Victorian Nurse Practitioner Program (VNPP)
Evaluation of Phase 4

Nursing and Midwifery Workforce
Workforce Development
(People in Health)

Department of Health & Human Services
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<th>Acronym</th>
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<tr>
<td>ACNP</td>
<td>Australian College of Nurse Practitioners</td>
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<tr>
<td>DH</td>
<td>Department of Health</td>
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<tr>
<td>DHHS</td>
<td>Department of Health and Human Services</td>
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<td>MBS</td>
<td>Medical Benefits Scheme</td>
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<td>NMBA</td>
<td>Nursing and Midwifery Board of Australia</td>
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<td>NMW</td>
<td>Nursing and Midwifery Workforce</td>
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<td>NP</td>
<td>Nurse Practitioner</td>
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<td>NPC</td>
<td>Nurse Practitioner Candidate</td>
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<td>PBS</td>
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Executive summary

The Department of Health and Human Services (the Department) established the Victorian Nurse Practitioners Program (VNPP) to support the development of the Nurse Practitioner’s (NP) role in the Victorian health system by developing NP models of care. The first NP demonstration projects were commenced in July 1998. The VNPP has supported organisations to develop NP models of care that are aligned with the strategic policy directions of both the government and local service needs and priorities.

NPs are a relatively new form of advanced nursing, extending the practice of nursing to a more autonomous role than that of Clinical Nurse Consultants or Nurse Specialists. The NP role was first established in the USA in 1965, though it was not until 1990 that the first NP committee was convened in NSW. NPs have a Master’s degree and are endorsed by the Nursing and Midwifery Board of Australia to practice at an advanced level. The extensions to practice include: advanced assessment and management of clients using nursing knowledge and skills within a defined scope of practice; prescribing medications; ordering diagnostic investigations; and direct referral of patients to medical specialists.

The first three phases of the VNPP helped define NP scope of practice and demonstrated the feasibility of the role. Amendments to the Nurses Act 1993 set the scene for the recognition of advanced clinical nurses who had been practising in extended roles for a number of years. The Nurses (Amendment) Act 2000 protected the title ‘Nurse Practitioner’ and made provision for suitably experienced and qualified advanced clinical nurses to be authorised to prescribe a limited range of drugs and poisons under the Drugs Poisons and Controlled Substances Act 1981 (DPCS Act). Subsequent pilots supported NP models of care in a range of health services and areas of practice, including emergency and urgent care centres. Within these models of care, NPs were leading clinicians working collaboratively with a multidisciplinary team. The first Victorian NP was endorsed in 2004.

The fourth phase of the VNPP commenced in 2007. It continues to be managed by Nursing and Midwifery Workforce (NMW) in the Health Workforce Branch of the Department. The VNPP has six core elements:

1. NP model development grants
2. Nurse Practitioner Candidate (NPC) support packages
3. The Victorian NPC Mentoring pilot
4. NP scholarships
5. Publication grants
6. NP collaborative groups (communities of practice).
In 2015, NMW commissioned an evaluation of the VNPP Phase 4 to inform future directions of the program. Campbell Research & Consulting was engaged in May 2015 to undertake the evaluation.

**Evaluation objectives**

The objectives of the evaluation were to:

- Determine the effectiveness of VNPP Phase 4, exploring the viability and sustainability of model development activities funded to date;
- Make recommendations to ensure the VNPP remains aligned with government priorities and policy in the context of current Commonwealth and State funding;
- Demonstrate how present funding activities support the viability and sustainability of NP models of care.

**Method**

Campbell Research & Consulting used a multi-method approach. A qualitative component used site visits and interviews to identify the range of issues encountered by nurse practitioner candidates (NPCs), NPs, health services and community-based organisations when considering and implementing NP model development and other activities of the VNPP. A variety of sites in metropolitan and rural regions were visited, including large health services, small community-based services and specialist services. Consultations were held with stakeholders including counterparts in other states. A quantitative component used two online surveys to assess the extent to which the VNPP impacted the NPs and the organisations in which they were located.

This evidence has been used to evaluate the impact of the VNPP on the implementation of NP models of care that were viable, sustainable and aligned with government policy.

Analysis of the qualitative and quantitative data was framed by an approach identifying barriers and enablers at four major levels: the individual clinicians (NPs and NPCs), the teams in which the clinicians work, the organisations in which they are located and broader system-level factors, including the policy settings of the Victorian and Commonwealth governments. Patient outcomes have been a focus of the NP models of care and clinical work; however, patients have not been included in the current evaluation which has focussed on evaluating the VNPP. The effectiveness of the role itself was not within the scope of this project.

**Findings**

The VNPP has supported the implementation of NP models of care in a wide range of organisations and clinical settings. Organisations where NP models of care have been funded include major teaching hospitals, regional hospitals, small rural health services and community-based services. Clinical settings include: renal, stroke, palliative care,
emergency and urgent care, oncology, mental health, alcohol and other drugs, neonatal services, aged care, and chronic disease management.

NPCs, NPs, executives and medical mentors involved in implementing the NP models of care identified substantial challenges facing NPCs and NPs. At the system level, these challenges included restricted access to Medical Benefits Scheme (MBS) provider numbers thereby diminishing the viability of NPs to practise as endorsed; for those with MBS provider numbers, the low level of MBS reimbursement affected the viability to practise as independent NPs. The opposition of medical stakeholder groups was identified as a systematic challenge, although the everyday support of medical professionals engaged in developing the NP models of care within health services was a vital enabler.

At the organisational level, a lack of awareness of the professional identity of NPs – who they were and what they did – has provided a challenge. This was particularly the case when there were changes in executive or organisational structures, and champions of the NP role were no longer in the organisation.

At the team level, the key challenge was establishing the identity of the NP, clarifying their role and how they would work with other team members (medical professionals, allied health and other nurses). The relationships and role clarification, established through the model development grants and the steering committees required for successful applications, proved to be important enablers for addressing these and other challenges.

At the level of individual clinicians, challenges included changing the nursing clinicians’ mindsets to become autonomous nurse leaders. The cost and workload required to achieve endorsement were also a major challenge for individual NPCs.

The evaluation found that the VNPP assisted NPCs and organisations to overcome a number of challenges, particularly medical opposition at a system and organisational level. This was achieved by engaging all stakeholders in establishing the NP models of care with clear clinical governance frameworks and alignment to health service priorities.

Other jurisdictions considered the focus on establishing organisational frameworks to be a core strength of the approach taken by the VNPP and these jurisdictions were themselves implementing organisation-focused programs. This organisational focus was contrasted to initiatives that had focused on outputs (the number of NPs endorsed) as opposed to the outcome focus of the VNPP (developing capacity to sustain NP models of care in organisations).

The VNPP

Since commencement of phase 4, the VNPP has funded: 44 NP models of care, 39 NPC Support packages, 103 Scholarships, seven NP collaborative groups and 13
publication grants. The Victorian NP Mentoring pilot supported 19 pairs of mentors and mentees through an intensive mentoring program, to develop leadership skills that are one of the core competencies required for endorsement as a NP.

There are now 231 NPs in Victoria with an estimated 70 NPCs. NPCs were found to be highly motivated, experienced nurses, prepared to take on Master’s study while working in full time nursing positions. NPs had been nursing for an average of 25 years while NPCs had been practising for an average of 23 years since graduation. NPs had been endorsed for an average of 3.5 years.

Most (64%) of the NPs’ work was direct service provision. The rest of their time was distributed relatively evenly between mentoring and supervision of other nurses, research, administration, capacity building and continuing professional development.

Nurses wanting to become candidates were actively involved in model development, together with a wide range of other stakeholders in the health services. Seventy-five per cent of NP/NPC survey respondents indicated some level of involvement in the application for model development funding, model design, steering committees, or the VNPP model development report. There was a high level of awareness of the need for the model to address organisational needs rather than promoting the interests of individual clinicians.

NP models of care have proved to be resilient and adaptable. Many (52%) of NPCs and NPs said the model of care they were providing was different to that initially proposed in the report for the model development grant. This demonstrates that model development was an ongoing process, responsive to service needs and patient demand. Eight per cent indicated the initial model was not suitable in practice, and a similar proportion that the organisation had discontinued or changed the model.

Engagement of medical professionals in the development of the model, clinical supervision and mentoring was important for successful implementation. For medical directors, consultants and GPs interviewed during the site visits, the key to success was a suitable clinical governance framework.

Many medical professionals were clear that the NP model of care was not a substitution for a medical professional, but a sophisticated nursing model of care. There was some overlap in NP and medical tasks and a continuum with direct substitution of some medical work at one end and very little overlap at the other. In some NP models of care, such as urgent care services, the NP’s role came closer to being seen as medical substitution. This was substitution for tasks within the NP scope of practice. It was not medical replacement. Funding sourced from a traditionally “medical” budget sometimes compounded this perception.

A number of restrictions on NPs being able to work within their scope of practice were identified. Only 42% of NPs said they could prescribe all their formulary, with NPs in rural regions more likely to prescribe all. Only a few (10%) of NPs indicated the
Pharmaceutical Benefits Scheme (PBS) was the reason for restriction. Only 32% of NPs could order diagnostic investigations when they needed and a similar proportion could so most of the time. Not being able to order diagnostic investigations or refer patients to specialists were identified, during site visits, as major impediments to the viability of NPs practice, particularly in rural areas. Without a MBS provider number, NPs had work duplicated by medical professionals, creating inefficiencies and reducing their effectiveness.

The purpose of the NPC Support packages was to support organisations to provide the clinical and professional supervision required to apply for endorsement. The majority of NPs and NPCs reported they had sufficient time to attend collaborative groups (86%), get clinical supervision (80%), spend time with clinical supervisors (75%) or study for their Master’s degree (72%). The minority who reported they did not get sufficient quarantined time is of concern. During the site visits, NPs and NPCs from smaller organisations indicated difficulty in getting time free for NPC development.

Both NPs/NPCs and Directors of Nursing (DONs) indicated that there was support for time for NPCs to work with mentors.

Log books, using a spreadsheet to code hours of clinical and professional supervision against clinical supervision, mentoring and other activities, as well as the Nurse Practitioner Standards of Practice, were developed in 2011. The purpose of the log books was to assist NPs to prepare for endorsement and provide accountability for the NPC support package. Log books were used by the Department to identify if NPCs were appropriately supported by mentors and clinical supervisors, and by line managers within organisations to monitor NPC’s work.

Half of the survey respondents reported they did not complete the log books. Of those that did complete the log books, only half completed them at least weekly. The rest filled them in erratically or when due for submission to the Department. During the site visits, none of the NPCs or NPs reported enthusiasm for the log books. A number of NPs and NPCs reported duplicating the work, keeping separate diaries. The log books were acknowledged (reluctantly) as being useful for portfolio endorsement. The value of submission to the Department was questioned as there was no awareness of how the log books had been used.

Seven collaborative groups (or communities of practice) have been supported to provide peer support and shared-learning opportunities for specific clinical areas. These groups have received VNPP funding with additional support provided from the Palliative Care unit and the Integrated Cancer Services unit of the Department. The collaborative groups include NPCs, NPs and prospective candidates looking to enhance their understanding of what is involved in training to become a NP, prior to investing in their candidature. The VNPP has focused on specific clinical areas by targeting specific clinical areas in some rounds. This has developed cohorts of NPs in these clinical areas, in sufficient numbers for a viable NP collaborative group. Cross-
disciplinary local collaborative groups have been established in regional areas and in larger health services, independent of the VNPP.

Collaborative groups were seen to be providing a number of functions to support NPs, NPCs and others who are considering becoming a candidate. These include: advanced clinical training in the specific clinical area, mentoring, professional development and a forum for the presentation of research findings, networking and identification of employment opportunities. Most NPs and NPCs considered the NP collaborative groups an important support. They represent an excellent return on investment for the VNPP.

The Victorian NPC Mentorship Pilot was used to trial the value of providing intensive support to pairs of health service executive mentors and NPC mentees. The Pilot resulted in improved skills and capacity for leadership. A number of relationships established during the Pilot continued well after it ceased, and are still active. Mentees subsequently took on mentoring roles. However, the momentum has not been maintained and guidelines for mentors and mentees were not identified in the course of the site visits. The NP collaborative groups provided opportunities for prospective candidates to identify mentors and provided professional support that enhanced mentoring relationships. The Department has expressed interest in supporting a similar initiative in the future, but one that could cost-effectively include a wider representation of NPCs.

Publication grants were offered. These were primarily used for conference presentations with some peer reviewed articles published. Some collaborative groups also provided support for preparing conference presentations. The publication outcomes are not strong. Building the capacity of NPs as a professional group to develop research, evaluation and publication capacity is developing. This is likely to be enhanced as some NPs complete doctorates.

**Outcomes**

The three elements of the VNPP that NPs and NPCs considered to be important contributors to endorsement were the collaborative groups (rated 7.3 out of 10), the clinical supervision they received in the organisation where they were employed (7.0) and the model development grants (6.7). The lowest rating was given to the log books (4.1), the NPC Support packages (5.1), external supervision (5.1) and the Department (5.1). In the site visits it was revealed that NPCs were not always aware of the NPC Support package and how the funds were spent.

DONs and managers rated the model development grants (7.7), medical mentors (7.5) and clinical governance frameworks (7.5) as the three most important elements of the VNPP for the viability of the model within their organisations. External mentors (6.2), NPC Support packages (6.3) and Scholarships (6.5) were given the lowest rating for impacting on the viability of the NP model within the organisation.
The model development grants were considered by NPs and NPCs to contribute to improved patient outcomes (8.0), improved service delivery (7.5) and increased skill levels of clinical teams (7.0). Improved understanding of the model by executives in the organisation was rated positively, but scored lower (6.4). DONs and managers also perceived the biggest impact was on patient care (6.2) together with meeting specific service needs (6.2), although they did not rate these impacts as highly as NPs and NPCs.

For NPs and NPCs, working with the team stood out, with 93% agreeing that they worked well with the team. Close to half agreed that they were understood or supported by their team or the organisation where they worked. Nearly all (97%) DONs and managers saw the NPs as providing clinical leadership, as team players and being supported by other nurses.

For DONs and managers the impact of cost was identified as an issue for sustainability, with 67% agreeing that NPs cannot be sustained because of their cost. Access to MBS, and the quantum of NP fees when access was obtained, limited the viability of NP models of care.

NPs and NPCs most commonly identified communication and increasing awareness (mentioned by 37%), funding for sustainability (31%) and improved access to MBS and PBS (23%) as the best way for the VNPP to support sustainability of NPs. DONs and managers mentioned more flexible funding (26%), succession planning (24%) and support for rural health services (18%) as the most important future directions.

A minority (19%) of DONs and managers indicated that they were considering applying for a model development grant in the next round. More (39%) thought they may apply in a later round. The development of models outside the VNPP (mentioned by 51% of DONs and managers) indicates that there is an increased capacity in larger Victorian health services to develop NP models of care independently to the VNPP.

Clinical areas identified for future NPs were: aged care and oncology in metropolitan regions. Rural regions were most likely to identify aged care, emergency/urgent care and chronic disease management.

**Conclusion**

The VNPP has made a strong contribution to building the capacity of Victorian health and community services to develop and implement NP models of care. However, model sustainability remains vulnerable. There has not always been a strong and consistent commitment by health services to continue funding once a NPC has been endorsed by the Australian Health Practitioners Regulatory Agency (AHPRA). Where executive management has changed in an organisation, support for the NP model of care has, at times, been difficult to sustain. This was particularly the case where new executives were not clear about the role of NPs and where no clear business case has
been established for ongoing funding for the NP role (or where no details of an existing business case have been passed to new leadership).

The NPs and NPCs must constantly explain their role and what they contribute. These explanations are to executives, other nurses and medical professionals, usually when these personnel first encounter the NP. However, the leadership competency required for endorsement should mean that NPs can identify opportunities to evaluate their contribution and articulate that contribution within and outside the organisations. NPs should be expected to rise to the challenge.

There is a continuing need for support of model development. This was particularly evident in smaller organisations that are community-based and those in rural regions. Health services see aged care NP models of care as a priority and an area of future demand.

The collaborative groups stand out as being a successful element of the VNPP, providing a good return on investment.

The value of one-to-one mentoring, particularly external mentoring (over and above clinical supervision), was recognised, but perhaps not well understood.

Future directions for the VNPP include supporting smaller and more isolated regional services to develop NP models of care. Smaller rural organisations identified funding of NP level salaries as difficult and suggested salary supplements would enhance viability. Aged care has been identified as a priority for future development. Refocusing the grants from model development to implementation (including developing a business case) would provide an opportunity for supporting less well-resourced services within the existing policy framework of the Department.

Continued support for NP collaborative groups will provide value for NPs, NPCs and the organisations in which they are delivering services. Support for mentoring, research and publications are areas that could be developed further.
1 Background

Nurse Practitioners (NPs) are registered nurses (Division 1) endorsed by the Nursing and Midwifery Board of Australia to practise at an advanced level. NPs are educated to a Master's degree level and authorised to function autonomously and collaboratively in an advanced and extended clinical role. The extensions to practice for NPs include: assessment and management of clients using nursing knowledge and skills, prescribing medications, ordering diagnostic investigations and direct referral of patients to other health care professionals. The scope of practice of the NP is determined by the context in which the NP is authorised to practise (Australian Nursing and Midwifery Council, 2014).

In Victoria, a taskforce was established in 1998 to develop a framework and process for the implementation of the NP role within the state. Nine Demonstration Projects were established concurrently as action research projects to identify how NPs would be accepted by patients and other health professionals. These action research projects also explored how the NP scope of practice reflected international trends.

The evaluation of the Demonstration Projects found that:

"The nurse practitioner is a safe effective provider of care in a variety of settings. They are readily accepted by clients in the community and the clients are satisfied with the care received from the nurse practitioner."

(Parker et al, 2000)

Subsequent to that evaluation, the Victorian Parliament passed the Nurses (Amendment) Act 2000 that protected the title ‘Nurse Practitioner’ and made provision for suitably experienced and qualified advanced clinical nurses to be authorised to prescribe a limited range of drugs and poisons under the Drugs Poisons and Controlled Substances Act 1981 (DPCS Act). The then Nurses Board of Victoria established processes to endorse nurses who had completed clinical training, had appropriate qualifications and who could demonstrate they met the competencies to practise as autonomous nurse practitioners within a specific scope of practice.

The VNPP was established in 1998. By 2006, 39 demonstration projects had been funded under the Victorian Nurse Practitioners Program (VNPP). Twelve projects had been funded in Emergency Departments including regional and small rural hospitals.

Phase 4 of the Victorian Nurse Practitioners Program (VNPP) commenced in December 2008 when health services were invited to apply for funds to develop models of care to support NPs in Victorian health services.

The objective of the VNPP was to establish sustainable NP models of care in Victorian public sector and community-based health services. The VNPP has been robust and responsive to the priorities set by different governments since its establishment.
Six elements of the VNPP have been considered in this evaluation:

1. NP model development grants
2. NPC Support packages
3. The Victorian NPC Mentoring pilot
4. NP scholarships
5. Publication grants
6. NP collaborative groups (communities of practice).

