Department of Health and Human Services

Review of Nursing and Midwifery Graduate Transition to Practice Programs in Victoria

Final Summary Report

January 2017
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List of Abbreviations

- AHPRA: Australian Health Practitioner Regulation Agency
- ANUM: Associate Nurse Unit Manager
- DHHS: Department of Health and Human Services (the ‘Department’)
- FTE: Full Time Equivalent
- GNMP: Graduate Nurse Midwife Program
- NUM: Nurse Unit Manager
- PMCV: Postgraduate Medical Council of Victoria
- RM: Registered Midwife
- RN: Registered Nurse
- T&D: Training and Development

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Executive summary

The Victorian government aims to ensure that the health care system is supported by an educated, experienced and skilled nursing and midwifery workforce of adequate size and distribution to meet the needs of the Victorian community. As an integral part of ongoing support the Department of Health and Human Services (the Department) provides annual Training and Development (T&D) grants for nursing and midwifery to assist with transition to practice programs run by Victorian public health services. At present the Department allocates over $26 million annually to health services to support transition to practice programs. This financial investment in transition to practice programs for nurses and midwives is higher per funded position than any other Australian jurisdiction.

At the Australian Nursing and Midwifery Federation (Vic Branch) 2014 Delegates Conference, Victorian Labor Leader, Daniel Andrews, committed to review the transition to practice graduate programs; undertake an audit of the costs and resources associated with supporting new graduates; and review the effectiveness of the Training and Development grant in creating opportunities for new nursing and midwifery graduates. The objectives of this review are consistent with this commitment.

Over the past five years, the total number of funded and unfunded graduates employed by public health services has increased by ~13%, from 1615 (in 2011) to around 1832 (in 2016). The most notable increases have occurred in regional, sub-regional, and small rural health services, in addition to a recent growth in numbers within tertiary metropolitan health services.

Barriers to more graduate nurses and midwives being employed within a health service were identified as follows: the number of positions available to employ staff; staff ratio and rostering constraints; and the capability to provide additional support to graduates, particularly in areas of high patient turn-over in high acuity areas.

The average number of rotations for transition to practice program graduates has reduced over recent years, to an average of 3.09 in 2015. Reducing the number of graduate rotations enabled health services to better identify any issues or concerns with particular graduates, allowed graduates to settle into professional positions, and provided more time for graduates to consolidate their clinical and professional skills. Where health services had deliberately reduced the number of clinical rotations, graduate feedback had indicated a preference for greater clinical exposure. Accordingly, a number of health services had introduced or expanded opportunities for graduates to spend one or more days on ‘observational’ placements in different areas, working alongside more experienced members of staff.

Rotations were reported to occur across all areas of public health services including acute medical and surgical units, emergency departments and other areas of higher patient acuity, hospital outpatient and day procedure clinics with high patient throughput, in sub-acute and aged care environments, and in a range of community outreach and primary care environments.

Opportunities for new or expanded graduate rotations include: higher acuity patient environments such as intensive care and cardiothoracic wards; areas of
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high daily patient throughput, including medical imaging, catheterisation laboratories, dialysis, day oncology clinics, and hospital in the home; hospital outpatient and outreach clinics including: wound and plaster clinics, other ambulatory care clinics, and primary care clinics; together with aged care assessment services, community care services, and community health promotion services; and an increase in the number of rotations to mental health units and clinics.

The overarching aim of transition to practice activity is to provide a flexible range of supports to assist graduates in adjusting to their professional roles as part of a high quality and sustainable workforce. There is significant variation across the health services in the approach to training, education, support and feedback. Analysis of health service and staff reports revealed that local and small rural health services on average provided the least amount of support services for their graduates. A variety of strategies that might potentially be considered by other health services include: the development of graduate competencies and/or specific learning objectives; participation in specific training programs/modules, particularly simulation training where it is available; increasing the frequency of scheduled progress checks with each individual graduate; increasing supernumerary support and/or the length of other transition to practice program components; and graduate retreats and new approaches to graduate orientation workshops.

The Department provides funding to health services for eligible transition to practice programs on a per graduate basis, for an approved number of graduates each year. The current funding of more than $17,000 per graduate is a contribution towards the training and development of new graduates. Health services may also provide the transition to practice programs to additional unfunded graduates. As such the total funding provided to individual health services is not intended to cover all graduates employed. In addition to the base Training and Development grant, the Department provides funding to health services for specific purposes such as contributing to the cost of establishing a collaboration, for specific ATSI and/or Midwifery graduates, to introduce a technological improvement to a program (e.g. video-conferencing), and to encourage expansion of the settings involved in a program.

A costing and resources review was completed by ten health services, with detail sought for three financial years (2012-13 to 2014-15) on revenue and expenditure associated with the transition to practice programs. When taken as a whole, the total transition to practice expenditure incurred by health services as a percentage of program revenue per year over the three years was 139%, 144% and 149% respectively, indicating that expenditure is increasingly outstripping revenue. This may be driven by the percentage of graduates that are funded – that is, the number of graduates for which funding from the Department is received as a percentage of the total number of graduates employed by the health service. Whilst the Department is funding similar numbers of graduates each year, the health services, on average, are recruiting more. Therefore revenue is not keeping pace with expenditure. On average, health services are spending $5k more per graduate than the revenue they receive. Despite a large variation between different health services, it remains clear that funding from the Department is an important contribution to a significant investment made by individual Victorian health services in graduate nursing and midwifery transition to practice programs.
Many health services reported undertaking local evaluation of their transition to practice program. The main focus of evaluation activity has been upon graduate retention, followed by consolidation of clinical skills, graduate job satisfaction, and employer satisfaction. By contrast, fewer health services have focused upon evaluating ongoing professional development activities undertaken by graduates. The level and frequency of evaluation varies across health services. Evaluation activities appear to have been more comprehensively undertaken by larger health services compared with local and small rural health services.

In 2015, 93% of graduates were reported to complete the program, representing a 14% increase in completions compared with the 2013 cohort. Following completion of their transition to practice program in 2015, 77% of graduates were retained in either full or part time employment. Retained graduates are employed for at least twelve months after completing a transition to practice program, at the health service at which they undertook the program. This rate of retention has been relatively stable since 2013, with the majority of graduates opting for ongoing part-time employment. Retention was significantly higher in metropolitan health services (82%) compared with non-metropolitan health services (62%).

Based upon the evidence obtained throughout the review, a number of areas for further improvement in program design, implementation and outcomes were identified. It is suggested that any additional funding available to the Department might be directed towards incentivising rotations in expanded settings within particular health services, promoting an increase in interdisciplinary training and development, and encouraging a larger number of more formal collaborative arrangements between regional/sub-regional, local and small rural health services.

Collaborative programs are already promoted by the Department through the provision of additional funding. An increase in the number of formal collaborations would not only promote greater standardisation of transition to practice program content and delivery across regional Victoria, it would also reduce competition for graduate placements between smaller health services, and provide a wider range of rotations for individual graduates. It has also been suggested that formal education agreements between larger and smaller health services could capitalise upon the materials and infrastructure already established by larger health services, to promote wider implementation and clinical staff understanding of better practice in transition to practice program design and implementation.

Areas for improvement in identifying and managing clinical staff expectations in relation to graduate support have also been proposed, together with minimum standards for graduate orientation to specific clinical units within Victorian public health services.

Evaluation findings also identified that there are surprisingly few reporting requirements placed upon public health services to acquit against the significant amount of program funding provided by the Department. Eight performance indicators have therefore been suggested for reporting by funded health services against nursing and midwifery transition to practice programs on an annual basis.
Finally, it is suggested that the Department adopt an independent and centralised process for undertaking transition to practice program feedback annually, in order to standardise information gathered, promote a higher response rate from graduates, validate information reported by health services, investigate further information about graduate retention on a statewide basis, and undertake de-identified benchmarking and feedback to health services.
Review

Background

Within Victoria, the Department of Health and Human Services, through the Nursing and Midwifery Workforce unit, ensures that the government is provided with timely, accurate and appropriate nursing and midwifery workforce policy advice. The government aims to ensure that the Victorian health care system is supported by an educated, experienced and skilled nursing and midwifery workforce of adequate size and distribution to meet the needs of the Victorian community.

