ACT Government | ACT Health

Our reference: **ACTHDFOI21-22.48**

[redacted]

Dear [redacted]

AMENDED – DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by ACT Health Directorate (ACTHD) on **Thursday 10 March 2022**.

This application requested access to:

> *'All documents/correspondence for the last 18 months to and from the Health Minister's office about nurse numbers, nurse shortages and nurse recruitment in the ACT. Also the number of FTE nurses in permanent employment as well as nurses on contracts and the length/nature of those contracts.'*

I am an Information Officer appointed by the Director-General of ACT Health Directorate (ACTHD) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. ACTHD was required to provide a decision on your access application by **Wednesday 4 May 2022**.

I have identified 15 documents holding the information within scope of your access application. These are outlined in the schedule of documents included at Attachment A to this decision letter.

Decisions

I have decided to:

- grant full access to 10 documents;
- grant partial access to four documents; and
- refuse access to one document.

My access decisions are detailed further in the following statement of reasons and the documents released to you are provided as Attachment B to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

Full Access

I have decided to grant full access to 10 documents at references 1, 3-9, 11 and 15.

Refuse Access
I have decided to refuse access to one document at reference 13 as this is comprised of Cabinet information under *Schedule 1.6 (1) Cabinet Information,* and therefore they are taken to be contrary to the public interest to release.

Partial Access
I have decided to partially grant access to four documents at references 2, 10, 12 and 14. Documents at the references contain information that I consider to be contrary to the public interest to disclose under the test set out in Section 17 of the Act as the information contained in these folios is partially comprised of personal ACT Government employee mobile numbers.

I have identified that there are no relevant factors favouring disclosure of this information under Schedule 2.1.

This information has not been disclosed as this could reasonably be expected to prejudice the protection of the individual's right to privacy under *Schedule 2.2 (a) (ii) prejudice the protection of an individual's right to privacy or any other right under the Human Rights Act 2004*. The disclosure of this detail would not provide any government information pertinent to your request therefore, I have decided this factor outweighs the public interest factors in the disclosure of this information.

Charges
Processing charges are not applicable to this request.

Disclosure Log
Under section 28 of the FOI Act, ACTHD maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.
https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log.

Ombudsman review
My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman
GPO Box 442
CANBERRA ACT 2601
Via email: ACTFOI@ombudsman.gov.au
Website: ombudsman.act.gov.au

ACT Civil and Administrative Tribunal (ACAT) review
Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal
Level 4, 1 Moore St
GPO Box 370
Canberra City ACT 2601
Telephone: (02) 6207 1740
http://www.acat.act.gov.au/

Further assistance
Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email HealthFOI@act.gov.au.

Yours sincerely

Helen Matthews
Chief Allied Health Officer
Office of Clinical Leadership

4 May 2022

ACT Government | ACT Health

FREEDOM OF INFORMATION SCHEDULE OF DOCUMENTS

Please be aware that under the *Freedom of Information Act 2016*, some of the information provided to you will be released to the public through the ACT Government's Open Access Scheme. The Open Access release status column of the table below indicates what documents are intended for release online through open access.
Personal information or business affairs information will not be made available under this policy. If you think the content of your request would contain such information, please inform the contact officer immediately.
Information about what is published on open access is available online at: http://www.health.act.gov.au/public-information/consumers/freedom-information

APPLICANT NAME	WHAT ARE THE PARAMETERS OF THE REQUEST	FILE NUMBER
[redacted]	***'All documents/correspondence for the last 18 months to and from the Health Minister's office about nurse numbers, nurse shortages and nurse recruitment in the ACT. Also the number of FTE nurses in permanent employment as well as nurses on contracts and the length/nature of those contracts.'***	**ACTHDFOI21-22.48**

Ref Number	Page Number	Description	Date	Status Decision	Factor	Open Access release status
1.	1 – 2	Advisory Note – Strategies to strengthen the Nurse Practitioner role in ACT	29 April 2020	Full release		YES
2.	3 – 8	Arrangements Brief – Minister for Health – Nurse Practitioner Week 2020 – A Celebration of the Nurse Practitioner Role in the ACT – 8 December 2020 at 5.30pm	24 November 2020	Partial release	Schedule 2.2 (a)(ii) Privacy	YES
3.	9 – 13	Ministerial Brief – Nurse Practitioner Project	10 December 2020	Full release		YES
4.	14 – 137	Ministerial Brief and attachments – Nurse Practitioner Professional Practice Project – Outcome Evaluation and Workforce Survey	10 March 2021	Full Release		YES

5.	138 – 139	Budget Day Brief – Health Staffing Breakdown	17 August 2021	Full release		YES
6.	140	Budget Day Brief – HEA E02 - Improving our public health system – Introduction of nursing and midwifery ratios	26 August 2021	Full release		YES
7.	141 – 143	Minister for Health - Request for Speech - Delivering Better Care Across our Hospital System	30 September 2021	Full release		YES
8.	144 – 145	Minister for Health - Request for Speech - Nurse Ratios and Improving Outcomes	30 September 2021	Full release		YES
9.	146 – 148	Ministerial Brief – Changes to the nurse recruitment campaign	17 November 2021	Full release		YES
10.	149 – 152	Ministerial Brief – Implementation of Nurse/Midwife to Patient Ratios	27 January 2022	Partial release	Schedule 2.2 (a)(ii) Privacy	YES
11.	153 – 159	Ministerial Speech Health Specific - Minister for Health - Chief Minister's Economic Statement - 7-10 February Sitting	4 February 2022	Full release		YES
12.	160 – 170	Email – FW: Event proposal – Ratios announcement and Arrangements Brief	22 February 2022	Partial release	Schedule 2.2 (a)(ii) Privacy	YES
13.	171 – 177	Ministerial Brief – Ministerial Statement – ACT public health workforce and implementation of nurse-patient ratios	7 March 2022	Refuse release	Schedule 1.6 Cabinet	NO
14.	178 – 190	Email – FW: URGENT RFA – MIN22/392 – Advice by Email: Ratios Announcement - 10 March 2022	10 March 2022	Partial release	Schedule 2.2 (a)(ii) Privacy	YES
15.	191 – 194	Assembly - March 2022 - Minister for Health - Speeches - Nurse/Midwife ratios	16 March 2022	Full release		YES
Total Number of Documents						
15						

ACT Government | ACT Health

UNCLASSIFIED

ADVISORY NOTE

Minister for Health

TRIM Ref: MIN20/432	Strategies to strengthen the Nurse Practitioner role in ACT
Critical Date	Not applicable
Deputy Director-General, HSPR	Meg Brighton …….. ..../..../....

Minister's question/s:

To provide strategies to strengthen the Nurse Practitioner (NP) role during the COVID-19 period as requested by the Australian College of Nurse Practitioners in their letter dated 25 March 2020.

ACT Health Directorate's response:

In the correspondence from the Australian College of Nurse Practitioners, they requested that attention should be given to strategies to permanently or temporarily remove restrictions on NPs in the ACT in relation to the following:

Prescribing:

- The prescribing limitations for NPs is a national issue.
- ACT Health Directorate has been informed of the legislative changes to s100 of the *National Health Act 1953* which stipulates Pharmaceutical Benefits Scheme (PBS) changes to enable NP prescribing for HIV, Hepatitis B and Hepatitis C came into effect on 1 April 2020. Although this change was welcomed, it did come at a challenging time for NP colleagues and for Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine (ASHM) as an education provider to support implementation. This s100 change sets precedent for changing other legislation involving s100 medications including *Medical Termination of Pregnancy Act*.
- This legislative change only applies to prescribing in the community setting and outpatient clinics that are not located as part of the hospital. This is because the ACT Government has not signed on to the MBS and PBS reform which would allow doctors and nurse practitioners employed by public hospitals to use the MBS and PBS.

Medical Certificate of Cause of Death:

- In the ACT, NPs can verify a death by conducting a physical examination and pronounce life extinct but cannot certify and sign a Medical Certificate of Cause of Death. A doctor still needs to complete the Medical Certificate of Cause of Death before a funeral can take place.

- To enable NPs to certify and sign the Medical Certificate of Cause of Death, legislative change is required to the *Births, Deaths and Marriages Registration Act 1997* (the Act).
  In the aged care setting, funeral directors may refuse to collect a body until this paperwork is completed.

Advance Care Planning:

- The request from Australian College of Nurse Practitioners is to remove any barriers to advance care planning whereby a NP can develop, in consultation with the client and family, a Health Direction or Advance Care Plan Statement of Choices in the Aged Care, Community or Acute Care Settings.

- The *Medical Treatment (Health Directions Act) 2006* Section 9(1) states that a non-written health direction must be witnessed by two health professionals (one of whom is a doctor). NPs should be able to witness a non-written health direction with another health professional (e.g. Registered Nurse or Enrolled Nurse).

Credentialing:

- There is a standardised process across ACT that is reflective of Legislative requirements pertaining to NPs.

- NPs in ACT Health are aware of their capability and competence to practice and are able to articulate the requirements to maintain ongoing competence as per regulatory and legislative requirements.

- The requirements can only be relaxed with legislative changes to the *National Health Act 1953*.

Signing of Workcover/Worksafe:

- The Chief Nursing and Midwifery Officer recommends to do a background analysis in consultation with WorkSafe ACT whose role it is to enforce the Territory's health and safety and workers' compensation laws.

Noted / Please Discuss

…….

Rachel Stephen-Smith MLA
Minister for Health

…./…./….

Signatory Name:	Meg Brighton, Deputy Director-General, Health Systems, Policy and Research	Phone:	49180

ACT Government

Rachel Stephen-Smith MLA

Minister for Health
Minister for Families and Community Services
Minister for Aboriginal and Torres Strait Islander Affairs

Member for Kurrajong

ARRANGEMENTS BRIEF

FUNCTION:	An event to celebrate 20 years of the Nurse Practitioner role in Australia, as part of the International Year of Nursing and Midwifery.
VENUE:	The Conservatory, Midnight Hotel, 1 Elouera Street, Braddon ACT 2612
HOST:	Anthony Dombkins, Chief Nursing and Midwifery Officer, ACT Health Directorate Mobile: [redacted]
DAY:	Tuesday
DATE:	8 December 2020
TIME:	17:30 –19:30
TIME COMMITMENT:	Two hours
CATERING:	Refreshments and canapes
DRESS CODE:	Business casual
YOUR ROLE:	Speech: 5-10 minutes, welcome and acknowledgement of nurse practitioner contributions to healthcare in the ACT. *Available equipment*: Microphone and Lectern
WHERE TO PARK:	Underground free validated parking available Free street parking after 17:30
WHO WILL MEET YOU:	Anthony Dombkins will greet you in the hotel foyer
ADVISOR ATTENDING:	Caitlin Cook
AUDIENCE:	Approximately 40 attendees who are nurse practitioners, health consumers, and senior nursing executives, leaders and academics across both the public and private health sectors.

Rachel Stephen-Smith MLA - Arrangements brief

VIPs:	• Kylie Jonasson, Director-General, ACT Health Directorate • Anthony Dombkins, ACT Chief Nursing and Midwifery Officer, ACT Health Directorate • Adjunct Professor Anne Gardner, Queensland University of Technology • Juliane Samara, Nurse Practitioner, Clare Holland House and ACT Chapter Chair of the Australian College of Nurse Practitioners
PAST INVOLVEMENT:	Unknown
SENSITIVITIES:	• Nurse practitioners have been awaiting a Commonwealth response to the work of the Nurse Practitioner Reference Group from the Medicare Benefits Scheme Review Taskforce since late 2018. There has been no action taken from the 14 Nurse Practitioner Reference Group recommendations (see recommendations here: https://www.acnp.org.au/client_images/2186326.pdf). • It is largely felt by the ACT nurse practitioner community that nurse practitioners working in the ACT Health walk-in centres are highly under-utilised due to policy and legislative restrictions that limit scope of practice (for example, they are not allowed to prescribe PBS-subsidised medicines, make use of diagnostic imaging and pathology services, nor provide follow-up care, even for a minor illness or injury. • An election commitment made by ACT Labor in 2017 for an additional 39 public sector nurse practitioners' positions has not been actualised. • In 2020 ACT Labor made an election commitment for an additional five nurse practitioner positions across the existing ACT Health walk-in centres, plus one for each of the additional five centres being planned across Canberra.
ORDER OF CEREMONIES	Master of Ceremonies – Mrs Juliane Samara 5:30pm: Anthony Dombkins will greet the Minister in the hotel foyer. 6:00pm: Formal proceedings begin. MC will do an introduction, Welcome to Country, and introduce Minister Stephen-Smith. 6:05pm: Minister provides 5-10 minute speech. 6:15pm: MC introduces Prof. Anne Gardner. 6:20pm: Prof. Anne Gardner's presentation topic: *What We What have we Learned from the History of Nurse Practitioners in Australia; how these learnings should help us advance the Nurse Practitioner role quickly, efficiently and effectively.* 6:40pm: MC introduces Dr Chris Helms. 6:45pm: Dr Chris Helms' presentation topic: *The ACT Nurse Practitioner Professional Practice Project.* 7:00pm: Anthony Dombkins provides closing comments and takes questions. 7:10pm: Networking and photo opportunities.

Rachel Stephen-Smith MLA - Arrangements brief

	7.30pm: Event concludes.
MEDIA:	The Minister's Office advises that media is not required.
SOCIAL MEDIA ACCOUNTS	ACT Health Directorate Facebook page Canberra Health Services Facebook page Australian College of Nurse Practitioners Facebook, Twitter and Instagram pages
OUTSTANDING REGULATORY ISSUES	To confirm all regulatory compliance, please contact the relevant business area for the following issues. Is the event taking place at a: • Worksite? No. • New building? No. • Restaurant/Food Handling business? Yes.

Rachel Stephen-Smith MLA - Arrangements brief

SPEAKING NOTES FOR:

NURSE PRACTITIONER WEEK 2020: A CELEBRATION OF THE NURSE PRACTITIONER ROLE IN THE ACT

5:30PM –7:30PM, TUESDAY 8 DECEMBER 2020
MIDNIGHT BAR, MIDNIGHT HOTEL, 1 ELOURA STREET, BRADDON ACT

Acknowledgements

- **Traditional owners**: I acknowledge the traditional custodians of the land we are meeting on, the Ngunnawal people. I acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

- VIPs
  - Kylie Jonasson, Director-General, ACT Health Directorate;
  - Anthony Dombkins, Chief Nursing and Midwifery Officer, ACT Health Directorate;
  - Adjunct Professor Anne Gardner, Queensland University of Technology; and
  - Juliane Samara, Nurse Practitioner, Clare Holland House and ACT Chapter Chair of the Australian College of Nurse Practitioners.

- The World Health Organisation designated 2020 as the International Year of the Nurse and Midwife, and today we are celebrating 20 years of the nurse practitioner in the Australian healthcare system.

- It was in the year 2000 that Australia's first two nurse practitioners were endorsed to practice in emergency nursing, and rural and remote nursing. The first, Dr Jane O'Connell, still works as a nurse practitioner. The second was Sue Denison, who has since retired.

- Nurse practitioners joined the ACT health system shortly after, in 2003, and I was excited to learn that the ACT's very first nurse practitioner is here with us this evening: Elissa O'Keefe who specialises in women's health.

- I am in awe of nurse practitioners, who are some of the most senior clinical nurses in our health care system. Not only are you required to obtain advanced qualifications, including a master's degree, but you're also required to clock up extensive experience before even practising as a nurse practitioner. I was advise that you need to do a minimum of 5000 hours of advanced practice experience and at least 10 years' clinical experience.

- Hats off to you.

- I am so delighted that we now have more than 50 nurse practitioners in the ACT, registered with and endorsed by the Nursing and Midwifery Board of Australia.

- Nurse practitioners in the ACT are working in the public and private sectors in areas such as emergency medicine; palliative care; mental health; sexual health; women's health; aged care; and primary health care.

- That's a world-class contribution you're all making to the health and wellbeing of our city and our region. You should be very proud. I know I am very proud of you.

- One of the areas in which nurse practitioners are contributing greatly is through their leadership role in our network of nurse-led walk-in centres across the city. These centres are an important part of the suite of free health care services across the ACT.

- Through this, the general public is becoming more aware of the presence and role of nurse practitioners in our healthcare system. We in government are keen to make sure that we normalise the role of nurse practitioners in the ACT, in line with other

health professionals such as doctors, dentists and eligible midwives who are reviewed and credentialed for clinical privileges.