In addition to these program elements, Nursing and Midwifery Workforce (NMW) has provided support for applicants for grants through forums, workshops and information sharing, and have offered feedback for unsuccessful applicants.

1.1 NP model development grants

The VNPP supports health organisations to develop nurse practitioner models of care. Since 2008 up to $37,000 per model has been available to support the implementation of the role and the appointment of at least one NPC. The guidelines and assessment criteria require the applying health organisation to identify how the proposed model aligns with Victorian government policy directions, local and regional service needs and the service plan of the organisation.

1.2 NPC Support packages

The NPC Support packages are $8,000 where a model development grant has been given and $10,000 to support each subsequent NPC appointed to the same model.

In 2011, NMW developed a log book for NPCs to document their activities in a way that would facilitate preparation for endorsement and provide accountability for the funds disbursed. NPCs for whom a NPC Support package was paid to an organisation were required to submit a log book detailing how their time was spent on clinical supervision, mentoring activities and self-directed learning. The log books were designed to facilitate the preparation of the NPC for endorsement by identifying work undertaken against the competencies to be assessed for endorsement. Log books were required to be submitted to the Department every six months, with a view to collating data for evaluation purposes. The Department has used this information to monitor the support received by NPCs and provide advice where gaps were identified.

1.3 Victorian NPC Mentoring Pilot

The Victorian NPC Mentoring Pilot was established with the support of Continuing Care (Palliative Care unit) and Cancer Strategy and Development. The Pilot was contracted to Qualityworks Pty Ltd. It commenced in July 2012 and was completed in December 2013. Twenty mentor/mentee pairs were selected from the applications, with 16 of the original mentors and 19 mentees completing the program.
Participants committed to involvement in an 18 month program comprising three face-to-face workshops, monthly meetings with their mentor/mentee using an action learning model, monthly email contact with the program consultants, one meeting of each mentor pair, and participation in evaluation of the program via pre and post questionnaires (Department of Health, 2013).

1.4 NP scholarships

NP scholarships of $6,000 for a full scholarship or $3,500 or less for a part scholarship are provided under the VNPP to registered nurses (Division 1) employed by Victorian public health and aged care services. Applicants are required to demonstrate they have the appropriate educational preparation, experience and commitment to a clinical area (career trajectory) that indicates the applicant is positioning to be successfully endorsed as a NP in a timely way. They must be enrolled in an AHPRA approved course of study that will lead to endorsement as a NP.

1.5 Publication grants

NP Publication grants of up to $4,000 are offered to health services to encourage NPs to produce papers for publication in peer reviewed industry and professional journals or for presentation at professional or industry conferences.

1.6 NP collaborative groups (communities of practice)

Funding of $15,000 was provided for the establishment of each of the seven NP collaborative groups since 2008. The objectives of the Department in funding the collaborative groups were to:

- Provide forums for advice and comment on issues regarding NP model development
- Facilitate updates on the local progress of NP models
- Facilitate sharing of resources such as educational opportunities
- Provide networking opportunities for members of the group
- Advise the relevant departmental Clinical Networks of progress and issues that impact on NP services in that area.

The collaborative groups have been developed for specific clinical areas, broadly corresponding to the areas of model development funded by the VNPP:

- Emergency
- Stroke care
- Chronic disease management (formerly renal)
- Mental health, alcohol & other drugs
- Oncology
- Palliative care
- Aged care (Older Persons).
The Palliative Care NP Collaborative group was also partially funded by the DHHS Palliative Care unit. Collaborative groups provide an annual budget acquittal to the Department and can apply for further funding as required.
2 Experience in other jurisdictions

Programs to develop NP models of care and support the development of NP workforce have been implemented in other jurisdictions.

2.1 South Australia

The South Australian (SA) program was driven by an election commitment that focused on specific outputs – a specific number of NPs to be trained in specific areas. Ongoing NP positions have, however, not been funded. The focus in SA has been providing scholarships to support training. However, SA reported a high failure rate with only 32% of candidates achieving endorsement. A major factor has been that candidates have been unable to transition into a NP role at the completion of their Master’s because there are not sufficient positions available. The difference in the VNPP has been the development of NP models in situ. While this has not always resulted in NP positions, it has developed the acceptance of the model as appropriate for service delivery.

The most recent SA election commitment was to support 16 new NP roles in four speciality areas: four in diabetes, four in epilepsy, four in palliative and four in oncology.

SA has drawn upon the Victorian model to move toward a more outcome-driven program:

“[SA has] picked up a few of the things Victoria has done – in terms of providing some seed funding for the local health network to undertake scoping to identify where NP roles would complement their population of service needs.”

SA policy officer

This included provision of model development grants of $30,000 for each Local Health Network and grants of up to $22,500 for clinical practices support for organisations supporting individual NPCs and NPs. The later includes organisations wishing to employ an endorsed NP in a model of care different to that in which they have been endorsed.

Development of a business case, to demonstrate that there is an organisational commitment to integrating the NP signed off at a CEO level, is an important element of the grants to ensure alignment with service delivery priorities of the organisation and the SA government.

“Because it [the SA program] had to have a rapid start in 2010/11, it did not get a good start for SA in terms of really maximising and optimising the use of NPs, where we know the evidence says they get the best outcomes for patients. So having not had a good start, I think it has continued to evolve and I think NPs within SA… we now have a large number of them … but my feeling is that it could be done better.”

“We could use NPs far more strategically, and in places where we really know that we need them. And one of the areas that I think we have not been able to get traction is within community, primary health. And in some of the areas where we...
know they could make a real difference. So prison health as an example of that…
there are many examples, rural and remote, we have not done enough there.

SA policy officer

The health system in SA is undergoing a structural review. NP models of care are
“mixed up in that”.

“What we are trying to do… looking at various models in various states and [we
are] very attracted to Victoria because of all the benefits that the model offers.”

SA policy officer

In summary, for SA:

“These roles function best when they are based on service need. And… function
best when it is approached in a collaborative, multi-disciplinary team approach and
you get the buy in of all the various different stakeholders… I sense from a state
and national perspective that we are still underutilising NPs. We actually do need
to resolve the barriers around MBS/PBS as I think there is more evidence of their
[NP] effectiveness within the primary health care arena, and that is the most
difficult area in many respects to utilise them to their full scope of practice.”

SA policy officer

### 2.2 Western Australia

The candidate-driven model has proved to be a barrier to sustainability in WA. Issues
include:

- Candidates developed in highly-specialised roles in tertiary teaching hospitals. These roles have been candidate-specific and not readily transferable to community settings;
- Difficulty in recruiting to community-based rural and remote regions.

A new initiative in WA was the provision of a grant of $10,000 to organisations wishing to implement a NP model of care. This is comparable to the Victorian NPC Support package but is focused on establishing the model rather than progressing the candidate.

### 2.3 New South Wales

In NSW the Department of Health has directly funded a number of positions to meet an identified area of need – chronic and complex health care in rural and remote regions. However, the implementation was described as less effective than Victoria because the focus was on supporting individual clinicians rather than organisations. Specifically there was no:

- Initial implementation framework;
- Steering committee; or
- Engagement of a project officer to write up the model.

As a result, the organisations where NPCs were located were not as well supported.
There are now 268 NP positions in NSW. NSW Health funds NP positions and can thus maintain the expectation that the role will exist and be filled. Successful models in NSW are “usually driven by the individual and accepted by the organisation”.

Understanding of the NP role (professional identity) was a barrier to implementation. However, at an organisational level, individual medical professionals were supportive of NPs once they understood how NPs worked:

“NSW nurses don’t tend to experience much resistance from medical staff. When they do, the issues can be identified and resolved in about a six month period – as medical staff are made aware of the role of the NP and their position within the clinical team.”

NSW policy officer

Nurses were considered to be more of a barrier than medical professionals. Nurses were not willing to embrace change and the nursing stream issues were described as “continuous and more difficult to resolve”.

In both NSW and WA a barrier to implementation of the NP program across each state has been that early candidates have achieved NP positions as a reward for long service, as their “veteran’s badge”. In WA a number of nurses had become NPs in major tertiary hospitals where they had a very narrow scope of practice, geared to their specific role in a specialty unit.

NSW had a “massive scholarship program”. However, even with centralised allocation of positions, NSW had not been able to place NPs in areas of need, particularly remote services.

“We are not establishing a critical mass even though there are centrally-funded positions.”

NSW policy officer

There was a level of concern that the NP model of care became vulnerable at the point when NPs became endorsed. NSW is commencing a peer support program, partnering organisations that implement roles with organisations that have successful models – setting up relationships at each level, such as management and clinical. This moves the onus away from individuals to generate a successful model. The goal has been for managers, DONs, and others to talk to each other to identify enablers and barriers to implementation, before starting the model. This system is still in development, not yet available for review – but it will target particular areas where NPs can make a difference:

- Alcohol and other drugs
- Mental health in the community
- Hospital avoidance in aged care
- Rural
- Women’s health, particularly Aboriginal women
- Complex care – heart failure/Aboriginal health.
3 Evaluation objectives

In May 2015 the Department commissioned an evaluation of Phase 4 of the VNPP.

The objective of the evaluation was to:
- Determine the effectiveness of VNPP Phase 4, exploring the viability and sustainability of model development activities funded to date
- Make recommendations to ensure the VNPP remains aligned with government priorities and policy in the context of current Commonwealth and State funding
- Demonstrate how present funding activities support the viability and sustainability of NP models.

Campbell Research & Consulting was commissioned to undertake the evaluation.
4 Method

A multi-method approach has been adopted for the evaluation. This comprised:

- An establishment meeting and on-going communication with NMW to identify the parameters of the evaluation and measurable outcomes;
- Development of a program logic model, in collaboration with the NMW team, to identify inputs, processes and outputs of the program together with short, medium and long-term outcomes. This is included as Appendix A;
- An environmental scan including interviews with other states, relevant Department policy areas (palliative care, oncology, aged care) and review of documentation. Identification of other research related to the success of NP program in general was reviewed insofar as they relate to the VNPP;
- Site visits. These comprised qualitative in-depth interviews with the NPCs and NPs, mentors, supervisors, organisation executives and personnel that have been engaged in the application for the VNPP grants. These were conducted face-to-face or by telephone when relevant personnel were not available at the time of site visits. The objective of the site visits was to provide an in-depth understanding of the range of perspectives that have affected implementation of the specific model. Other elements of the VNPP were also examined;
- Online surveys of:
  - NPs and NPCs;
  - Health services, and other community organisations that have applied, or may consider applying, for grants under the VNPP, NPC Support packages, scholarships, publication grants, participants in the Victorian NPC Mentoring pilot, or support NP collaborative groups.

Campbell Research & Consulting has used an approach informed by Ferlie and Shortell (2001) and subsequently put into practice in a number of evaluations completed by Campbell Research & Consulting. This approach analyses barriers and enablers that have facilitated, or otherwise, how the VNPP has contributed to the implementation of NP models of care in Victoria. Five levels are used to analyse the implementation process.

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These levels are:

- **System** – systematic factors that facilitate the implementation of the program. These include State and Commonwealth legislation and policy, key stakeholders, and government funding;
- **Organisation** – the VNPP has supported organisations (health services and community-based services) to establish sustainable models of care;
- **Team** – NPs’ work in team-based environments. The support or otherwise of the other team members is vital to the successful implementation of NP models of care;
- **Individual clinician** – the drive and approach of individual clinicians, NPCs or NPs, has been examined;
- **Patients** – patients are the ultimate end users of services provided by NPs. While understanding the effectiveness of outcomes is vitally linked to both patient experience and clinical outcomes, the patient dimension is largely outside the scope of this evaluation.

This evaluation has not set out to examine the effectiveness of nurse practitioners per se, as the scope of this project is limited to a review of the effectiveness of VNPP funding. Nevertheless, the issue of effectiveness of the NP role has informed attitudes and actions of key stakeholders, and affects the implementation of individual models of care.

### 4.1 Site visits

Site visits comprised interviews with NPs, NPCs, supervisors (line management and clinical support), medical mentors, NP mentors and executives (Directors of Nursing/Clinical Services). The interviews comprised a mix of face-to-face and telephone interviews.

The purpose of the site visits was to obtain a rounded perspective of the issues faced by NPCs and NPs in the context of everyday practice and the challenges faced during implementation. The site visits identified barriers and enablers for the six components of the VNPP at:

- **The system level:**
  - Specifically, the impact of commonwealth and state government programs on nurse practitioner candidates;
  - Identification of external stakeholder groups, specifically the medical associations and the College of Nurse practitioners (Victoria).
- **The organisational level:**
  - Identification of governance arrangements, health service policy, leadership support, and other factors specifically relating to the health services and other organisations. Implementing the NP model of care and supporting NPCs.
VNPP Evaluation
Department of Health & Human Services

- Team level:
  - Identification of the impact of internal relationships, direct supervision, interface with other nurses, allied health professionals and medical staff;
  - Relationships with mentors were an important part of the development of the NP as an advanced form of nursing.
- The nurse practitioner level:
  - NPC’s time management, clinical learning, and everyday work.

While the ultimate success of NPs will be measured by patient outcomes, the focus of this evaluation has been on the VNPP as a program. Though patients are aware of services provided, they are unlikely to be aware of how programs are funded or implemented. The achievement of patient outcomes and the extent to which these have been measured has been considered, but patients have not been included within the consultations or surveys.

Findings from the site visits have been used to determine the extent to which funding of VNPP model development has improved the sustainability of NPs in organisations.

Recruitment was challenging, with a number of health services appearing to participate reluctantly. Substantial delays were encountered in many of the health services contacted. Some delays were associated with first point of contact (a senior manager or DON) being on leave. In other instances, appointments were not made until the first point of contact went on leave. Nobody refused. However, extended leave for some potential respondents meant that they were not available for interview.

When conducting interviews, respondents were assured that they would not be identified as individuals. This was an important factor in encouraging disclosure of some of the more difficult experiences. Every attempt has been made to ensure that individuals have not been identified in this report.

The initial proposal was to conduct eleven site visits (Table 1). Recruitment for site visits aimed to include some sites that were successful with implementation and some that were unsuccessful. However, in the course of recruiting and conducting the interviews, these terms have not been useful. The term “challenging” has been used instead of unsuccessful to identify those health services that are undergoing change that puts stresses on the NP model proposed. The health services with challenging circumstances provided useful information about the resilience and viability of the NP models of care.
Some sites were selected to reflect the more recent rounds that have focused on community care, specialist forensic mental health and primary care. Recruitment included NPs working in a range of areas:

- Aged care
- Palliative care
- Mental health
- Emergency medicine/ urgent care
- Sexual health
- Drug and alcohol service
- Oncology.

<table>
<thead>
<tr>
<th>Table 1: Location of site visits</th>
<th>Metro</th>
<th>Rural</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Successful implementation</td>
<td>2</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Challenging implementation</td>
<td>2</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Forensic mental health</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Primary care</td>
<td>1</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Community care</td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
</tbody>
</table>

Site visits and interviews were conducted in:

- Metropolitan teaching hospitals
- Regional hospitals
- Small rural health services
- Community based organisations.

Interviews were also conducted with convenors of NP collaborative groups for:

- Oncology
- Emergency medicine
- Palliative care
- Aged care (Older Persons).

### 4.2 Project establishment

The project establishment phase was vital to the overall success of the project. It provided an opportunity for exploring, and modifying the elements of the approach, and clarifying expectations for the output and outcomes of the evaluation. An establishment meeting was held on 9 April 2015.
4.3 Environmental scan

The environmental scan included discussion with academics working in the field, policy officers in other Australian jurisdictions, collaborative groups and their convenors and a review of the evaluations of VNPP Phases 1 to 3.

4.4 Surveys

Two online surveys were undertaken: the first was a survey of NPs and NPCs in Victoria (the NP/NPC survey), while the second was a survey of Directors of Nursing (DONs) and managers of organisations that have employed NPs and NPCs (DON survey). NPs and NPCs were recruited by emailed invitation from the Department to NP collaborative groups and the Victorian branch of the Australian College of Nurse Practitioners (ACNP) for the NP/NPC survey. DONs and managers were invited to participate directly by the Department. For both surveys, initial response rates were low and an extension of closing time was required. Three reminders were sent for each survey.

The NP/NPC survey was open for responses between 29 June and 10 August 2015. A total of 76 responses were received; 59 from endorsed NPs and 16 from NPCs. One respondent had commenced study but was waiting for appointment as a NPC. This represents a response rate of 25% based on the 231 NPs and estimated 70 NPCs whose principal place of residence is Victoria, giving an estimated total of 300 NPs and NPCs.

Invitations to participate in the DON survey were sent to 102 Directors of Clinical Services, Directors of Nursing and senior managers of organisations that were eligible to participate in the VNPP. The DON survey was open between 15 July and 11 August. A total of 41 responses were received. This represents a response rate of 40%.
5 VNPP Program elements

The VNPP has been designed to develop the capacity of organisations to implement NP models of care specifically aligned to the needs of a health service. This can be compared to other jurisdictions where implementation has focused on supporting individual clinicians, thereby upskilling the competencies of individual nurses.

All elements have focused on developing the NP workforce to meet the needs of public health organisations, with a view to longer-term sustainability of the NP model (See the Program logic model in Appendix A).

5.1 VNPP model development grants

The core of the VNPP has been the funding of NP models of care that were aligned to the specific needs of each health service, as well as the overarching policies of Victorian governments since 2008. A total of 44 model development grants have been offered over 14 rounds (Table 2).

The grants were initially focused on a type of health service and subsequently on specific clinical areas. Other areas of the Department have contributed to the focus. Specifically, the rounds 4.4 and 4.5 included funds to support NPs meet the objectives in the strategic plans of Palliative Care and Integrated Cancer Services (see Section 6.2 below for more detail).

This was in part to generate a critical mass in specific clinical areas to overcome the isolation of NPs developing new and innovative models of care. In recent years the program has focused on renal, stroke, palliative care, ED, oncology, mental health, alcohol and other drugs, neonatal services, aged care, and chronic disease management. In 2014 the VNPP extended its eligibility criteria to support NP models of care in community based organisations including forensic mental health, sexual health and youth services in drug and alcohol.