As an integral part of ongoing support the Department provides annual Training and Development (T&D) grants for nursing and midwifery to assist with transition to practice programs run by Victorian public health services. These transition to practice programs provide formalised education/support by employers for graduates in their first year of practice. Transition to practice programs share three primary goals: to develop competent and confident registered nurses (RNs) and registered midwives (RMs); to facilitate professional adjustment; and, to develop a commitment to a career in nursing.

As such, the workplace-based programs are designed to consolidate knowledge, skills and competence and to help graduates make the transition to practice as safe, confident and accountable professionals during their first year of professional employment. Transition to practice programs go beyond normal orientation and induction and offer graduates formal education time (including study days), supernumerary time and direct clinical support, including preceptorship. In general it is accepted that these programs provide an opportunity for the novice practitioner to develop skills in clinical assessment and ethical judgement and learn about the regulatory framework in which they need to work in an environment that offers readily available support.

At present the Department allocates over $26 million annually to health services to support transition to practice programs. The financial investment in transition to practice programs for nurses and midwives is higher per funded position in Victoria than any other Australian jurisdiction. Transition to practice funding is a contribution towards the training of new graduates. As such the total funding provided to individual health services is not intended to cover all graduates employed. In addition, the Victorian Government:

1. Supports the implementation of midwifery collaborative transition to practice programs to expand the employment of new graduate midwives and dual qualified registered nurses/registered midwives in rural settings;
2. Provides a nursing and midwifery graduate handbook to ensure graduates have comprehensive information about their first year employment options;
3. Funds the Graduate Nurse and Midwife Program Computer Match. This computer system matches graduates and employees for transition to practice programs. It preferences Victorian trained nursing and midwifery graduates as well as Victorian residents studying via distance education; and
4. Supports health services to have the opportunity to consider a range of expanded or unexplored settings that provide solid and innovative experience for nursing and midwifery graduates through collaborative transition to practice programs.
The transition to practice program for Bachelor of Midwifery and Bachelor of Nursing graduates also focuses on attracting new midwifery graduates to work in rural settings; supporting existing rural registered nurses to undertake midwifery postgraduate studies; and retaining existing rural midwives by enhancing mechanisms for increased clinical support.

There is currently no prescribed model for providing graduate transition to practice programs. Accordingly, the Department has provided a number of guidelines, best practice reviews and evaluation frameworks. These publications are intended to assist public health services in providing programs that promote the capacity of new graduates to function safely and efficiently, and to continue to develop professionally. Whilst many health services have reported adopting guidelines and elements of best practice presented in a variety of publications, the Department was aware that current practices remain locally determined by individual public health services across Victoria.

Review objectives

At the Australian Nursing and Midwifery Federation (Vic Branch) 2014 Delegates Conference, Victorian Labor Leader, Daniel Andrews, committed to review the transition to practice graduate programs; undertake an audit of the costs and resources associated with supporting new graduates; and review the effectiveness of the Training and Development grant in creating opportunities for new nursing and midwifery graduates. As such, the specific objectives of this review of all nursing and midwifery transition to practice programs in Victoria were to:

- Assess current levels of graduate activity, including an assessment of the utilisation of graduate nurses and midwives within health services, retention of graduate nurses and midwives and barriers to more graduate nurses and midwives being employed within a health service;
- Assess the costs and resources associated with providing a transition to practice program at health services;
- Identify new opportunities available for graduate nurses and midwives that are not currently being utilised within the Victorian public or private health sector and primary/community settings; and
- Recommend actionable strategies to improve current Victorian transition to practice programs on their structure, content and alignment with best practice and efficacy in transitioning graduates to professional practice.

Approach

Aspex Consulting was contracted to undertake this evaluation, the findings of which are outlined in the following sections of this report. A summative, mixed method evaluation methodology was employed to address the statewide review objectives. Key policy, program and literature reviews were examined, together with program data outlining the number of graduate positions funded between 2011 and 2015. A total of 50 transition to practice program coordinators, representing 85% of statewide program funding, provided information about the graduate nursing and midwifery transition to practice programs operating at their health services via a statewide survey of all transition to practice program coordinators. A total of 928 staff from metropolitan, regional and rural health services...
provided perceptions about their experiences working as, or with, graduates in programs via
a survey of Victorian health service staff.

A stratified sample of ten health services incorporating tertiary, major, regional, sub-regional
and rural facilities were also selected for in-depth interviews and program costings. A total
of 40 nominated staff from these health services provided detailed information about their
transition to practice programs in addition to information about the resources and costs
associated with local program administration. This information was synthesised and
examined to answer 20 key evaluation questions which were drawn together to address the
evaluation objectives (Refer to Appendix 1).

Program objectives

As noted, the fundamental aim of transition to practice programs for registered nurses and
midwives is to provide a flexible range of supports to assist graduates in adjusting to their
professional roles as part of a high quality and sustainable workforce. Health services
identified the primary objective to be the successful recruitment, support, development and
retention of staff. The program also affords opportunities to consolidate the clinical skills of
recent graduates, promote their personal development as working professionals, commence
a planned career pathway, and increase the likelihood that they would be willing to stay with
or return to the health service as a future employee.

Collaborations

A total of 49 health services were participating in around 19 collaborative transition to
practice programs across the state. Refer to Appendix 2. The size of collaborations varied
from two to eight health services, with the majority of health services involved in
collaborations with more than one other public hospital. These collaborations were relatively
evenly distributed across regional Victoria. A map of all reported public health service
collaborations across Victoria is presented in Appendix 3. Unsurprisingly, transition to
practice program coordinators from non-metropolitan health services reported undertaking a
high number of collaborations with public health services and other non-public hospital
organisations.

Consultations with selected public health services identified three examples of specific
collaborations that were established with the support of the Department:

- **The Central Hume Collaboration** has now been operating for around seven years. Five
  regional and rural health services recognised that they could reduce inter-organisational
  competition for graduate recruitment, and improve the efficiency of expenditure on
  graduate training and development by centralising their resources. Recruitment and
  training are co-ordinated by Northeast Health Wangaratta, recognising the independent
  contributions and operations of each of the other health services. Currently funded for
  around 14 graduates, the collaboration is able to provide up to 25 positions across the
  five participating health services.

- **The Northern Rivers Collaboration** was established in 2013. Four regional and rural
  health services participate in order to increase graduate nursing and midwifery training
  across the geographic area, particularly for smaller rural health services. Half of the total
  funding for all graduate positions is provided by Echuca Regional Health, which co-
  ordinates the program on behalf of the collaborative members. Local evaluations of the
collaborative training model were reported to have been positive, creating real opportunities to develop skills within the region.

- The Barwon South-West Collaboration commenced in 2014 between University Hospital Geelong (Barwon Health) and Lorne Community Hospital. Recruitment is undertaken by the University Hospital and two graduates are seconded to Lorne for six-month rotations each year. Staff at both health services were reported to be very supportive of the model. Interest in expanding the collaboration has now been expressed by one other local health service and two other small rural health services within the region.

Nine health services also reported co-ordinating their transition to practice programs with other (non-public hospital) organisations.

**Computer matching**

GNMP Match is the computer matching system administered by the Postgraduate Medical Council of Victoria (PMCV) on behalf of the Department. It utilises a mathematical algorithm to match graduate candidates with health services according to the preferences of the candidates and health services. Participating in GNMP Match is one component of the eligibility criteria for Victorian public health services to apply for the T&D grant funding. The Department is aware that every provider of a transition to practice program in Victoria does not necessarily participate in computer matching. This includes private health services and aged care facilities.