- There is also ongoing work being led by the Chief Nursing and Midwifery Office to reduce the barriers that both public and private sector nurse practitioners face, which unnecessarily restrict your practice. This will help us have an even more efficient and sustainable nurse practitioner workforce into the future.

- We're in the process of increasing the numbers of nurse practitioners in the ACT so that everyone can have better access to safe, effective, and affordable health care. For example, this year we committed to developing an additional five walk-in centres across Canberra, which includes employing more nurse-practitioners to lead these centres.

- Nurse practitioners are making a big difference to our health care system, working in a collaboration with other health professionals bringing health care to those in our community who need it most.

- I also want to specifically acknowledge the contributions of nurse practitioners during the COVID-19 pandemic. It has been amazing to see you help address this public health emergency. Thank you.

- It is hoped that the work we do here in the ACT can be replicated nationally, to enable nursing to reach its greatest potential.

- It is an absolute pleasure to be here today to celebrate 20 years of Australian nurse practitioners.

ENDS

ACT Government

MINISTERIAL BRIEF

ACT Health Directorate

UNCLASSIFIED

To:	Minister for Health	Tracking No.: MIN20/1877
From:	Meg Brighton, Deputy Director-General	
Subject:	Nurse Practitioner Project	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

- DG .../.../...

Recommendation

That you:

1. Note the information contained in this brief.

Noted / **Please Discuss**

Rachel Stephen-Smith MLA 5/4/21

Minister's Office Feedback

Background

1. A Nurse Practitioner (NP) is a registered nurse who has been endorsed by the Nursing and Midwifery Board of Australia (NMBA) to practise independently and collaboratively through an extended clinical nursing role. The NP role reflects that of an advanced practice nurse, but whose specific focus is on the provision of expert clinical care.

2. This care includes an extended scope of practice that allows for the following, as relevant to their individual scope of clinical practice:

   - autonomous prescribing of medicines;
   - requesting and interpreting diagnostic examinations; and
   - independent referral to medical, surgical, and allied health professionals.

3. The scope of clinical practice is determined by the employer and the individual NP.

4. In 1998, Australia legislated title protection for NPs, and in 2000, the first two roles were authorised to practice by the NSW Nursing and Midwifery Board. NPs hold a national endorsement and are regulated by the NMBA, which identifies those Registered Nurses who have achieved additional qualifications and specific expertise for independent practise, which meets requirements for national registration standards.

5. NPs undergo contextualised state and territory, as well as local authorisation processes, and adhere to the NMBA's *Safety and Quality Guidelines for Nurse Practitioners*.

6. Currently, there are over 2000 NPs endorsed to practice across all Australian states and territories, with 54 listing their principle place of practice as the Australian Capital Territory (ACT). NPs in the ACT work across both the public and private sectors, with the vast majority working in the public sector.

7. There have been several key reviews and reports specifically published about NPs in the ACT. For example, the ACT NP Project (2002); Aged Care NP Pilot Project (2005); ProACT Evaluation of the NP Framework (2007); Adrian Report (2017); and the Francis Report (2018).

8. Despite the outcomes and recommendations provided in these reviews, there continues to exist significant barriers to funding, role actualisation, and full implementation of NPs across health services in the ACT and nationally. These barriers are leading to workforce uncertainty and unhealthy workforce growth, with new NP endorsements and Medicare Benefits Schedule (MBS) item number use significantly slowing year on year.

9. In April 2020, in response to correspondence from the Australian College of Nurse Practitioners (ACNP), the ACT Office of the Chief Nursing and Midwifery provided advice to you on legislative and policy issues affecting NPs. This body of work was initiated in response to that advice.

10. The project will identify policy options for Government's consideration to enable NPs to safely and effectively work to their full scope of clinical practice.

Issues

11. Specific issues have been identified with ACT and Commonwealth legislation that preclude an NP from working to their full scope of clinical practice, which create workforce inefficiencies resulting in duplication of care and increased out of pocket costs for health consumers, uncertainty about the clinical scope of practice of NPs, and issues with sustainability of the role. These primary issues are outlined below:

    i. Public sector NPs in New South Wales (NSW) and the ACT are unable to write Pharmaceutical Benefits Scheme (PBS)-subsidised prescriptions for non-admitted patients seen in outpatient clinics. This is due to the **Public Hospital Pharmaceutical Reform Agreement**, of which NSW and the ACT are not participants under Section 100 of the **National Health Act 1953**. For example, if a prescription for care is required in the Walk-in Centres (WiC), and cannot be supplied by the limited WiC formulary, NPs must write a private prescription for conditions that would have otherwise been subsidised by the PBS if they were working in private practice. Patients seeing medical practitioners working in the public sector do not appear to have this same issue.

    ii. Both public sector and private sector NPs are experiencing significant issues in accessing subsidised medical imaging, pathology, and specialist referral for patients, which are key tools used in the NP role.

    In the public sector, these issues revolve around the inability to obtain a 'request and refer' provider number, which only medical practitioners are provided in the public sector. In the private sector patients who choose a NP as their primary healthcare provider have very limited access to existing MBS items.

    An attempt was made to remedy these issues in the private sector, through the work of the NP Reference Group (NPRG) of the MBS Review Taskforce. The work of the NPRG was finalised in 2018, with fourteen recommendations made to help address these barriers. Nothing has resulted from this work to date.

iii. NP working with marginalised women are unable to provide medical terminations of pregnancy for their patients, if under nine weeks' gestation. A bill was debated on 19 September 2018, which proposed to amend the Health Act 1993, to allow NPs and general practitioners to provide medical terminations of pregnancy. NP were eventually excluded from the bill.

iv. NP are unable to sign death certificates for patients who choose them as their primary healthcare or palliative care provider under the Births, Deaths and Marriages Registration Act 1997, Coroners Act 1997, and Cemeteries and Crematoria Act 2020. This creates significant issues for patients and families, as well as workforce inefficiencies, when a patient chooses a NP as their healthcare provider.

v. Nurse practitioners working in primary healthcare or specialist outpatient clinics are unable to authorise driver's license medicals under the Road Transport (Drivers Licensing) Regulation 2000.

vi. The Medical Treatment (Health Directions) Act 2006 requires that at least one doctor serve as a witness for a health direction. When a patient has instead elected a NP to be their palliative care or primary healthcare provider, this requires the NP to involve another party outside the usual care team.

vii. The Workers Compensation Act 1951 disallows NPs, who have diagnosed and treated a patient sustaining an injury arising from their workplace or associated duties, to write their medical certificate excusing them from work, or develop and manage their injury and recovery plan.

1. In total, there are 81 Acts, Regulations, and/or Instruments in the ACT that impact upon the practice of NPs.

Financial Implications

2. Funding for this NP project has been funded within existing resources.

Consultation

Internal

3. Consultation will occur with relevant stakeholders prior to further advice to you.

4. .

Cross Directorate

5. Not applicable.

External

6. Not applicable.

Work Health and Safety

7. No work health and safety issues have been identified for the purposes of this project.

Benefits/Sensitivities

8. The Australian Medical Association and Royal Australian College of General Practitioners have previously indicated they would not support changes of legislation regarding the scope of NP.

9. Changes to legislation that may arise from the work of this project will benefit patients who are marginalised, vulnerable, or choose a NP as their preferred healthcare provider. It may result in decreased duplication and providing of care, improve health system and workforce efficiencies, reduce out-of-pocket patient expenditure, and provide better clarity on the NP role.

Communications, media and engagement implications

10. A communication strategy will be required for any legislative or policy changes but is too early in the project to determine what this will look like at this stage.

11. A webpage has been developed and can be found at https://health.act.gov.au/nursepractitioners. It will result in a register of NPs working in the ACT, which will facilitate communication with employers and NPs alike. As suite of Frequent Asked Questions relating to various aspects of NP clinical practice is currently being developed.

Signatory Name:	Meg Brighton, Deputy Director-General,	Phone:	5124 6240
Action Officer:	Anthony Dombkins, Chief Nursing and Midwifery Officer	Phone:	5124 9628

ACT Government

OFFICIAL MINISTERIAL BRIEF

ACT Health Directorate

To:	Minister for Health	Tracking No.: MIN21/407
Cc:	Rebecca Cross, Director-General	
From:	Meg Brighton, Deputy Director-General	
Subject:	Nurse Practitioner Professional Practice Project – Outcome Evaluation and Workforce Survey	
Critical Date:	Not applicable	
Critical Reason:	Not applicable	

- DDG .../.../...

Recommendations

That you:

1. Agree for the Chief Nursing and Midwifery Officer to progress with the Nurse Practitioner Practice Project;

Agreed / Not Agreed / Please Discuss

2. Agree to publish Attachment A on the nurse practitioner section of the ACT Government website once feedback is incorporated and appropriate clearances have been obtained;

Agreed / Not Agreed / Please Discuss

3. Agree to publish Attachment B on the nurse practitioner section of the ACT Government website once feedback is incorporated and appropriate clearances have been obtained;

Agreed / Not Agreed / Please Discuss

4. Agree to publish Attachment C on the nurse practitioner section of the ACT Government website once feedback is incorporated and appropriate clearances have been obtained;

Agreed / Not Agreed / Please Discuss

5. Agree to publish Attachment D on the nurse practitioner section of the ACT Government website once feedback is incorporated and appropriate clearances have been obtained;

Agreed / Not Agreed / Please Discuss

6. Agree to publish Attachment E on the nurse practitioner section of the ACT Government website once feedback is incorporated and appropriate clearances have been obtained;

Agreed / Not Agreed / Please Discuss

7. Agree to publish Attachment F on the nurse practitioner section of the ACT Government website once feedback is incorporated and appropriate clearances have been obtained;

Agreed / Not Agreed / Please Discuss

8. Note the draft document at Attachment A, *Results from the ACT Nurse Practitioner Workforce and Employer Survey*, and provide feedback;

Noted / Please Discuss

9. Note the draft document at Attachment B, *Outcome Evaluation on Nurse Practitioner Policy and Legislation in the Australian Capital Territory*, and provide feedback;

Noted / Please Discuss

10. Note and provide feedback on the draft consultation paper at Attachment C;

Noted / Please Discuss

11. Note and provide feedback on the draft document *Nurse Practitioners in the ACT: Frequently Asked Questions (FAQ) for Employers* at Attachment D;

Noted / Please Discuss

12. Note and provide feedback on the draft document *Nurse Practitioners in the ACT: Frequently Asked Questions (FAQ) for Health Consumers* at Attachment E; and

Noted / Please Discuss

13. Note and provide feedback on the draft document *Nurse Practitioners in the ACT: Frequently Asked Questions (FAQ) for Nurse Practitioners* at Attachment F.

Noted / Please Discuss

Rachel Stephen-Smith MLA 8/11/21

Minister's Office Feedback

Re recs 2-4, please discuss with Ms Brangrove minor amendments + plain language in some places.
Thank you.

Background

1. The purpose of this brief is to inform you of the progress made to date on the Nurse Practitioner Practice Project (NP-PP).

2. A Nurse Practitioner (NP) is a Registered Nurse (RN) regulated by National law through an endorsement process established by the nursing regulatory authority, the Nursing and Midwifery Board of Australia (NMBA). The NMBA establishes registration, endorsement, education, and practice standards for Australian nurses and midwives. The NMBA also establishes safety and quality guidelines for the nursing and midwifery professions.

3. Currently, there are over 2000 NPs endorsed to practice across all Australian states and territories, with 54 listing their principal place of practice as the ACT.
NPs practise in over 50 different specialty areas and are found across both the public and private healthcare sectors in every Australian jurisdiction.

4. NPs practise independently and collaboratively through an extended clinical nursing role. The NP role reflects that of an RN working at an advanced level of practice, but whose specific focus is on the provision of expert clinical care. That care includes the practice authority to independently and collaboratively perform *core* and *supplemental activities*.

5. Commonly cited *core activities* that all NPs perform include:
    - comprehensive and advanced health assessments;
    - diagnosis and treatment of medical conditions;
    - autonomous prescribing of medicines;
    - requesting and interpreting diagnostic examinations such as blood tests and imaging exams; and
    - independent referral to medical and allied health practitioners.

6. *Supplemental activities* arise from NPs providing a complete episode of care, as a consequence of performing core activities of their employed roles to their full scope of practice. Such activities include completion of official documentation, such as insurance documentation, as well as sick and carers' certificates.

7. In April 2020, the Chief Nursing and Midwifery Officer (CNMO) provided advice to you on legislative and policy issues affecting NPs, in response to correspondence received from the Australian College of Nurse Practitioners (ACNP). The NP-PP was initiated by the CNMO in response to that advice.

8. The NP-PP aims to better understand the current ACT NP workforce, their requirements, and the legislative and policy barriers that preclude NPs from achieving full practice authority in the ACT. The project aims to develop recommendations for legislative and policy change that ensures a "right touch" regulatory approach to the NP workforce, which maximises workforce potential and ensures sustainable NP contributions to the ACT health system.

9. In the context of the NP-PP, "right touch regulation" enables proportionate, consistent, targeted, transparent, accountable and agile regulation of the health workforce. It uses the minimum regulatory force to facilitate efficient and effective healthcare delivery, whilst prioritising protection of the public.

10. The NP-PP first sought to better understand the existing ACT NP workforce. A NP workforce and employer survey was completed in January 2021; the results can be found at Attachment A.

11. The NP and employer survey identified that ACT NPs experience significant issues in performing core and supplemental activities required of their employed roles. This was especially so for NPs employed in the public sector, where NPs are unable to request diagnostic imaging or pathology, prescribe medicines, or initiate referrals to medical specialists to their full scope of practice, despite the presence of credentialing frameworks supported by legislation.

12. The survey suggests a lack of supporting funding mechanisms is the primary reason why barriers exist to NPs performing core activities required of their roles. The other reason relates to key health professions not understanding the regulation, authority or clinical requirements of the NP role. Draft recommendations to address this issue will be addressed in the NP-PP final project report.

13. Importantly, barriers to core and supplemental activities required by NPs employed in the ACT were experienced differently, depending on their individual competence and employed roles. This is one of the primary reasons why the NP-PP is concerning itself with legislative and policy mechanisms that relate to *practice authority* as opposed to *scope of practice*.

14. *Practice authority* is reflective of what a profession or role is legislatively authorised to do, whereas *scope of practice* is what the individual practitioner is authorised by legislation to perform, and competent to do. Therefore, NP scope of practice is myriad and determined by the individual NP and their employer.

15. The NP survey identified outcomes measures relevant to NP models of care are not being uniformly measured or reported in the public or private health sectors. This has led to a lack of clarity about the value-add of NP roles, and has not led to refinement of existing models.

16. Finally, the survey revealed there were important differences in organisational culture between public and private sector NPs, with the private sector being more favourable to NP practice. Public sector NPs require, but do not have the same organisational support as, medical practitioners. The combination of organisational culture and barriers to practice result in a public sector NP workforce which perceives their work to be unsupported and clinically inefficient.

17. The NP workforce and employer report was used to inform an outcome evaluation that discusses significant projects relating to NP practice, policy and legislation in the ACT since 2002. The draft outcome evaluation was completed in February 2021 and can be found at Attachment B.

18. The evaluation examined the aims, recommendations and outcomes of significant projects relating to legislation, policy and the broader professional practice of NPs in the ACT. It proposed an ideal logic model to inform the strategic development of the NP workforce, in order to achieve the NP role's intended short-, intermediate-, and long-term outcomes.

19. The evaluation determined that, despite a 21-year history in Australia, many of the intermediate and long-term outcomes envisioned for the NP role have not yet been realised.

20. A key finding from the evaluation is that a clear strategy informing the development of the NP role has never been articulated at the jurisdictional or National levels. This has resulted in piecemeal development of legislation and policy relating to NPs. In turn, disjointed legislation and policy arising from unclear strategy have created significant confusion about the intended purpose of the role, issues with workforce integration, and led to significant variability in models of care.

21. Both the survey and outcome evaluation reports have been used as informing documents for consultation on proposed changes to legislation and policy, which would allow for "right touch legislation" of the NP workforce in the ACT. A draft consultation document has been created and can be found at Attachment C.

Issues

22. The ACT NP workforce survey identified that NPs across both the public and private health sectors have ongoing and significant difficulties in performing core and supplemental activities of their roles due to legislative and policy barriers. For example, the report highlighted that NPs:

    a. Have ongoing issues in fulfilling *core activities* of their role to their full scope of practice; namely: prescribing medicines, requesting diagnostic tests and initiating requests for medical specialist and allied health review, particularly in the public health sector.

    b. Experience fewer barriers to clinical practice in the private sector than the public sector, particularly when operationalising core activities of their roles.

c. Are unable to perform *supplemental activities* required of their roles such as: authorising death certificates, driver's license medicals, and workers' compensation certificates due to ongoing legislative and policy barriers.

d. Have identified significant differences in organisational culture in the public sector versus private health sector.