The breadth of organisations and clinical areas reflects the flexibility of NP models of care to address service needs across Victorian government funded health services.
## Table 2: VNPP NP model development grants by financial year and round

<table>
<thead>
<tr>
<th>Year</th>
<th>Round</th>
<th>Focus</th>
<th>Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007-08</td>
<td>4.1</td>
<td>Small rural health services</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>4.2</td>
<td>Large metropolitan health service</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>4.3</td>
<td>Large health services (1 regional)</td>
<td>6&lt;sup&gt;1&lt;/sup&gt;</td>
</tr>
<tr>
<td>2008-09</td>
<td>4.2 (2)</td>
<td>Large health services (1 regional)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4.3 (2)</td>
<td>Large metropolitan health service</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4.4</td>
<td>Palliative care</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>4.5</td>
<td>Palliative care (regional)</td>
<td>5&lt;sup&gt;2&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Oncology&lt;sup&gt;3&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>2009-10</td>
<td>4.6</td>
<td>Mental health</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>4.6</td>
<td>Drugs and alcohol</td>
<td>1</td>
</tr>
<tr>
<td>2010-11</td>
<td>4.6</td>
<td>Mental health</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>4.7</td>
<td>Integrated aged/palliative care</td>
<td>3&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>4.8</td>
<td>Neonatal ICU</td>
<td>3</td>
</tr>
<tr>
<td>2011-12</td>
<td>4.8</td>
<td>Neonatal ICU</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>4.9</td>
<td>Chronic disease management (CDM)</td>
<td>7&lt;sup&gt;5&lt;/sup&gt;</td>
</tr>
<tr>
<td></td>
<td>4.9</td>
<td>Aged care</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>4.10</td>
<td>CDM and aged care</td>
<td>4</td>
</tr>
<tr>
<td>2012-13</td>
<td>4.11</td>
<td>Open</td>
<td>9</td>
</tr>
<tr>
<td>2013-14</td>
<td>4.12</td>
<td>Aged care / CDM</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>4.13</td>
<td>Open</td>
<td>19</td>
</tr>
<tr>
<td>2014-15</td>
<td>4.14</td>
<td>Aged care/CDM</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Total</td>
<td>44</td>
</tr>
</tbody>
</table>

1 One grant was subsequently withdrawn in 2008-09
2 Five additional regional palliative care models funded by Palliative care under the Strengthening Palliative Care Funded by Integrated Cancer Services
3 Two funded by Palliative Care
4 Includes one funded in 2008-09
The impact of model development has been felt by NPCs to contribute to sustainability and is appreciated by candidates in health services that have received grant funding.

“I have a job at the end of this because of this program and the way it’s been developed, and us having to do the modelling, having to do the business modelling, the financial modelling, etc. And having to commit to it, to a certain degree, because we’ve actually received funding for it and with the assurance that there will be a job at the end of it, not just to get me through my training, off you go, let’s get another student in.”

NPC

The model development grants have been provided to organisations – health services and other community based organisations that have been considering a model of care.

At the organisational level there was not unanimous agreement that the VNPP model development grants contribute to sustainability. In the DON survey, only 39% identified the model development grant as contributing to a sustainable model of NP care. Of those who were successful in obtaining a model development grant (n=16), 67% considered the model development grant contributed to sustainability. Others were more likely not to know what the impact was (17%) compared to those who considered it did not contribute to sustainability (13%).

Over the period of the VNPP, NPs themselves, as well as NPCs and organisations in which they are located, have come to appreciate the value of the NP model of care. The model development grants and the publication of the grants through the Department website, along with NPs sharing their experiences (through the Collaborative groups), has started to build capacity within Victorian health services.

“In the beginning … didn't know what the options were. Nobody understood what you can do with a NP.”

Collaborative group convener

The challenge for the NPCs and NPs has been explaining the NP role to patients and their families as well as professional colleagues.

“Every day I am still having to explain my role as a NP.”

NP

While the models of care established a core framework of support within organisations, as personnel changed, and champions’ moved on, new executives did not always support the NP model of care, particularly when they had to find the funding.

Some managers would comment:

“I've got a lot of doctors here and a lot of nurse consultants. Explain to me why I need a NP.”

Collaborative group convener

The missing element in supporting the implementation of a NP role after endorsement was a commitment by the health service to funding the NP positions.
Characteristics of success varied. While larger metropolitan health services reported a small but stable number of NPs, smaller services were under more stress and had difficulty in getting the extra support (including clinical supervising of candidates) that was available in larger organisations.

Successful models tended to demonstrate:

- Recognition that the NP provided a model of care based on a sophisticated nursing service;
- Capacity to address specific gaps in services had been identified as suitable for a NP position;
- Clear governance arrangements (often prior to the model development had commenced).

Health services that reported less successful implementation of the VNPP model identified:

- Governance structures for the NP were not strong;
- Structural change in the organisation including amalgamation and change of Executive Personnel with early champions being replaced by Executives who were not clear about the value and purpose of the NP;
- NPs who were not engaged with service delivery teams. Signs of non-engagement included the NP’s office not being at the same site as the rest of the team and the NP not participating in team meetings;
- No clear business model that was sustainable beyond the endorsement of the NPC.

Effective implementation required team and organisational support with commitment by the individual clinicians (NPs and NPCs) to work closely with their teams and organisations.

5.1.1 Developing the model

Having an independent project officer was seen as valuable for the development of the model, particularly in small rural areas when engaging with established local medical professionals.

DONs and managers were most likely to see DONs (34%), Directors of clinical services (15%) and nurses wanting to become candidates as the initiators of the models (Table 3). They did not identify Medical Directors and medical consultants as having a role in this regard. A similar proportion of NPs and NPCs identified the DONs (33%) and directors of clinical services (21%) as initiating the model. A greater proportion identifies NPCs (33%).

NPs and NPCs identified Medical Directors (18%) and medical consultants (10%) as initiating the model of care.
Table 3: Development of the model (DONs and NP/NPCs)

<table>
<thead>
<tr>
<th>Question</th>
<th>DONs</th>
<th>NP/NPC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q16 NPC- Who initiated the development of a NP model of care in the organisation?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>n = 41</td>
<td>n = 76</td>
<td></td>
</tr>
<tr>
<td>NPC</td>
<td>2%</td>
<td>33%</td>
</tr>
<tr>
<td>DON</td>
<td>34%</td>
<td>31%</td>
</tr>
<tr>
<td>Director of clinical service</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>Nurses wanting to become candidates</td>
<td>17%</td>
<td>21%</td>
</tr>
<tr>
<td>Project Officer</td>
<td>5%</td>
<td>21%</td>
</tr>
<tr>
<td>Medical Director</td>
<td>0%</td>
<td>18%</td>
</tr>
<tr>
<td>CEO</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>Medical consultants</td>
<td>0%</td>
<td>10%</td>
</tr>
<tr>
<td>Program manager</td>
<td>7%</td>
<td>10%</td>
</tr>
<tr>
<td>Someone else (please specify)</td>
<td>9%</td>
<td>8%</td>
</tr>
<tr>
<td><strong>Base:</strong> All NP/NPCs, all DONs</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A DON champion was extremely important in implementing the NP model of care.

“If you don’t have a DON who’s a real advocate for nurses and wants to push the profession, then NPs are dead in the water.”

But this support was not, by itself, sufficient. In a number of instances, there were difficulties in getting the scoping finished, due to the lack of qualified project workers. As a result, the model was written by a senior nursing manager, and in other cases the prospective candidates wrote the model. This cut both ways:

“It was a double-edged sword. I had a lot of organisational knowledge, I had a lot of experience with the dominant medical practice in the area. It’s always difficult to leave your other roles behind. In some ways it would have been cleaner to have someone from outside who didn't have such a history with an organisation doing it. So it wasn’t something I was jumping up and down about saying ‘pick me, pick me’, but it did need to happen.”

Seventy five per cent of NPCs had some input into the development of the model of care (Table 4). A small number (9%) of NPs and NPCs reported they had involvement in the steering committee as part of their ongoing development as a candidate.
Table 4: Involvement of NPs/ NPCs in model development

<table>
<thead>
<tr>
<th>Q17</th>
<th>Did you have input to the development of the model?</th>
<th>n = 76</th>
</tr>
</thead>
<tbody>
<tr>
<td>By contributing to the design of the model</td>
<td>61%</td>
<td></td>
</tr>
<tr>
<td>As member of a steering committee</td>
<td>32%</td>
<td></td>
</tr>
<tr>
<td>By writing the model development report</td>
<td>26%</td>
<td></td>
</tr>
<tr>
<td>By completing the application for funding</td>
<td>17%</td>
<td></td>
</tr>
<tr>
<td>Ongoing development/ as a candidate</td>
<td>9%</td>
<td></td>
</tr>
<tr>
<td>As an interested observer</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Some other input (please specify)</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Total some input</td>
<td>75%</td>
<td></td>
</tr>
<tr>
<td>No input at all</td>
<td>25%</td>
<td></td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs
Percentages add to more than 100% because of multiple response

Models are also being developed outside the VNPP. Fifty one per cent of DONs and managers reported developing a NP model of care independently to the VNPP. In larger health services, model development is becoming independent of the VNPP.

“Our own models have progressed the role more slowly, models we have supported are generally more viable and sustainable because of the way we have controlled that growth. The deliverables we require have helped health services to focus upon clearly identified service gaps while ensuring the role genuinely requires the skill/scope of practice of a NP.”

Clinical Director

A medical consultant from the same organisation supported continued funding of new NP models of care by the VNPP which he considered could meet future emerging service needs. The demand for the positions was expected to come from changing therapeutic needs that required longer term support of patients in the community. This required in-depth knowledge and understanding of the available services that medical registrars were unlikely to be aware of. The capacity of NPs to assess patients, working in close collaboration with the medical consultants, was proving to be a successful and trusted solution.

A NP from a service that did not receive funding for model development, but where there had been models in different clinical areas (not all successful), worked with a steering committee to develop and refine the model:

“We developed the model as we went. Through meetings with our steering group, and through mentoring with our geriatricians, we worked out what our model would look like, so by the time we were ready to be endorsed, we were able to submit a scope of practice and a model of care. It was quite a broad one, we went for a very generic sort of model. And I don’t think we would have developed, would have been anywhere near it had we had to develop it beforehand.”

NP
In summary, prospective NPCs were actively involved in developing NP models of care with their organisations. The model development grant is not always used to employ a project worker. The intention of separating the development of the model from the NPC has been important in focusing models on organisational needs rather than the needs of individual clinicians. The involvement of NPCs in model development has not prevented this focus on organisational needs. It is unlikely that the development of models would have been as successful as they have been, without the input from potential candidates. Sustainability of the models after the NPC is endorsed is determined by the organisation. The clinicians remained committed; indeed, committed enthusiastically.

5.1.2 Steering committees

The VNPP model development grants required that a steering committee be established as an indicator of organisation support. The role of a steering committee was identified as an important element in the success of implementing a NPC model of care. Steering committees set the governance arrangements and provided an organisational focus for the model of care.

Steering committees were initially established to develop the role and prepare the funding application. In some instances, once funding was received, the steering committee continued with a shift in role to an 'advisory committee'.

"[The] Steering Committee met monthly, then less frequently as role was established and there was less to do in that advisory capacity."

Medical consultant

Steering committees were co-ordinated and led by senior nursing executives, with medical input.

However, steering committees did not always continue beyond the grant. In a successful model the Medical Director noted:

Steering committees were co-ordinated and led at the senior nursing level.

Fifty three per cent of the NPs and NPCs reported that the initial model proposed during the VNPP application process, changed upon implementation. (Table 5). Nine per cent reported that they had never seen the application of model development report.
During one of the site visits, it was identified that the initial model proposed was proven to be unviable before the candidate commenced. This was because the patients for whom the model was being developed were no longer accessible because of organisational constraints. However, the organisation continued to employ the NPC. The rules of the VNPP model development grant required that the funds be returned.

Change in clinical demand or patient presentation was identified as the reason for change by 12% of those consulted. More frequent was an evolution of the model as it was developed to meet service need, mentioned by 25% of NPs and NPCs (Table 5).

NPs and NPCs identified the main reason for changing the model was because of service need or a change.

### 5.1.3 Local medical professionals enabling model development

Some GPs actively engaged with the development of the model and the NPC, providing mentoring and clinical supervision. In rural health services NPs were engaged to provide out of hours support for Urgent Care services. This proved invaluable in areas where providing out of hours care was a burden for GPs. Some health services were motivated to develop a NP model of care after experiencing a “walk out” of GPs from the hospital Urgent Care service.

The model development enabled under VNPP has facilitated engagement with local medical professionals (GPs and in-house Medical Officers), that has generally resulted in support by consultants, medical team leaders and executives. This engagement has been initiated during the engagement with stakeholders for the model development grants, but has continued as NPCs and subsequently NPs have worked with medical professionals. As the quality of care provided by the model has been demonstrated...
and the NPCs and NPs have engaged with medical professionals internal and external to the organisations, the initial reticence has been overcome.

Central to the acceptance of NPCs and NPs by local medical professionals has been the implementation of strong clinical governance.

5.1.4 Not just a substitute for medical professionals

“If I had a firm belief that the NP role of was not a valuable one, I would not have been involved in the Steering Committee. It has been very valuable for me, and for patients in practice. I think there is a role that exists that NPs can only fulfil; that is unique and different to nursing staff and clinical nurse specialists. And that it is not a substitute medical staff member. It is not a substitute resident or registrar. It fulfils a very specific role... the specialist skills they have got allows me to provide significant extra care to my patients that I have not been able to in the past.”
Medical Consultant (mentor)

The issue of medical substitution – where NPs were seen to be a cheaper substitute for medical professionals – was at the core of the opposition of representative medical organisations to the use of NPs. It was seen as compromising the quality of the services provided because of the less extensive training undertaken by NPs.

There was some overlap of NP roles with medical staff in health services and GPs in the communities. However, this was not necessarily a duplication or replacement of medical staff. NPs were being developed to undertake a sophisticated nursing role rather than the medical role.

“[Medical registrars] often don’t have time to do it all and whatnot. Working at the MAP, [NP work is] a lot about continuity of care. You know, we have a lot of blow-in registrars, or registrars moving around rotations. It’s about continuity of care. It’s that more whole of care, I work a lot around psychosocial issues.”
NP

Within health services, some tension arose when NPs were funded out of the medical budget.

Successful implementation occurred in services where the NP role was firmly defined as an enhancement of the service, filling a service gap and offering services that were complementary but different to those offered by medical professionals. The NP role was clearly articulated as an advanced, sophisticated nursing role:

“One of the things that was critical to the whole thing ... was the emphasis that this is not a quasi-medical role. The fact that they can make diagnoses, the fact they can prescribe, the fact they can do investigations: that does not define what they do. This fundamentally was constructed as a higher level of nursing care, a higher level of sophistication in the assessment and the development of a management and care plan, for complex patients, primarily from a nursing perspective.”
Clinical Supervisor

Medical professionals were clear that the NP model of care was not a substitute for a medical professional, but a sophisticated nursing model of care. However in some NP models of care – such as urgent care services – NPs came closer to being seen in a medical substitution light. In larger health services these were distinct models including
fast track. In smaller regional services, support for after-hours services was important for local medical professionals and the health services.

### 5.1.5 Funding

VNPP funding for NP models of care was considered an important element of successful implementation of NPs in organisations:

“It wouldn’t have gone ahead without the funding.”

Clinical Supervisor

The provision of the funding prior to engagement of a person in the position enabled co-consultation with medical, nursing and allied health professionals with whom the NPC, and eventually the NP, would work. This facilitated some understanding of the role, but ultimately it was up to the NPC to demonstrate how they could operate in practice.

The timing of the funding was identified as an issue by a number of organisations (this was also an issue for the NPC support packages). When the funds were disbursed close to the end of the financial year, some had difficulty in recruiting a project officer for model development, particularly in rural areas. Organisations were able to manage this by freeing senior staff time to undertake model development. However, there was a general desire for more flexibility in how the funds were used.

The model development included commitment of the recipient organisation to ongoing funding, and operating costs (including salaries) were identified in the model of care. However, there was seldom a clear identification of how the model would be funded once the NPC was endorsed. Some smaller organisations stated that they had not fully appreciated the vulnerability of their modelling. Model development usually relied on the clinical background of the staff at the time, and they did not consider that any alteration in staff qualifications might introduce a financial risk.

“We did not fully appreciate the implications of the amount of time required to support the NPC and the resources needed from within the service... We didn’t consider the fact that [current staff member] I might leave, that we might not find a replacement and that that might introduce a level of risk to the candidature… it certainly makes our financial modelling a bit less robust.”

Service Manager

The VNPP model development grants have been targeted at organisations, not individuals. This is in marked contrast to South Australia and Western Australia where the initial focus was on supporting individual NPCs through scholarships. In the case of SA, policy has been driven by outputs (achieving a target number of NPs) rather than outcomes (achieving sustainable NP models in health services).
5.2 NPC Support packages

The NPC Support packages were given to organisations to provide support for NPCs during their training.

DONs and managers that received a NPC Support package reported it was mainly used for attending conferences (71%) and collaborative meetings (64%) as well as back fill for supervisors (57%) (Figure1).

Figure 1: How the NPC Support package was used (DONs)

Q23 How was the NPC Support package used?

<table>
<thead>
<tr>
<th>Option</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NP to attend conferences</td>
<td>71%</td>
</tr>
<tr>
<td>Attend NP collaborative groups</td>
<td>64%</td>
</tr>
<tr>
<td>Back-fill staff for clinical...</td>
<td>57%</td>
</tr>
<tr>
<td>Backfill so NPC could attend...</td>
<td>43%</td>
</tr>
<tr>
<td>Paying mentors</td>
<td>36%</td>
</tr>
<tr>
<td>Project support</td>
<td>7%</td>
</tr>
<tr>
<td>Don't Know</td>
<td>7%</td>
</tr>
</tbody>
</table>

Base: Organisations that received a NPC Support package (n = 14)
Percentages sum to more than 100% because multiple responses were allowed.

Thirty six per cent of DONs reported that the NPC Support package was used to pay mentors. While none were unhappy to take on the role, some external medical mentors acknowledged the lack of payment. Some resented this situation, not so much for the lack of payment, but because lack of payment suggested a lack of recognition of the amount of time and effort they put into the mentorship or clinical supervision.

In other instances, small rural health services found that the fees charged by regional health services for clinical supervision were prohibitive and a barrier to NPC development. The support of the larger regional health services in training was important, as the smaller centres did not have the expertise required to provide necessary clinical experience or supervision for NPCs. The NPC Support package assisted with the purchase of external clinical supervision but was rarely sufficient to cover the full cost.

NPs and NPCs were not necessarily aware of the NPC Support packages. Some health service executives made the decision not to involve the NPCs in decisions about the funding, preferring them to focus on clinical rather than administrative issues.
Where a NPC is operating a nurse-led clinic, and requires time off to attend university, the organisation either needs to manage without the NPC, which impacts on income and client care; or if they are able to find a suitable replacement they may backfill the NPC, a situation which is unfunded after the first year.

The problem of being unable to carry forward any of the funds from the NPC Support packages was brought up by several sites, and is both a system and organisational barrier. Executives and managers considered it would be more helpful and realistic to spread the funding over the length of the candidacy.

The $37,000 funding was confusing for some participants, and hard for health services to carry forward to future years to properly support the NPC over the duration of the program:

“They had this whole thing about you’re allowed to spend 37 on this, but not on this, the 8 on this… we still don’t really get it, and so to me I feel like the 8,000 is just support her during her candidacy rather than the application process. And... it’s very difficult for us to carry funds forward, so if they’re trying to support us for the life of the program – because we’ll have to pay for mentorship and supervision, etc. and ongoing program management costs, they need to go: “Okay, we’re giving you 20,000 a year, for establishment, and then we’ll give you 15 or whatever for the subsequent,” rather than giving a bunch of money at the start and saying you can pay it over 3 years, because it doesn’t work like that. When you account, that money’s gone at the end of the year.”