In 2015, 90.2% of graduate positions were filled using the PMCV online computer matching service. At metropolitan health services, 92.9% of positions were computer matched, compared with 82.2% of non-metropolitan health services. Additional graduates may be employed in health services without being enrolled in a transition to practice program. These graduates are recruited through traditional recruitment processes. Graduates for more specialised placements, such as indigenous health clinics, were sought via direct applications rather than the computer match.

In 2015, 102 computer matched graduates withdrew from the program prior to commencement. This represented 7.5% percent of all matched graduates. The most common reasons for withdrawal of computer matched graduates were relocation to another area (50.0%) and family responsibilities (20.6%).

Consultation with health services revealed that computer matching was not ideally suited to mid-year intakes. Some health services reported needing to over-recruit, or advance recruit a number of graduates and hope that they were happy to commence at a later point in time. Others reported relying on additional applications to top-up mid-year recruitments.

**Graduate intake**

Over the past five years, the total number of funded and unfunded graduates employed by health services has increased by around 13%, from 1615 (in 2011) to around 1832 (in 2016). The most notable increases have occurred in regional, sub-regional, and small rural health services, in addition to a recent growth in numbers within tertiary metropolitan health services.
In general, most health services considered that they were currently operating at near full capacity in relation to employment of nursing and midwifery graduates. Reported barriers to increasing the number of graduates were identified as:

- The number of positions available to employ staff. The number of graduate placements was expected to increase for health services located in areas of population growth;
- The need to maintain an appropriate skill mix of new and/or more junior staff to other more experienced clinicians; and
- The capability to provide additional support to graduates. This was particularly relevant in areas of high patient turn-over of high acuity areas.

Program rotations

Rotations present an opportunity to provide graduates with comprehensive experience through exposure to a wide range of settings. A 2012 study proposed that two to three rotations were optimal for nursing and midwifery graduates, with four rotations in total for double degree graduates. It was recognised that a smaller number of rotations helps graduates to develop a sense of belonging and promotes confidence and competency. Multiple changes in setting was not considered best practice. Health services were aware of these recommendations and many had made recent changes to reduce the number of rotations provided to graduates.

The average number of rotations for transition to practice program graduates has reduced over recent years, to an average of 3.09 in 2015, compared with 3.23 in 2014 and 3.21 in 2013. However, a wide range in the number of rotations offered in different transition to practice program streams was observed, specifically for: Bachelor of Nursing graduates in local and small rural health services; Bachelor of Midwifery graduates in major health services; and Double Degree graduates in specialist, major and regional health services. In 2015, the average number of rotations was 2.89 for nursing graduates, 3.10 for midwifery graduates and 3.58 for double degree graduates.

Reducing the number of graduate rotations enabled health services to better identify any issues or concerns with particular graduates (that may not otherwise emerge until later in the transition to practice program), allowed graduates to settle into professional positions, and provided more time for graduates to consolidate their clinical and professional skills.

Where health services had deliberately reduced the number of clinical rotations, graduate feedback had indicated a preference for greater clinical exposure. Accordingly, a number of health services had introduced or expanded opportunities for graduates to spend one or more days on ‘observational’ placements in different areas, working alongside more experienced members of staff.

Range of current clinical rotations

Whilst the locations of graduate rotations varied across all health services, the five most common locations for graduate rotations were acute medical (91.5%), emergency department (70.2%), acute surgical (68.1%), theatre (63.8%) and residential aged care.

(61.7%). Rotations to high volume clinical areas such as dialysis units, medical imaging, and outpatient departments were undertaken by 10-20% of health services. Rotations to high acuity areas such as intensive care, coronary care and high dependency units were also reported by 10-20% of health services across the State. Sub-acute and aged care rotations occurred in up to 60% of health services, and community care rotations were reported by up to 36% of statewide public health services.

The majority of Bachelor of Nursing rotations typically occurred in medical and/or surgical areas followed by areas of specific preference expressed by individual graduates. Midwifery rotations typically occurred in antenatal clinics, the birthing suite, and postnatal care, with additional rotations in areas such as domiciliary care, and where available, special care nurseries. Double degree graduates typically undertook the same basic rotations as midwifery graduates, in addition to spending time in an acute medical or surgical unit.

**Reported constraints to the location of graduate rotations**

In addition to the barriers to increasing the number of graduates, health services that were consulted as part of the review reported a number of constraints impacting upon the location of transition to practice program rotations.

The unwillingness of graduates to be rotated to particular areas was reported to be an issue by a number of health services. Aged care rotations were singled out as the least desired area by graduates. This was attributed to a lack of understanding about the complex needs of older people in residential care environments, together with a lack of knowledge about the level and breadth of experience that could be gained in this environment. In order to address these misunderstandings, a number of health services reported promoting the chance to develop leadership skills as part of any rotation to residential aged care units. Health services also reported that some graduates perceived that their level of exposure to a range of different clinical conditions would be limited if they were rotated to smaller campuses of larger health services.

For areas of high patient turn-over or high acuity, the need for additional graduate support and supervision was reported to limit opportunities for rotation by some health services. For these clinical environments, some considered that graduates would need to undertake further training (for example, in specialised medications), or that rotations to these areas should only be undertaken by more experienced staff (such as post-graduate trained employees).

Some graduates expressed a desire to have rotations in community care settings. In addition to the requirement for more senior staff to work independently in these environments, “historical” perceptions of current staff working in community care settings was reported to be a barrier to graduate rotations in a number of these areas. Changes were reported to be occurring in staff perceptions about their capacity to support graduate rotations.

One final area impacting on the quality of graduate rotations in rural areas related to the absence of technology. The budget to implement live streaming for the purposes of timely clinical support, and/or delayed telecasting of group education sessions, was considered to be an area of future development that would support the number of rotations available in smaller rural health services.

**Areas of current and/or potential expansion**
Consistent with reports from individual health services and the observed range of current graduate rotations, opportunities for new or expanded graduate rotations were reported by health service staff to potentially include:

- Higher acuity patient environments such as intensive care and cardiothoracic wards;
- Areas of high daily patient throughput, including medical imaging, catheterisation laboratories, dialysis, day oncology clinics, and hospital in the home;
- Hospital outpatient and outreach clinics including: wound and plaster clinics, other ambulatory care clinics, and primary care clinics; together with aged care assessment services, community care services, and community health promotion services; and
- An increase in the number of rotations to mental health units and clinics were also encouraged.

Program support and training activities

The overarching aim of transition to practice activity is to provide a flexible range of supports to assist graduates in adjusting to their professional roles as part of a high quality and sustainable workforce. The 2009 Department of Health Early Graduate Nurse Program Guidelines state best practice transition to practice programs are provided in a safe and supportive work environment that complies with the principles of the Occupational Health and Safety Act 2004. Literature suggests that support must be appropriate to the stage of the nurse’s/midwife’s transition and should change over time to encourage reflective practice, clinical decision-making and autonomous practice according to the individual's needs. In the first six months, the focus should be on communication and learning and then shift to enhancing independence in the last six months. The support provided during the first four weeks of the program, as well as at the beginning of each new rotation, is seen as critical. Studies reveal that individualised and flexible support may ease anxiety for graduates and enhance job satisfaction. Key program components relating to support and supervision include:

- Providing clinical support in situ in a timely manner;
- Formal structured reviews of performance at key points in the transition;
- Opportunity for informal engagement to discuss progress and any issues;
- Supernumerary time;
- Support from preceptors and/or mentors;
- Study leave and/or study days including formal classes/PD days/tutorials;
- Regular opportunities to debrief and engage in reflective practice;
- Opportunities to network with other newly graduated enrolled nurses;
- Rotations or placements; and
- Other activities to address individual needs.