23. Many of these barriers have significantly impacted the clinical efficiency and sustainability of the NP workforce. There is evidence from the survey and outcome evaluation that ongoing restrictions to NP clinical practice contributes to workforce uncertainty, duplication of care and increased out-of-pocket patient costs. In some instances, restrictions to NP clinical practice have resulted in poor outcomes for patients and families in the ACT community.

24. The outcome evaluation identified that many barriers to NP clinical practice have persisted since the introduction of the role to the ACT workforce in 2002. The evaluation describes several "missed opportunities" to address barriers to NP practice by projects that have been sponsored by Territory and Commonwealth Governments.

25. Many ACT projects have led to changes that have addressed some of the barriers to NP practice, but in a piecemeal fashion. For example, it is likely the 2005 ACT Aged Care NP Pilot Project led to NPs as eligible providers under the 2010 Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) reforms. However, piecemeal access to the MBS and PBS remains a key concern for NPs and health consumers to this day.

26. The survey and outcome evaluation have identified the recurring theme of not understanding the NP role's regulatory oversight, its authority, as well as core and supplemental activities required of the clinical role. The NP-PP developed a suite of Frequently Asked Questions (FAQ) for employers, NPs, and health consumers as a means of addressing this theme. Drafts of these FAQ documents can be found at Attachments D, E, and F.

27. Both the survey and outcome evaluation reports have led to a number of draft recommendations for the NP workforce in the ACT. Those recommendations have far-reaching financial, political, legislative, employer and professional implications. Those recommendations will be detailed to the ACT Government in a final project report.

28. The consultation paper proposes that language used in ACT legislation relating to healthcare and Australia's nationally regulated health practitioner workforce, inclusive of NPs, be systematically reviewed to align with contemporary approaches to right-touch regulation. It suggests that a review may address many of the barriers affecting core and supplemental activities for NPs, as well as other regulated health professions in the ACT. This may have implications for other jurisdictions and may also be influenced by provisions in Commonwealth legislation.

Future Consultation Requirements

29. It is anticipated that an extensive internal consultation process will need to occur with a discussion paper on proposed changes to legislation and policy prior to external consultation.

30. The action officer is currently developing a consultation document for this project, which will outline proposed changes to legislation and policy that negatively impact upon NP clinical practice in the ACT. The consultation document will be finalised as soon as your feedback is received and incorporated in the consultation paper at Attachment C.

31. Wide-ranging external consultation on proposed legislative and policy changes is planned, and would include health consumer groups, regulators, professional bodies, and employers.

Financial Implications

32. Due to the extent of workforce issues identified in the survey and outcome evaluation reports, the projects arising from the NP-PP were required to be continued beyond the anticipated project end date of April 2021.Consultation

Internal

33. Consultation has occurred with the ACT Government Health System Strategic Policy Committee. Members of the committee have provided feedback on the first draft of the consultation document at Attachment C, with recommended changes reflected in the current document.

Cross Directorate

34. Canberra Health Services and Calvary Public Hospital Bruce were involved in the design and distribution of the NP and employer workforce survey.

External

35. Not applicable.

Work Health and Safety

36. Not applicable.

Benefits/Sensitivities

37. There are indicators the national NP workforce has been plateauing since 2010, instead of growing in a healthy manner. The peer-reviewed and grey literature suggest the primary reasons for this are the multitude of barriers to NP clinical practice, both in the ACT and nationally. The aim of the NP-PP achieving "right-touch" regulation of the NP workforce in the ACT is sound and may assist with the growth and appropriate use of this highly trained workforce. Outcomes from the NP-PP may serve as an exemplar for other jurisdictions.

38. An additional benefit from the NP-PP may be growing the body of work relating to workforce strategy, which will provide clarity about the NP role for employers, health consumers, and other health professions.

39. Unions and professional bodies representing medical practitioners will likely not be supportive of the aims and objectives of the NP-PP, given previous evidence. A transparent, fair and comprehensive means of internal and external consultation will be required to ensure the success of the NP-PP.

Communications, media and engagement implications

40. Not applicable.

Signatory Name:	Meg Brighton, Deputy Director-General, Health Systems, Policy and Research	Phone:	02 5124 6240
Action Officer:	Anthony Dombkins, Chief Nursing and Midwifery Officer	Phone:	02 5124 9545

Attachments

Attachment	Title
Attachment A	Draft Report: *Results from the ACT Nurse Practitioner Workforce and Employer Survey*
Attachment B	Draft Report: *Outcome Evaluation on Nurse Practitioner Policy and Legislation in the Australian Capital Territory*
Attachment C	Draft Consultation Paper: *Proposed Legislative Changes to Authorise Core and Supplemental Activities Performed by Nurse Practitioners*
Attachment D	Draft FAQ: *Nurse Practitioners in the ACT: FAQ for Employers*
Attachment E	Draft FAQ: *Nurse Practitioners in the ACT: FAQ for Health Consumers*
Attachment F	Draft FAQ: *Nurse Practitioners in the ACT: FAQ for Nurse Practitioners*

Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey

Christopher J. Helms[1]

[1]Senior Project Adviser, ACT Health Directorate, Office of Professional Leadership and Education

Author Note

Table of Contents

Background

This paper presents the results of a workforce survey conducted with Nurse Practitioners (NP) and their employers in the Australian Capital Territory (ACT). It was completed as part of the ACT Nurse Practitioner Practice Project (NP-PP). The NP-PP was led by the ACT Office of the Chief Nursing Officer at the request of the ACT Minister for Health, Rachel Stephen-Smith, MLA.

Nurse Practitioners are Registered Nurses whose practice is regulated by the Nursing and Midwifery Board of Australia (NMBA) through a rigorous endorsement process (Nursing and Midwifery Board of Australia, 2020c). They practice independently and collaboratively in an expanded clinical role (Nursing and Midwifery Board of Australia, 2020a). That expanded role includes common core activities in which they receive extensive postgraduate education and training, including: advanced assessment and diagnostic capabilities, prescribing medicines, requesting and interpreting diagnostic examinations, and independently referring to medical and allied health practitioners (Australian Nursing and Midwifery Accreditation Council, 2015).

The nursing profession achieved legislated title protection for the NP role in 2000 (Foster, 2010). Australian NPs work in every jurisdiction, across both the public and private health sectors, in over 50 different areas of specialty practice (Helms et al., 2017a). Currently there are over 2000 NPs holding the NMBA endorsement, 55 of which declare their principal place of practice as being the ACT (Nursing and Midwifery Board of Australia, 2020b).

The NP-PP aims to better understand the current ACT NP workforce, their requirements, and the legislative and policy barriers that preclude them from achieving full practice authority in the ACT. Information gained from this survey will be used to inform a broader consultation strategy aiming to explore solutions to legislative and policy burdens affecting NP clinical practice in the ACT.

This survey represents a scoping exercise and not empirical research. Any recommendations should be interpreted with caution and may require further validation through external consultation. The intent is to provide insight into the current state of the ACT NP workforce and whether the aims and intended outcomes of the NP-PP are appropriate.

Methods

An online survey was created to better understand the following:

- Current NP workforce characteristics and practice profiles;
- How employers use their perceptions of the NP workforce; and
- Barriers and facilitators to NP practice in the ACT.

Inclusion criteria for this survey included the following:

- Working within the ACT or surrounds (e.g., Queanbeyan); and
- Nursing and Midwifery Board of Australia (NMBA)-endorsed NP; or
- Student enrolled in an NP academic program; or

- NP employer/manager.

Potential participants were screened for eligibility at the beginning of the survey through adaptive survey questioning. Those respondents who provided responses indicating they did not meet the above inclusion criteria were screened and excluded from further participation by re-directing them to the end of the online survey. Those respondents were thanked for their interest, provided with contact details if they had any questions or concerns, and excluded from further data analysis.

The Survey Monkey platform was used as an online survey tool. Questions were designed to obtain a mixture of dichotomous, (e.g., yes/no, public/private, etc.) categorical (e.g., NP, employer, student, etc.), and scale-level data (e.g., years practising as an NP). Questions were primarily presented as a mix of multiple choice and Likert scale responses. Additional open-ended questions with open text boxes were provided to elicit further detail from survey participants in relevant areas where the supplied options did not fit their individual circumstances. At the end of the survey participants were invited to provide their contact details if they would like to provide further detail or feedback on the survey to ensure their views were adequately represented.

Questions were adapted from validated Australian nursing workforce surveys (Health Workforce Australia, 2012), NP toolkits derived from Australian research (Gardner et al., 2009), and organisational climate surveys specifically focussed on understanding the NP experience when working within a larger organisation (Poghosyan et al., 2013; Scanlon et al., 2018).

The survey was presented as a single online tool but used "adaptive questioning" to provide three different survey experiences for participants (Helms et al., 2017b). This meant the total survey length was 70 questions, but its true length was much shorter and was dependent upon participant responses. If a participant responded to a single question in one manner, whereas another respondent provided a response to the same question in an alternative manner, divergent subsequent questions would be presented depending on a respondent's initial response. Thus, the survey length ranged anywhere from two questions (at its shortest) to 40 questions (at its longest) for participants. Most of the questions were mandatory and required a response in order to proceed to subsequent pages of the survey. A copy of the survey can be found at Appendix A.

The survey was piloted amongst a group of health service administrators, policy officers, NPs, and the ACT Chief Nursing and Midwifery Officer (CNMO) project management team. Relevant feedback included a request to shorten the survey and consolidate where possible, use contextual Australian terminology where relevant, improve flow of presented questions, and provide greater clarity of intent with certain questions through simplification of sentence structure.

Recruitment for the survey occurred between 20 November and 23 December 2020. A combination of convenience and snowball sampling was used. An email providing information about the survey was sent to a list compiled of public and private sector NP employers in the ACT, as well as through a database of NPs practising within the ACT

maintained by the Australian College of Nurse Practitioners (ACNP). The ACNP report their membership represents 50% of the Australian NP workforce (Boase, 2020). According to the Nursing and Midwifery Board of Australia (NMBA) there are currently 2,097 NPs practicing in Australia, with 55 declaring the ACT as their principal place of practice (Nursing and Midwifery Board of Australia, 2020b). Email recipients were asked to forward a copy of the email to those who they thought might be eligible or interested in taking the survey. A copy of the invitation email can be found at Appendix B. Finally, a reminder email was sent to the list of employers and NPs three days prior to closing of the survey.

Quantitative data were analysed using simple descriptive statistics. Qualitative data arising from open text boxes underwent summative content analysis (Hsieh & Shannon, 2005). Comparisons of proportionality were made between NPs and employers/managers, as well as public vs private sector NPs due to the expected low sample size. Participants who indicated they wanted to be interviewed were allocated a one-hour timeslot via Webex using a semi-structured interview format. See Appendix C for a list of interview questions. Responses to these questions were recorded and again underwent summative content analysis, to provide richer insight into the presented quantitative data.

Results

A total of 32 persons responded to the survey invitation email, with two persons excluded from the survey, as they reported they did not work in the ACT or surrounds or were not an NP or NP employer/manager. There were a total of 30 eligible participants with an 81% overall survey completion rate; two of the 26 eligible NPs did not complete the survey. This means that approximately 44% (n=24/55) of the eligible population of ACT NPs participated in this survey (Nursing and Midwifery Board of Australia, 2020b). Participants took an average of 10 minutes to complete the survey.

Of those eligible to take the survey, 87% (n=26/30) stated they were NMBA-endorsed NPs and 13% (n=4/30) stated they were an NP employer or manager. No students enrolled in an NP program participated in the survey. Of eligible participants, 50% (n=13/26) of NPs and 25% (n=1/4) of NP managers/employers indicated they would like to be interviewed after completion of the survey.

Nurse Practitioner Responses

Of the NPs completing the survey, 96% (n=23/24) described their current role as a clinician, with one describing their role as a teacher or educator. When asked about their work setting, 75% (n=18/24) described settings in the primary healthcare sector, including Walk-in Centres (WiCs), general practices, community health services, independent private practices, and aged care. The remaining 20% (n=5/24) worked in inpatient and/or outpatient hospital settings or in the tertiary education setting (4%; n=1/24). Most (71%; n=17/24) of the ACT NP workforce work in the public sector.

When asked about the metaspecialtie(s) (Gardner et al., 2019) that were most representative of their clinical practice, 63% (n=15/24) stated primary healthcare, followed by ageing and palliative care (38%; n=9/24), chronic and complex care (38%; n=9/24), mental health care (25%; n=6/24), emergency and acute care (17%; n=4/24), and child and family health care (8%; n=2/24). Participants had the option of providing the area of practice in which they

worked through an open text box. Specific areas listed by NP respondents can be found in *Table 1* below:

Table 1: Specific Areas of Practice of Nurse Practitioner Respondents

Specialty Area	Number
Sexual and Reproductive Health	4
Oncology/Haematology Care	2
Palliative Care	4
Wound Management	1
Alcohol and Other Drugs	1
Gerontic Health	7
Primary Healthcare	5
Cardiac Care	1
NOTE: Some participants listed more than one area of practice, and specialty areas have been grouped into the formal Australian nursing specialties and *practice strands* (King et al., 2010).	

Forty-two percent (n=10/24) of NP respondents had been endorsed for 0-5 years, followed by an additional 42% (n=10/24) having been endorsed for 6-11 years. Four of the NP respondents (17%) had been endorsed for 12+ years. Of those participants who had been endorsed for more than 5 years, 29% (n=4/14) stated they intended to remain within the nursing workforce for an addition 1-5 more years before retirement. All (n=5) NPs working in the private sector indicated they intend to work in nursing for 6 or more years, and 76% (n=13/18) of public sector NPs indicated they would remain in the nursing workforce for the same period of time.

Few NP respondents (n=3) stated they were currently working in a clinical role not requiring them to be an NP. Responses about the reason this might be were: actively working on a project to expand their current clinical role (n=1), providing contractual consultancy services (n=1), or had family obligations (n=1) precluding them from obtaining an NP role.

Most NP respondents stating they were currently employed in a role requiring them to be an NP were working full-time (77%; n=17/22) and 95% of those (n=21/22) stated "clinician" best described their role. One participant stated their role was best described as a "teacher or educator."

Nurse Practitioner respondents were asked about their organisational climate during the survey. A comparison of responses between public and private sector NPs is provided in *Table 2* below as weighted averages. Weighted averages were calculated from participant's ratings on a 5-point Likert scale (Strongly Disagree [1] – Strongly Agree [5]) to better compare between the private and public sectors:

Table 2: Nurse Practitioners' Perceptions of their Organisational Climate According to Health Sector

Statement	Public Sector (n=17)	Private Sector (n=5)
	Weighted Ave. (Max 5)	Weighted Ave. (Max 5)
The organisation makes efforts to improve working conditions for NPs.	2.53	4.60
Doctors and NPs have similar support for care management.	2.59	4.40
In my organisation, there is constant communication between NPs and the executive team.	2.65	4.40
The organisation shares information and resources equally with NPs and doctors	2.71	4.20
I regularly get feedback about my performance from my organisation.	2.76	4.60
In my organisation, the NP role is well understood.	3.00	4.40
I feel valued by my organisation.	3.00	5.00
My organisation inappropriately restricts my abilities to practice within my scope of practice.	3.00	1.20
Doctors seek NPs' advice and input when providing patient care.	3.18	3.60
My manager is well-informed of the skills and competencies of NPs.	3.29	4.40
My manager takes NP concerns seriously.	3.59	4.80
Doctors in my practice setting trust and support my patient care decisions.	3.65	4.40
The organisation is open to NP ideas to improve patient care.	3.71	4.80
My organisation creates an environment where I can practice independently and collaboratively.	3.76	4.80
I feel valued by my medical colleagues.	3.88	3.80
NPs are an integral part of the organisation.	3.88	5.00
In my organisation, I freely apply all my knowledge and skills to provide patient care.	4.00	4.80
In my practice setting, I have colleagues who I can ask for help.	4.24	4.80
I do not have to discuss every patient care detail with a doctor.	4.71	4.80

NOTE: Analysis beyond simple descriptive statistics is outside the scope of this project. For example, a t-test to compare these samples for statistical significance was not performed. In these results, values were highlighted if there was more than a 1-point difference in the weighted average. The colour green reflects a more favourable result, and red reflects a less favourable result.