CEO

This budgetary situation was further exacerbated by the winds of political fortune for smaller organisations, which often were uncertain of their organisation’s future funding:

“We’re funded by government and we’re at the whim of which particular party is in and which department has an interest in whatever.”

Clinical Director

Since the funding is very tight, it’s hard to deal with unexpected events, or unforeseen needs (such as when needed support was underestimated). This can put a strain on the business, and the contingencies were seen as being impossible to predict.

“...when you anticipate what it will look like and what the impact that model will have... often differs in reality. And because we’re operating a small business that’s quite vulnerable financially, it’s a bulk-billing service. The implications of... the amount of time that would be needed to support that role over the course of the candidacy, and the resources that would be needed from within the service ... to support it. I didn’t fully appreciate it, and I don’t know that I could.”

CEO

The CEO quoted above and other participants would appreciate more guidance on risk and potential pitfalls be included in future VNPP guidelines.

Smaller services would like to see the NPC Support packages spent on more general support over a number of years rather than for a project officer for the three months currently funded to write the model.
5.2.1 “Quarantined time” for NPCs

While nearly all NPs and NPCs reported they had sufficient time to attend collaborative groups (86%), get clinical supervision (80%), time with clinical supervisors (75%) or study for their Master’s (72%) (Figure 2), the proportion that reported they did not get sufficient time is of concern.

During the site visits, NPs in smaller community health services reported it was difficult to get “quarantined time” for their NPC development. One convenor of a collaborative group reported that all the members of their group had problems in getting quarantined time for the work required to develop their competencies for endorsement.

**Figure 2: Allocation of NPCs’ time**

Q29 As a NPC, did the organisation ensure you had sufficient time in your regular working hours to:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attend collaborative groups/ professional development</td>
<td>86</td>
<td>14</td>
</tr>
<tr>
<td>Clinical supervision</td>
<td>80</td>
<td>20</td>
</tr>
<tr>
<td>Time with clinical supervisors</td>
<td>75</td>
<td>25</td>
</tr>
<tr>
<td>Study for Masters</td>
<td>72</td>
<td>28</td>
</tr>
<tr>
<td>NP mentor</td>
<td>50</td>
<td>50</td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs (n = 76)

5.2.2 Log Books

The Department developed log books in 2011 to facilitate NPCs to record clinical and professional supervision, self-directed learning and other professional development activities that could be used to prepare a portfolio for endorsement. A condition of the NPC Support package funding was that the NPC submit a completed log book to NMW every six months.

The log books were developed in Excel. They included summary sheets with a report for each six month period broken down by month. The calculations were automated so all the NPC had to do was fill in details and the report would be automatically produced.

The summary calculated number of hours spent on broad categories of activities: Individual Clinical Supervision, Group Clinical Supervision, Professional Supervision/Mentoring, Self-Directed Learning and Other (for example, site visits). The entry of data also had an option of marking each activity against the competencies.
required for each of the standards required for endorsement. This option was updated twice. First, when AHPRA became responsible for endorsement and a second time in 2014 when the standards were reviewed.

NPCs were sent a brief introduction by NMW and invited to contact the Senior Policy Adviser who would work through the use of the log book over the phone. About half of the candidates made contact with NMW who reported that, after initial telephone briefing, there were no problems identified by NPC in regard to log book use.

A total of 39 NPCs submitted a log book. The survey identified that 52% completed the log book at least weekly (Table 6).

<table>
<thead>
<tr>
<th>Table 6: Frequency of log book completion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q28</td>
</tr>
<tr>
<td>n = 36</td>
</tr>
<tr>
<td>Every 1-3 days</td>
</tr>
<tr>
<td>Weekly</td>
</tr>
<tr>
<td>Monthly</td>
</tr>
<tr>
<td>When due for submission</td>
</tr>
<tr>
<td>Erratically</td>
</tr>
</tbody>
</table>

Base: NPCs who completed log book

The log books identified how NPC time was allocated (Table 7). Independent self-directed learning comprises 33% of the time spent by NPCs. Group clinical supervision and mentoring each comprised 11% of NPCs’ time.

<table>
<thead>
<tr>
<th>Table 7: Distribution of supervision hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = 39</td>
</tr>
<tr>
<td>Self-directed learning</td>
</tr>
<tr>
<td>Individual clinical supervision</td>
</tr>
<tr>
<td>Other (site visit, etc.)</td>
</tr>
<tr>
<td>Group clinical supervision</td>
</tr>
<tr>
<td>Professional supervision/mentoring</td>
</tr>
</tbody>
</table>

Base: NPCs who submitted log book
In the course of the site visits NPCs and NPs reacted negatively to the log books but, reluctantly, agreed that they were useful for endorsement. Supervisors (direct line managers) reported the log books to be useful to keep in touch with what the NPC was doing.

Log books were seen as a burden and aggravation but something that needed to be done.

“I can see the benefit of them, I’m just probably being a bit whingey. I can see the benefit in them, and I also understand the Department of Health has to collect some kind of data. It’s just a bit of a ‘one more thing’, but [NMW] said to us that we can actually submit that to the board when we go for endorsement to justify our hours, or something like that. I’m not mad about them, no, but I see their value.”

NPC

The task of completing the log book was disliked; perhaps not surprisingly from health professionals who have decided to pursue a clinical rather than an administrative career. On probing, the log books were begrudgingly, described as:

“A necessary evil.”

“Providing a focus on the endorsement application requirements.”

“It did allow you to keep track of, y’know, I’ve seen this many of these cases, I’m feeling relatively confident, I need to see some of this condition, or these presentations. So it is good in that respect, the only thing is, since time is the essence, not to make it too labour-intensive and only pick out a couple of cases that you might like to write up to discuss with your mentor, because having big reams of excel files, you just don’t have enough time to go back and do them, especially when you’re studying and doing Uni and meeting all those criteria as well.”

NP Mentor

Some NPCs were resentful and could not see the purpose of submitting them to the Department.

“What do they do with them?”

NPC

One recently appointed NPC was not aware of the log book and commented:

“What log book?”

NPC

This lack of awareness is somewhat surprising given the highlighting of log books by the Department at all information sessions. It suggests a disconnection between the NPC appointed and the model development process. A recently endorsed NP did use the log book, and found it to be useful but ultimately unnecessary:

“Honestly it was annoying. To some extent it was useful in that eventually we did our portfolios integration for endorsement, we could reflect back on that and it had a bit of a timeline there of what we did, where we did it and who we did it with. But we didn’t necessarily need to have that to do it. I would have preferred not to do it.”

Endorsed NP

It was completed because it was a requirement, but not with enthusiasm.
“I think it probably is useful, and I’ve got all the data in a spreadsheet, where I could easily enough do it. I just have to go out and do it. I speak to people who did it, I know [NMW] was fairly keen that it formed part of the portfolio for submission. There’s a lot of time, it would require a lot of time and effort to do it and I haven’t gotten around to it yet.”

NP

Time issues prevented the filling in of the log books, especially as their function was duplicated by diary and spreadsheets.

“I thought I could retrospectively do it. I just never got to do it because of the time requirement. I work full time, the last twelve months I’ve had full-time study load, I’ve been busy in the clinic, I just did not have time to do it.”

NPC

5.3 NP collaborative groups

Since 2008 the VNPP has funded NP collaborative groups or communities of practice around specific clinical areas. These groups built on the outputs from the model development grants which had supported a sufficient number of NPCs commencing at a similar time. This resulted in a critical mass of NPCs and NPs to support a community of practice.

Collaborative groups provided a number of functions to NPs, NPC and others who were considering becoming a candidate. These included:

- Advanced clinical training in the specific clinical area
- Mentoring
- Opportunity for potential NPCs to identify mentors
- Professional development
- A forum for the presentation of research findings
- Networking
- Identification of employment opportunities.

The collaborative groups provided a supportive environment for NPs and NPCs to present issues they were facing, as well as an opportunity to present initial research findings to get constructive feedback.

“We have already been very successful because we have supported a lot of people (particularly in the last twelve months) to endorsement”

Collaborative convenor

“[NPC] brought her folder that she presented up to AHPRA. Those of us who are in an NPC category we can get a sense on what we need to have available. That would not happen if we weren’t part of the collaborative.”

Collaborative convenor

Prospective NPCs could meet with others who were willing to act as mentors.

“We have a number of Nurse Practitioners in different areas and if there is someone coming through who needs to put a portfolio together, we can set them up with someone who has already gone through the endorsement process to assist them with their portfolio.”
Collaborative convenor

As a group, they provided a contribution over and above the individual mentor relationships:

“The mentoring provided something in addition to the mentor I was allocated by the Department [through the Quality works mentoring project]. I spent time with other members and it really helped me build my confidence: Am I on the right track? Am I meeting the mark? Without the collaborative, the danger is you could get lost.”

NP

The collaborative groups assisted in dealing with navigating the mechanics of the bureaucratic processes for endorsement:

“Expediting the process. Some of the early Nurse Practitioners experienced delays.”

Collaborative convenor

“Where they’ve got help they get though in one week. AHPRA have a checklist and some can help with that checklist. Make sure you have the same date in different documents. If you don’t get it right it (endorsement) can be delayed a couple of months.”

Collaborative convenor

“I’ve just got my endorsement and met with [mentor] a couple of times. … How do I do it? What do I need to put together? How can I Best do it to get through in one go? What am I missing what do I need to build on? Without that mutual professional support.”

NP

“Networking provides information on what is happening in different areas. I work in an acute hospital and I don’t know much about what is happening in residential area and I really need to because a lot of my clients are going there.”

NP

Networking provided a resource for information sharing about services and clinical tools:

“I work in a small residential nursing home. Without coming to a meeting like this I would not know about a lot of services available such as pain clinics, other external resources and assessment tools.”

NP

“Sometimes it’s just nice to have a name to ask for if you’re calling an area mental health service. Like, in all honesty, you’re not pulling in every favour, but at least you can call them and say I’ve got this guy, who can I call to help him further?”

NPC

Presentation of case studies offered the opportunity to learn from each other:

“Candidates have an opportunity to present a case study and get feedback. Endorsed [NPs] present more complex ones.”

Collaborative convenor

“It is an opportunity to get feedback about extensions of practice, or how to bring particular things out, or how to refine [what they have represented] to reflect the standards we practice against.”

Collaborative convenor

NPs and managers also pointed out that they needed to keep up with conferences related to their clinical speciality as well as attending the collaborative group meetings.
The cumulative number of professional meetings could become a burden on NP time. The Collaborative groups provided a vehicle that assisted in prioritisation:

“A lot of discussion around conferences, things that might be coming up that may be appropriate for us to attend, or we might be interested in, we talk about that sort of stuff.”

NPC

As with mentoring, the collaborative groups dealt with more than clinical issues. They dealt with the issues of practising as a NP:

“People send out emails, especially those who are looking to move into private practice about Medicare billing that, and that kind of practical thing.”

NP Supervisor

“I hear from them, from the three [NPCs] how useful they are, just to have connection with others working, to hear about other models of practice being developed, that collegial support.”

NPC

“A great amount of support as well as, it’s very educational… just hearing some of the struggles other NPs or NPCs are having, or you yourself might be having, they can offer advice, or give you tips about how they might have resolved the situation.”

NPC

Collaborative groups also provided an opportunity to develop one’s view of progress through training, and this is especially helpful for NPs or NPCs working in a health service where there are no other NPs.

“If somebody presented something and I didn’t know, [what was presented] I would go back and say ‘my knowledge should be at that level’”.

NP

“This collaborative had been invaluable to know I am going in the right direction; this is something I need to look at …”

NPC

The help provided by collaborative groups could be unexpected:

“It’s a case of you don’t know what you don’t know.”

NP

However, nursing executives did not always appreciate the benefit of collaborative groups:

“Why do you need a collaborative when you are actually working with your friends in the area you want to work in?”

DON

“They’re preaching to the converted in that space, though, that’s what I’m saying.”

Clinical Director

However, some clinical areas were so small that it was not feasible to form a collaborative group. Some NPCs felt isolated in their ability to make contact with other NPCs. Local cross-disciplinary collaborative groups have been initiated in some
regions and larger health services and serve to provide the non-clinical support for NPs in these areas.

Some sites had a local cross-disciplinary community of practice. What was noticeable was that, for many sites, NPs didn’t meet together as a group if their scope of practice was different. The justification offered by some participants in the site visits was that it was better for such peer support groups to evolve organically and not be forced. Others pointed out that an internal peer support program is unlikely to develop unless funding is dependent on it or the organisation insists on it. In one instance a senior nursing executive had taken responsibility for organising the local group but had not actioned the task.

Where the local collaborative groups existed, they were highly valued by NPs and NPCs alike, as an opportunity to discuss professional issues and medical issues that cross all scopes of practice. Participants acknowledged they all needed to do such things as manage difficult clients, communicate well, complete OHS training and learn to speak at conferences. For smaller organisations, geographical groups might offer such possibilities.

Where such a support group exists, NPs and NPCs are furthering their professional role through involvement in research, writing and conferences.

5.4 NP scholarships

Scholarships are paid directly to the individual nurses who apply. Like other elements of the VNPP, they have an organisational focus: applicants must provide evidence of organisational support of their preparation as a NP. Continued employment in that role is a requirement of the scholarships.

Applicants were assessed against the criteria and 103 scholarships have been provided since 2010.

“The ones that are not supported invariably come from individuals employed by health services that have not committed to employing them as candidates and so do not meet the eligibility criteria. These are increasingly rare as Victorian Master’s students are now very aware of the VNPP and how it operates.”

NMW

Three to four applications for scholarships were not funded in each year. The unsuccessful applicants were generally people who withdrew before the start of the academic year. Reasons reported to the Department were overall cost or, more commonly, burden of study/life balance.

In the course of the site visits, NPs and NPCs reported that scholarships were used to pay course fees. They were considered as a valuable and useful contribution to defraying some of their expenses, although they did not cover the full cost of course fees and other costs incurred in undertaking the Master’s study.
But not all were aware of the scholarships or of the detail of how it was spent. One recently endorsed NP said he was not aware of VNPP scholarships. Another said the scholarship money was helpful, but they didn’t think of it as a ‘scholarship’ per se, and weren’t really sure about “what went on with it”:

“I recall filling in some forms, yeah, I believe we filled in the forms… I’m assuming it was used for fees, perhaps even supervision.”

NPC

In the survey, only 61% gave the scholarship a rating. The scholarships were rated as making a contribution to endorsement, although not outstanding, rating 5.8 out of ten (Figure 4). This compares with 7.1 for the collaborative groups and 5.1 for the NPC Support package.

A substantial minority did not rate the scholarships highly. Thirty three percent rated the scholarship as less than five on the scale of one to ten (where 1 was “no help at all” and 10 was “could not get by without it”).

5.5 VNPP Mentorship pilot

One of the core competencies required for endorsement as NP is leadership. The objective of the VNPP Mentorship Pilot (the Pilot) was to develop leadership skills and capacity through an intensive support of 20 pairs of mentors and mentees by consultants with strong expertise leading cultural change in health organisations.

Mentoring was distinguished from clinical supervision. The content:

“[E]volved throughout the program from basic issues about candidacy and organisational acceptance to exploration of career paths, leadership paths and competencies, action learning, skills application, and proactive promotion of the NP role.”

NP

The Pilot was successful in building mentor and mentee relationships. In some instances, impact lasted beyond the Pilot with participants continuing the relationships. Some of the NPs interviewed at the site visits, who had been mentored, still kept the relationship past their candidature. Others had subsequently taken on mentoring roles after they had become endorsed.

Specific recommendations for improvement from participants included:

- More and earlier workshops
- More regular meetings of mentor/mentee pairs
- More information at commencement
- More resources for leadership
- Wider content including conflict resolution and clinical content
- More formal preparation of mentors before they assumed their roles.
The impact of the Pilot appears to have been effective in developing leadership capacity of a small group of participants. However, the impact of the Pilot seems to have dissipated with only a small number (18 out of 231 NPs) having participated and resources from the Pilot not readily accessible in a digestible format.

NP collaborative groups also provided mentoring support. But there was a difference. The mentoring relationships set up under the Pilot developed a long-term relationship. Qualityworks provided support and coaching for the relationships and encouraged participation when the relationships went “off track”. However, the cost of the intensive program was high, given the small number of participants, even given the longer-term outcomes.

During the site visits a number of NPs had the belief that the Department had mentoring guidelines. This was most likely a reference to the guidelines developed for the Pilot. However, these have not been directly distributed, although they are accessible through the website.

5.6 Publication Grants

Fourteen publication grants have been provided through the VNPP. Six were offered in 2010, three in 2011, three in 2013 and two in 2014. Publication grants were made available for NPs to present papers at conferences in Australia and overseas.

The importance of research is recognised, but is very much secondary to the clinical role:

“My personal preference is on the clinical role, but I’m open to research, if it’s going to improve [practice] or is related to the clinical role.”

NP

NPs estimated that, on average, five per cent of their time was allocated to research (Table 11).

“It’s very much part of our role and part of our standards; there needs to be research, there’s a research component to our positions. This does, however, get side-tracked as a fair bit of the NP’s day is spent on carving out their position.”

NP and Collaborative coordinator
Publication grant recipient

In the course of the site visits no publications were identified, although the grants were used for preparation of abstracts for presentations to conferences, including international conferences, which presented the experience of implementation of NP models in Victoria to an international audience.

“It also gave me the opportunity to put out a good news story about NPs in Australia.”

NP, Grant recipient

There was no evidence of an awareness of the competencies required for publication in refereed journals.
6 Factors affecting the implementation of the VNPP

The evaluation was structured to identify enablers and barriers to implementation of the NP role and the impact of the six different elements of the VNPP in achieving implementation of the VNPP. As with any new initiative, Nurse Practitioners have faced a number of challenges implementing their role. Many of these challenges reflect the recent emergence of the NP role. The following section presents some of the challenges identified through the site visits and surveys. The issues are structured as system, organisation, team and clinician. The role of the VNPP in overcoming the challenges has been identified from the evaluation data.

6.1 System level – national

6.1.1 Medicare provider numbers

There are three areas where Medicare provider numbers are required in order for a NP to be able to practise within their endorsed scope of practice. These are:

- Referral to specialists
- Requests for diagnostics (imaging and pathology)
- Claiming fees.

NPs who are employees of a public hospital or other government-funded entity are specifically excluded from applying for a MBS provider number. Consequently, although NPs are endorsed to make referrals, without a provider number, patients are not eligible for Medicare rebates. In practice, not having a MBS provider number prevents NPs from referring to specialists, as pathology laboratories and diagnostic imaging providers will not accept a referral without a provider number.