Graduate support

Executive and senior clinical staff support for transition to practice programs was considered to be a vital precondition to the ongoing sustainability of the program at each health service. The majority of staff considered that hospital management (80%) and senior clinical staff (85%) supported their transition to practice programs and were aware that a transition to practice program coordinator existed to manage their programs. Similarly, the level of overall staff commitment was considered to be an essential element to operating an effective transition to practice program. Virtually all staff were committed to supporting graduates as an important part of broader nursing and midwifery workforce development agreeing that graduate development is needed to support workforce development (98%), and that all nurses and midwives are responsible for supporting graduate development (97%).

However, only three quarters (or less) of all staff who responded to the survey agreed that:

- Senior clinical support was available to assist with graduate development (75%);
- Graduates felt well supported during their rotations (70%); and
- Support was flexible and adjusted to meet the needs of individual graduates (66%)

Support for graduates working after standard business hours, including weekends, was raised as an area for further improvement.

Better practice support

Health services and staff were asked about the extent to which their graduate transition to practice programs complied with key elements of ‘better practice’. All health services indicated that graduates were provided with an induction/orientation to the health service and oriented to organisational policies and procedures. Other elements of better practice in transition to practice program design and implementation were lacking in many health services, including a failure to report 100% compliance with:

- Inducting new graduates to clinical practice at their health service;
- Inducting of graduates to specific clinical units;
- Setting clear personal learning objectives for graduates;
- Providing appropriate occupational violence training;
- Providing a range of appropriate educational opportunities;
- Providing team work and communication skills development; and
- Providing opportunities for graduates to develop professional self-management skills.

Staff perceptions were consistent with reports by individual health services. Survey results were examined according to different groups of staff who worked as, or with graduates. Here, nurses and midwives working in specific clinical units provided lower ratings of the level of support and training provided to graduates than current or recent graduates, nurse managers, and other staff involved in graduate education.

Analysis of health service and staff reports revealed that local and small rural health services on average provided the least amount of support services for their graduates.
Better practice training and education

The range of educational opportunities offered to graduates at different health services varied from as high as 95% to as low as 68% depending on the specific activity. Graduate Coordinator survey responses indicated that 95% of health services offered online learning programs, but:

- Only 83% of health services offered simulation or specific situational training;
- Only 81% of health services offered clinical risk management education;
- Only 70% of health services educated graduates in areas of professional accountability and scope of practice; and
- Only 68% of health services provided graduates with an opportunity to review their core clinical skills, or offered graduates approved independent study programs as part of their transition to practice programs.

The survey of transition to practice program coordinators identified 100% of health services provide dedicated days per annum for graduate study days, whilst only 51.1% provide dedicated days for program activities, and 42.6% provide dedicated days for de-briefing or peer group support. 78.7% of all responding health services provide FTE for support/education.

Graduate feedback

Almost all health services reported providing regular feedback and performance appraisals for their graduates (98%). In order to explore the nature of feedback provided to graduates, staff who worked with graduate employees were asked a number of questions about the nature of graduate feedback and performance appraisal. Whilst almost all staff (95%) considered that graduates were encouraged to ask questions and seek help, as few as three quarters of all staff agreed that:

- Graduates had clearly allocated mentors/preceptors/supervisors (80%);
- Staff on the wards or other clinical units within the health service were happy to spend time supporting graduates (81%);
- Staff provided positive and productive feedback to graduates (77%). Significantly fewer graduates agreed with this statement (69%), compared with nurse managers (90%);
- Staff were encouraged to provide regular feedback to graduates (77%). Interestingly, only half of all current or recent graduates agreed with this statement (55%), compared with all other groups of staff.

Better practice approaches reported by health services

Health services were asked to self-nominate areas of perceived best practice in the supports they provide to graduates. A variety of strategies that might potentially be considered by other health services include:

- The development of graduate competencies and/or specific learning objectives;
- Graduate retreats and new approaches to graduate orientation workshops;
- Participation in specific training programs/modules, particularly simulation training where it is available;
- Increasing the frequency of scheduled progress checks with each individual graduate; and
- Increasing supernumerary support and/or the length of other transition to practice program components.

Program costs and resources

The Department provides funding to health services for eligible transition to practice programs on a per graduate basis, for an approved number of graduates each year. This funding is currently more than $17,000 per graduate. Health services may also provide the transition to practice programs to additional unfunded graduates.

A costing and resources review was completed by ten health services. The review sought detail for three financial years (2012-13 to 2014-15) on revenue and expenditure associated with the transition to practice programs in scope for the current project. This included funding received, direct and indirect program costs associated with support activities, overhead allocation, and other costs.

Of the sampled health services, funding was provided for between nine and 139 graduates in a given year. This equated to between $160k and $2.4m. In addition to the base Training and Development grant funding, the Department provided funding for additional purposes such as contributing to the cost of establishing a collaboration, for specific ATSI and/or Midwifery graduates, to introduce a technological improvement to a program (e.g. video-conferencing), and to encourage expansion of the settings involved in a program. Across the three financial years additional funding from the Department has ranged from $250k to $1.3m. This additional funding has covered graduates as well as one-off asset or establishment costs. None of the ten sampled health services identified revenue from any source other than the Department.

The revenue identified by each health service varied (for at least one financial year) to the information provided by the Department. For some health services the revenue identified was in excess of the Department’s advice and for others it was lower. These discrepancies may be the result of a number of factors: health services spreading the funding received for a calendar year program across financial years; identifying only the training and development portion of the funding and not additional funding; or inability to record and identify revenue in the absence of a dedicated cost centre.

The sampled health services were requested to provide detail on costs directly associated with the operations of their graduate transition to practice programs. Support activities together with the costs associated with staff directly involved in the programs were categorised as direct program costs.

In total there were 24 support activities identified as being provided as part of the programs. Of these, induction programs were the main activities where health services provided estimated costs. Across the health services that provided detail for one or more of these items, the average cost per graduate was approximately $530. Whilst there were many support activities identified by the sampled health services as being provided as part of the program, the associated costs were not able to be estimated to any degree of certainty. This may be due to the fact that the resource costs of these support activities are often related to staff time; that is, health service staff are involved in delivering the support activities, whether
these are structured training, supervising, mentoring, conducting assessments, providing feedback or other activities. It may be difficult to estimate the time commitment of the various staff, and therefore difficult to determine cost. Additionally, some of the supports may not be 'timed' activities – for example, developing peer support networks or self-reflection journals – which are again, difficult to attribute a cost.

The staff directly involved in the programs include transition to practice program coordinators, preceptors, mentors, clinical support nurses, human resource managers and clinical coordinators. For staff involved in delivering the program, the costs associated with time on tasks directly related to the program were requested. Program Coordinator costs varied between $80k and $130k. This would appear to reflect that most health services employ one transition to practice program coordinator who is dedicated to working on the program. This coordinator may be full-time or part-time, and this would explain some of the variation in costs across these health services. The costs identified by these health services show stability with little variation over the three years.

From the data provided on the number of graduates involved in each program and the costs of the coordinators, it shows that across the health services the cost of the coordinator on a per graduate basis ranges from $1k to $8k. This large range likely occurs because to run a program, a staffing resource is required regardless of whether there are five graduates on the program or 50 graduates.

When combined, the total direct costs (on a per graduate basis) ranged from $5k to $28k. This is a significant range. It is too significant to be related to graduate numbers or differences in the level of support provided and is more likely to be the result of different methodologies for categorising costs.

Health services were requested to provide estimates of indirect costs associated with the program, such as supernumerary costs or costs within a clinical education department that support the program (but are not costs of direct support activities provided to graduates). Supernumerary costs were the largest component of indirect costs reported by health services. Typically, each program allocated around 11 supernumerary days per graduate each year. Overall, at an individual health service level, per graduate supernumerary costs were around $3,600 per annum and broadly stable across the three years. The number of supernumerary days varied across health services, largely due to variation in the number of observation days per rotation, and the number of rotations. As the number of supernumerary days is an important component and contributor to overall cost of delivering the program, there is value in measuring this consistently at the health service level over time.