In addition, NP respondents were asked about the tools and resources required to do their work safely, effectively and efficiently. They ranked the importance of the following tools and resources according to a 4-point Likert scale (Not Important [1] – Very Important [4]). Again, weighted averages between public and private sector NPs are provided for comparison purposes in *Table 3* below:

Table 3: Importance of Tools and Resources to Nurse Practitioner Practice

How important are the following tools and resources?	Public Sector (n=17)	Private Sector (n=5)
	Weighted Ave. (Max 4)	Weighted Ave. (Max 4)
Access to online patient support databases.	3.88	4.00
Access to prescribing support software.	3.82	4.00
Prescribe subsidised medicines.	3.65	4.00
Access to peer review of patient care.	3.65	4.00
Access to mentorship.	3.59	3.75
Request subsidised diagnostic imaging.	3.53	4.00
Request subsidised allied health review.	3.47	4.00
Clinical documentation and support software.	3.47	4.00
Request subsidised diagnostic pathology.	3.41	4.00
Access to portable technology (e.g. mobile phones, laptops)	3.41	3.25
Clerical support.	3.29	3.50
Request subsidised medical specialist review.	3.20	4.00
Access to the Australian Immunisation Handbook.	3.18	4.00
Access to the My Health Record.	2.82	3.75
Access to the Australian Immunisation Register.	2.82	3.75
Ability to sign advance care directives.	2.59	3.25
Ability to sign worker's compensation certificates.	2.25	1.75
Hospital admission privileges.	2.06	1.00
Hospital visitation privileges.	2.00	1.75
Ability to sign death certificates.	2.00	2.25
Ability to sign driver's license medicals.	2.00	2.50
Hospital discharge privileges.	1.82	1.00

NOTE: Analysis beyond simple descriptive statistics is outside the scope of this project. For example, a t-test to compare these samples for statistical significance was not performed. In these results, values were highlighted if there was more than a 1-point difference in the weighted average. The colour green reflects a more favourable result, and red reflects a less favourable result.

To delve further into the importance of the above tools, NP participants were asked if they were able to perform core activities of the NP role to the fullest extent of their individual scopes of practice. The following tools have traditionally defined the expanded role of the NP, namely:

- Prescribing medicines;
- Requesting diagnostic pathology;
- Requesting diagnostic imaging;
- Referral to medical specialists; and
- Referral to allied health specialists.

Participants rated their ability to perform the stated tasks to their full scope of practice on a 4-point Likert scale (Not at All [1] – Yes, Absolutely [4]). Again, NP participants are compared between public and private sectors using weighted averages, as per the results outlined in *Table 4* below:

Table 4: Ability of Nurse Practitioners to Perform Core Scope of Practice Activities in their Role

Are you able to perform the following to your full scope of practice?	Public Sector (n=17)	Private Sector (n=5)
	Weighted Ave. (Max 4)	Weighted Ave. (Max 4)
Prescribe medicines	3.00	3.75
Refer to allied health specialists	2.41	2.50
Request diagnostic pathology	2.24	3.00
Refer to medical specialists	2.12	3.25
Request diagnostic imaging	1.82	1.75
NOTE: Analysis beyond simple descriptive statistics is outside the scope of this project. For example, a t-test to compare these samples for statistical significance was not performed. In these results, values were highlighted if there was more than a 1-point difference in the weighted average. The colour green reflects a more favourable result, and red reflects a less favourable result.		

Clinical efficiency is defined as a clinical outcome divided by time (Usherwood, 1987). Participants were advised this includes the time to assess, diagnose and treat a health condition, but also includes time taken for administrative processes that result in care outcomes. Clinical efficiency would include documenting care, filling out forms, requesting screening and diagnostic testing, prescribing, and referring to other health professionals.

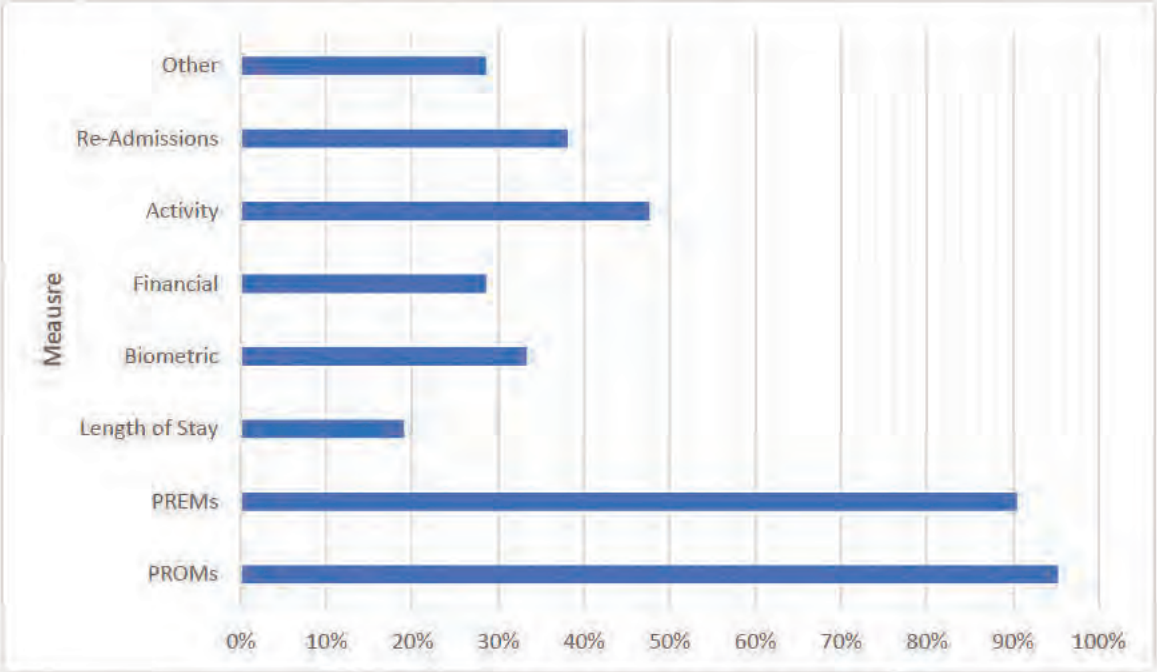
Nurse practitioner participants were asked whether they had all the tools and resources they require for clinically efficient care. Participants rated this statement on a 4-point Likert scale (Not at All [1] – Yes, Absolutely [4]). Again, NP participants are compared between public and private sectors using weighted averages, as per the results outlined in *Table 5* below:

Table 5: Clinical Efficiency Perceived by Nurse Practitioners

	Public Sector (n=17)	Private Sector (n=5)
	Weighted Ave. (Max 4)	Weighted Ave. (Max 4)
Do you have all the tools and resources you require for clinically efficient care?	2.82	3.50

Finally, NP participants were asked about the outcomes of NP-directed care and the different ways to measure and identify success, or areas for improvement in care provision. Participants were asked what measures they believed were helpful in identifying the "value-add" of NP clinical practice. Most respondents identified patient-reported outcomes measures [PROMs] (95%; n=20/24) and patient-reported experience measures [PREMs] (91%; n=19/24) as being helpful. Participant responses are shown in *Figure 1* below:

Figure 1: Outcomes Measures that Nurse Practitioners Believe are Helpful



Participants provided additional insight and measures into this question in the 'other' field. Responses included:

- Appropriateness of consultation referrals initiated by NPs
- Consultations performed upon request from other health professionals
- Intervention delay (e.g. dialysis start) and associated cost savings
- Family and staff feedback on performance
- Decreased emergency department presentations

Nurse practitioner participants were asked if the measures they've identified were monitored and reported by their health services. Participants responded to this statement on a 5-point Likert scale (Never [1] – Always [5]). Again, NP participants were compared between public and private sectors using weighted averages, as per the results outlined in *Table 6* below:

Table 6: Monitoring of Outcomes Measures in Healthcare

	Public Sector (n=17)	**Private Sector** (n=5)
	Weighted Ave. (Max 4)	**Weighted Ave.** (Max 4)
Are the measures you've identified monitored and reported by your health service?	2.65	1.67

At the end of the survey, NP participants were asked if they had any additional comments. These are summarised below:

- Some questions relating to organisational climate were not applicable to the work setting, as the respondent worked in a nursing-only health service.

- Responses to scope of practice questions were relevant to the position and health service in which the respondent was currently working, and not reflective of their full scope of practice.
- Some roles did not require access to diagnostic examinations or referral to specialists.
- Ability to achieve full scope of practice differs between inpatient and outpatient settings.
- Survey was not reflective of the advanced role of the NP outside the clinical environment, such as serving on national committees and strategic groups.
- Health services are monitoring admissions and numbers of visits, but this does not accurately represent the care NPs provide.

Nurse Practitioner Interviews

At the end of each survey NP participants were asked if they would like to be interviewed to further discuss their responses. Thirteen NP respondents indicated they wanted to be interviewed upon completion of the survey, with eight proceeding to the interview stage. Written notes were recorded during each interview, with results summarised in this section.

Overall, participants felt the survey was representative of their views. A minority of interviewees advised they felt the survey was orientated towards the public sector, or larger health services involving multidisciplinary care teams. Those views were primarily held by NPs working as sole providers or in nurse-led clinics. One NP interviewee was unsure how to respond to certain questions as they held two clinical NP roles within the public sector.

Participants requesting to be interviewed were then advised on the aims of the NP-PP in achieving "right touch" legislation and policy to enable NP practice. They were asked about any barriers they experience in their practice. In addition, they were specifically requested to comment on the unintended consequences of facilitating the ability of NPs in the ACT to authorise/perform:

- Death certificates and advance care directives;
- Worker's compensation and Comcare certificates;
- Driver's license medicals; and
- Medical terminations of pregnancy.

When providing their responses, respondents were also asked what frameworks, education or support would be required for a NP working within their scope of practice to authorise or perform the above activities.

All respondents were supportive of an NP working within their scope of practice to be authorised to perform the above activities in the ACT. None could identify any unintended consequences of legislative or policy reform that would allow these activities, although some participants voiced concern that worker's compensation could be complicated and require long-term follow up. They also voiced the observation that worker's compensation cases are viewed through a different clinical and medico-legal lens than your average clinical case, and that this requires consideration when providing education and training to fulfill the required practice activity. They also suggested the type of patient and presenting condition arising

from a work-related incident would need to be considered in the context of the model of care or NP practice context in order to properly oversee the care of the patient.

Participants shared several stories of their long-term patients who had died in the community, who lay in state for days at home while waiting for a medical practitioner to sign their death certificate, even though the NP was the patient's primary carer and most familiar with their medical history. These issues were not only distressing for families, but for the practitioners themselves.

With relation to advance care directives, some NPs did not feel that many medical practitioners had the time or expertise to lead such discussions with their patient. Despite the NP initiating and leading advance care directive discussions, a medical practitioner was still required for the witnessing of a non-written health directive, even though in many instances that medical practitioner had no relationship with the patient, did not take part in or lead the discussion, and was unfamiliar with the patient's medical history.

Much of the participant concern cited around death certificates, driver's license medicals, and advance care directives was the fact the long-term relationship shared between the NP and the patient were not accounted for in the legislation. Several NPs in both the public and private sectors were either the primary or only provider of care for the patient. The involvement of practitioners outside the patient's preferred care team for the purposes of satisfying legislative requirements for the above activities was seen as a breach of trust and privacy for the patient or their families, as well as inefficient care. All participants in the private sector voiced frustration around a lack of, or inconsistent direct communication back to them from public sector referrals made to medical specialists. When questioned why this may be, they stated the public sector administration did not acknowledge NPs as primary providers or carers: only general practitioners were recognised.

Some participants felt current restrictions on the above activities disadvantaged patients and were anticompetitive. One NP in the private sector shared the experience of having to refer a non-Medicare card holding patient for medical termination of pregnancy that ended up costing the patient thousands of dollars. A medical termination of pregnancy is a safe, non-surgical approach to ending a pregnancy that involves the prescription of MS2Step (a medicine containing the abortifacient RU486) before 9 weeks' gestation. Instead, the NP could have safely performed the medical termination and not only reduced her inconvenience and shame, but could have achieved significant cost and time savings for the patient.

All participants felt that continuing professional development activities would be required to ensure any legislative, safety and/or policy issues relating to the above activities were correctly followed, and that the public were protected against harm. They felt this could be done through existing mechanisms that regulate the nursing profession, as well as guidance documents and education activities organised by the jurisdiction and/or professional bodies.

Common barriers to practice seen as relating to core NP activities were reflected in the participant interviews. An inability of NPs to initiate comprehensive diagnostic pathology, imaging, or specialist review that was reflective of the NP's individual scope of practice was a common theme amongst public sector NPs. It was also reflective of their inability to obtain a

provider number or supportive policies and funding mechanisms to enable such activities. For example, in the public sector NP access to diagnostic imaging is very limited, and in all cases require authorisation by a medical practitioner or standing policy. In contrast, the inability to initiate imaging was a less common theme amongst private sector NPs, who could autonomously request any X-ray or ultrasound subsidised by the MBS. However, they experienced difficulties in requesting a comprehensive array of X-rays and ultrasounds, as well as advanced imaging studies (e.g. CT Scans, MRIs, DEXA Scans). This was because such exams were not subsidised by the MBS when requested by an NP. Although within their scope of practice and authorised to do so, requesting such exams would result in higher out-of-pocket costs for the patient. In this instance many private sector NPs would either provide financial consent resulting in higher patient out-of-pocket costs or such exams would be referred to a medical practitioner so the exam could be subsidised. Both public and private sector NPs cited the inability to initiate subsidised allied health referrals as a significant barrier to holistic and comprehensive patient care.

Many NPs in both the public and private sectors voiced concern around a lack of access to patient subsidies when prescribing medicines within their scope of practice through the Pharmaceutical Benefits Scheme (PBS) or Repatriation Pharmaceutical Benefits Scheme (RPBS). Many medicines within the NP's scope of practice were not subsidised by the PBS/RPBS when prescribed, even though those medicines were subsidised when prescribed by a medical practitioner. In the management of many long-term health conditions, the PBS/RPBS required the NP to have many medicines prescribed initially by a medical practitioner before it would be subsidised with NP prescription. Several NPs stated in such circumstances they would then either prescribe the medicine privately or refer the patient to a medical practitioner for the initial prescription. In both instances out-of-pocket costs were increased for the health consumer when seeking care from an NP, and placed them at a disadvantage due to unaccumulated safety-net costs or through duplicated care pathways. In some instances, it was not clear if the patient chose to *not* fill the prescription to have their condition properly managed because of the costs or pathways involved for obtaining medicine after being seen by an NP.

Some NPs working in the public sector voiced concern around the inflexible barriers surrounding a health service's model of care, which didn't properly account for the true NP scope of practice, and lacked support in NPs interpreting the "grey areas" in that model. Those NPs were concerned that if they took the initiative and worked within those grey areas they would be "stepping on toes" politically or with medical colleagues. When NPs chose to take the initiative and provide care within their individual scope of practice in the interests of the patient, efficiency and cost minimisation, they felt heavily scrutinised by their nursing colleagues and management. Others stated that, even when working within an established model of care, significant NP clinical practice decisions that prioritised patient and family choice would be undermined by medical practitioners in the community who felt the patient was "theirs", as opposed to a mutual collaboration required for the best interests of the patient. Those NPs acknowledged this wasn't typically an issue for those medical practitioners who were familiar with NPs and trusted the NP's decision-making. Others voiced confidence, not knowledge or ability, as being a barrier to these issues that would be best served by mentorship, activities and policies that promoted collaborative practice.

Several NPs in the public sector voiced concern that as they grew within their roles they had greater professional requirements for teaching, leadership, serving on committees and researching, which were not accounted for or supported in the same manner as their medical colleagues. Their expertise was felt to be discounted by management and they constantly had to "seek excessive permission and jump through additional hoops" to contribute professionally, even though such activities formed part of their endorsement standards. Participants suggested this could be remedied by supporting co-joint academic appointments and ensuring time and recurring education funding is quarantined for these purposes. Interestingly, private sector NPs did not appear to voice these same concerns as they either owned their own businesses or were supported by their organisations to undertake such activities in their own time. Public sector NPs voiced frustration over being supported through their academic NP programmes only to find there was no NP position for them once achieving endorsement. They suggested a strategic plan on how the NP workforce is implemented and integrated into the larger workforce, as well as the use of transitional NP positions, may be helpful in addressing this issue.