Not having a provider number was not an issue in larger health services where these services are provided within the service and NP patients could access in-house services. It was a barrier to effective implementation of NP models of care in smaller regional health services and community based services where there are no in-house specialists, imaging or pathology services. It could also be a barrier for NPs working in a community outreach model from larger health services where referral to appropriate local services, accessible to the patient, was not possible.

NPs work around this barrier by requesting GPs, consultants or registrars to order diagnostic tests or refer to specialists on their behalf. This duplication of effort is inefficient and unnecessarily adds to the administrative burden of medical professionals.

Medical professionals, in some instances, are eligible for a limited provider number that allows for referral of patients to specialists or ordering diagnostic tests. Any reform of the NP provider applications would be a useful strategy for NPs.
That's the biggest obstacle in rural health about putting more NPs on. If you think about how a hospital in Victoria staff urgent care departments, they staff them with GP on-call rosters. A GP on-call roster, you pay your GP an on-call fee, then they top up their fee by swiping Medicare cards when patients come in to urgent care. So effectively, they double dip, and we speak to Medicare, they say it never happens, but it does. So effectively, patients pay some state money to their GPs, but the majority of it is being paid by Commonwealth. So NPs are more expensive than having GPs on call.”

“If NPs could have a provider number and do exactly what the GPs are, then yes it would be [financially viable], but it’s not cost saving for any organisation to have a NP in urgent care.”

6.1.2 MBS fees

Where NPs did have a provider number, or were considering the option of getting one, the amount reimbursed through the MBS schedule was reported to be insufficient. Several participants felt strongly that the MBS schedule fees were a barrier to establishing as private practitioners:

“If you look at sessional rates for Nurse practitioners, a 15-minute contact is, I think, $8? A 15-minute contact for a GP is $47. Now, you can’t compare MBBS [medical undergraduate] study of five years and a Nurse Practitioner’s study. But what you can say is a Nurse Practitioner has done a 3-year nursing degree and then [another] 3-year nursing [Master’s] degree and has at least five years’ clinical practice. So...there is six years of study and five years of clinical practice.”

“Clinical Director

“Our organisation has doctors too but they obviously can bill crazy amounts of money per session, hence their hourly rate is high. But that’s the frustrating part of being a NP; the billing is nowhere near the tasks we’re doing.”

NP

Some NPs felt the amount allowed in the MBS was an indicator that NPs were not being taken seriously.

6.1.3 PBS provider numbers

In the course of the site visits and interviews, access to PBS provider numbers was not identified as an issue. Formulary was more likely to be restricted by the credentialing process within individual organisations.

It was also noted that NPs, when presenting material for endorsement, found that inclusion of classes of drugs rather than specific drugs or brand names was most effective for ensuring continuity of practice.

6.1.4 Prescribing

Forty two per cent of the NPs reported that they could prescribe all the medications that were listed in their formulary (Table 8). The survey indicated that NPs in rural regions were more likely to be able to prescribe all the medications in their formulary that those in metropolitan regions (32%).
When asked what has had the most impact upon their capacity to prescribe, the key issues identified were: “own knowledge” (17%), organisation-level issues relating to credentialing (17%) and PBS related issues (10%).

The evidence from the survey indicates that the PBS is a barrier for a small proportion of NPs after endorsement. Organisation credentialing and NP knowledge were also mentioned as barriers.

Only 32% of NPs were able to order diagnostic tests when needed, with slightly more ability to order diagnostic tests most of the time (Table 9).

### Table 9: Capacity to order diagnostic tests

<table>
<thead>
<tr>
<th>Q33</th>
<th>NP (n = 54)</th>
<th>NPC (n = 16)</th>
<th>Total (n = 70)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Whenever needed</td>
<td>32%</td>
<td>19%</td>
<td>29%</td>
</tr>
<tr>
<td>Most of the time</td>
<td>37%</td>
<td>25%</td>
<td>34%</td>
</tr>
<tr>
<td>Some of the time</td>
<td>8%</td>
<td>19%</td>
<td>11%</td>
</tr>
<tr>
<td>Occasionally</td>
<td>14%</td>
<td>0%</td>
<td>11%</td>
</tr>
<tr>
<td>Never</td>
<td>8%</td>
<td>38%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs who had some problem with prescribing

#### 6.1.5 Medical stakeholder groups

Both the Royal Australian College of General Practitioners (RACGP) and Australian Medical Association (AMA) issued position statements opposing, in principle, nurse practitioners. Following the listing of NP items on the MBS, the RACGP developed
practice guidelines for collaboration of GPs with NPs (RACGP, 2013). None of the NPs or GPs interviewed during the site visits mentioned these guidelines.

There was a perception by some respondents that medical professionals see the NPs as a threat by impinging on their professional territory and, in the case of GPs in rural areas, impacting on their income sources. One manager of community services in a small rural health service wishing to engage a NP for residential aged care in-reach mentioned the opposition of one GP who was servicing a number of nursing homes in the area. That GP was adamantly opposed to engaging with a NP and influenced the other GPs in his practice.

6.1.6 Medical opposition

The formal opposition of the AMA and RACGP has not hindered individual medical professionals working with health services to develop NP models of care. They have highlighted aspects of clinical governance which have been instrumental in successful implementation of NP positions in health services.

The model development has been used to focus on an existing need and identifying appropriate modes to address the service.

There is some degree of overlap with the work of medical professionals. However NPs are not substitutes for GPs or for medical staff in a health service. To be clear, NP training has neither the breadth nor the depth of medical training. Their undergraduate study, clinical experience and two years of Master’s study is not the same as the six years of undergraduate medical training, intern training and three years of postgraduate training required by medical professionals to become eligible to practise as GPs. Also, where GPs may specialise after they have received their admission to the RACGP, NPs are expected to specialise in a particular clinical area and are aware of the limitations of their scope of practice (though in some cases, the scope is broad).

In the course of this consultancy, the issue of medical substitution was raised by medical professionals, but not by NPs. NPs did not present themselves as a medical alternative, although they did resent the exclusion tactics practised by local GPs, in particular.

When developing a model, some small rural health services encountered strong opposition from local GPs:

“Those words, ‘Nurse Practitioner Candidate,’ were met with so much resistance from the GPs.”

Director of Clinical Services

“Their greatest fear, reading between the lines, was the bottom-line impact. They were not happy about a NP, me or anyone else, entering into areas that directly cut across billing. It was put in a variety of ways, one of the more dominant ones was around continuity of care, but they have no problem with another medical practitioner going in and disrupting the continuity of care... eventually they were willing to talk about money and funding, but it took a little while to get there.”

NP
One NP described the concern of medical professionals as relating to the quality of care:

“Not opposition, but caution that the doctor was not the centre piece of everything and there was a concern about what happens if this goes wrong[.]”

NP

This NP identified the lack of awareness or understanding by medical professionals of what a NP was, the training they undertake and the legislative recognition of a NP, as the cause for concern:

“They would say: ‘Are you a community nurse? are you a practice nurse?’”

NP

The model development grants have overcome the more generic “at a distance” opposition by professional associations through engagement with medical consultants and medical directors. Successful recognition of NPs as a model of advanced nursing practice has been achieved through a consultation process that has engaged all members of the health care teams with whom the NPs would interact.

“We did go through a process, we got to the stage by the end where there were only one or two die-hards among the consulting body who were really unhappy… there was strong support for them [the NPs] from a number of key people, including myself, as we worked through the issues, I was satisfied we had sufficient clinical governance processes in place, and I could see there was…a way to enhance the overall work we did for them.”

Medical consultant

6.1.7 Clinical governance

The VNPP ensured there was structure for NPCs. This included elements such as a steering committee, models and documents. It provided a framework for clinical governance that engaged executive, medical and nursing stakeholders within the organisation. Initially, steering committees were established for the model development. Some continued after the NPC was engaged, while in other instances team meetings provided a more informal vehicle to manage the NPC in the NP model as it developed.

By establishing a clear clinical governance structure, medical consultants had confidence in the NPs to deliver the particular services required.

“By clinical governance I’m talking about a process that ensures that not just NPs but everyone is operating in conformity with the overarching policy framework that [our organisation] conducts its arrangements… clinical governance includes appropriate accountability to more senior management, transparency of operation. It includes a requirement that they conform to whatever operational guidelines are in place around the care of patients.”

Medical consultant

Clinical governance comprised two elements: professional supervision or mentorship and clinical supervision. Professional supervision was described by one NP as assisting NPCs to “stick within the role and to develop professionally”, as well as providing collegial support for leadership development and the skills required to
negotiate how the NP role fits with the needs of the team and its stakeholders. Clinical supervision included team meetings, discussions about patient management and appropriate prescribing as well as review of patients with medical consultants.

The way in which clinical supervision was built into the model was identified as very important. If it is not set up correctly, the scope of practice may not be achieved:

“I think I've had to modify my expectations of what [NPC] is able to do, because we have not been able to satisfactorily provide her with sufficient clinical skills development in working with people with [inaudible]. So that's not [NPC]'s fault, really, it's a problem with the model we set up.”

Medical supervisor

Clinical governance for NPCs requires time to be set aside for clinical supervisors. This has been enabled by the NPC Support packages (see Section 5.2).

In instances – outside the VNPP – where governance was lacking, it could mean there would be no recourse in the case of a personality clash between NP and other staff.

“Because it is such an autonomous role, that you run a risk with personalities sometimes overrunning the role. And for one reason or another, that certainly struck a chord with me. And I thought, perhaps it is a risk of that kind of role, that either it absolutely flies and it’s fantastic, or because it’s got power and it’s autonomous, if you don’t have the structure, the governance structure around it, there’s a risk there.”

Director Community Services

6.2 System level – Victorian government

The department has allocated a Senior Policy Adviser to support the implementation of the VNPP. This position has been identified as contributing to the successful implementation of these program elements, during the site visits. The support of the current incumbent was highlighted consistently throughout the interviews. The Manager, Nursing and Midwifery Workforce, also provides support to promote and administer applications for each of the program elements.

A guiding principle of the VNPP has been to focus on alignment with the policy initiatives and programs of the Department. Applications for NP model development grants were for:

- Alignment of proposed NP service model with key organisational, state or national service/policy framework for the targeted clinical area.

DHHS (2015)

The VNPP has also included working directly with Integrated Cancer Services and the Continuing Care, Palliative Care unit of the Department.

6.2.1 Palliative care

Government funding supports palliative care nurse practitioner candidates to complete their education and work experience requirements. The aim of this initiative is to
strengthen the palliative care sector’s capacity to meet demand. In 2013 Victoria had eleven palliative care NPs and eleven palliative care NPCs.

These positions were funded under the Strengthening Palliative Care strategy. The NP Palliative Care Collaborative Group was also partially funded under this strategy, including funding for an executive officer position.

6.2.2 Integrated Cancer Services (ICS)

Victoria’s Cancer Action Plan 2008–2011 (DHS 2007) identified the expansion of the oncology workforce, particularly in regional Victoria, as a priority. Some Regional Integrated Cancer Services were involved in developing oncology models of care for NPs and scholarships were provided to NPs in rural areas.

In 2008-09 the Integrated Cancer Services (ICS) funded six NP model development grants in metropolitan and regional health services. Regional ICSs were involved in model development.

In some instances, general models of care have been followed by models that have addressed more specific service needs, with oncology NPs providing long-term management through outpatient clinics. Oncologists were supportive of the NP model of care and saw the opportunity for new NP models of care, as treatments evolved to meet the need for working with cancer survivors.

The ICS in the Department, while continuing to focus on enhancing the development of the nursing workforce, is not initiating NP specific programs.

6.2.3 Mental Health

In 2009 a mental health reform strategy was developed. One element of this strategy was to improve workforce quality, recruitment and retention by providing mental health staff with ongoing professional development. Advanced practice roles were proposed as part of the delivery of existing and new service models. In the context of addressing rural workforce shortages, the Victorian Mental Health Reform Strategy proposed exploring:

The feasibility of diversifying the roles of workers in rural areas to deliver new service models, such as nurse practitioner-led clinics.

(Department of Health, 2009)

6.3 Organisation level

A level of organisational commitment was required for applications for model development grants to be successful. Eligibility for a model development grant has been contingent upon the organisation that was applying having done a considerable amount of work to identify how a NP model of care can address organisational need. Applications for model development grants that were considered to be “aspirational” were not funded. These were organisations where there was no consideration by the
service’s executive, no identification of a specific role for the NP in service delivery and no internal consideration of how the model would work prior to applying for the grant.

The value of the VNPP funding was in assisting health services to review and identify an area of need (or service gaps). From the time of application through to endorsement, the grants have encouraged a culture to foster career development for nurses. They have promoted early buy-in of senior clinical management, before the NP is even employed.

“The most important thing about that funding, is that it is very easy for a hospital… to say: ‘Oh we want a NP’… but one of the important things is that you need to define an area of need, and the role in which you want your NP to work.”

“If you just start throwing NPs into the system anywhere and generally under a nursing stream it doesn’t add much value.”

“Funding allowed us to look at our work streams and experience and determine if there was a gap that needed to be filled, which were the more important and what role.”

Clinical Manager

Engagement of medical staff on steering/advisory committees has been identified as an important enabler of successful implementation.

“If I had a firm belief that the NP role was not a valuable one, I would not have been involved in the Steering Committee. It has been very valuable for me, and for patients in practice. I think there is a role that exists that NPs can only fulfil; that is unique and different to nursing staff and clinical nurse specialists. And that it is not a substitute medical staff member. It is not a substitute resident or registrar. It fulfils a very specific role… the specialist skills they have got allows me to provide significant extra care to my patients that I have not been able to in the past”.

Medical Consultant

Continued involvement of medical personnel is driven by commitment to development of the model and is (unpaid) work that is over and above normal duties. Continued involvement without funding was identified as a potential barrier. Specific evidence of withdrawal of support has not been identified for larger organisations but is more likely to occur in smaller organisations.

There were strong arguments put that organisational support was necessary for the sustainability of the NP models of care.

- Need NPs to have a supported way of working in the organisation (organisation invests in the NP role)
- Need an individual, or a group of individuals committed to the NP project
- Needs to be acceptable to the patient population
- Doesn’t work if model is based on an individual’s desire to be a NP, unless all those other elements are in place.

6.3.1 Funding

Investment by the organisation was considered important for the success of the NP model of care. One NP commented that the earlier phases of the VNPP supported
models of care in emergency departments. However, only three were sustained – the Alfred, the Children’s and the Austin. Several others are no longer operating.

Lack of ‘investment’ from the organisation, in terms of support and integration, was a barrier to successful implementation; where that support was not forthcoming, NPs and NPCs identified problems. For example, one NP reported that an organisation’s collaborative group (that is, a regular meeting of NPs in the organisation) had been agreed to but not actioned. In other instances where there had been a restructure of the service or a change of senior management, the leadership support for the NP position was lost.

Where there was no clear business case with a funding stream identified, the NP position was at risk.

“Unfortunately now we’re at the point of getting that up to go forward, there’s no internal funding, so we now no longer can. So that’s incredibly disappointing for our service.”

Director Community Services

The support of the organisation includes financial commitment but also includes developing a supportive culture, which includes backfilling roles when the NP takes leave, succession planning for when a NP leaves the organisation, facilitation of NP meetings within the organisation, and supporting NPs and medical clinicians to provide support for NPCs both inside and outside the organisation.

A barrier to the implementation of sustainable NP models of care was in cases where an executive had an “I want one of those” attitude. Some described executives as wanting to take a model development grant because it was there and they had a current profile within the sector, without thinking through the longer term implications.

“The sign-off was due to wanting the funding for that position, but not really wanting or willing to support a NP.”

NP

This problem was mentioned in both Victorian and interstate jurisdictions.

“Some models are amazing. Some models that are amazing and don’t work. No succession planning. So when somebody levels, they are not replaced.”

NP

6.4 The Team level

The term “first through the wall” has been used to describe leaders who break through into new domains for the first time. NPs in the earlier phases of the VNPP and continuing into the fourth phase were breaking into new territory. When these new models were being implemented neither the NPs nor their mentors were clear about the detail of the NP role and how it would work.

“We had to work it out as we went along. There was no real precedent.”

NP
Initially NPs had to define their own role as candidates and later as NPs. There were no guidelines for clinical training, and the unique models of care based around specific scopes of practice meant that there was no standard approach that could be applied to all NPCs. Each NPC had to develop a strategy for interacting with other health professionals. This lack of clear identity has proved to be a major challenge for NPCs and NPs.

“That’s half the problem, I don’t know actually know what the hell a Nurse practitioner can and can’t do. That would be my first step, to find that out, really.”

Unit Manager

To some extent, there is more recognition of NPs identity but the need to explain their role was a continuing challenge.

There are two aspects of team engagement for the development of NPs. First is the engagement of teams in the development of the model of care, applying for the model and providing the NPC with appropriate levels of support through supervision and mentorship. Secondly, the support of, and integration with, service delivery teams is important to the success of the NP model of care.

Underpinning team engagement was the lack of recognition by many health professionals of the role of NPs. This required vigilance, adroitness and mindfulness by NPs when first engaging with new team members or other professional and administrative staff in their organisation.

6.4.1 Professional identity

Often, the role of NPs was not clearly understood by other team members or other administrative staff and health professionals in their organisation. In most instances, NPs and NPCs reported that they have to explain their role to medical registrars, consultants, other nurses, hospital administrators, patients and even reception staff. This was particularly the case when they engaged with other members of the teams for the first time.

Communicating awareness of the NP role was identified by NPs and NPCs as a task for the Department and VNPP to take on in the future (see Section 9 below).
6.4.2 Teams as enablers

How well the NP fitted into the team was dependent on the personality of the NP and how visible their work was (which was, in turn, related to the number of hours worked – full time was better than part time): Part-time NPs were not seen to fit into the team as well. This hampered other team members the real effectiveness of the role. Part-time positions also require a level of compromise for the organisation such as moving established team meetings to days when the NP could attend.

Most commonly, NPs saw themselves as good team players and enjoyed working in the team environment. NPCs commonly expressed that they felt extremely well-supported.

“It’s a good team and I suppose that’s why I feel quite fortunate and quite well-supported, because I have a good team to work with. And they don’t see me on my pathway to becoming a Nurse Practitioner as a threat, either, which is something that gets mentioned quite a bit. They’re aware of a nurse practitioner and how they work, they’re aware that I’m a nurse and I plan to stay a nurse, I don’t plan to become a quasi-doctor.”

NP

It is clear from the interviews that NPs do not see themselves as replacing medical professionals, but see their role in supporting the doctors and the rest of the team. This suggests that implementation grants can be successful in further strengthening team roles.
One NP in private practice has ensured that he has a team for support and to maintain clinical oversight. He has medical contacts (local GPs and some medical professionals in Melbourne). This helps to avoid the "solo NP" problem of becoming isolated.

Key success for the NP is the drive of the individual practitioner, the experience and values they bring and the depth of skill with which they come. But the drive of the NPC was not enough in itself. The support of the team and the organisation was seen as essential for the success of the model.

“Drive of the candidate, but also support and understanding of the role by key senior nursing and medical staff within the unit, within the organisation. That has been key, important. We have not had other senior medical staff (within our unit) push back against this role… Part of that is because we have worked with [NPC] for years.”