Health services were asked to provide indicative overhead costs associated with the transition to practice programs, which are fixed for a business and are usually spread across all business activities (typically by the finance area using a standard methodology to apportion the costs). On average, overhead costs represented around 10% of total transition to practice program revenue and averaged around $1,400 per graduate. Large variations were observed between health services and these were attributed to different methods of overhead costing allocation. Most of the sampled health services advised that they do not use a dedicated cost centre to capture revenue and expenditure associated with the programs and therefore attributing overhead costs was difficult.

During the stakeholder consultations, a number of other resource-intensive activities associated with the program were discussed. These mainly related to recruitment of graduates to the program and the travel expenses and the cost of staff involved in the process.
When taken as a whole, the total transition to practice expenditure incurred by individual health services as a percentage of revenue per year over the three years was 139%, 144% and 149% respectively, indicating that expenditure is increasingly outstripping revenue. This may be driven by the percentage of graduates that are funded – that is, the number of graduates for which funding from the Department is received as a percentage of the total number of graduates employed by the health service. Whilst the Department is funding similar numbers of graduates each year, the health services, on average, are recruiting more. Therefore revenue is not keeping pace with expenditure. On average health services are spending $5k more per graduate than the revenue they receive.

Despite a large variation between different health services, it remains clear that funding from the Department is an important contribution to a significant investment made by individual Victorian health services in graduate nursing and midwifery transition to practice programs.

**Program evaluation**

Many health services reported undertaking local evaluation of their transition to practice program. The main focus of evaluation activity has been upon graduate retention, followed by consolidation of clinical skills, graduate job satisfaction, and employer satisfaction. By contrast, fewer health services have focused upon evaluating ongoing professional development activities undertaken by graduates. The level and frequency of evaluation varies across health services. Evaluation activities appear to have been more comprehensively undertaken by larger health services compared with local and small rural health services.

The monitoring of transition to practice program outcomes is most commonly performed using:

- **Graduate retention (85.1%).** This included measures of:
  - The number of graduates employed part-time after completing the program (66.0%),
  - The number of graduates employed full-time after completing the program (31.9%),
  - The number of graduates employed for at least 12 months after completing the program (44.7%), and
  - Program drop-out (51.1%);
- **Consolidation of basic clinical skills (72.3%);**
- **Graduate job satisfaction (72.3%);** and
- **Employer satisfaction (70.2%).**

Graduate professional development was measured in less than two thirds of health services:

- **Ongoing self-directed learning (66.0%);**
- **Setting of current and future professional goals (59.6%);** and
- **Career development plans (48.9%).**

The Graduate Program Experience Survey was developed by Healy & Howe (2014) to support quality improvement activities related to graduate transition to practice programs. Its purpose is to provide subjective measures of the graduates' perceptions of their experience with the program and complements other tools and activities which health services can use to monitor and evaluate the success of their program. 77.5% of health services reported using the Graduate Program Experience Survey, some with and some without modifications.
Metropolitan health services reported higher usage of the Graduate Program Experience Survey (or similar) than non-metropolitan health services.

In addition to assessment of graduate outcomes, the Graduate Program Experience Survey enables health services to undertake a continual process of quality improvement in program design and implementation. However, the level of responses by graduates to local program evaluations was reported to vary, with some health services receiving few responses and others a large number of responses to surveys undertaken by transition to practice program coordinators.

A number of health services reported making extensive use of information published by the Department about best practices in transition to practice program development and implementation. For other health services, local program evaluation is still improving.

**Program outcomes**

Examination of current graduate perceptions of transition to practice programs demonstrated that almost all current graduates enjoyed the program (92%) and thought it was well run at their health service (90%). Interestingly, those who had graduated from a program within the past three years provided slightly lower ratings of program enjoyment (74%) and program implementation (79%). This may indicate either a genuine program improvement over recent years, and/or a re-appraisal on the part of recent graduates of their program experience in the light of subsequent professional practice following program completion.

By the end of the transition to practice program, around 80% of all staff also reported that graduates turned out to be confident (81%) and independent (78%) professionals. Around two thirds of all staff thought that the transition to practice program could be further improved (73%), but many agreed that graduates were satisfied with their career choice at the end of the program (68%). Interestingly, only three quarters of both current (73%) and recent (76%) graduates reported being satisfied with their professional occupation at the end of the program.

Exploratory analysis of potential causes and/or consequences of professional satisfaction at program completion was undertaken using the current sample of current and recent graduates. Findings of this analysis indicated that the following factors were significantly associated with higher levels of graduate satisfaction with their professional occupation at completion of their transition to practice program (in descending order of importance):

- **Higher confidence in communicating** with patients;
- **Higher perceived encouragement to ask questions**;
- **Higher perceived working of rosters** that are the same as other members of staff;
- **Higher levels of program enjoyment**;
- **Higher levels of perceived flexibility/adjustment of support to meet individual needs**;
- **Higher levels of confidence to escalate** patient management when needed;
- **Higher levels of perceived support during graduate rotations**;
- **Higher levels of perceived clarity about allocated mentors/preceptors/supervisors**;
- **Lower levels of perceived support from senior clinical staff**; and
- **Lower levels of perceived responsibility of all nurses/midwives** in supporting graduates.
Program completion

Around 93% of graduates were reported to complete the program in 2015, representing a 14% increase in completions compared with the 2013 cohort. In 2015, 93.2% of graduates in metropolitan health services completed the program, compared with 92.4% of their non-metropolitan counterparts.

Program non-completion was highest for Bachelor of Nursing graduates. In 2015, 92.2% of nursing graduates, 98.4% of midwifery graduates, and 99.1% of double degree graduates completed the program. A range of reasons was reported for the few who did not complete their transition to practice program including: failure to meet performance standards; decisions to discontinue professional training; family reasons (including pregnancy); illness; difficulties commuting long distances; the desire to travel overseas; a preference to work in metropolitan health services (for those in rural or regional programs), or other unspecified personal reasons.

Graduate retention

Following completion of their transition to practice program in 2015, 77% of graduates were retained in either full or part time employment. Retained graduates are employed for at least twelve months after completing a transition to practice program, at the health service at which they undertook the program. This rate of retention has been relatively stable since 2013, with the majority of graduates opting for ongoing part-time employment. Retention was significantly higher in metropolitan health services (82%) compared with non-metropolitan health services (62%). Interestingly, the relative lack of attention upon teamwork and communication training (77%), and encouraging graduates to develop peer group and other professional networks (79%) as part of the transition to practice program, particularly in local and small rural health services, may be a hidden factor influencing lower retention in these areas.

Consultations with health services identified that over recent years the majority of graduates preferred to work on a part-time basis for a variety of reasons, including work-life balance, and the flexibility to work around family commitments. Health services also indicated that organisational budgetary constraints meant that they could employ more graduates if they were employed on a part-time rather than a full-time basis. Throughout the consultations, health services emphasised their wish to retain as many staff as possible following their graduate year of employment, offering more intensive and/or tailored support to promote this outcome.

Opportunities for program development

Based upon the evidence obtained throughout the review, a number of areas for further improvement in program design, implementation and outcomes have been identified.

Matching of graduates to health services

Computer Matching has been successfully used to recruit the majority of graduates. However, significant concerns and difficulties had been experienced by at least one health service. The most significant issues arising from the Computer Match process, related to the matching and selection of graduates who had not yet received their full registration to practice. It was recognised that AHPRA registration is contingent upon the provision of final
assessments from all universities. Delays in submitting final assessment marks to AHPRA was considered to be the underlying reason for subsequent delays in registration.