Finally, respondents were asked about the use of credentialing across both the public and private sectors in the ACT. Most private sector NPs were strongly against this notion because they could not see any additional benefit to themselves or their patients. Some private sector participants suggested that if they were required to undergo credentialing without a clear benefit to themselves or their patients, they would invoice the ACT Government for associated costs for time lost in preparing for the process. Others in the private sector were more circumspect and viewed the credentialing process as a means of gaining visitation rights for their patients in ACT public hospitals, akin to general practitioners. Many in the private sector described difficulties in legitimising their roles with public sector specialists, and viewed the credentialing process as one means of legitimisation and facilitation of patient care with those specialists.

Many public sector NPs voiced frustration with evolving credentialing processes and a lack of transparency in decision-making. Most felt it was a "tick and flick" exercise that did not translate to any real benefit to the NP, their individual scope of practice, or their patients. However, all public sector NPs acknowledged the need for credentialing as a requirement for hospital accreditation. Some public sector NPs working in community settings felt admission and discharge privileges would be helpful for their patients, although these were in the minority. They stated current credentialing process did not support admission or discharge privileges, as with medical practitioners.

Manager, Supervisor and Employer Responses

Of the eligible persons to take the survey who were managers, supervisors or NP employers, 100% (n=4) worked in the public sector and all completed the survey. When asked about their work setting, two respondents reported they worked in a public hospital setting, and two in a community setting.

With respects to the development of the NP role in their health services, all stated they had involvement (somewhat or very involved) in the introduction of the NP role. Half were either not involved (minimal or no involvement) or involved (somewhat or very involved) with the daily clinical work of NPs. Three out of four survey participants were nurses themselves.

Participants were asked to rate their agreement on a 5-point Likert scale (Strongly Disagree [1] – Strongly Agree [5]) with the statements presented in *Table 7* below:

Table 7: Nurse Practitioner Employer, Manager or Supervisor Perceptions

	Public Sector (n=4)
	Weighted Ave. (Max 5)
NP prescribing is necessary.	4.67
NPs offer holistic care.	4.67
NPs offer safe care.	4.67
The NP has a positive impact on patient care.	4.67
The NP role results in improved health service for patients.	4.67
NP practice is safe.	4.67
The NP uses an organised and systematic approach to history taking.	4.67
I fully understand the NP role.	4.33
Overall, the introduction of NP services has been a success.	4.33
NP service meets the needs of patients.	4.33
I trust the NP to diagnose correctly.	4.33
The NP service is easy to access.	4.33
The introduction of the NP has reduced delays in patient care.	4.33
NPs are adequately educated and prepared for their role.	4.00
The introduction of the NP has increased patient satisfaction levels.	4.00
The NP service enhances patient compliance with treatment.	4.00
NPs can refer patients directly to medical specialists.	3.67
The NP has access to a second opinion from medical colleagues when necessary.	3.67
The introduction of the NP has reduced duplication of service.	3.67
The introduction of the NP has reduced the number of health care professionals a patient must interact with.	3.67
The introduction of the NP has had a positive impact on inter-professional relationships.	3.67
The introduction of the NP has freed up doctors' time.	3.33
NPs are supported by doctors in their role.	3.33
I fear NPs will make an incorrect diagnosis.	2.00
NP prescribing increases the risk of incorrect treatment.	1.33
I am worried that NPs do not have the necessary knowledge to prescribe.	1.33

When asked if they had any other comments they would like to make about the NP role, one participant responded. They indicated the lack of provider numbers in public services meant that NPs couldn't request diagnostic exams or make referrals without sign off by a doctor, and requested review to better support the NP role.

One person requested to be interviewed at the conclusion of the survey. Overall, they felt the survey was representative of their views. The participant was then advised on the aims of the NP-PP in achieving "right touch" legislation and policy to enable NP practice. They were

specifically requested to comment on the unintended consequences of facilitating the ability of NPs in the ACT to authorise/perform:

- Death certificates and advance care directives;
- Worker's compensation and Comcare certificates;
- Driver's license medicals; and
- Medical terminations of pregnancy.

The participant did not comment on most aspects of the project, but did feel the issues surrounding worker's compensation was of particular importance. They did not support a model of NP care that acutely manages a work-related injury, but requires the provision of a worker's compensation certificate for that injury by the person's primary healthcare provider. They felt the initial certificate should be given by the NP treating the injury, and if follow up required, could then be followed by the person's primary healthcare provider.

Discussion

This survey achieved its aim in gaining insight into the NP workforce in the ACT. It provided valuable perspectives into the barriers and potential solutions to the NP role across both the public and private sectors, and provided validation to proceed with the proposed intent of the NP-PP. To the author's knowledge, this is the first Australian survey to provide direct comparisons of practice and policy considerations between the NP workforce in the public and private health sectors.

In both the public and private health sectors, NPs have ongoing issues in fulfilling core activities of their role to their full scope of practice; namely: prescribing medicines, requesting diagnostic tests and initiating requests for medical specialist and allied health review. The survey data indicate NPs rate these activities as highly important to their roles. This is consistent with many of the barriers encountered by the Australian NP workforce that have been thoroughly described in the peer-reviewed and grey literature (Currie et al., 2019; Helms et al., 2015; Nurse Practitioner Reference Group, 2018; Smith et al., 2019).

However, what has not been immediately clear in the literature are the differences in barriers experienced by NPs in completing core activities of their roles when comparing the public vs. private health sectors. Data from this survey suggest that NPs in the private sector experience fewer barriers when initiating referrals to medical specialists. In addition, there appear to be marginally fewer barriers in requesting diagnostic pathology when compared to the public sector. This finding was somewhat surprising given NPs have the same level of access to subsidised diagnostic pathology in the private sector as general practitioners (Australian Government, 2018). It is likely this finding is reflective of limited private sector NP understanding of MBS funding, individual scope of practice, or their employed role. Interview data from public sector NPs indicate they can only request limited diagnostic pathology through protocols with limited funding mechanisms, or under the provider number of an identified medical practitioner. Dependence upon the medical profession to undertake core activities of the NP role is at odds with the nursing regulator's statement that NPs are *independent* practitioners, not solely autonomous and collaborative health professionals (Nursing and Midwifery Board of Australia, 2020a).

Survey data seem to indicate that both public and private sector NPs experience the same barriers in requesting diagnostic imaging tests. However, interviews suggest this limitation is somewhat less in the private sector. In the public sector NPs are not able to freely request diagnostic imaging because they lack provider numbers or allocated funding for such requests. They may only initiate diagnostic imaging through restrictive protocols with limited funding mechanisms, or under the provider number of a medical practitioner. In the private sector NPs appear to have less restriction on basic imaging tests, and are only really limited in their requests for comprehensive imaging tests because of concerns over cost-shifting the price of those tests to health consumers. A review of the ACT legislation reveals the *Radiation Protection Act 2006* does not limit the scope of diagnostic imaging an NP may request.

Although there are many common tools and resources that NPs consider important (including their core activities) for practice, there are notable differences between health sectors. Access to the My Health Record, Australian Immunisation Register, and the ability to authorise advance care directives appear to hold more importance in the private sector than public sector NPs. Although survey data seem to indicate that authorising advance care plans and death certificates are less important tools, interview data with individuals within both the public and private sectors indicate the ability to authorise advance care plans, as well as death certificates, is very important. Likewise, the ability to admit, discharge or hold visitation privileges within the public hospital system did not appear to be an important tool for many NPs in either health sector currently, although interview data with individuals suggested future practice models could evolve to use such tools if enabled for the workforce. These findings are likely reflective of a heterogenous sample of NPs working within the public and private sectors and the diverse models of care in which they work.

There appears to be important differences in organisational culture between private and public sector NPs in the ACT, with the private sector perceived as being more favourable to practice by NP participants. The private sector appears to make greater efforts in improving working conditions, resulting in NPs feeling valued by their organisations. Likewise, it appears NPs and doctors are given similar support for care management, and information and resources appear to be shared more equitably in the private sector. There also appears to be improved communication amongst the executive team and NP clinicians. None of these findings are entirely surprising given the private sector is generally represented by smaller organisations, typically have more amenable working hours, and have smaller work units resulting in direct reporting lines. An Australian study recently conducted with a small sample of NPs practising across Australia examining organisational culture appears to have similar findings to those in the private sector, although direct comparisons are difficult as they did not provide this level of analysis (Scanlon et al., 2018). Interestingly, survey data from NP employers, managers and supervisors in the public sector suggest a discrepancy between the high value they place on the NP workforce, and how public sector NPs themselves perceive their value. This finding likely reflects issues surrounding communication and merit further exploration.

Finally, survey and interview data suggest that significant practice barriers, and potentially organisational culture, are important factors contributing to NP workforce clinical efficiency in the ACT. There appears to be fewer practice barriers and improved organisational culture for NPs practising in the private sector given the survey data and interview results, which

likely aids clinical efficiency. Clinical efficiency ultimately translates to outcomes, of which NP participants indicate that data measuring PROMs and PREMs would be most helpful in measuring their value. Despite the utility of such outcomes measures in value-based healthcare (Porter & Lee, 2013), they appear to be highly underutilised in both health sectors, but especially so in the private sector. This is likely reflective of a lack of funding support to undertake such activities in the private sector. Enterprise bargaining agreements and funding mechanisms in the public sector generally better support such activities on an individual or service-level basis.

Ultimately, the survey and interview results appear to be reflective of the differences between NP *scope of practice* issues and the role's *practice authority*. Scope of practice entails what activities the *individual* practitioner is authorised by legislation to perform, and is *competent* to do. Practice authority is a broader construct, and reflective of what a *profession or role* is legislatively authorised to do (American Association of Nurse Practitioners, 2021; Hudspeth & Klein, 2019; Nurse Practitioner Schools, 2020). As individual NPs and their employers are already accountable for NPs competently practising within their individual scope of practice, it is perhaps important to consider the role of 'right touch' legislation in allowing the independent role of the NP in achieving full practice authority.

Strengths and Limitations

Overall, this online survey had strong representation from the current NP workforce in the ACT. The survey had an excellent NP response and completion rate, compared to many online surveys (Helms et al., 2017b). This survey provides a unique perspective in the differences seen in NP practice in the ACT across both the public and private health sectors.

Unfortunately, NP workforce employers, managers and supervisors were under-represented in this study. It is uncertain why this might be, but this should be accounted for in future consultations to ensure public and employer contributions are seen in the outcomes of the NP-PP. Given the sample of NPs were recruited from databases in both the public sector and through the ACNP, it is likely private sector NPs were under-represented in this sample.

The lens used by the author in this report lends both strengths and limitations. It has been influenced by the author's extensive experience working across both the public and private health sectors as a NP.

Conclusion

The survey and interview data from this project provided valuable insights into the current NP workforce in the ACT, across both the public and private sectors. It provided clarity the NP-PP is about achieving full practice authority for the existing NP workforce, and not necessarily individual scope of practice. It identified there are ongoing significant barriers to the core activities of the NP role that impact upon clinical efficiency. It appears these barriers can be effectively addressed through strategy development, as well as legislation and policy reform.

References

American Association of Nurse Practitioners. (2021). *Issues at a Glance: Full Practice Authority* https://www.aanp.org/advocacy/advocacy-resource/policy-briefs/issues-full-practice-brief

Australian Government. (2018). *Eligible nurse practitioners questions and answers*. Department of Health. Retrieved 28 March from http://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-ganda-nursepract

Australian Nursing and Midwifery Accreditation Council. (2015). *Nurse Practitioner Accreditation Standards*. ANMAC.

Boase, L. (2020, 22/12/2020). [Membership of the Australian College of Nurse Practitioners].

Currie, J., Chiarella, M., & Buckley, T. (2019, Feb). Privately practising nurse practitioners' provision of care subsidised through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme in Australia: results from a national survey. *Aust Health Rev, 43*(1), 55-61. https://doi.org/10.1071/AH17130

Foster, J. (2010). *A History of the Early Development of the Nurse Practitioner Role in New South Wales, Australia* [Dissertation, University of Technology Sydney]. Sydney, NSW. https://opus.lib.uts.edu.au/handle/10453/20243

Gardner, A., Gardner, G., Coyer, F., Gosby, H., & Helms, C. (2019). *The nurse practitioner clinical learning and teaching framework: A toolkit for students and their supervisors*. CLLEVER2 Research Consortium. https://doi.org/10.6084/m9.figshare.9733682.v2

Gardner, G., Gardner, A., Middleton, S., & Della, P. (2009). *The nurse practitioner research toolkit*. https://eprints.qut.edu.au/72604/1/72604.pdf

Health Workforce Australia. (2012). *Nursing Workforce Survey Form*. Australian Commonwealth Department of Health.

Helms, C., Crookes, J., & Bailey, D. (2015, Apr). Financial viability, benefits and challenges of employing a nurse practitioner in general practice. *Aust Health Rev, 39*(2), 205-210. https://doi.org/10.1071/AH13231

Helms, C., Gardner, A., & McInnes, E. (2017a, Feb). Consensus on an Australian Nurse practitioner specialty framework using Delphi methodology: results from the CLLEVER 2 study. *J Adv Nurs, 73*(2), 433-447. https://doi.org/10.1111/jan.13109

Helms, C., Gardner, A., & McInnes, E. (2017b, Dec). The use of advanced web-based survey design in Delphi research. *J Adv Nurs, 73*(12), 3168-3177. https://doi.org/10.1111/jan.13381

Hsieh, H., & Shannon, S. (2005). Three Approaches to Qualitative Content Analysis. *Qual Health Res, 15*. https://doi.org/10.1177/1049732305276687

Hudspeth, R. S., & Klein, T. A. (2019, Aug). Understanding nurse practitioner scope of practice: Regulatory, practice, and employment perspectives now and for the future. *J Am Assoc Nurse Pract, 31*(8), 468-473. https://doi.org/10.1097/JXX.0000000000000268

King, S. J., Ogle, K. R., & Bethune, E. (2010). Shaping an Australian nursing and midwifery specialty framework for workforce regulation: criteria development. *The International Journal of Health Planning and Management, 25*(4), 330-349. https://doi.org/10.1002/hpm.997

Nurse Practitioner Reference Group. (2018). *Report from the Nurse Practitioner Reference Group to the Medicare Benefits Schedule Review Taskforce*. Australian Government. https://www1.health.gov.au/internet/main/publishing.nsf/content/BEB6C6D36DE56438CA258397000F4898/$File/NPRG%20Final%20Report%20-%20v2.pdf

Nurse Practitioner Schools. (2020). *Scope of Practice vs Practice Authority*. Nurse Practitioner Schools. Retrieved 13 January from https://www.nursepractitionerschools.com/faq/scope-of-practice-vs-practice-authority/

Nursing and Midwifery Board of Australia. (2020a). Nurse Practitioner Standards for Practice [Type]. Australian Health Practitioner Regulation Agency. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia. (2020b). *Registrant data*. https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

Nursing and Midwifery Board of Australia. (2020c). *Safety and quality guidelines for nurse practitioners*. Australian Health Practitioner Regulation Agency. Retrieved 19 February from http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations/Safety-and-quality-guidelines-for-nurse-practitioners.aspx

Poghosyan, L., Nannini, A., Finkelstein, S. R., Mason, E., & Shaffer, J. A. (2013, Sep-Oct). Development and psychometric testing of the Nurse Practitioner Primary Care Organizational Climate Questionnaire. *Nurs Res, 62*(5), 325-334. https://doi.org/10.1097/NNR.0b013e3182a131d2

Porter, M., & Lee, T. (2013). The strategy that will fix health care. *Harvard Business Review, 91*(10), 50-70. https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

Scanlon, A., Murphy, M., Tori, K., & Poghosyan, L. (2018). A National Study of Australian Nurse Practitioners' Organizational Practice Environment. *The Journal for Nurse Practitioners, 14*(5), 414-418.e413. https://doi.org/10.1016/j.nurpra.2018.01.003

Smith, T., McNeil, K., Mitchell, R., Boyle, B., & Ries, N. (2019, April 02). A study of macro-, meso- and micro-barriers and enablers affecting extended scopes of practice: the case of rural nurse practitioners in Australia. *BMC Nurs, 18*(1), 14. https://doi.org/10.1186/s12912-019-0337-z

Usherwood, T. P. (1987, Jun). Clinical efficiency in general practice. *Fam Pract, 4*(2), 149-151. https://doi.org/10.1093/fampra/4.2.149

Appendix A: Nurse Practitioner and Workforce Survey

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Introduction

Welcome to the ACT Nurse Practitioner (NP) Workforce and Employer Survey! This survey informs part of the Nurse Practitioner Professional Scope of Practice Project (NPPSPP), which is sponsored by the ACT Office of the Chief Nursing and Midwifery Officer.