Medical Consultant

The model development grant facilitated these relationships by dedicating resources to engage with team members prior to engagement of the NPC. This was important where team members were external to the organisations.

NPCs spoke glowingly of the support they were offered by their colleagues and organisations, whilst able to realistically reflect on the strengths and weaknesses of their particular situation. While it did indeed appear that this support was considered to be well-deserved by the NPCs supervisors and mentors, it also was apparent that those in larger institutions had greater flexibility in that there was more likely to be other staff who could back fill their role if they needed to be absent.

It was commonly expressed by NPCs that they felt extremely well-supported.

“It is busy, and there’s a lot to fit in. But it is working, because I want it to work, and I’m incredibly well-supported here, and the doctors want it to work….. So it’s working because everyone wants it to work.”

NPC

Engagement of medical personnel through the steering committee, actively establishing governance structures and supporting candidates through clinical supervision, have all enhanced the successful implementation of models.

Recognition of the NP role as providing advanced, sophisticated nursing care that is not a simple substitute for medical staff was considered to be an important element of the success by a number of people consulted. This was seen as particularly important for getting medical professionals on side:

“NPs are trained, have those advanced skills that I can rely on… help me as part of my medical team” …requirements of registrar training is wide spread, breath of experience rather than a specialist.”

Medical Consultant

Steering committees did continue as an advisory committee. Ongoing roles included:

“Report back on their measurable outcomes… has it worked…. Are we meeting a need…providing that oversight to make sure the roles are working as they should.”
“The main thing up until now is reporting on those outcomes… documentation of exactly who she is seeing, what her interventions are with given patients so she can document where her work is at because it is a new role…”

Medical Consultant

Where NPs do not work with a team, the model is likely to have problems, particularly when organisational pressures related to structural changes, budget pressures or renewal of the leadership team occur.

“You’re staffing above the ratios and there has to be a really good benefit financially, financially it’s a problem. When you come to the bean counters and the CEOs, doesn’t matter which organisation you are.”

Manager

“A lot of our time is spent grant-writing, juggling staffing EFT against meeting targets, and then when that funding’s run out we’ve got a critical service that can be compromised.”

Director Community Services

6.4.3 Mentors

When asked to describe the difference between supervision and mentoring, one participant stated that a supervisor has a level of power and authority and is a person from whom one is meant to learn new skills. A mentor is more part of a peer partnership, where issues and ideas can be bounced between people.

Mentoring was essential to assist NPs in making the leap from consensus decision making to autonomous practice.

“So to the point, getting from Advanced Practice Nurse to NP, it is essential to have robust mentorship that challenges your decision-making in a supportive, learning environment to facilitate that cognitive transition.”

NP

The mentor process can be “very daunting” for some people. At least two mentors commented on the lack of mentoring advice, and whilst acknowledging that it could be challenging for the VNPP to provide mentoring guidelines across different scopes of practice, still felt this would be useful.

“It’s difficult in a way to give specifics, I guess, because essentially it is adult learning and it’s about, I guess, what the candidate identifies. But then, having an overarching view about that and suggesting: ‘Have you thought about adding this in,’ and things like that.”

NP mentor

Mentors and NPCs both commented that it would be good to have time for NPCs and mentor relationships built into the structure, with better support from the department for this:

“It’s about time, getting to [the NPC], spending some time with her. Which is probably going to end up being in my own time. And that’s fine, I’m happy to support her, that’s no problem, but would be nice if there were some sort of formalised structure.”

NP mentor
Mentor relationships also included clinical advice. A NPC described meeting with his GP mentor “five or six” times, which involved talking through issues and approaches to patients. The GP was not paid, although the NPC bought him lunch. In another case a GP who had mentored a NPC was somewhat terse and mentioned that he had not been paid for his time, suggesting this reflected a lack of recognition of his role.

A label such as “accredited Nurse Practitioner mentor” might help with recognition of the importance of the role, but might need to be specific to services or scope of practice.

6.4.4 Engaging with teams at service delivery

Some identified barriers to implementation from other nurses, particularly NUMs:

“It was nursing [who were the barriers]. Definitely nursing. The medical staff were fabulous and really signed on to it. Because they had had [experience with] earlier projects.”

NP

“They get paid more than I do and I run the place.”

NUM

Some nurses in management saw the high cost of NPs as a barrier, preferring to have medical staff. There was some resentment by those involved in administration:

“When I look at the EBA for NPs, a lot of them are being paid higher than a DON at a 500-bed hospital.”

Director Community Services

In NSW the Department of Health funds NP positions. The Department has ceased providing top-up funding (to convert CNCs into NP positions) because of the resentment caused among CNCs.

“[In NSW] CNCs are threatened by [the introduction of a NP role]… hang over because CNC roles were replaced by NPs and they saw their role as being overtaken by the NP and that created an instant barrier.”

NSW policy officer

When there is antagonism from nursing management, once a NP leaves the organisation, their position is not replaced by a NP.

“Individual level, NUM was threatened by the project … Some models are amazing. Some models that are amazing and don’t work. No succession planning. So when somebody leaves, they are not replaced”

NP

6.5 Clinician-level factors

NPs are a relative new model of service delivery in the Victorian health system, with the first NPs endorsed in December 2004. The number of NPs whose principal place of practice is Victoria, as at June 2015, has increased to 231 from the nine who
commenced training under the nine demonstration models established under the first phase of the VNPP 1999 (Human Services, 2000). There are also more than 70 NPCs working towards endorsement, approximately 50 of whom are supported by the VNPP.

Undertaking a NP career path was identified as challenging for individuals. One respondent summed it up as:

“It requires a commitment to put time aside to study while juggling family and work. There is a cost with the fees. And there is no guarantee of a career path.”

Manager

The first NPs to become endorsed had the challenge of defining what their position was. There was a great deal of uncertainty expressed about how they went about defining their role:

“We had to work it out as we went.”

NP

The individual NP clinician could sometimes act as a barrier. Two reasons were identified. First, some NPCs were not prepared to take on the workload required for preparing for endorsement. Second, some had difficulty with the shift from a nursing role to the autonomous role of the NP, even as a NPC.

“Unfortunately the candidate that they appointed into the role, discontinued (could not make the cognitive autonomy jump required for NP.”

NP mentor

Shifting from a nursing mindset to a NP mindset was identified as a substantial challenge for individuals.

“My personal experience and discussion with other people that have made the journey (or unfortunately not completed it), is that they struggle with the transition from Advanced Practice nurse to NPC to NP. A hallmark of nursing practice is collaborative decision making. An issue arises, we all chatter and a group consensus is reached. This doesn’t happen as an NP. The expectation of the endorsement is that you can conduct advanced assessment (including appropriate diagnostics), assimilate that information to a diagnosis and formulate a plan of care that has ongoing review. During this, just like a medical officer, you may collaborate for advice, or refer a patient on via a medical colleague for specialist input. When the plan is enacted you are the responsible person, and that accountability is the bit that many registered Nurses struggle with. Most RNs struggle getting to the diagnosis point that they could robustly stand behind.”

NP

In other instances the NP was not seen to work well with the team. In an extreme case, the NP’s office was not located with the team that the organisation expected them to work with. This was one of a number of factors that resulted in a breakdown of the relationship and the NP not continuing in the position.

Mentorship relationships were important in overcoming this transition. Peer support, especially through the collaborative groups, was identified as an important factor in assisting NPCs to make the transition through their candidature.
6.5.1 Individual NPs

NPCs were found to be highly motivated and experienced nurses prepared to take on Master’s study while working in full time nursing positions. All NPCs who participated in the interviews were very enthusiastic, committed, hard-working, and grateful for the opportunity they had been given. Their motivation was driven by a desire to extend and practise their advanced clinical knowledge.

“It’s not a money thing. You don’t expect a return on investment. You expect improved patient flow and support.”

NPC

NPs have a strong clinical focus. One of the drivers of individual NPs has been to progress their career through clinical practice. Frequently they have made a decision not to pursue an administrative career path. Some have come from positions of DON, NUM and even as a CEO, prior to taking up their candidature.

Many NPCs were already practising at some level of independence when they were taken on as NPCs, which clearly was a benefit in the transition to the new role.

“She was already operating at an advanced level.”

CEO

NPs had been nursing for an average of 25 years while NPCs had been practising for an average of 23 years since graduating (Table 10).²

**Table 10: Time working and studying**

<table>
<thead>
<tr>
<th>Q12</th>
<th>What year did you … graduate, start working at your current organisation, commence Master’s, compete Master’s, get endorsed</th>
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<tr>
<td></td>
<td></td>
<td>NP (n = 59)</td>
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<tr>
<td>-----</td>
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<td></td>
<td></td>
<td>Years</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------------------------------------------------------------------------------------------</td>
<td>----------------------------------------</td>
</tr>
<tr>
<td></td>
<td>Since graduation</td>
<td>24.9</td>
</tr>
<tr>
<td></td>
<td>At current organisation</td>
<td>11.4</td>
</tr>
<tr>
<td></td>
<td>Since commenced Master’s</td>
<td>8.4</td>
</tr>
<tr>
<td></td>
<td>Since completed Master’s</td>
<td>6.4</td>
</tr>
<tr>
<td></td>
<td>Since endorsement</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Base: NPs and NPCs

² This is higher but reflective of the mean of 22.5 years reported by Middleton et al (2011) in the report of the 2009 National NP survey.
Most NP work was direct service provision. When asked about the allocation of NP work time, there was close congruence between the NPs and NPCs on the one hand and Directors of Nursing and organisation managers on the other (Table 11). The equivalent of three out of five working days was estimated to be allocated to direct service provision with the remainder being allocated equally between mentoring other nurses, research, management and administration, service development and continuing professional development.

### Table 11: Allocation of NPs’ work time (NPs/NPC and DONs)

<table>
<thead>
<tr>
<th>Q13 (DON) How should a NP’s work be allocated?</th>
<th>Q13 (NP/NPC) - Thinking of your work over the last month, what proportion of your normal work time is allocated to by:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DONs (n = 41)</strong></td>
<td><strong>NP/NPC (n = 76)</strong></td>
</tr>
<tr>
<td>Direct services to clients/patients</td>
<td>62%</td>
</tr>
<tr>
<td>Providing mentoring/ advice/ supervision to other nurses</td>
<td>12%</td>
</tr>
<tr>
<td>Research</td>
<td>6%</td>
</tr>
<tr>
<td>Management/ administration</td>
<td>6%</td>
</tr>
<tr>
<td>Service development/ capacity building</td>
<td>7%</td>
</tr>
<tr>
<td>Professional development/ study/ continuing education</td>
<td>7%</td>
</tr>
</tbody>
</table>

While the drive of the individual clinicians is important, it has been facilitated by organisations quarantining time for study during the candidature.

NPC training is facilitated by organisations and a system-level enabler – the Nursing Enterprise Agreement. The Award allows one day per week of study leave for nurses while studying for a Master’s degree.

NPs bring experience that can be greater than that of general/rotating registrars. There are also benefits to NPs having established relationships within the health service prior to becoming a NPC. One medical consultant commented:

“One of the valuable things about the NP role… is that those who apply usually… have got a fair bit of experience already… self-selecting, have worked in an area for many years and know within themselves they have that scope to do more. Building on an existing wealth of experience already.”

Medical consultant

### 6.5.2 Recruitment of NPCs

In the course of the site visits, it was found that almost all sites had a person in mind when they developed the model. Very occasionally the position was advertised internally, and responses were received from internal applicants. Sometimes models were developed around potential candidates, only to find that the candidate had not
realised the full extent and commitment involved in the role, or other life events intervened to prevent the potential candidate from taking on the role.

NPs had been working in the organisation where they became candidates for an average of 11 years, while NPCs had been working in their organisation for an average of nine years (Table 10). NPs and NPCs working in regional and rural areas were likely to have a connection with the local community with 58% of survey respondents from non-metropolitan areas having a connection with the local area before they even became a nurse.

Where NPC positions were advertised externally, responses were received from external applicants but no instances were identified where a person other than the “person in mind” was selected.

The long-term work relationship which some NPCs had with their organisation, led them to see their appointment as a NPC as a reward for service or an incentive for retention. Without exception, all NPCs saw their appointments as a reflection of their competence. In other jurisdictions the development of a model of care was identified as problematic because of a scope of practice being developed around very narrow and specific models of care, often within tertiary hospital settings. One NP used the term “veteran’s badge” to describe the endorsement of NPs who have been working in a narrow and specific area for a considerable period of time.

In one large metropolitan hospital a model was developed where there was an experienced senior nurse who was interested and involved in model development. The position was advertised externally and that external recruitment ensured confidence in the appropriate recruitment of the internal candidate.

### 6.5.3 NP clinicians driving implementation

A strong enabler of success of VNPP model development grants in achieving a sustainable workforce of NPs is the quality of the NPCs themselves. NPCs are clinicians who are highly motivated to undertake postgraduate study on top of full time work and busy family lives. This starts from the drive to develop the model.

While the grants have been focused on developing a sustainable role of NPs in the organisation, NPs have often been the driving force behind the application, or, at the very least, actively involved in developing the model. The surveys found that 19% of Directors of Nursing identified nurses waiting to become candidates as the main driver of the NPC, as did a similar proportion of NPs and NPCs. Sixty seven per cent of NPs and NPC had been working at the health service at the time of model development, and only 25% had no input into the model development (Table 4).

Nurse practitioners’ positions have been seen by some as a retention strategy. The position is attractive for organisations wishing to keep experienced clinical nurses who did not wish to pursue an administrative or management career. Survey results
showed NPs had been working in their organisation for an average of 11.5 years, while NPCs had been employed for an average of nine years.

For rural health services, 58% of NPs and NPCs (n = 31) had a connection with the local area before commencing to work as a nurse, a factor that has been shown to be important in retaining workforce in rural locations.

6.5.4 NP remuneration as a barrier to recruitment

Some argued that remuneration could act as a barrier to attracting potential NPs into the role. They felt NPs weren’t paid significantly more than senior registered nurses:

“There’s no financial incentive. The wage itself, at the end of the day, is about the same as a unit manager. There’s no financial incentive to work in it. It’s about professionalism that people choose to do it.”

Clinical Director

Others commented that the cost of paying for study was not recompensed by the increased salary.

On the other hand, the higher salary of NPs upon endorsement was a barrier to health services employing them.

There was little incentive for NPs to enter private practice as the MBS rebates made a private practice model barely sustainable, even when supported by work contracted to health services.

6.5.5 Time required for candidature

All NPCs reported their NPC role as very busy:

“It’s stressful trying to fit it all in, to have a job that’s a full-time job in itself. When you chuck Uni in there, well, I’m doing the same job in less time. It does mean staying back a bit late every now and then. But that’s, I suppose, the reality of it and I didn’t walk into this thinking I’d be there 9 ‘til 4:30 and still have my lunch.”

NPC

While NPCs believe they manage their time well, some things can fall behind, such as formal clinical supervision, as highlighted earlier.

“[My clinical supervisor] and I have found it hard to put specific time aside. And even... this week we’ve sort of been saying, we need to try and get back on to this, we’ve had a month off, things have just sort of fallen off the wagon a bit, as they do.”

NPC
6.5.6 Personal costs

For NPs who had completed training prior to this package being available, there was recognition that the financial costs had been high. Most had been helped out by their place of employment to attend classes through the offer of non-clinical paid time. NPCs mostly said they had not expected that the workload would be so high. Many stated they were grateful that they had no young children, or that they had no children, as the hours are very demanding, although rewarding.

Personal events also sometimes have cut into time:

“I think next semester will be fine. ... I’ve had a lot going on outside of work, then I went straight into this, so I think it’s just ... I need a break with nothing for a little while, then I’ll be fine... it’s all good, it’s just Uni, it makes you tired.”

NPC
7 Sustainability

Sustainability can be an issue for NPs if the service develops a single NP. That NP becomes, effectively, a sole practitioner. The position is tied to the individual and not sustainable beyond that individual NP’s tenure:

“This is something we’ve been talking about, and it’s been a problem with the development of the NP model, in that organisations would take on one, and they would develop that person but they wouldn’t go any further and it wouldn’t be an ongoing thing, and so it was great while that NP was there, but the service that they ran or worked in was entirely dependent on that one person, so if they went on leave, the service stopped.”

The model development grants were perceived by DONs to play an important role in establishing sustainable NP models of care. Thirty nine per cent of DONs considered that model development grants contributed to a sustainable model of care (Table 12). Sixty seven per cent of DONs, from organisations that were successful in receiving a VNPP model development grant, considered the grant to have contributed to a sustainable model of care. Those from metropolitan Melbourne were more likely (72%) to agree that the grants assisted sustainability.

<table>
<thead>
<tr>
<th>Table 12: DON perception of impact of model development grants</th>
</tr>
</thead>
</table>

Q11 – Has the grant for a project officer contributed to a sustainable model of care?

<table>
<thead>
<tr>
<th></th>
<th>Total (n = 41)</th>
<th>Applied (Successful n = 24)</th>
<th>Applied (Unsuccessful n = 2)</th>
<th>Did not apply (n = 15)</th>
<th>Metro Melb (n = 11)</th>
<th>Rural (n = 30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>39%</td>
<td>67%</td>
<td>0%</td>
<td>0%</td>
<td>73%</td>
<td>27%</td>
</tr>
<tr>
<td>No</td>
<td>20%</td>
<td>13%</td>
<td>50%</td>
<td>31%</td>
<td>18%</td>
<td>20%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>41%</td>
<td>21%</td>
<td>50%</td>
<td>69%</td>
<td>9%</td>
<td>53%</td>
</tr>
</tbody>
</table>

Base: All DONs (n = 41)
7.1 Impacts

7.1.1 Impacts on endorsement

NPs and NPCs identified the model development grants as having an impact on endorsement (Figure 4) but not as much as the collaborative groups and clinical supervision by someone within the organisation (Figure 4).

The Victorian NP Collaborative Groups were rated by NPs and NPCs as having the most positive impact on endorsement out of all the elements of the VNPP.

External supervision and mentoring, input from NMW and internal mentors were given average ratings. The NPC Support package was given a rating that was barely positive (although from the site visits, NPs and NPS were not necessarily aware of the NPC Support package and how it was spent). The very low rating of the log books may “rub off” as it were, on the rating of the NPC Support packages.