It was recognised that whilst the Department is not responsible for the timeliness of registrations granted by AHPRA (nor the timing of final submission of grades by universities), the Department does have a significant stake in workforce impacts of delays in registration of new graduates for Victorian public health services. Accordingly, the Department may consider:

- Further investigation of the extent to which delays in new graduate registration impact upon the capacity of new graduates commence professional duties in the workplace (particularly for early calendar year intakes); and
- Facilitate some discussion with AHPRA about the extent of this issue and any strategies that the Department may facilitate to secure more timely registration, in order to ensure that new graduates are fully registered at the commencement of their transition to practice program.

**Use of additional program funding**

As previously identified, the funding provided per graduate by the Department is currently higher than that offered by other Australian jurisdictions. Funding is provided as a contribution to the training and development costs that are otherwise borne by individual health services. In the current public hospital funding environment, this additional support is factored into budgetary planning and allocations. Accordingly, any reduction in the amount of base funding allocated to public health services on a per graduate basis is unlikely to support and may in fact impede further program development.

Where available, the Department has invested significant additional funding, in addition to funding for specific case-by-case requests for graduate support resources such as information technology and collaboration development. The majority of allocated additional funding has been provided on a per graduate basis to support increased throughput of graduate nurses/midwives at particular health services. Based upon evidence gathered through the program evaluation, the use of additional funding might be considered for alternative methods of strengthening current transition to practice programs.

Consideration may be given to:

- **Expanded settings incentives.** Initial support for staff in areas where graduate placements have not occurred for a variety of reasons, which in the main appear to relate to the level of seniority of staff required to undertake (largely independent) clinical duties in particular areas such as Hospital in the Home, Transitional Care, Community Nursing, Hospital Admission Risk Program etc., and/or the level of patient throughput, creating concerns that time devoted to patient care may be diverted to graduate support in areas such as dialysis, day oncology, radiology, day theatre, procedure suites etc. It is proposed that a limited period of ‘incentive’ funding might be considered in some of these areas to provide time-limited supernumerary support, particularly during the early stages of graduate placement (for example, 0.5 supplementary FTE for up to four weeks). This might be considered as a one-off incentive in any new expanded setting within an individual health service to accommodate existing staff concerns about the potential impost of a graduate rotation and to modify staff perceptions about future graduate positions.

- **Inter-disciplinary induction, orientation and basic education.** Opportunities exist to promote further inter-disciplinary training. The availability of any available one-off funding might well be targeted to increase these activities. Historically, funding opportunities for
inter-disciplinary graduate training have been relatively siloed. Increasingly however, health services have identified opportunities to conduct induction/orientation, and a range of basic clinical skills training across a range of different professional graduates. These opportunities afford internal economies of scale for health services, and workforce benefits of early consolidation of inter-disciplinary knowledge and co-operation. Whilst some health services have reported challenges relating to differences in the timing of graduate intakes between nursing/midwifery, allied health and medicine, others appear to have resolved these issues, and may be a useful source of advice in relation to methods of expanding opportunities for inter-disciplinary training.

- **Formal collaborations between (sub) regional, local and small rural health services.** A large number of graduate training collaborations were reported between public health services across Victoria. However, the extent to which these collaborations have been formalised (including consolidation of program staff and resources) remains unclear. Where more formal collaborations have been identified, they have been reported to result in successful program outcomes for graduates and for staff. In the context of observed variations in better practice design and implementation of transition to practice programs, an increase in the number of formal rotation collaborations between regional/sub-regional, local and small rural health services is suggested. Additional funding may be considered to promote more formal rotation collaborations between sub-regional and smaller health services. An increase in the number of formal collaborations would not only promote greater standardisation of transition to practice program content and delivery across regional Victoria, it would also reduce competition for graduate placements between smaller health services, and provide a wider range of rotations for individual graduates.

**Management of staff expectations**

Respondents were asked to briefly list any opportunities to improve the Graduate Bachelor of Nursing and/or Bachelor of Midwifery programs at their health service. Of 416 responses, almost half (46%) highlighted the need for improvements in the delivery of support to graduates. Interestingly, a number of staff suggested that additional support should be directly provided by the transition to practice program coordinators or dedicated education staff. It remains unclear as to whether calls for further support from dedicated coordinators or nurse educators rather than from ward/unit staff as professional peers, was influenced by perceptions of graduates as ‘students’ who may be on ‘placements’, rather than as fully qualified (albeit novice) clinical professionals. Based upon the perceptions of public health service staff, further work would appear to be needed to identify and manage clinical unit staff understanding of the role of graduates (compared with students on placement), and their own role as primary day-to-day supports to their professional peers as they commence their clinical careers. This would appear to be the responsibility of nurse unit managers, who may benefit from further support by transition to practice program coordinators in order to improve clinical staff understanding of their primary role in graduate support, identify areas where further staff training in clinical support may be needed, and develop appropriate professional activities to facilitate peer based professional support skills and networks at a local level to support graduates.

**Establishing minimum standards for clinical unit orientation**

Notwithstanding the need to provide further support to clinical unit staff in day-to-day support of novice professional peers, the need for a more systematised approach to graduate orientation within individual clinical units was also commonly cited by health service staff as an area for further improvement. Feedback provided from the transition to practice program coordinators and other staff specifically highlighted variations in the level of orientation to
individual clinical rotations, including policies and procedures, relevant clinical guidelines, graduate learning objectives, clearly allocated preceptors/mentors, and supervisory arrangements. Based upon the degree and consistency of feedback from clinical staff working with graduates, it is suggested that a minimum standard be introduced for every graduate rotation in the form of a ‘graduate support contract’ between the nurse unit manager, and all novice practitioners (including transition to practice nurses and midwives).

Whilst the format of this agreement may be free to vary according to individual health services (or health service collaborations), it is suggested that the mandatory minimum content specify:

- The name and specialty area of the clinical unit;
- The graduate name;
- Up to three mutually agreed primary learning objectives for the duration of the rotation;
- The date by which specified unit policies and procedures are to have been read;
- The date by which specified clinical guidelines or protocols are to have been read;
- The names of unit staff who are assigned as nominated preceptor(s)/mentor(s);
- The name of a back-up clinical support position (for example, ANUM/NUM); and
- The name of a back-up professional development support (for example, transition to practice program coordinator).

In the case of transition to practice graduates a copy of these co-signed agreements would be forwarded to the program coordinator for monitoring.

**Pooling/sharing of training resources**

For the purposes of professional development and educational activities, larger regional and sub-regional health services may be in a more advantageous position compared with smaller organisations, by virtue of the greater number of graduates employed and the resources developed to promote their transition to practice. As has been previously reported, local and small rural health services were not able to provide the full range of better practice program elements. Many of these elements related to educational activities, including:

- A review of core clinical skills;
- Accountability and scope of practice education;
- Clinical risk management education;
- Occupational violence training;
- Simulation/specific situational training;
- Independent study programs;
- Self-reflection journals;
- Team work and communication skills development;
- Professional self-management skills development;
- Assistance with career development planning; and
- Assistance in developing peer support networks.
The development of formal rotation collaborations (as discussed above) or formal educational agreements between larger and smaller health services could capitalise upon the materials and infrastructure already established by larger health services.

One-off funding may be considered to assist in establishing some of these agreements, however, negotiations would also be expected between larger and smaller health services (that are not in any formal collaboration arrangement) to determine appropriate funding of these components of transition to practice program delivery for graduates working in smaller organisations. It would be expected that the cost of extending current education to graduates from smaller health services would be negotiated at a marginal rate, given that resources and the infrastructure for administering them were already established by larger health services.

As a complementary or alternative arrangement, the Department may consider sponsoring a regular statewide community of practice between transition to practice program coordinators. This could include those involved in nursing and midwifery transition to practice, in addition to those involved in graduate training for other nursing, allied health and medical professions.