The NPPSPP aims to provide expert advice that shapes "right touch" legislation and strategic policy, which enables NPs working in the Australian Capital Territory (ACT) to safely and effectively work to their full scope of clinical practice. It is anticipated that outcomes from this project will affect NP workforce strategy across both the public and private health sectors.

This survey aims to better understand the following:

- **Current NP workforce characteristics and practice profiles;**
- **How employers use and their perceptions of the NP workforce; and**
- **Barriers and facilitators to NP practice.**

Data from this survey will be used to inform a broader stakeholder consultation strategy.

Important Information:

- **This survey will close on 23 December 2020 @ 5PM;**
- **This survey is open to endorsed NPs, student NPs and their employers/managers who work within the ACT;**
- **Your responses are confidential and data will be aggregated to ensure anonymity;**
- **If you have any questions or concerns regarding this survey please contact:**
  - **Chris Helms, Senior Project Adviser**
  - **ACT Health Directorate**
  - **Office of Professional Leadership and Education**
  - **E: christopher.helms@act.gov.au**
  - **T: 02 5124 9545**

This survey will take approximately 10-15 minutes of your time. Please find a comfortable and quiet time to complete at your convenience.

By clicking the "Next" button below you consent to participating in this survey:

1

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Eligibility Criteria

* 1. Do you **work** in the Australian Capital Territory or surrounds (e.g. Queanbeyan)?

- Yes
- No

* 2. What **perspective** best describes your views in this survey?

- NMBA-Endorsed Nurse Practitioner (NP)
- NP Employer/Manager
- Student Nurse Practitioner
- Other

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Student Nurse Practitioners

You have stated that your views represent those of a student nurse practitioner.

* 3. Are you currently enrolled in a Master of Nurse Practitioner academic program?

- Yes
- No

* 4. What best describes your current employment status?

- Employed, Full-Time
- Employed, Part-Time
- Casual Worker
- Contractor
- Other (please specify)

* 5. What best describes the health sector in which you work?

- Public
- Private (including non-profit organisations)

* 6. What best describes your current role?

- Clinician
- Administrator
- Teacher or educator
- Researcher

* 7. What is your principal work setting of your main job?

- General practitioner (GP) practice
- Independent private practice
- Hospital (excluding outpatients)
- Outpatient service (co-located with hospital)
- Community health service (excluding Walk-in Centres)
- Walk-in Centre
- Residential health care facility
- Other (please specify)
- Aboriginal health service
- Hospice
- Tertiary education facility
- School
- Correctional service
- Defence force

8. What is your *specific* specialty area in which you are seeking endorsement?

* 9. How many more years do you intend to remain in the nursing workforce?

* 10. Do you currently work with an endorsed NP?

- Yes
- No

* 11. Do you currently have an NP mentor or supervisor that is helping you develop into the NP role?

- Yes
- No

* 12. What year do you expect to seek endorsement as an NP?

* 13. In my organisation, the NP role is well understood.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree

* 14. My manager is well informed of the skills and competencies of NPs.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree

* 15. I feel valued by my organisation.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 16. I regularly get feedback about my performance from my organisation.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 17. Doctors in my practice setting trust my patient care decisions.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 18. In my organisation, I freely apply all my knowledge and skills to provide patient care.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 19. My organisation inappropriately restricts my abilities to practice within my scope of practice.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 20. My organisation creates an environment where I can practice autonomously.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

21. Please enter your details below if you would like to be interviewed about your survey responses:

Name	
Email Address	
Phone Number	

22. Do you have any further comments?

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Nurse Practitioner Demographic Data - 1

You have stated that your views represent those of an NP endorsed by the Nursing and Midwifery Board of Australia.

* 23. What best describes your current employment status?

- Employed, Full-Time
- Employed, Part-Time
- Casual Worker
- Retired
- Contractor
- Unemployed

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Nurse Practitioners Workforce

* 24. Are you currently working in a role requiring you to be a nurse practitioner?

- Yes
- No

* 25. What best describes your current role?

- Clinician
- Administrator
- Teacher or educator
- Researcher

* 26. What is your principal work setting of your main job?

- General practitioner (GP) practice
- Independent private practice
- Hospital (excluding outpatients)
- Outpatient service (co-located with hospital)
- Community health service (excluding Walk-in Centres)
- Walk-in Centre
- Residential health care facility
- Other (please specify)
- Aboriginal health service
- Hospice
- Tertiary education facility
- School
- Correctional service
- Defence force

* 27. What best describes the health sector in which you work?

- Public
- Private (including non-profit organisations)

* 28. Which metaspecialty(ies) is/are most representative of your clinical practice?

You may select one or more metaspecialty areas.

- [ ] Primary Healthcare
- [ ] Mental Healthcare
- [ ] Emergency and Acute Care
- [ ] Child and Family Health Care
- [ ] Ageing and Palliative Care
- [ ] Chronic and Complex Care

29. If relevant, what specific specialty area do you work in?

For example: cardiology, wound care, emergency fast-track, etc.

* 30. How many years have you been endorsed as an NP in Australia?

* 31. How many more years do you intend to remain in the nursing workforce?

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Nurse Practitioners Not Working in Clinical Practice

* 32. You have indicated that you are not currently working in clinical role or a position requiring you to be a nurse practitioner. Why?

Please choose the most relevant reason.

- Family obligations.
- Retired (or nearing).
- Insufficient remuneration for role.
- Lack confidence to practice.
- Lack employer support for role.
- Current scope of practice does not align with available NP jobs.
- Current position doesn't require clinical practice.
- Personal health-related reason.
- Personal preference.
- Greater opportunity for advancement.
- Other (please specify)

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Organisational Climate

In this next section, we would like you to describe your current organisational climate.

* 33. In my organisation, the NP role is well understood.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 34. My manager is well informed of the skills and competencies of NPs.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 35. I feel valued by my organisation.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 36. I regularly get feedback about my performance from my organisation.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 37. The organisation is open to NP ideas to improve patient care.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 38. My manager takes NP concerns seriously.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 39. The organisation shares information and resources equally with NPs and doctors.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 40. The organisation makes efforts to improve working conditions for NPs.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 41. In my organisation, there is constant communication between NPs and the executive team.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 42. I feel valued by my medical colleagues.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 43. Doctors seek NPs' advice and input when providing patient care.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 44. Doctors in my practice setting trust and support my patient care decisions.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 45. In my practice setting, I have colleagues who I can ask for help.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 46. NPs are an integral part of the organisation.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 47. I do not have to discuss every patient care detail with a doctor.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 48. In my organization, I freely apply all my knowledge and skills to provide patient care.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 49. My organisation inappropriately restricts my abilities to practice within my scope of practice.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 50. Doctors and NPs have similar support for care management (e.g. help with patient follow-up, referrals, labs, etc.).

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

* 51. My organisation creates an environment where I can practice independently and collaboratively.

Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree
○	○	○	○	○

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Safe, Effective, and Efficient Care

In this section, you will be asked about significant enablers and barriers to NP clinical practice.

* 52. There are tools and resources that NPs need in order to do their clinical work *safely, effectively and efficiently.*

Rank the importance of the following tools and resources to your **current and future** NP role:

	Not Important	Somewhat Important	Important	Very Important
Prescribe subsidised medicines	○	○	○	○
Request subsidised medical specialist review.	○	○	○	○
Request subsidised diagnostic pathology	○	○	○	○
Request subsidised allied health review.	○	○	○	○
Request subsidised diagnostic imaging.	○	○	○	○
Clinical documentation and support software	○	○	○	○
Access to the My Health Record	○	○	○	○
Access to the Australian Immunisation Register.	○	○	○	○
Clerical support	○	○	○	○
Hospital admission privileges.	○	○	○	○
Hospital discharge privileges	○	○	○	○
Hospital visitation privileges.	○	○	○	○
Ability to sign death certificates	○	○	○	○

	Not Important	Somewhat Important	Important	Very Important
Ability to sign worker's compensation/worksafe certificates.				
Ability to sign advance care directives				
Ability to sign driver's license medicals				
Access to prescribing support software (e.g. eTG Complete, Micromedex)				
Access to the Australian Immunisation Handbook.				
Access to Australian Medicines Handbook or similar (e.g. MIMS).				
Access to online databases (e.g. UpToDate Online, NICE Guidelines, CINAHL, etc.).				
Access to peer review of patient care				
Access to mentorship.				
Access to portable technology (e.g. mobile phones, laptops, diagnostic equipment).				

* 53. Clinical efficiency is simply defined as *clinical outcome* divided by *time*. For example, the time taken to assess, diagnose and treat an un-displaced minor fracture, hypothyroidism, or dementia.

Importantly, clinical efficiency also encompasses administrative processes that result in care outcomes, such as documenting care, filling out forms, requesting screening and diagnostic testing, prescribing, and referring to other health professionals.

As indicated in the previous question, there are certain tools NPs require for clinically-efficient care.

Do you have all the tools and resources you require for clinically-efficient care?

Not At All	Somewhat	Mostly	Yes, Absolutely
○	○	○	○

If desired, please expand upon your response:

* 54. Are you able to prescribe medicines to your full scope of practice?

Not At All	Somewhat	Mostly	Yes, Absolutely
○	○	○	○

* 55. Are you able to request diagnostic pathology (e.g. blood tests, histology, etc.) to your full scope of practice?

Not At All	Somewhat	Mostly	Yes, Absolutely
○	○	○	○

* 56. Are you able to freely refer to medical specialists within your full scope of practice?

Not At All	Somewhat	Mostly	Yes, Absolutely
○	○	○	○

* 57. Are you able to freely refer to allied health specialists within your full scope of practice?

Not At All	Somewhat	Mostly	Yes, Absolutely
○	○	○	○

* 58. Are you able to request diagnostic imaging (e.g. X-rays, CT-Scans, Ultrasounds) to your full scope of practice?

Not At All	Somewhat	Mostly	Yes, Absolutely
○	○	○	○

59. When thinking about outcomes of NP-directed care, we might think of many different types of measures to identify success or areas for improvement.

What are specific measures of success that you believe are helpful in identifying the "value add" of NP clinical practice?

- [ ] Patient-reported **outcomes** measures (PROMs)
- [ ] Patient-reported **experience** measures (PREMs)
- [ ] Length of Stay
- [ ] Biometric Measures (e.g. HbA1c, Blood Pressure, Weight, etc.)
- [ ] Financial Measures (e.g. income generated)
- [ ] Activity Measures (e.g. number of clients seen, procedures performed, etc.)
- [ ] Hospital re-admissions
- [ ] Other (please specify)

60. Are the measures you've identified monitored and reported by your health service?

Never	Rarely	Sometimes	Usually	Always
○	○	○	○	○

61. Do you have any further comments?

62. Please enter your details below if you would like to interviewed about your survey responses:

Name	
Email Address	
Phone Number	

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Employer Demographic Data

You have stated your views in this survey are reflective of an employer or manager of nurse practitioners.

* 63. What best describes the health sector in which you work?

- Public
- Private (including non-profit organisations)

* 64. What is your principal work setting of your main job?

- General practitioner (GP) practice
- Independent private practice
- Hospital (excluding outpatients)
- Outpatient service (co-located with hospital)
- Community health service (excluding Walk-in Centres)
- Walk-in Centre
- Residential health care facility
- Other (please specify)
- Aboriginal health service
- Hospice
- Tertiary education facility
- School
- Correctional service
- Defence force

* 65. Please choose the best descriptor for your role:

- Executive
- Manager
- Director
- Other (please specify)

* 66. Please indicate your level of involvement in:

	No Involvement	Minimal Involvement	Somewhat Involved	Very Involved
The introduction of the NP role.	○	○	○	○
The daily clinical work of the NP	○	○	○	○

* 67. Please indicate your profession:

- ○ Aboriginal and/or Torres Strait Health Practitioner
- ○ Chinese Medicine Practitioner
- ○ Chiropractor
- ○ Dental Practitioner
- ○ Medical Practitioner
- ○ Medical Radiation Practitioner
- ○ Nurse
- ○ Midwife
- ○ Occupational Therapist
- ○ Optometrist
- ○ Paramedic
- ○ Pharmacist
- ○ Physiotherapist
- ○ Podiatrist
- ○ Psychologist
- ○ Other (please specify)

ACT Government
Health

ACT Nurse Practitioner Workforce and Employer Survey

Perceptions of Nurse Practitioner Service

These questions are designed to elicit your views on the NP role. In responding to the items please draw upon your current experience of working with a nurse practitioner.

* 68. Please read and rate each statement:

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
I fully understand the NP role.	○	○	○	○	○
Overall the introduction of NP services has been a success.	○	○	○	○	○
NP service meets the needs of the patients.	○	○	○	○	○
NP prescribing increases the risk of incorrect treatment	○	○	○	○	○
NP prescribing is necessary.	○	○	○	○	○
NPs offer holistic care	○	○	○	○	○
NPs offer safe care	○	○	○	○	○
I trust the NP to diagnose correctly.	○	○	○	○	○
I am worried that NPs do not have the necessary knowledge to prescribe	○	○	○	○	○
The NP service is easy to access	○	○	○	○	○
The NP has a positive impact on patient care.	○	○	○	○	○
NPs are adequately educated and prepared for their role	○	○	○	○	○
NPs can refer patients directly to medical specialists.	○	○	○	○	○

	Strongly Disagree	Disagree	No Opinion	Agree	Strongly Agree
The NP has access to a second opinion from medical colleagues when necessary.	○	○	○	○	○
The NP role results in improved health service for patients.	○	○	○	○	○
I fear NPs will make an incorrect diagnosis.	○	○	○	○	○
The introduction of the NP has reduced delays in patient care.	○	○	○	○	○
The introduction of the NP has reduced duplication of service.	○	○	○	○	○
The introduction of the NP has reduced the number of health care professionals a patient must interact with.	○	○	○	○	○
The introduction of the NP has increased patient satisfaction levels.	○	○	○	○	○
The introduction of the NP has freed up doctors' time.	○	○	○	○	○
The introduction of the NP has had a positive impact on inter-professional relationships.	○	○	○	○	○
The NP service enhances patient compliance with treatment.	○	○	○	○	○
NP practice is safe.	○	○	○	○	○
The NP uses an organised and systematic approach to history taking.	○	○	○	○	○
NPs are supported by doctors in their role.	○	○	○	○	○

69. Do you have any other comments about the NP role?

70. Please enter your details below if you would like to interviewed about your survey responses or NPs generally:

Name	
Email Address	
Phone Number	

Appendix B: Survey Invitation Email

OFFICIAL

Dear Stakeholder –

The ACT Office of the Chief Nurse and Midwifery Officer invites you to take part in an important **nurse practitioner workforce and employer** survey. This survey will provide key information for targeted stakeholder consultation strategies planned in the ACT during January 2021.

The online survey will take approximately 10-15 minutes of your time, and is intended for:

- Endorsed Nurse Practitioners;
- Student Nurse Practitioners; and
- Nurse Practitioner Employers

Feel free to forward this email and survey link to those you think may want to take this survey or that you think may have missed out on this email.

To access the survey, please click HERE.
Alternatively, you can copy and paste this hyperlink into your web-browser:
https://www.surveymonkey.com/r/ACT_NPSurvey

Surveys will close on **23 December 2020 at 5PM**. Please fill yours out today!

If you have any questions or concerns regarding this survey or project, please feel free to contact:
Chris Helms, Senior Project Adviser
ACT Health Directorate
Office of Professional Leadership and Education
E: Christopher.Helms@act.gov.au
T: 02 5124 9545

Kind Regards,
Chris Helms
On Behalf of the ACT Chief Nursing and Midwifery Officer, Anthony Dombkins

Chris Helms, Senior Project Adviser

Ph: 02 5124 6262 | Email: christopher.helms@act.gov.au
Nursing and Midwifery Office | ACT Health Directorate
Level 3, 2-6 Bowes Street Phillip ACT 2606
health.act.gov.au
Working Days: Wednesdays - Fridays

Appendix C: Interview Questions

1. Thank you for taking the time to meet and discuss your survey. Please tell me about your survey experience.
    a. Why did you choose to be interviewed today? Did you find the survey representative of your views?
2. This project aims to look at the barriers to nurse practitioner (NP) full practice authority (scope of practice). It aims to provide recommendations for "right touch" legislation and policy that enables NP practice.
    a. Please tell me about any barriers you experience and how you see these could be resolved.
    b. What are the potential unintended consequences of allowing nurse practitioners working within their scope of practice to authorise the following:
        i. Death Certificates;
        ii. Advance Care Directives;
        iii. Worker's Compensation Certificates;
        iv. ComCare Certificates; and
        v. Driver's License Medicals
    c. What frameworks, education and/or support would be required to demonstrate to ensure nurse practitioners could perform the above activities safely and effectively?
    d. Should a credentialing framework be used for nurse practitioners across both the public and private sectors? Why or why not?
    e. What are the advantages and unintended consequences of creating transitional NP positions in the public sector?
    f. What frameworks, education and/or support would be required for a nurse practitioner working within their scope of practice to perform a medical termination of pregnancy?
    g. Do you have any further comments or concerns?

