at EIT and do decide to take part, you can withdraw from the research at any time and this will not affect treatment or assessment in any courses at EIT.
• If you are a patient or under the care of students or staff from EIT, you can withdraw from the research at any time and this will not affect your treatment or assessment in any way.
• Once you have completed the interviews you have a three (3) month period within which you can withdraw any information collected from you.
• You are welcome to have a support person present (this may be a member of your family/whanau or other person of your choice).
• You may have access to the research findings and may request a copy of the completed research.

Confidentiality.
Identifiable information about you will not be made available to any other people without your written consent. All identifying information will be omitted from the research findings. All paper copies of data will be stored in a locked filing cabinet and all electronic data will be stored in password protected files for a total of one year after publication of research findings.

If you wish to participate in this research, or if you wish to know more about it, please contact
Contact Person: Natasha Ashworth

Work phone # 06 8690500 8522
Email address natashaa@tdh.org.nz

Mobile phone # 0275798800
Home phone # 06 8632643

: Natasha Ashworth – Faculty of Health and Sport Science

For any queries regarding ethical concerns, please contact:
Professor B. Marshall, Chair, Research Approvals Committee, EIT. Ph. 974 8000 ext 5422
Appendix viii

Schedule of Interview Questions

1. Tell me about long term condition services available in primary care in Turanganui Primary Health Organisation.

2. Tell me about whether you think these programmes meet the needs of all of your clients with regard to long term conditions.

3. What do you think about evidence based guidelines for long term condition management in theory and in practice?

4. What barriers do you see to improving long term condition services in Turanganui Primary Health Organisation?
Appendix ix

Confidentiality Agreement

I _____________________________ understand that I must maintain confidentiality of any information or opinions contained in the taped research interviews that I will transcribe for Natasha Ashworth.

I will not discuss the contents of the tapes with any other individual and will keep the tapes in a secure location during the transcription process.

Transcriber______________________________________

Researcher______________________________________

Date___________________________________________
CONSENT FORM

Project Title: Chronic Disease Management: What are Health Professionals Perspectives.

Researcher(s): Natasha Ashworth

I have read and I understand the Information for Research Participants sheet dated----/----/------ for volunteers taking part in this study. I have had the opportunity to discuss this study and am satisfied with the answers I have been given.

I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future health care / continuing health care / academic progress/ employment (insert only those phrases which are appropriate)

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I have had time to consider whether to take part, and know who to contact if I have any questions about the study.

No

I agree to take part in this research

I consent to my interview/activity being videotaped/audiotaped

I wish to receive a copy of the results

I would like the researcher to discuss the outcomes of the study with me

Yes

Signed: _______________________________________________

Name: ________________________________________________

Signature of Research Participant’s Support Person (if applicable)

_________________________________________________

Date:  _____________________

Witness:  _______________________________________________

I/We as researcher(s) undertake to maintain the confidentiality of information gather during the course of this research.

Signed_________________________________________________

Dated______________________
Appendix xi

HAWKE’S BAY

Ref: 19/09

3 August 2009

Natasha Ashworth
C/- Faculty of Health & Sport Science
EIT Hawke’s Bay

ashworth.tash.rob@xtra.co.nz

Dear Natasha

Thank you for the further information received, as requested by the EIT Research Committee for your project “Chronic disease management: what are health professionals’ perspectives”.

I am pleased to inform you, your project has been approved. You are reminded that if the proposal changes in any significant way, then you must inform the Research Committee.

The Committee wish you well for the project.

Kind regards

Jeanette Fifield
Secretary – Research Approvals Committee

CC: Dr Shona Thompson, Faculty of Health & Sport Science
Appendix xii

Northern Y Consent