Figure 4: Impact of VNPP elements on endorsement

Q20 Please rate how each of the elements of the VNPP has contributed to your endorsement

<table>
<thead>
<tr>
<th>Element</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaborative group</td>
<td>7.3</td>
</tr>
<tr>
<td>Clinical supervision (Organisation)</td>
<td>7.0</td>
</tr>
<tr>
<td>Model development grant</td>
<td>6.7</td>
</tr>
<tr>
<td>Scholarship (VNPP)</td>
<td>5.8</td>
</tr>
<tr>
<td>Internal NP Mentor</td>
<td>5.6</td>
</tr>
<tr>
<td>External NP Mentor</td>
<td>5.4</td>
</tr>
<tr>
<td>NPC Support Package</td>
<td>5.1</td>
</tr>
<tr>
<td>NMW DHHS (not funding)</td>
<td>5.1</td>
</tr>
<tr>
<td>Clinical supervision (External)</td>
<td>5.1</td>
</tr>
<tr>
<td>Log book</td>
<td>4.4</td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs (n = 76)
7.1.2 Impacts on patients

The model development grants were perceived by NPs and NPC to have the strongest impact on improving outcomes for patients (Figure 5), followed by improved efficiency of service delivery. The leadership of the NPs was reflected in the perception that they were increasing the skill level of clinical teams, but the lowest rated impact was on increasing executive understanding of the role. Nevertheless, rating of the impact on executive understanding was positive (6.4 out of 10).

Figure 5: Impact of VNPP model development grants

Base: All NPs/NPCs (n = 76)
DONs and managers also perceived the biggest impact to be on patient care together with meeting specific service needs, although they did not rate the impact as highly as NPs and NPCs (Figure 6). DONs did rate the impact of models of care on the capacity of regional workforce to meet service needs, as positive but the lowest of all the impacts (5.5 out of 10).

Figure 6: Perceived impact of models of care by DON

Q26 To what extent has the funding to support NP models of care contributed to...

In the course of the site visits, the capacity of the NP model of care to deliver services in a range of settings was consistently identified. These included:

- Long term relationships with women who had survived breast cancer and required follow up over a number of years
- Provision of support for youth in rural settings for both drug and alcohol and mental health issues
- Mental health services for prisoners
- Fast track emergency department services enabling improved performance in KPIs
- Management of patients in sub-acute settings enabling the improved utilisation of beds.

For a full listing of the see the reports of model development grants at http://www.health.vic.gov.au/nursing/furthering/practitioner/nurse-practitioner-models
NPs and NPCs were asked whether they agreed or disagreed with a series of statements describing the impact of the role on the organisation, team and themselves (Table 13). Related but different statements were asked of DONs and managers (Table 14).

For NPs and NPCs, “working with the team” stood out with 93% agreeing that it was enjoyable. This reflects the strong levels of satisfaction with working as a NP identified in the site visits. Only half or just over half agreed that they were understood or supported by their team, other nurses or the organisation where they worked:

- 57% agreed “other team members understood their scope of practice”;
- 58% agreed that “other nurses were always supportive”; and
- Only 50% felt “well-supported by the organisation” in which they were working.

<table>
<thead>
<tr>
<th>Q41</th>
<th>For the following statements about NPs please indicate whether you agree or disagree with each statement as it applies to you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Disagree</td>
<td>Agree</td>
</tr>
<tr>
<td>I enjoy working with the team</td>
<td>1%</td>
</tr>
<tr>
<td>Other nurses see NPs as clinical leaders</td>
<td>9%</td>
</tr>
<tr>
<td>The NP role is well-integrated into the model of care</td>
<td>15%</td>
</tr>
<tr>
<td>Involved in research projects</td>
<td>17%</td>
</tr>
<tr>
<td>Team members understand my scope of practice</td>
<td>20%</td>
</tr>
<tr>
<td>Other nurses are always supportive of me as a NP</td>
<td>26%</td>
</tr>
<tr>
<td>NPs are well-supported by the organisation</td>
<td>27%</td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs (n = 76)

Ninety seven per cent of DONs and managers saw the NPs as “providing clinical leadership”, as “team players” and being “supported by other nurses”. (Table 14)

There is a gap between the Executive leaders and NPs in the perception of how NPs are supported by the organisation and their team.

Nevertheless the leadership role of NPs was recognised by the NPs themselves and the DONs and managers.
Table 14: DON Perception of team and organisation support

<table>
<thead>
<tr>
<th>Q25</th>
<th>Disagree</th>
<th>Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>NPs provide clinical leadership</td>
<td>3%</td>
<td>97%</td>
</tr>
<tr>
<td>Other nurses are supportive of NPs</td>
<td>3%</td>
<td>97%</td>
</tr>
<tr>
<td>NPs are team players</td>
<td>3%</td>
<td>97%</td>
</tr>
<tr>
<td>NP role is only viable with additional recurrent funding</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>NPs are a good investment</td>
<td>11%</td>
<td>89%</td>
</tr>
<tr>
<td>NPs are well-supported by my organisation</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>My organisation cannot sustain NPs because of the cost</td>
<td>33%</td>
<td>67%</td>
</tr>
<tr>
<td>Medical professionals understand the role of NPs</td>
<td>59%</td>
<td>41%</td>
</tr>
<tr>
<td>NPs duplicate the work of medical registrars</td>
<td>76%</td>
<td>24%</td>
</tr>
</tbody>
</table>

Base: All DONs (n = 41)

The impact of cost was identified as an issue for sustainability. Sixty seven per cent agreed that “NPs cannot be sustained because of their cost.”

It was also clear that DONs did not see NPs as “duplicating the work of medical registrars” (76% disagreed). Forty one per cent of DONs felt that “medical professionals did understand the role of NPs”. The majority disagreed with this statement, indicating that the majority of DONs felt that medical professionals did not understand the role of NPs.

Cost of NPs was perceived by most DONs and managers to be an impediment to the sustainability of NP models of care.
7.2 Impacts of the elements of the VNPP

The rating of different elements of the VNPP on the sustainability of the NP model (Figure 7) reflects the rating of the impact on endorsement (Figure 4 above).

Collaborative groups, the medical team and the executive of the organisation had the highest impact (more than 7 out of 10). Steering committees (5.4), the model development grant (6.4), external medical practitioners (6.3) and the model itself (6.4) were perceived to have the lowest impact.

Figure 7: Perceived impact of stakeholders on sustainability (NPs/NPCs)

Q22 Now thinking of the sustainability of the NP model in the organisation please indicate whether the following influences have been positive or negative

<table>
<thead>
<tr>
<th>Influence</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding for model of care</td>
<td>7.7</td>
</tr>
<tr>
<td>Medical mentors for the NPC</td>
<td>7.5</td>
</tr>
<tr>
<td>Clear clinical governance framework</td>
<td>7.5</td>
</tr>
<tr>
<td>A NP Mentor within the Health Service</td>
<td>7.3</td>
</tr>
<tr>
<td>Support by other nurses in the organisation</td>
<td>7.2</td>
</tr>
<tr>
<td>Consultation with staff prior to engagement</td>
<td>7.2</td>
</tr>
<tr>
<td>NP collaborative groups</td>
<td>6.7</td>
</tr>
<tr>
<td>Scholarship from the VNPP</td>
<td>6.5</td>
</tr>
<tr>
<td>NP Support package</td>
<td>6.3</td>
</tr>
<tr>
<td>A NP Mentor (external)</td>
<td>6.2</td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs (n = 76)

DONs identified the model development grant as having the highest impact on viability, rating it (7.7). Internal mentors (medical (7.5) and NP (7.3)) and clinical governance frameworks (7.5) were also rated highly.

External mentors (6.2), NPC Support packages (6.3) and scholarships (6.5) received the lowest rating from DONs.
During the site visits, a number of indicators of successful implementation were identified. These indicators included:

- Acceptance by patients
- Acceptance by patients and their families
- Referral by local GPs
- Specialists providing feedback after referral.

One of the signs of success identified was being able to find a replacement for NPs when they took leave.

The objective of the VNPP is to achieve sustainability of NPs in Victorian health services and the viability of NP models of care within individual health services and other government-funded organisations. Achieving a critical mass of NPs in the health workforce underpins the sustainability of models of care, independent of the individual NPs engaged at the health service.

One indication of the success of the VNPP in achieving a critical mass of NPs is the extent to which there are sufficient NPs to keep positions as NPs move, or continue the service while they are on leave.

The survey found that 20% of NPs reported using a locum when they are on leave (Table 15).
One service was able to recruit a replacement NP with a Mental Health scope of practice for an extended (one year) leave of absence. Because of the specialised nature of the health service, a three month “probation” period with close supervision and mentor support was required.

However, during the site visits, many NPs and NPCs reported that there was no replacement for them and the work waited until they returned from leave.

“Currently there’s no-one to back-fill me at my other locations. Nothing happens, really, [the work] is there when you get back. I now have a candidate with me NP who can pick up the other details… it’s very limited, obviously he can’t see other people who are more complex people, or people who need prescribing or been referred for medication reviews. We can back-fill to a certain extent. So if I’m going on leave, and I generally know months in advance, I won’t book people for that time.” NP

When a NP wished to take substantive leave, the service contract could be put at risk, particularly for small organisations. Some organisations spoke of the difficulty in finding a replacement NP in a particularly challenging field of care:

“With [one of the NPs] going away for a year, we were on the verge of saying: ‘We’ll need to amend the contract, because we can’t supply the service for a year, we can’t just find another mental health practitioner that has [specialty] experience and can work in the same way.” Service Manager

Most NPs reported that “some of the NP work was undertaken by medical staff” or other nurses, while 55% reported that some or all of the work just waited until they returned (Table 15).

<table>
<thead>
<tr>
<th>Q25. When you take leave, which of the following apply:</th>
<th>n = 76</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part of your work is done by medical staff</td>
<td>63%</td>
</tr>
<tr>
<td>The work just waits until you return</td>
<td>55%</td>
</tr>
<tr>
<td>Part of your work is done by other nursing staff</td>
<td>47%</td>
</tr>
<tr>
<td>Another Nurse Practitioner will act as a locum</td>
<td>20%</td>
</tr>
</tbody>
</table>

*Percentages add to more than 100% because of multiple response*  

7.3 Professional identity of NPs

The VNPP results in very good work that is seen as adding value to the organisations in which NPCs have been supported and endorsed. Neither the VNPP grant nor the NPC Support packages require reporting of either outputs (successful endorsement of
supported NPCs) or outcomes (models of NP care and NPs established in health services and community organisations or patient outcomes).

However, even where organisational evaluations of the NP program have been undertaken, information is not made publicly available; this is a missed opportunity for promotion of the program.

One participant further commented that the VNPP hides its light under a bushel, and that more effort should be made to promote the program publicly and at conferences.

“There should be an obligation for them to either publish it or present it at a national level. And then there’s a value in it not just for this agency, but, I don’t know, Kalgoorlie Community Health can go: ‘Oh, that’s a great idea, how can we pinch that idea?’”

Clinical Director

Another stated:

“We don’t go out and say to the community: ‘Look we have got NPs, look what they can do, look what the state government has funded!’”

Clinical Director
8 After endorsement

8.1 Business case

Funding became an issue when the NPC became endorsed and there was no clear business case established to support NPCs beyond endorsement. Up until that point of time a NPC would have been employed as a nurse, usually in a senior capacity. Salary was covered “under the ratios” since, while studying and undertaking the clinical work for endorsement, the NPC would normally be employed as a nurse doing nursing duties. As a NP, the substantive position required funding as a supernumerary position. With nursing budgets determined by the ratios, funding for the position had to be found from other sources.

Some NPs argued that the funding should come out of the medical budget. This created a level of tension with executives considering they were losing out by employing a nurse rather than a medical registrar.

One organisation, in the NP model of care, identified the NP position as providing:

“A cost-effective and strengthened, comprehensive and accessible service.”

Model report

This organisation was funded as an independent organisation and the funding for NPs has been built into the overall budget.

There is lack of funding for ongoing professional development. Additional funding for further professional development would be welcomed by some organisations:

“I would love it if we had funding for [the NP] role to be able to go somewhere, say, two days a week, something like that. She is developing as a [specific role] NP, so the work does have to be rooted in [this] environment. I wouldn’t want to send her away somewhere for twelve months, but if we had funding for something like a couple of days a week for her to be [in an alternative related setting], where she could get that kind of clinical skills development, that would be excellent.”

Clinical Supervisor

“For me, with NPs, the risk is that they’re working autonomously and they’re not being professionally developed.”

Clinical Supervisor

There was acknowledgement by several NPs that following endorsement there was no non-clinical time for NPs to attend CPD (20 hours plus 10 hours pharmacology required annually). The level of organisational support varied. The strong support for the NP collaborative groups and the high levels of attendance for some indicated organisational support. On the other hand, some NPs reported that there was not support by the organisation where they worked. In some smaller organisations, making time for CPD was difficult because there was nobody to replace the NPC or NP.
9 Future directions

"Would like to see it continue. What the Department is doing is adding an extra, a new layer of practitioners that fulfil a role and a need that was not being filled previously. So long as ... there are lots of areas to continue that ... can think of two perfect models within [my health service] that would fulfil a massive need ... sustaining, encouraging and growing in the areas ... I am biased, it is good for my patients to be able to pick up the phone, or shoot off an email to the NP ... is something they didn’t have six years ago."

Medical Consultant

The suggestions from NPs and NPCs were related to professional identity, sustainability and structural reform of the MPS and PBS.

The need for better communication strategies was identified by 37% of NPs and NPCs. This reflects the high proportion of NPs and NPC who report they have to explain their role to other staff, medical professionals, other nurses and patients (see section 6.4.1).

Promotion of the professional identity of NPs is not an appropriate role for the Department. As autonomous health professionals who have been endorsed as leaders in their clinical field, it should be the responsibility of NPs and their professional association to take on the role task of establishing the professional identity.

<table>
<thead>
<tr>
<th>Table 16: Suggestions for future directions – NP/NPCs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q43</strong> What is the best way the VNPP can support the sustainability of Nurse Practitioners in Victorian organisations in the future</td>
</tr>
<tr>
<td>n = 76</td>
</tr>
<tr>
<td>Communications strategies/ Increase awareness/ understanding</td>
</tr>
<tr>
<td>More jobs/ funding / Improve sustainability</td>
</tr>
<tr>
<td>Lobby to Improve Access MBS/PBS</td>
</tr>
<tr>
<td>Provide scholarships</td>
</tr>
<tr>
<td>Support mentors/ mentorship</td>
</tr>
<tr>
<td>Improve organisational governance / handle complaints</td>
</tr>
<tr>
<td>Support collaborative groups</td>
</tr>
<tr>
<td>Develop policy to support structure of role/ work with NPs/ ACNP</td>
</tr>
<tr>
<td>Organisations to report how funds are spent / improve accountability</td>
</tr>
<tr>
<td>Broaden scope of practice</td>
</tr>
<tr>
<td>Split funds across years</td>
</tr>
<tr>
<td>Fund individuals (not organisations)</td>
</tr>
<tr>
<td>Address organisational restriction of formulary/SOP</td>
</tr>
<tr>
<td>Support private NPs</td>
</tr>
<tr>
<td>Something else</td>
</tr>
<tr>
<td>Improve access to TAC, WorkCover</td>
</tr>
</tbody>
</table>

Base: All NPs/NPCs
DONs and managers suggested the focus for future directions should include funding (mentioned by 26%), succession planning (24%) and support for rural health services (18%) (Table 17).

A range of other suggestions were made, including supporting collaborative groups and mentors, improving communication and advocacy.

<table>
<thead>
<tr>
<th>Table 17: Suggestions for future directions – DONs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Q27</strong> What can the VNPP do differently to support sustainable Nurse Practitioner models of care in the future</td>
</tr>
<tr>
<td>More flexible funding, improve financial viability</td>
</tr>
<tr>
<td>Ensure succession planning/sustainability</td>
</tr>
<tr>
<td>Help rural health services</td>
</tr>
<tr>
<td>Support mentors/collaborative groups</td>
</tr>
<tr>
<td>Improve communication/understanding of NP roles</td>
</tr>
<tr>
<td>Not sure/Don’t know</td>
</tr>
<tr>
<td>Advocate for expansion/more roles</td>
</tr>
<tr>
<td>Improve access to Medicare</td>
</tr>
<tr>
<td>Help establish models of care</td>
</tr>
<tr>
<td>Conduct research to determine best models</td>
</tr>
<tr>
<td>Open up funding rounds to wider areas</td>
</tr>
<tr>
<td>Nothing</td>
</tr>
</tbody>
</table>

**Base: DONs and managers (n = 41)**

### 9.1 Is there a need for more model development grants?

“If DHHS don’t maintain a focus, our current precarious political position will transition to ‘dead as a Dodo’.”

Rural NP

Nineteen per cent of respondents to the DON survey indicated that they were considering applying for a VNPP in the next round. Thirty nine per cent were considering applying in a later round. Twelve per cent reported they had never considered applying for a grant.

Fifty nine per cent of the respondents to the DON survey reported they had developed models of care independently to the VNPP. Seventy one per cent of those whose organisations were successful indicated they had developed models separately to the VNPP. Respondents who had applied for grants, but were unsuccessful, indicated they had developed models independently of the VNPP and did not indicate they would apply in future rounds.
The capacity of Victorian public health services has consolidated over the period the VNPP has been operating.

One perspective is that the profession is reaching a level of maturity and needs some structural change rather than tinkering around individuals:

“We’ve been developing models for quite a while, and I don’t think we need to develop any new models necessarily, take that with a grain of salt, but we need to build a critical mass, we need to establish a place within health. Some places have really pushed and developed these roles, other organisations have very few, because they’re not interested. Whereas, really, we need to cement our position. And, part of the problem of NPs is we’re not part of the funding model. Public Health in particularly is funded by the ratios, and we’re outside of the ratios. Large organisations that have multi layers probably can pull things together and get their models going, in small organisations it’s much more difficult, there aren’t as many layers.”

Collaborative convenor

Some NPs were confident that the models which have been developed could be applied to other models of care. One NP who developed an early model of care considered the model to be generic:

“I made a generic pathway for people so it did not matter which part of the hospital you were in[.]”

NP

This included strategies such as writing the formulary based on classes of drugs, not specifying individual drugs or brands that could become redundant. The health service applied for, and was successful in obtaining subsequent model development grants; the planning for these other models was seen to be different to that of the earlier work and involved engagement with a different set of stakeholders relating to the model of care (aged care as opposed to urgent care). For example, the doctors who staffed the urgent care service were different to those who were involved in delivering medical services to residential aged care or palliative care.

In a larger metropolitan health service where oncology models of care had been put into practice, a medical consultant leading a team with a NP considered that further grants would be useful since new models were anticipated. The first model of care was generic in oncology. The second model was providing services to meet a need generated by changing treatment, which required less inpatient treatment and was more community focused, engaging patients over a longer term.

Respondents to the DON survey were asked to identify areas of practice where future NP models would be viable (Table 18). Aged care, emergency/urgent care and palliative care were the most frequent areas. There were some differences between metropolitan and rural organisations with metropolitan organisations most likely to mention oncology and stroke/neurology.
### Table 18: Future models by metropolitan and rural organisations

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Total</th>
<th>Metropolitan</th>
<th>Rural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aged Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>41</td>
<td>11</td>
<td>30</td>
</tr>
<tr>
<td>Emergency / Urgent Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic Disease Management</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Palliative care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexual Health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oncology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol and drugs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke / Neurology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Burns</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Endoscopy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9.2 Models for rural health services

“From my point of view, at least in the rural areas, NPs’ places in the community would be far more beneficial than the inpatient environment.”