Outcome Evaluation on Nurse Practitioner Policy and Legislation in the Australian Capital Territory

Christopher J. Helms[1]

[1]Senior Project Adviser, ACT Health Directorate, Office of Professional Leadership and Education

Author Note

Contents

Introduction

Outcome evaluations are commonly performed to assess progress against the short, medium, and long-term objectives of a program or service (Centers for Disease Control and Prevention, 2011; Ebener et al., 2017). This outcome evaluation specifically examines the aims and recommendations of projects relating to legislation, policy and the broader professional practice of nurse practitioners (NP) working in the Australian Capital Territory (ACT). This evaluation will then contextualise those projects using a logic model (Centers for Disease Control and Prevention, 2021), to better help the reader understand what the intended short, medium, and long-term outcomes of those projects were. It will examine available evidence to determine whether recommendations from those projects were achieved. This evaluation will then conclude with recommendations for achieving any outstanding outcomes from the logic model, and provide guidance for future work relating to NPs in the ACT.

This outcome evaluation was conducted as part of the NP Practice Project (NP-PP). The NP-PP was sponsored by the ACT Office of the Chief Nursing and Midwifery Officer (CNMO) at the request of the ACT Minister for Health, Rachel Stephen-Smith, MLA. Information gained from this evaluation and other projects developed through the NP-PP will be used to inform a broader consultation strategy that aims to reduce legislative and policy burdens affecting NP clinical practice in the ACT.

Nurse Practitioners

Nurse practitioners are registered nurses holding an endorsement with the regulatory authority to practice independently and collaboratively in an expanded clinical role (Nursing and Midwifery Board of Australia, 2020a). That expanded role includes common core activities in which they receive extensive postgraduate education and training, including: advanced assessment and diagnostic capabilities, prescribing medicines, requesting and interpreting diagnostic examinations, and independently referring to medical and allied health practitioners (Australian Nursing and Midwifery Accreditation Council, 2015).

The nursing profession achieved title protection for the NP role in 2000, and their practice is regulated by the Nursing and Midwifery Board of Australia [NMBA] (Foster, 2010; Nursing and Midwifery Board of Australia, 2016). In 2010 NPs were admitted as eligible providers under the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS), which provides patients with subsidies to help offset the costs of NP-directed care in the private primary healthcare sector (Australian Government, 2018). Australian NPs work in every jurisdiction, across both the public and private health sectors, in over 50 different areas of specialty practice (Helms et al., 2017). Currently there are over 2000 NPs holding the NMBA endorsement, 55 of which declare their principal place of practice as being the ACT (Nursing and Midwifery Board of Australia, 2020b).

There have been many evaluations of NP-directed health services in Australia (Masso & Thompson, 2014). Most evaluations conducted during the early history of the Australian NP role were sponsored by the individual jurisdictions, who piloted demonstration projects to establish the safety and ability of nurses to undertake the advanced clinical role of the NP (ACT Government, 2002, 2005; Anderson et al., 2009; Gardner, Carryer, et al., 2004; Marlow, 1996; NSW Government, 1993; Parker et al., 2000; Pearson et al., 2003; SA Government, 1999; Victorian Government, 1999, 2004). Much of the Australian NP literature subsequent to those years describe models of care within discrete specialty areas, or barriers to implementation into wider health services (Haines & Critchley, 2009; Helms et al., 2015; Scanlon et al., 2015).

There is a plethora of research demonstrating equivalent or superior outcomes from NP-directed care when compared to medical practitioners (College of Registered Nurses of Nova Scotia, 2016). For example, patient satisfaction (Budzi et al., 2010; Gagan & Maybee, 2011; Jennings et al., 2009; Wand et al., 2012) is a highlight in the literature, as is reduced hospital re-admissions (David et al., 2015), lower costs of hospital-based care (Wall et al., 2014) and lower morbidity in persons diagnosed with long-term health conditions (Solomon et al., 2015). Some have critiqued the Australian NP literature because of the paucity of outcomes research extending beyond safety or ability of nursing to undertake the NP role (Masso & Thompson, 2017). These authors likely desire more research demonstrating value-based healthcare outcomes aligning with Patient-Reported Outcomes Measures (PROMs) or Patient-Reported Experience Measures (PREMs) (NSW Health, 2021; Porter & Lee, 2013), although the paucity of such literature extends well beyond the nursing profession. Outcomes relating to NP-directed care in Australia appears to have begun with empirical research in the ACT (ACT Health, 2007) and has revealed significant findings. For example, peer-reviewed research conducted in the ACT examining an NP-led palliative care intervention in aged care facilities demonstrated improved PREMs, clinically-significant reductions in length of hospital stay and considerable health system savings as compared to usual care (Chapman et al., 2016; Forbat et al., 2020; Johnston et al., 2016).

This outcome evaluation is unique in that it relates to policy and legislation, and does not relate to clinical measures or PROMs/PREMs arising from NP-directed care. The basis for this evaluation is the belief that if policy and legislation are insufficiently enabled to allow NPs to fully actualise their roles, existing and future clinical outcomes measures will under-represent the value-add of NP roles within the ACT and nationally. In effect, one may argue that existing outcomes measures would only represent operationalisation of a role within a health system that had effectively "tied the NP's hand behind their back".

Aims and Objectives of the ACT Nurse Practitioner Projects

In sum, there have been a total of six significant projects relating to legislation, policy and the broader professional practice of NPs in the ACT. The general aims and objectives of these projects are summarised below. One additional project evaluated the ACT nurse-led Walk-in Centres (WiC), but has been excluded from further examination as it did not provide formal recommendations that could be used in an outcome evaluation focussed on legislation and policy, nor did it specifically focus on NPs but a model of care using the broader nursing workforce. Specific aims and progress made towards project objectives, along with contextualised commentary for each project, can be found in Appendix A.

The ACT Nurse Practitioner Project [ACT-NPP] (ACT Government, 2002) was the first key milestone in establishing the safety, feasibility and efficacy of nurses working within a NP-like role in the ACT. It examined nursing roles in diverse specialty areas of practice, including: sexual health, wound care, mental health and military-based primary healthcare.

In 2005 the ACT Aged Care NP Pilot Project (ACT-ACNPPP) published its final report (ACT Government, 2005). This report was commissioned after the Australian Government identified key funding, safety and quality concerns plaguing the aged care sector (Andrews, 2003; Australian Government, 2003). The project informing this report was funded by both the Commonwealth and ACT Governments, and aimed to specifically demonstrate the feasibility of the NP role in aged care.

In 2007 an evaluation of the ACT NP governance framework was commissioned by the ACT Office of the CNMO. That governance framework was used as a means of legislatively authorising the clinical

practice of NPs in the ACT. The evaluation provided the opportunity to refresh the governance of NP roles across both the public and private health sectors.

During that same year, a final report was published from a project that had been co-funded by the Territory and Commonwealth health departments. The *Implementing the Nurse Practitioner Role in Aged Care* (INPRAC) project continued the work of the ACT-ACNPP. Data obtained from this project informed a larger national study conducted by the Joanna Briggs Institute, which examined NP-like models of care in the aged care sector across differing jurisdictions (Joanna Briggs Institute, 2007). The INPRAC study primarily aimed to contribute to the formulation of a national minimum data set for NP models in the aged care sector, describe the "value-add" of such models by reporting on health benefits and quality measures, identify barriers to actualising those models, and develop recommendations for process and service improvement.

Several years later, the ACT Office of the CNMO commissioned a review of the governance framework that authorised NPs to practise in the ACT (Adrian, 2017). This review was requested because of national reforms in 2010 that shifted responsibility for regulation of nursing and the NP role from the Territory to the National Nursing and Midwifery Board of Australia.

Finally, in 2018 the ACT Office of the CNMO commissioned a review of the requirements for the NP role within the ACT (Francis & Chapman, 2018). An ACT Labor election commitment triggered the review to increase NP numbers in the Territory (Johnston, 2016), which stemmed from increasing interest in the ACT Government nurse-led WiC (Kennedy, 2016). The review specifically requested an overview of the current status and future requirements for development of best practice NP models. In addition, it aimed to develop a strategy that would outline the benefits and change activities required to achieve future NP requirements as those models were developed.

Overall Comments

Overall, the aims and objectives of the ACT-NPP (2002) and ACT-ACNPPP (2005) reports resulted in significant legislative and policy reforms that enabled the NP role in the ACT and nationally. Those reforms legitimised the role in three primary ways: by demonstrating the safety and ability of nurses to undertake the NP role in diverse practice settings, by granting title protection for the role, and by developing recognised education pathways and professional standards for Australian NPs. The ACT-NPP led to title protection and a review of the legislation and regulation of the NP role in the ACT, long before the development of the national health professional regulatory scheme that was endorsed by jurisdictional governments in 2010 (Australian Health Practitioner Regulation Agency, 2021). It made significant contributions to a larger project that established the first iteration of professional and accreditation standards used for NP academic programs (Gardner, Carryer, et al., 2004; Gardner, Gardner, et al., 2004).

The ACT-ACNPPP and related INPRAC projects successfully examined the benefits and barriers to actualising the NP role by addressing significant concerns identified by the aged care sector. It is here where the association of 'transboundary' models within NP-directed care were first described. Such models "allow the NP to work across aged care settings independent of their principal place of employment (public or private), which promotes a flexible, coordinated, integrated and collaborative approach [to care]" (ACT Government, 2005, p. 7). The ACT-ACNPPP identified significant barriers to NPs fulfilling key activities of their role due to a lack of patient access to the MBS and PBS subsidies when seeking NP-directed care. In comparison, the INPRAC report identified that lack of access to these subsidies and other barriers to NP practice were contributing to critical delays in care that were

resulting in patient harm. These reports and their recommendations were therefore likely key contributors to the 2010 reforms that subsequently admitted NPs as eligible providers under the MBS/PBS. Finally, these projects identified clinical practice guidelines (CPGs) and medication formularies as key documents used to support actualisation of the NP role in the ACT. These documents were subsequently included in a governance framework that authorised NP clinical practice in the ACT. The vast majority of the recommendations from these reports were enacted, although it should be acknowledged that key recommendations were not enabled until significant time had elapsed (e.g. the 2010 MBS/PBS reforms).

The 2007 framework review provided a superficial appraisal of the authorisation process in the ACT. Many of the changes made to the governance framework that authorised NP clinical practice in the ACT concentrated on clarifying and simplifying the language used, in order to promote greater transparency and readability for both employers and health consumers. It also attempted to better translate and simplify the framework for employers outside the public sector. Unfortunately, the 2007 review did not truly examine or understand the ACT NP workforce itself, and can be viewed as a missed opportunity to identify key issues that still negatively impact upon the role today. Arguably, the only tangible benefit of the 2007 review was raising the health consumer's voice in helping shape individual NP scopes of practice and care models. Interestingly, no other regulated health profession has required the health consumer's voice to advocate for and advance their profession's scope of practice or model of care, with the notable exception of Aboriginal and/or Torres Strait Islander Health Practitioners (Kuipers et al., 2014). Thus, the healthcare consumer's voice was key in advancing development of NP scopes of practice and care models in the ACT, given ongoing and significant resistance to the role by traditional medical hierarchies.

The 2017 review into NP practice was innovative, in that it recommended changes that would remove the restrictive governance framework used to authorise NP clinical practice within the Territory. From the perspective of clinical governance, this review recommended the NP role be "normalised" and in line with other regulated health professions (Adrian, 2017, p. 3). Seven years after the introduction of the national regulatory scheme, the accountability that NPs hold to their employers and the nursing regulator was finally recognised. In effect, this meant that individual NPs and their employers would hold primary responsibility for business plan development, clinical scope of practice expectations, and monitoring of the role. This recommendation was strongly supported by private sector employers, who felt the ACT NP authorisation framework remained overly prescriptive and not entirely relevant to their models of care. In effect, it allowed the Australian NP workforce to freely enter private clinical practice in the ACT using a "right-touch" regulatory approach (Professional Standards Authority, 2015). It also aligned authorisation processes for NPs working in the public sector with credentialing processes used by other health professions. It resulted in legislative and policy amendments to the ACT's *Health Act* and *Medicines, Poisons and Therapeutic Goods Act* and subsidiary legislation so that NPs were no longer legislatively required to use an approved medicines formulary, business case and clinical practice guidelines. This made a significant step towards aligning authorisation processes with other jurisdictions within the Commonwealth. It effectively shifted governance oversight of NP clinical practice to the individual NP and their employer. Although the recommendations from this review were not fully operationalised until 2019, they were a significant step towards NPs achieving full practice authority in the ACT.

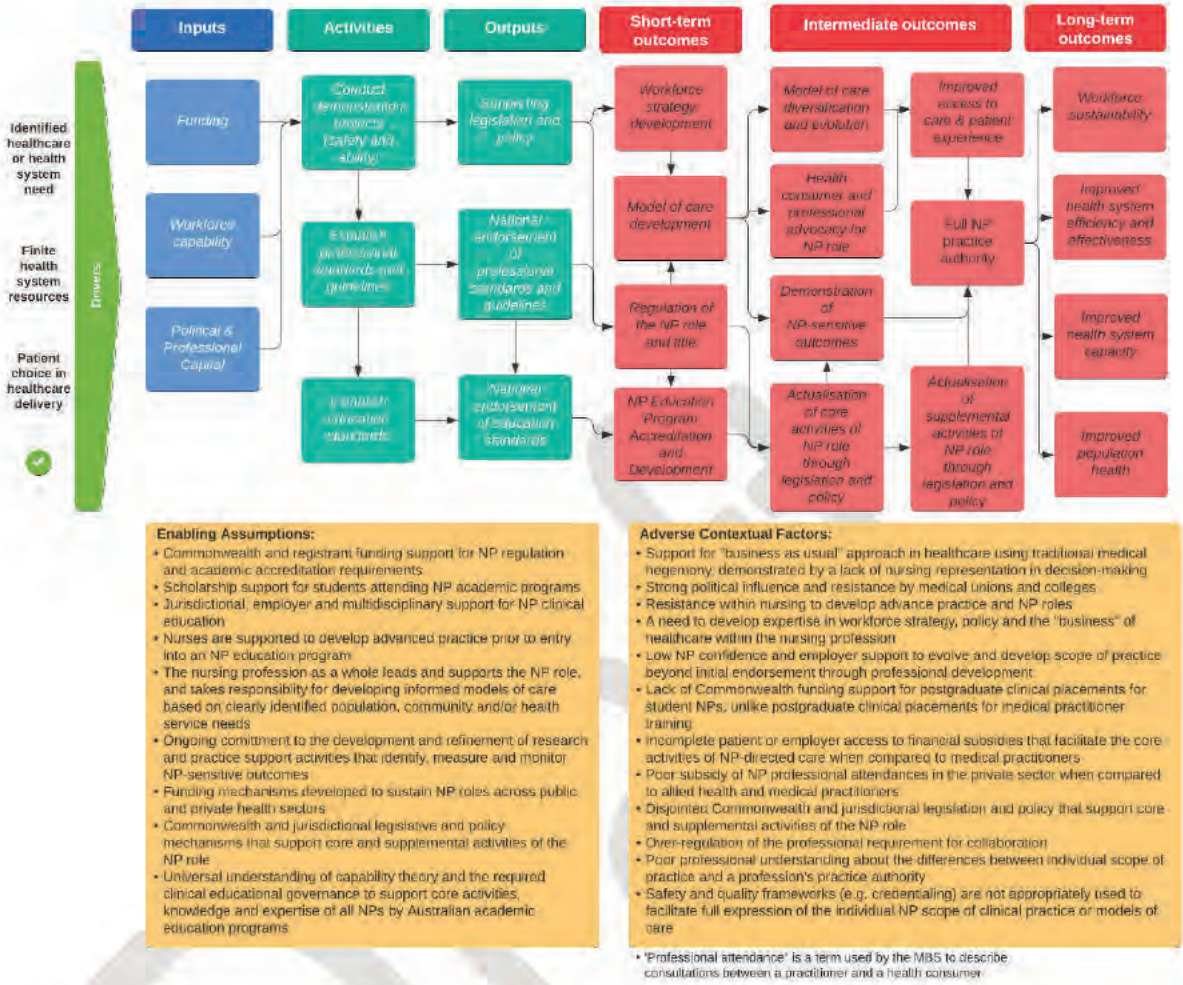
It appears the 2018 review did not achieve its aims, as the methodology used to obtain workforce data may have been insufficient to inform the proposed strategy. The authors did not demonstrate a comprehensive understanding of funding or regulatory issues that made several of its

recommendations unworkable. This is likely because it did not use a transparent or informed consultation strategy. It provided meaningful insight into current models of care using NPs in the ACT, but provided limited practical solutions to enable or measure outcomes in those models of care. It provided superficial insight into international models of NP care, and did not account for the differing regulatory, education or funding mechanisms informing those models. For example, it failed to recognise that NPs lack regulatory title protection in the UK, resulting in highly heterogeneous professional and academic requirements for its workforce. It did not identify an informed or desired future state for NPs in the ACT; therefore, it was unsuccessful in developing a workable change management strategy. The review would have been greatly assisted by developing a logic model describing the intended or desired future state of the NP workforce in the ACT. Arguably, it appears the authors did not fully comprehend the complexity of issues faced by NPs working in the ACT and nationally, and again represents a missed opportunity.