**Standardisation of best practice elements in graduate training**

Previous publications by the Department have identified and encouraged key elements of better practice in transition to practice program design and implementation. Many health services have reported adopting these. However, a significant number of health services have not incorporated all elements of better practice recommended by the Department, or have implemented them to standards that are not fully understood/appreciated by members of staff. These elements include: induction/orientation to the health service; orientation to organisational policies/procedures; occupational health and safety education; occupational violence training; induction/orientation to clinical practice; review of core clinical skills; induction/orientation to specific units; orientation to unit policies/procedures/guidelines; clearly defined job/role descriptions per rotation; clearly specified personal learning objectives; competency based graduate assessments; regular feedback and performance appraisal; organisational self-reflection journals; organisational online learning programs; approved independent study programs; accountability and scope of practice education; clinical risk management education; simulation/specific situational training; team work & communication skills development; professional self-management skills development; development of peer support networks; and assistance with career development plans.

Strategies to promote more widespread adoption of these approaches have been suggested above (for example, via increasing the number of formal collaborations, rotation agreements, and sharing of public health services resources for education and professional development). Accordingly, it is now suggested that the Department undertake regular monitoring of the extent to which these elements are incorporated across all health services where public funding is provided, to improve the consistency of supports and opportunities provided to all transition to practice nurses and midwives in Victoria. Methods of ongoing monitoring are discussed immediately below.

**Improved health service reporting requirements**

The amount of funding provided by the Department to public health services across Victoria is a significant investment. There are surprisingly few reporting requirements placed upon public health services to acquit against the amount of program funding provided by the Department.
The findings of the current evaluation have identified a number of areas where significant variance in financial accountability, program design and graduate outcomes have been observed. Accordingly, an increase in the specificity of information provided to the Department is strongly suggested, to enable better monitoring of key elements of program expenditure, standards of program design, and outcomes achieved for nursing and midwifery graduates who participate in current transition to practice programs.

Proposed reporting is to include reporting of program funding, recruitment, expenditure, design and implementation. Prospective rather than retrospective data capture is recommended to allow sufficient notification of the requirement to report this data.

The following eight performance indicators are therefore suggested for reporting by funded health services against nursing and midwifery transition to practice programs on an annual basis (Refer to Appendix 4 for additional information regarding calculations):

- Indicator 1: Total transition to practice funding by the Department
- Indicator 2: Proportion of graduates identified through computer match
- Indicator 3: Proportion of graduates funded by the Department
- Indicator 4: Total expenditure on nursing/midwifery graduate coordinators
- Indicator 5: Total expenditure on nursing/midwifery supernumerary support
- Indicator 6: Number of rotations per transition to practice program graduate stream
- Indicator 7: Proportion of best-practice elements included in program design
- Indicator 8: Proportion of graduate support contracts per rotation

Where formal collaborations are in place between sub-regional, local and small rural health services, indicators are to be calculated and submitted for the collaborative.

**Standardisation of program evaluations**

Whilst local evaluations of graduate transition to practice programs were reported by a number of health services, the type of questions asked and the level of graduate participation was reported to vary. Regardless, evaluation feedback was reported to be critical to ongoing continuous quality improvement in program design and delivery. In order to standardise graduate feedback, it is suggested that the Department take a central role in co-ordinating program feedback on an annual basis. By centrally co-ordinating transition to practice program evaluation, the Department would enhance the opportunities to:

- Independently collect information from individual graduates who may reasonably be concerned about the anonymity and confidentiality of their responses to health services (particularly those where they may be employed on an ongoing basis). Independent data collection is also likely to enhance the response rate from individual graduates;
- Standardise the information collected about the transition to practice program experience across all programs in Victoria;
- Validate information reported by individual health services about the structure and implementation of their transition to practice programs;
- Allow the Department to investigate additional areas of interest in relation to workforce retention (for example, ongoing employment, location of employment);
- Benchmark the perceived performance of health services across the state in order to identify areas in potential need of additional support; and
Provide de-identified benchmarked reports to health services to promote ongoing program improvements.

Given previous work to develop an outcome survey for graduates, this could be administered on behalf of the Department together with additional areas of interest.

**Strategies for future consideration**

Current nursing and midwifery transition to practice programs in Victoria offer many examples of ‘better practice’ in program design and implementation and positive outcomes for graduate employees. Health services have invested significant time and resources into managing and improving the level and nature of support provided to graduate nurses and midwives. They recognise that entry level professional support has a significant impact upon individuals’ professional competence, confidence and desire to pursue a future career.

In order to strengthen current achievements and maintain the quality of program outcomes, 12 strategies have been proposed to address nine strategic objectives of ongoing program design and implementation. These strategies can be implemented through three policy instruments suggested for future consideration by the Department (including further stakeholder consultation, implementation of performance monitoring and selected financial incentives). Refer to Appendix 5.

Suggested strategies are intended to ultimately standardise the quality of programs offered by public health services, continually improve the outcomes achieved for graduates and for health services, and be immediately actionable by the Department.

Current nursing and midwifery transition to practice programs operating across Victoria are well supported by the Department. There is however, limited capacity to further expand the number of graduate positions. Nine strategic objectives for ongoing improvement of nursing and midwifery transition to practice programs operating across Victoria have been identified:

- Improving the efficiency of Computer Matching;
- Monitoring the number of graduate positions;
- Monitoring key program funding and expenses;
- Increasing areas of graduate rotations;
- Understanding levels of graduate retention;
- Improving the quality of program design;
- Improving the consistency of program implementation;
- Improving the monitoring of program outcomes; and
- Increasing the effectiveness of program outcomes.

A total of 12 independent strategies have been proposed to address these strategic objectives. These strategies focus upon:

- Investigation of impediments to registration with a selection of health services;
- Discussing with AHPRA registration delays, perceived causes and possible improvements;
- Increasing health service reporting of program funding, expenditure and activity;
Promoting expanded settings, particularly in high patient volume and community areas;

Implementing an independent annual graduate experience survey;

Promoting an increase in the number of formal collaborations, particularly in non-metropolitan Victoria;

Promoting further increases in inter-disciplinary education;

Pooling/sharing of educational resources between health services;

Standardising the number of clinical rotations to align with better practice recommendations;

Promoting inclusion of best practice elements into all transition to practice programs;

Implementing rotational agreements for graduates in each clinical area; and

Undertaking ongoing outcome monitoring to understand determinants of a professionally satisfied graduate and using this information to further improve transition to practice programs.

The three policy instruments that are immediately available to the Department in order to implement the suggested strategies involve:

Undertaking further consultation with health services and AHPRA;

Implementing ongoing performance monitoring via;

 Eight annual key performance indicators for public health services, and

 An annual independent graduate outcome and experience survey; and

Implementing selected financial incentives (pending the availability of additional funding).

Suggested strategies are intended to ultimately standardise the quality of programs offered by public health services, continually improve the outcomes achieved for graduates and for health services, and be immediately actionable by the Department.
### Appendix 1  Key Evaluation Questions