NP

Executives, however, identified that the current service model combined with the problems with MBS restrictions, meant that it was difficult to fund ongoing substantive positions. Larger metropolitan hospitals were more able to provide ongoing funding for NP positions. One nursing executive stressed the importance of “thinking outside the ratios” when developing a model of care and a business case for NPs.

Another rural NP identified the Nursing Enterprise Agreement as a barrier:
The strength of NP models of care was the capacity for providing continuity of care outside acute hospitals or through outpatient clinics. These models of care move past the ratios required for inpatient service. They can play an important role in reducing inappropriate admissions and demand on emergency services. One NP has been able to support the hospital through achieving an appropriate utilisation of beds. This was described as an unusual but effective strategy.

9.3 Evaluation

There is no room in the funding for evaluation. A smaller organisation identified the need to have funding for evaluation:

“Our own evaluation, for example, is something we like to include when we’re taking on new projects, particularly something innovative and interesting like this. So, it’s a missed opportunity. And evaluation is expensive. We’d be looking at something like this, partnering with Burnett or equivalent, and you know.”

On the other hand, NPs that have been well established have identified impacts on the local health services.

9.4 Funding positions in health services

The funding of NP positions in an organisation was identified by nursing executives as a way of establishing NP models of care in small rural health services. This is an approach being used in WA for remote health services. In NSW, the Department funds positions directly. This is not compatible with the current funding structures of Victorian health services.

9.5 Spreading the funding

Some smaller organisations considered that it would be more useful to have the funding spread over a number of years. In some instances there was a lack of clarity, on the part of clinicians, about how the funds were supposed to be spent. Some executives held the views that NPCs should not be given information related to funding.

Some service managers noted problems with the NPC Support package being restricted to a single financial year particularly when the grant was received at the end of the financial year.

9.6 Business model

The current model development grants have not resulted in clear business cases. A number of executives and NPs have identified this as a shortcoming. Suggestions
were made for more guidance, on risk and potential pitfalls in funding the NP model of care, to be included in the guidelines for the funding applicants. Guidelines for establishing funding models for NPs to work in a private capacity were also identified as a useful way of overcoming the MBS provider number restrictions. However, it was recognised that such an approach required more work.
10 Conclusion

The VNPP has been successful in building the capacity of Victorian health services to incorporate NPs through establishing NP models of care.

The core strength of the program has been the focus on developing models of care for organisations. This had built a culture of practice within which NPs have developed clinical skills and have begun to successfully build relationships with relevant medical, allied health and nursing professionals. These relationships have been both within and outside the organisations where NPCs have completed their candidature and subsequently practised.

The first phase of the VNPP identified the feasibility of NP models of care and demonstrated how they could effectively develop NPs. The legislation recognising the title of Nurse Practitioner was an important step in establishing the foundation of a professional identity, and the enabling of prescribing under the Poisons Act established the legislative foundation for NPs to extend their practice.

The second and third phases continued to establish the models of care in a range of settings. The fourth phase has seen the consolidation of having a role in the Victorian public health system. The identity of NPs has been consolidated under the VNPP through the engagement of stakeholders in the delivery of care through organisations that have received grants for the development of models of care. Where the development work has resulted in clear governance structures, all stakeholders – including medical professionals – have supported and collaborated with individual NPs.

The fourth phase of the VNPP has resulted in further consolidation of NP models of care as standard practice in a wide range of Victorian health services from larger tertiary hospitals to small community based organisations.

The prioritisation of organisational development has focused NP models of care on meeting service needs. It has also helped build relationships between NPCs and the clinical teams with whom they work. Strong clinical governance processes have helped medical professionals have confidence in the NP models of care. The drive and commitment of individual NP clinicians have been required to continually develop the models. Other jurisdictions identified the VNPP as a leading model of capacity building for NPs.

Individual funding rounds focused on specific clinical areas has enabled sufficient numbers of NPs to provide peer support networks. The NP collaborative groups, funded under the VNPP, have been able to build on this foundation. They are providing: networks of support for NPCs working for endorsement; continuing professional development for endorsed NPs; a supportive network that gives new NPCs an opportunity to meet and identify appropriate mentors; advice about how to
manage the portfolio for endorsement; and continuing education opportunities for endorsed NPs.

The development of NP roles has been a complex process that has engaged Victorian and Commonwealth governments, as well as considerable work by organisations delivering health care. Endorsed NPs providing advanced nursing practice are now common and widely recognised. As the discipline has emerged, tertiary education providers have developed postgraduate courses.

Under the VNPP the number of health NPs in Victoria has increased to 231. Not all have been initiated by the VNPP, but the program has made a strong contribution to the growth. It is too early to identify whether a critical mass has been achieved to sustain NP models of care and continue to grow the NP workforce. Indeed, a number of senior NPs expressed the concern that the model may “fall over”. The key point of vulnerability for NPs is when they become endorsed, and are then seen as an expensive model for delivery of services, supernumerary to nursing budgets.

The VNPP has not developed strong business models that are sufficiently resilient to sustain NPs after endorsement. In situations where executive leadership of organisations changes and champions leave the organisation, new nurse leaders often see NPs as duplication of medical services, and are not necessarily supportive of continuing the positions.

NPs must continually explain their role to professional colleagues, patients and management. While NPs consulted were aware of literature that is supporting the effectiveness of NP models, and are claiming that 5% of their work time is spent on research, there is little to show in the way of peer reviewed publications or published evaluations of models of care. The publications grants remain the element of the VNPP with the weakest uptake, although there are some clear paths to refocusing this component outlined in the recommendations below.

NPs identified patient support as an important indicator of their success but there is little formal research or evaluation of patient outcomes. The development of an evidence base remains a challenge and an area for support.

The VNPP has provided a unique approach to the development of NPs by focusing on the organisations within which care is delivered. The traditional approach to workforce development is to provide scholarships to individual clinicians. This has been the practice in other jurisdictions. While the scholarship program has been an important element of the VNPP and has contributed to easing some of the financial costs incurred by individual clinicians, the model development grant has facilitated models of care that focus on service needs, as well as assisting individual nurse clinicians into advanced practice service models.

The stakeholder engagement required in the model development, with steering committees engaging with clinical services for the organisations (including medical
consultants and directors), helps to overcome the opposition to NP models by associations representing medical professions. Medical practitioners' concerns are also alleviated by working on an individual basis with NPs. This has been supported through the establishment of clear clinical governance frameworks, lines of accountability, engaging in mentoring activities, and engagement with a wide range of health professionals. NPs have operated as leaders in the nursing field and collaborated with the medical field.

As autonomous, self-directed primary healthcare professionals who have been endorsed as possessing leadership competencies, NPs should be expected to contribute to the promotion of their profession through involvement in representative professional associations, leadership roles in health services, and by taking up the opportunity to share their clinical knowledge and expertise in academic and professional settings.

While the focus of most elements of the VNPP have been on establishing models of care within organisations, it is the drive, enthusiasm and commitment of the individual nurse clinicians that has generally driven development of the model, bringing stakeholders together to support it and developing the model in practice. This has included innovative solutions, changing the model as required by service needs and patient demand.

There is evidence that models of care are being developed independently to the model development grants, particularly in larger health services. This suggests that future iterations could focus on smaller health services and community organisations. These organisations have less capacity to develop models specific to their local area needs.

In summary, the VNPP has been effective in establishing the capacity of the Victorian public health system to support NPs, but there remains a continued need to assist smaller organisations to develop models of care. There is no doubt that continued support of the collaborative groups will be of value in maintaining the quality of NPs.
11 Recommendations

It is recommended that the future direction of the VNPP should shift in emphasis from model development to organisations and processes that support NPCs throughout the candidature and to directly engage endorsed NPs to meet the needs of organisations. The shift to sustainable implementation would retain the focus on addressing service gaps and alignment with State government health policy.

Clinical directors, particularly those in small rural health and community based services, would like to see a contribution to the supplementation of funding for NP positions. Unlike other jurisdictions, direct funding of substantive positions is not compatible with the current policy for funding health services. It may be useful to trial an approach that supports the establishment for one to two years.

Re-focusing of the VNPP can be achieved through:

- Shifting the focus from model development to model implementation;
- Improving the capacity of organisations through supporting:
  - Evaluation capacity;
  - NP collaborative groups;
  - Processes to provide one-to-one mentoring;
  - Building business development capacity.

System-level challenges identified in earlier evaluations continue and remain to be addressed. These include the Commonwealth Government restrictions on MBS provider numbers and the development of the professional identity of NPs.

11.1 Focus on implementation

Recommendation 1. Model development to include a business case for NPs

Organisations receiving funding for model development grants or support packages should be required, as part of the funding, to include a business case for funding the NP position(s) post endorsement.

A business case should include:

- Clear identification of funding sources for the NPC and NP position(s) for the first three years post endorsement, specifying that NPs are supernumerary;
- Salary and salary on-costs;
- Estimates of leave time for NPC and NP when endorsed;
- Arrangements for continuity of care when NPC and NP is on leave;
- Costs associated with backfill for NPC and NP;
- Estimates of costs for clinical supervision and mentoring;
- Arrangements for professional indemnity insurance;
- Cost of infrastructure and consumables required for delivering services specified under the model of care.
Rationale

The model development grants and NPC Support packages were identified by health services, NPCs and NPs as enabling organisations to support NPCs through to endorsement. However, once a NPC was endorsed and eligible for a NP salary, not all organisations were prepared to sustain a NP position that was not income-generating and required funding “outside the ratios”.

Larger health services were able to sustain the funding of NP positions that address service gaps or improve performance (for example, fast-track models in Emergency Departments).

The reports provided for the model development grants include details of the cost components for NPs. However, the models seldom identify an income stream.

Recommendation 2. A flexible approach to model development grants and NPC support packages

Offer a combined model development/ NPC Support package to organisations with the objective of supporting the implementation of NPs.

Funds expenditure could include:

- Development of a business case to sustain the NP position after the NPC has been endorsed;
- A commitment by recipient organisations to expend the funds solely on support of the development of a NP model of care and the NPC;
- Inclusion of clinical governance structures with medical and peer review of cases;
- A commitment to periodic reporting using log books or an alternative (see below);
- A report on outcomes (NP endorsement, ongoing employment, patient satisfaction, clinical results) from the organisation receiving the grants;
- A flexible level of funding according to organisation need, particularly in the case of smaller or regional organisations.

Funds should not be restricted to a single year, particularly when disbursed toward the end of the financial year.

Rationale

The objective is to help organisations, particularly small rural health services and community organisations, to support candidates. At this stage of the development of NPs in the Victorian health system, there is a need to focus on implementation rather than the introduction of NPs as a new model of care. There has been substantial investment in model development that has introduced NP models of care to the
Victorian public health system. NPC positions are mostly filled by candidates who have been working within the recipient organisation for a substantial period of time. Such candidates have established networks and have been actively involved in model development. The focus of the VNPP, to date, has been on the development of models of care to address service specific needs and to assist in the training of NPCs. With the existing publication of models funded through the model development grants on the Department website, these models are now available for all services (and have been used outside the VNPP).

The current approach is vulnerable when the NPCs become endorsed and a service is required to fund the NP. With no clear idea of where the funding will be sourced from and whether it will be sustainable, continuity of the NP positions is at risk.

Recommendation 3. Support model development for already-endorsed practitioners

Provide model development grants for organisations to establish a NP model of care to employ an endorsed NP.

- Development of a business case to sustain the NP position
- A commitment by recipient organisations to expend the funds solely on support of the development of a NP model of care and the NPC
- Inclusion of clinical governance structures with medical and peer review of cases
- Agreement to participate in evaluation
- A succinct report on outcomes from the organisation receiving the grants.

Rationale

The VNPP has seen an increase of NP workforce to a point where there are sufficient numbers within the state (and in other states) to recruit experienced NPs directly into the position.

Recommendation 4. Improve utilisation of log books

A number of changes could be made to the log books to make them more useful:

- Make submission of the log book optional where an organisation or NPC is able to provide an alternative method of reporting activities
- Develop an automated reporting page directly related to preparing material for endorsement against the competencies
- Improve communication about the use and purpose of the log books:
  - Prepare a user’s manual. Test it before circulating
  - Record frequently asked questions and publish on the Department’s website.
• Consider developing a smart phone application for data collection to be uploaded and integrated with the Excel log book
• If data from log books is submitted to the Department, providing information to NPCs about how that data has been used would enhance NPC engagement.

Rationale

NPs and NPCs who were interviewed found completion of the log book a trying process. A number were concerned that the information was difficult to collate, the log books duplicated other diary recording, and that the data was being collected for the Department and nothing was being done with that data. Some did not submit the log book at all.

A number of NPs and NPCs reported that the log book duplicated other processes that were used to capture information required for submission for endorsement.

Recommendation 5. Rebadge publication grants

Rebadge the publication grant as research support and evaluation grants to enable NPs to:

• Purchase support for research design advice
• Purchase data processing, or data transcription, data analysis, and statistical advice
• Purchase support for writing at a level suitable for publication
• Purchase support to design and write a research grant application.

Where conference presentations are made, a strategy for publication should be included (for example, identifying suitable peer-reviewed journals).

All recipients should be required to provide:

• A report of activities on a periodic (six month) basis
• Agreement to report to the Department on outcomes (publications/presentations).

A small group of consultants external to the Department could be considered for the selection process. This should include at least one NP with a Doctorate or track record of publication and a person who is not a nurse.

Rationale

There has been poor uptake of publication grants.

It is challenging to write conference abstracts and peer-reviewed publications without both training and academic support. NPs are educated to a Master’s level with research training a small and variable component of NPC education.
Recommendation 6. Support for mentors

Publish the guidelines for mentors from the Victorian Mentoring Pilot and facilitate workshops for mentor/mentees when NPCs commence their candidature.

Consider an orientation day for mentors/mentees at the commencement of each year or round of grants. A presentation by a high profile NP and workshops on both supervision and service delivery would be an incentive for mentors to attend such a workshop. Presentation by previous mentors/mentees would facilitate new relationships to learn from the experience of others.

Where the VNPP funds are provided, agreement for ongoing contact by mentees for evaluation purposes and a commitment to report outcomes (succinctly) should be required.

Rationale

The Victorian mentoring pilot was successful in building leadership skills and capacity for a small group but would be costly to replicate across all NPCs. Nevertheless, resources to support mentors and developed guidelines should be published in a format that is readily accessible to mentors and mentees. Early guidance and workshops were identified as important as were resources for leadership. Some candidates indicated that advice on course selection for the Master's degree would have been helpful.

Recommendation 7. Continue to support NP collaborative groups

The collaborative groups based on specific clinical areas should continue, and larger metropolitan and regional health services should be encouraged to develop local cross-disciplinary NP collaborative groups/communities of practice. Local collaborative groups should not be restricted to NPs employed by a specific health service.

Rationale

The NP collaborative groups were identified by nearly all stakeholders as providing a valuable contribution to the development of NPCs and the continuing education of NPs. The discipline specific NP collaborative groups provided a good return on investment and helped focus on achieving the long-term goals of sustainability of NPs in Victoria. Local level collaborative groups that cross disciplinary boundaries have also provided support for NPs.
11.2 MBS provider numbers

The VNPP is a State Government-funded program. However, the Commonwealth regulations relating to provider numbers impact on the capacity of the VNPP to effectively develop sustainable models of care, particularly for smaller community organisations and rural health services. The following recommendations address the issue and follow previous evaluations that have made similar recommendations since 1999.

Recommendation 8. MBS provider number for Nurse Practitioners

It is recommended that the Department continue to work closely with the Commonwealth Government and other jurisdictions to facilitate endorsed Nurse Practitioners’ eligibility for a Medicare provider number while working in (or contracting to) public health services. This could be limited to referring patients to specialists or requesting diagnostic services within their scope of practice.

Rationale

Without a limited MBS provider number NPs cannot work to the scope of practice for which they have been endorsed. NPs without provider numbers require a medical professional to order diagnostics and/or make a referral to medical specialists for those referrals to be rebateable to the patient. A limited MBS provider number for NPs, that then enables referrals to be claimed by the patient, would overcome this barrier.

Only NPs working in a private practice are currently eligible for a Medicare provider number.

Under the National Healthcare Agreement, States and Territories have committed to provide services to public patients free of charge. Free of charge means that no charge is incurred by the patient or the MBS. This means that State salaried nurse practitioners employed in the public hospital system are not eligible to provide Medicare rebateable services to public patients.

(Department of Health, 2014)

At the very least this creates inefficiencies in the delivery of effective health services, and in instances where there are limited resources, may result in decreased quality of care and possibly adverse events associated with delays in diagnosis and treatment.

There is already a precedent whereby limited Medicare provider numbers for “referral only” are available to medical professionals outside of private practice. These medical professionals can therefore make referrals for diagnostic and specialist services for which patients can claim a rebate.

Some Medicare provider numbers will only be valid for referring or requesting services for your patients.

(Medicare Australia, 2006)
NP access to a limited Medicare provider number would mean that NPs employed in the public hospital system, while unable to bill Medicare, would be able to refer public patients to Medicare rebateable services.
Appendix A: References


Appendix B: Program Logic for VNPP

<table>
<thead>
<tr>
<th>Program Objective</th>
<th>Inputs</th>
<th>Activities</th>
<th>Outputs</th>
<th>Short-term</th>
<th>Medium-term</th>
<th>Long-term</th>
<th>Program Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>To improve patient experiences and access to Victorian health services and to achieve more desirable health outcomes through the establishment of NP Models of care in the Victorian health system that address a particular service need</td>
<td>3x million VNPP funding</td>
<td>VNPP</td>
<td>Number of NP model funding applications granted</td>
<td>Applications NPs incorporated into the clinical pathway within clinical teams</td>
<td>Improved access to appropriate care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Outlay of time and $ from health services</td>
<td>NP funding model framework established</td>
<td>Number of NPCs recruited</td>
<td>NPs taking on leadership roles in teams</td>
<td>Critical mass of NPs working in Victorian Health services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>~0.7 Senior Policy Officer in NMW</td>
<td>Medical and nursing staff collaborate to tailor NP model development according to an identified need</td>
<td>Number of NPCs who were endorsed</td>
<td>Clinical champions drive NP models</td>
<td>Continued improvement to patient experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NP training curriculum development (within universities/tertiary providers)</td>
<td>Number of patients treated by NPs</td>
<td>Patients have timely access to patient-centred care</td>
<td>NP models are replicated</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>NMW support</td>
<td>Number NP of communities of practice established</td>
<td>Improved teamwork, with NPs taking on mentor roles</td>
<td>Effective patient management</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Mentor relationships sustained until NPC endorsed</td>
<td>Succession planning for NP roles</td>
<td></td>
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</tr>
</tbody>
</table>

External/contextual influencing factors (outside of the program sphere of influence):
- Commonwealth legislation - Medicare licensing regulations/ License to prescribe regulations under PBS/MBS (external)
- Medical association resistance to the introduction of NPs (external)
- Extent of individual NP clinical experience and established relationships within the health services (contextual)