**Table A-1: Key evaluation questions and data sources**

<table>
<thead>
<tr>
<th>KEY EVALUATION QUESTIONS</th>
<th>DATA SOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are health services’ <strong>objectives in running the transition to practice program,</strong> and what are the benefits for the organisation?</td>
<td>Literature, Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>2. Do you <strong>collaborate with other public health services</strong> in order to run your transition to practice program, and if so, what benefits have you identified?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>3. Do you <strong>collaborate with other organisations</strong> that are not public health services, and if so, what are the major benefits for your organisation?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>4. How much do you <strong>rely upon computer matching</strong> to fill positions, and where relevant, what other approaches have been used)?</td>
<td>Literature, Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>5. Has the <strong>number, type or mix of graduates</strong> changed over recent years, and if so, how?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>6. Has the level of <strong>program retention</strong> changed over recent years?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>7. Has the <strong>number and/or mix of rotations</strong> changed over recent years, and if so, how?</td>
<td>Literature, Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>8. Has the <strong>location of rotations</strong> changed over recent years, and if so, where?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>9. What <strong>range of activities</strong> are undertaken to support graduates, and how do these align with current best practice recommendations?</td>
<td>Literature, Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>10. What <strong>outcomes</strong> are being monitored to evaluate and improve your transition to practice program?</td>
<td>Literature, Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>11. What <strong>level of funding</strong> has been provided to support your transition to practice program over the past three years?</td>
<td>Consultations, Cost Analysis</td>
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<td>12. What are the <strong>direct costs</strong> associated with the range of support activities you undertake?</td>
<td>Consultations, Cost Analysis</td>
</tr>
<tr>
<td>13. What <strong>indirect costs</strong> are involved in support activities?</td>
<td>Consultations, Cost Analysis</td>
</tr>
<tr>
<td>14. What <strong>overhead costs</strong> are associated with the program?</td>
<td>Consultations, Cost Analysis</td>
</tr>
<tr>
<td>15. What <strong>other costs</strong> are involved in program delivery?</td>
<td>Consultations, Cost Analysis</td>
</tr>
<tr>
<td>16. Are there opportunities to <strong>recruit more graduates</strong> into the program at your health service?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>17. Are there opportunities to <strong>retain more graduates</strong> who complete the program at your health service?</td>
<td>Consultations, Coordinator Survey</td>
</tr>
<tr>
<td>18. Under ideal circumstances, would you do anything more to <strong>improve the efficiency</strong> of your transition to practice program?</td>
<td>Consultations, Coordinator Survey, Staff Survey</td>
</tr>
<tr>
<td>19. Are there any other things you could do to <strong>enhance the effectiveness</strong> of your transition to practice program?</td>
<td>Consultations, Coordinator Survey, Staff Survey</td>
</tr>
<tr>
<td>20. Are there any <strong>other areas for improvement</strong> that you might consider for your transition to practice program?</td>
<td>Consultations, Coordinator Survey, Staff Survey, Cost Analysis</td>
</tr>
</tbody>
</table>
Appendix 2  Public health service collaborations (list)

The following public health service collaborations in transition to practice programs were identified:

1. Djerriwarrh Health Services, and Ballarat Health Services;
2. Yarram and District Health Service, and Latrobe Regional Hospital;
3. Rural Northwest Health, and Ballarat Health Services;
4. South West Healthcare, and Terang and Mortlake Health Service;
5. Barwon Health, and Lorne Community Hospital;
6. Kyabram & District Health Services, and Goulburn Valley Health;
7. Casterton Memorial Hospital, and Wimmera Health Care Group;
8. East Grampians Health Service, and Ballarat Health Services;
9. Moyne Health Services, Portland District Health, and Western District Health Service;
10. Bendigo Health, Inglewood and District Health Service, and Heathcote Health;
11. Albury Wodonga Health, Tallangatta Health Service, and Upper Murray Health & Community Services;
12. Bairnsdale Regional Health Service, Orbost Regional Health, and Omeo District Health;
13. Melbourne Health, the Royal Children’s Hospital, Northern Health, and Western Health;
14. Echuca Regional Health, Rochester & Elmore District Health Service, Boort District Health, and Cohuna District Hospital;
15. Eastern Health, Austin Health, Albury Wodonga Health, Goulburn Valley Health, and St Vincent’s Health (Public);
16. Northeast Health Wangaratta, Alpine Health, Benalla Health, Yarrawonga Health, and Mansfield District Hospital;
17. Wimmera Health Care Group, Ballarat Health Services, Casterton Memorial Hospital, Edenhope and District Memorial Hospital, and West Wimmera Health Service;
18. Ballarat Health Services, Beaufort & Skipton Health Service, Djerriwarrh Health Services, Hepburn Health Service, Rural Northwest Health, West Wimmera Health Service, and East Grampians Health Service; and
Figure A3-1: Geographic mapping of self-reported public health service collaborations to deliver transition to practice programs across Victoria
Appendix 4  Proposed indicator calculations

For reporting of program funding, recruitment, and expenditure:

Indicator 1: Total transition to practice funding by the Department

Total funding received for transition to practice program per annum

Indicator 2: Proportion of graduates identified through computer match

Total number of graduates recruited through computer match per annum  
The total number of graduates recruited per annum

Indicator 3: Proportion of graduates funded by the Department

The number of graduates funded by the Department per annum  
The number of all graduates recruited per annum

Indicator 4: Total expenditure on nursing/midwifery graduate coordinators

Total graduate coordinator expenditure for transition to practice programs per annum

Indicator 5: Total expenditure on nursing/midwifery supernumerary support

Total supernumerary expenditure for transition to practice programs per annum

Where fractional allocation of program coordinator time is spent on transition to practice programs this is to be reported.

For reporting of transition to practice program design:

Indicator 6: Number of rotations per transition to practice program graduate stream

The number of rotations for Nursing, Midwifery, and double degree graduates per annum

Rotations for Bachelor of Nursing, Bachelor of Midwifery and double degree graduates are to be reported separately (for each stream) per annum.

Indicator 7: Proportion of best-practice elements included in program design

The number of best-practice elements included in transition to practice programs per annum  
The total number of best-practice elements for transition to practice programs

For reporting of transition to practice program implementation:

Indicator 8: Proportion of graduate support contracts per rotation

The number of graduate support contracts submitted per annum  
The total number of graduate rotations undertaken per annum

Graduate support contracts are to be submitted for each rotation to the transition to practice program coordinator who would be responsible for calculating and monitoring this indicator.
## Appendix 5  Strategies to enhance programs

**Table A4-1: Summary of strategies to enhance transition to practice programs**

<table>
<thead>
<tr>
<th>9 STRATEGIC OBJECTIVES</th>
<th>12 STRATEGIES FOR CONSIDERATION</th>
<th>4 METHODS OF IMPLEMENTATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the efficiency of Computer Matching</td>
<td>Investigation of impediments to registration</td>
<td>Health service consultation</td>
</tr>
<tr>
<td></td>
<td>Discussion with AHPRA</td>
<td>AHPRA consultation</td>
</tr>
<tr>
<td></td>
<td>Increase health service reporting</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td>Monitoring the number of graduate positions</td>
<td>Increase health service reporting</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td>Monitoring key program funding and expenses</td>
<td>Increase health service reporting</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td>Increasing areas of graduate rotations</td>
<td>Promotion of expanded settings</td>
<td>Selective financial incentives</td>
</tr>
<tr>
<td></td>
<td>Increase health service reporting</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td>Understanding levels of graduate retention</td>
<td>Independent graduate experience survey</td>
<td>Annual graduate survey</td>
</tr>
<tr>
<td>Improving the quality of program design</td>
<td>Increase in formal collaborations</td>
<td>Selective financial incentives</td>
</tr>
<tr>
<td></td>
<td>Increase in inter-disciplinary education</td>
<td>Selective financial incentives</td>
</tr>
<tr>
<td></td>
<td>Pooling/sharing of educational resources</td>
<td>Selective financial incentives</td>
</tr>
<tr>
<td></td>
<td>Standardise the number of clinical rotations</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td></td>
<td>Promote inclusion of best practice elements</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td>Improving the consistency of program implementation</td>
<td>Increase in formal collaborations</td>
<td>Selective financial incentives</td>
</tr>
<tr>
<td></td>
<td>Implement rotational agreements</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td></td>
<td>Increase health service reporting</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td>Improving the monitoring of program outcomes</td>
<td>Increase health service reporting</td>
<td>Implementation of indicators</td>
</tr>
<tr>
<td></td>
<td>Independent graduate experience survey</td>
<td>Annual graduate survey</td>
</tr>
<tr>
<td>Increasing the effectiveness of program outcomes</td>
<td>Understand determinants of a professionally satisfied graduate</td>
<td>Annual graduate survey</td>
</tr>
</tbody>
</table>