Outcome Impacts

When examining the aims, objectives, and recommendations arising from the demonstration projects and policy reviews conducted in the ACT, one can identify common enabling assumptions and adverse contextual factors that have influenced the intended short, medium, and long-term outcomes of the NP role. A logic model describing the inputs, activities, outputs and outcomes, and the relationships amongst these factors is demonstrated in *Figure 1* below. This model represents an ideal progression from drivers to long-term outcomes. However, in reality that ideal progression may not always occur due to changing (or yet to be identified) inputs, assumptions and contextual factors.

Figure 1: Ideal Logic Model for the Nurse Practitioner Role



Key to the early success of achieving short-term outcomes relating to NP policy and legislation in the ACT was research demonstrating the safety and ability of nurses to undertake the NP role. Safety and ability were comprehensively established through demonstration projects not only in the ACT, but also New South Wales, Victoria, and South Australia in the early history of the Australian NP role. Enabling legislation and policy that allowed for regulation and title protection of the role, as well as establishing robust and transparent professional and accreditation standards, were instrumental in achieving several short and intermediate-term outcomes.

Nursing has clearly achieved nearly all short-term outcomes of the NP role in the ACT, with the clear exception of a transparent workforce strategy. There does not appear to be a transparent and agreed-upon NP workforce strategy published in the peer-reviewed or grey literature in the ACT or nationally. This may be a significant contributor to the confusion surrounding the role (Stasa et al., 2014), as well as the proliferation of specialty areas and models of care (Gardner et al., 2014). When examining NP model of care development in the ACT and nationally the following common themes arise, which suggest an underlying strategy influencing early development of the role:

- Improving access to care for marginalised and/or vulnerable populations (e.g. the homeless, sex workers, refugees, the aged, and Aboriginal and/or Torres Strait Islander communities);
- Improving access to healthcare in regional and rural/remote communities;

- Improving efficiency, productivity and value-based outcomes;
- Demonstrating the value-add and capability of nursing; and
- Supplementing, but not substituting the role of nurses and doctors.

It is perhaps timely to review, consider and achieve consensus on an NP workforce strategy in the ACT and nationally, in order to ensure all intermediate and long-term outcomes are achieved. Otherwise, the unintended consequence of strategic drift may result in outliers to the role, as seen with the developing field of cosmetic nursing practice (O'Keefe & Hoitink, 2013). Arguably, cosmetic nursing does not appear to align with the original intent of the NP role, although carefully constructed models of care aligning with holistic health promotion and disease prevention strategies may.

The reader should note the assumptions and contextual factors in *Figure 1* above are well-documented in the peer-reviewed and grey literature. They have played a significant part in achieving (or not achieving) the intended outcomes of the Australian NP role. The peer-reviewed and grey literature, as well as workforce data from the ACT, suggest that assumptions and contextual factors may shift and vary according to practice context or jurisdiction. For example, a report commissioned by the Australian Commonwealth on the education and training of nurses suggests that not all universities have a common understanding of the core *clinical* knowledge and skills that NPs require upon graduation (Schwartz, 2019). However, a well-published clinical learning and teaching framework for Australian NP students addressed this concern (Gardner et al., 2019; Gardner et al., 2020; Helms, 2017; Helms et al., 2017), but was not accounted for in that report. It is also well-documented in the literature that right-touch regulation and appropriately-targeted funding is not being consistently and systematically enabled to support development of the NP role (Buchan et al., 2015; Delamaire & Lafortune, 2010; Maier et al., 2018; Maier et al., 2016; Maier, 2015). A methodological approach to the ongoing examination and understanding of the assumptions and contextual factors should be considered when supporting strategic NP workforce development, so that it may achieve its intended long-term outcomes.

In addition, workforce data from the ACT suggests there are significant ongoing barriers to actualising core and supplemental activities of the NP role. These barriers are seen across both the public and private health sectors. For example, some barriers relate to the fact that NP-led transboundary models of care, where a NP may be the primary carer for a patient in the private sector, are not recognised by public sector hospital policies. Full expression of core and supplemental activities are required in order to realise the long-term intended outcomes envisioned for the NP role. A recent NP workforce and employer survey conducted by the ACT Office of the CNMO (Helms, 2021) suggests that NP-sensitive outcomes are not routinely being measured or considered in NP model of care development. In addition, the survey revealed that NPs (particularly in the public sector) are unable to perform core activities of their employed roles to the fullest extent of their individual scopes of practice, such as: independently prescribing medicines, requesting diagnostic tests, or referring to allied health specialists, despite having the legislative practice authority to do so.

The ACT workforce survey revealed that NPs across the public and private sectors are not authorised to perform supplemental activities appropriate for their individual scopes of practice and models of care, such as: performing medical terminations of pregnancy, authorising driver's licence medicals and worker's compensation certificates, witness non-written health directions, and authorise death certificates. The inability to perform core and supplemental activities of the NP role to the fullest extent of the individual practitioner's ability appears to severely limit the clinical efficiency of the workforce. In effect, NPs have not yet achieved full practice authority in the ACT despite ability,

competence and robust regulatory mechanisms. Ultimately, these contextual barriers significantly impact upon the ability of NPs and health services to fulsomely demonstrate the intended intermediate and long-term outcomes for the role.

Discussion

The intermediate and long-term outcomes envisioned for the NP role are at risk of remaining unfulfilled, despite extensive international and national literature demonstrating the safety, ability and positive outcomes associated with the role. The primary reasons for this relate to how policy and legislation have been enacted for the role, as well as significant contextual factors that have negatively influenced its "normalisation" within healthcare. Those contextual factors primarily relate to resistance to the NP role by medical practitioner lobby groups, inadequate funding mechanisms, unclear NP workforce strategy, and fragmented approaches to business model development.

Enabling legislation and policy change that facilitated the initial development of the NP role in the ACT in 2002, as well as funding mechanisms that helped support core activities of the NP role in the private sector through the MBS/PBS in 2010, can best be characterised as transformational. Legislation and policy change aligning with logical incrementalism (Lindbloom, 1959) has otherwise defined the development and evolution of the NP role since its early introduction in the ACT and nationally. However, because of uncoordinated legislation and policy change at both the Territory and Commonwealth levels, the role has suffered from disjointed incrementalism (Johnson, 1988) and strategic drift. In turn, this has led to uncertainty in the NP workforce and negatively influenced its ability to achieve intended intermediate and long-term outcomes.

This uncertainty is best observed in the closure of four Australian NP education programs since 2013, the rejection of critical recommendations for MBS reform as relating to NPs (Medicare Benefits Schedule Review Taskforce, 2020; Nurse Practitioner Reference Group, 2018), decreasing annual MBS utilisation from NP-directed services since 2010 (Australian Government, 2021), and decreasing annual NP endorsements nationally (Nursing and Midwifery Board of Australia, 2020b). These changes are especially concerning when comparing available workforce data from similar regulatory jurisdictions, such as New Zealand. For example, in 2014-2015 there was a 33% annual increase in the New Zealand NP workforce, and in 2018-2019 there was a 54% annual increase (Nursing Council of New Zealand, 2018). However, in Australia growth in the NP workforce decelerated from 44% to 21% over the same time periods, respectively (Nursing and Midwifery Board of Australia, 2020b). It is likely these differences are a reflection of uncertainty around the strategic direction of the Australian NP role, despite both jurisdictions achieving regulation of the NP role over similar time periods. In New Zealand, uncertainty surrounding the workforce has been improved by developing a clearer NP workforce strategy, which includes using NPs as primary healthcare providers that provide services similar in scope to general practitioners (Carryer & Adams, 2017; Carryer & Yarwood, 2015; New Zealand Government, 2020). The New Zealand perspective provides a level of clarity and vision that may be helpful in developing a future Australian NP workforce strategy, which avoids the unintended consequences associated with strategic drift.

In order to address workforce uncertainty and ensure the NP role is able to address its intermediate and long-term outcomes, the ACT must first recognise that NPs and medical practitioners carry the same level of authority and accountability in healthcare (Cashin et al., 2016; Chiarella et al., 2020) by 'leveling the policy and legislation playing field'. For example, under the ACT's *Public Health Act 1997*, *Sex Work Act 1992*, and *Road Transport Act 1999*, NPs hold the same legal authority and accountability in performing core and supplemental activities as medical practitioners after completing a

comprehensive health assessment (i.e. a core activity for both medical practitioners and NPs). Despite this, NPs are unable to authorise death certificates or driver's licence medicals (supplemental activities that arise from conducting a comprehensive health assessment) under the *Coroners Act 1997* or the *Road Transport (Driver Licensing) Act 1999*. This in itself demonstrates a form of disjointed incrementalism: NPs in the ACT are authorised and accountable for competently performing comprehensive health assessments within their individual scopes of practice, but are not authorised to perform supplemental activities arising from this core activity because of existing legislative provisions.

In total, there are 17 legislative provisions in the ACT that specifically authorise core and/or supplemental activities of NPs working within their individual scopes of practice. However, there are an estimated 63 additional legislative provisions relating to core or supplemental NP activities that, by virtue of specifically mentioning the term "doctor", "medical examination" or "medical certificate" in the legislation, restrict NPs from actualising their full scope of practice. These include provisions that would enable NPs to:

- Authorise driver's licence medicals;
- Authorise death certificates;
- Witness non-written health directions;
- Perform medical terminations of pregnancy; and
- Authorise worker's compensation and Comcare certificates.

Given insights gained from a recent NP workforce survey demonstrating the high prevalence of primary health care, ageing and palliative care NPs in the ACT (Helms, 2021), legislative change authorising NPs to perform the above supplemental activities should be prioritised. Importantly, the proposed authorisations would not mean that *all* NPs would be able to perform the above supplemental activities; only those who were performing those activities within their individual scopes of practice. Scope of practice is determined by legislative authorisations, employers and the *competence* of individual practitioners. This is not a construct unique to nursing or nurse practitioners, but common to all registered and regulated health practitioners in Australia.

The above legislative changes would, in part, address the intended intermediate outcomes for the NP role. However, policy and legislative change addressing discrete supplemental activities can be viewed as incremental in nature, and result in ongoing requirements for legislative reform. Alternatively, a potential transformational policy or legislative solution would be to change fundamental definitions of who is authorised to write medical certificates or perform medical examinations.

For example, in 2017 New Zealand passed "omnibus legislation" authorising NPs to issue death certificates, complete compulsory mental health treatment orders, carry out medical examinations ordered by a court, assess fitness to drive and authorise worker's accident and compensation certificates by simply replacing the term "medical practitioner" with "health practitioner" in their legislation (Coleman, 2015; Nurse Practitioners New Zealand, 2021). The education and regulation of NPs in New Zealand is based upon the same core research that informed the development of the role in Australia (Carryer et al., 2007; Gardner et al., 2006). A solution such as this in the ACT would be transformative, and align with intent of the *Trans-Tasman Mutual Recognition Act 1997* (C'wealth), which facilitates recognition of regulated health professions between Australia and New Zealand. In addition, the outcomes from such transformational change could easily be monitored for any unintended consequences given the size of the Territory. If shown to be safe and effective after a

period of evaluation, the Territory could be used as an exemplar of "right touch regulation" of the NP workforce for the remaining jurisdictions.

Finally, a review of previous NP projects in the ACT and the resulting logic model developed for this outcome evaluation suggests that additional work is required to build nursing workforce capacity to better understand concepts associated with strategic planning, strategic management, innovation, business planning, and the policy cycle when co-designing NP models of care. Foundational work to establish important short-term outcomes in NP-related legislation and policy has afforded Australian NPs with the "space" to shift from reaction to a period of reflection about intent and purpose. It provides opportunity for nursing executives, health systems administrators and clinicians to reflect upon the original intent and projects informing the NP role, and whether recommendations arising from those projects have been fulsomely explored and implemented.

For example, in 2005 the ACT-ACNPPP recommended a nationally-consistent minimum data set be established to evaluate cost effectiveness, client and health professional satisfaction, and efficacy of the NP role. A toolkit was developed (Gardner et al., 2009), but has not been applied consistently across jurisdictions, nor does it examine cost-effectiveness or efficacy of the NP role using NP-sensitive outcomes that have been identified since publication. A review of the toolkit's current relevance and applicability to a national minimum dataset would be timely. In addition, the development of a cost-effectiveness dataset is required to demonstrate cost-benefit outcomes to the health system, particularly for NP roles or models that are funded using taxpayer dollars. This issue was highlighted in a report commissioned by the Commonwealth on NP models of care (KPMG, 2018), although one might argue cost-benefit analysis should be extended to *all* health professionals subsidised by the public dollar. Simply or reactively developing models of care to demonstrate ability, without fulsome consideration of their alignment with strategy or the "business" of healthcare, may result in unclear rationale to support extension or upscaling of NP-directed health services.

Impact Statement

The NP role in the ACT has achieved significant short and medium-term outcomes over the past twenty years. However, a lack of clarity in workforce strategy has resulted in piecemeal development of legislation and policy. The resulting strategic drift has impeded the ability of NPs to achieve full practice authority in the ACT. Without full practice authority, the NP role will have ongoing difficulties in demonstrating its intended long-term outcomes.

Recommendations

Draft recommendations arising from this outcome evaluation address issues adversely impacting the intended intermediate and long-term outcomes of the NP workforce in the ACT. Those recommendations advise on potential solutions to those issues, and will relate to overarching funding, legislative and policy considerations for the ACT Government and interested stakeholders. Final recommendations will be prepared for the evaluation report arising from the NP-PP, which will be authored by the ACT Office of the CNMO. Those recommendations will then be reviewed, negotiated and approved through the ACT Government Office of the Director General.

Conclusion

The safety and ability of nurses to undertake the NP role has long been established in the ACT and nationally. This evaluation has examined the short, medium and long-term outcomes of significant projects relating to policy and legislation affecting NPs in the ACT. Many short-term outcomes have

been realised; however, several intermediate and long-term outcomes are yet to be realised because there does not appear to be a transparent workforce strategy. This in turn has led to piecemeal policy and legislative approaches to the NP workforce, as well as strategic drift. Nurse practitioners have not yet achieved full practice authority in the ACT. This has contributed to significant issues with clinical efficiency and the ability of NPs to actualise their roles. Any current outcomes demonstrated by the workforce represent those with NPs who have not yet achieved full practice authority. This outcome evaluation has proposed a logic model to help inform future strategies relating to the NP workforce, and will develop recommendations for future legislative and policy reform to enable full practice authority of NPs within the ACT.

References

ACT Government. (2002). *The ACT nurse practitioner project: Final report of the steering committee*. ACT Government. https://catalogue.nla.gov.au/Record/1030451

ACT Government. (2005). *The aged care nurse practitioner pilot project (ACNPPP)* [Report]. ACT Health.

ACT Health. (2007). *Implementing the nurse practitioner role in aged care (INPRAC) Final Report* [Report]. ACT Government.

Adrian, A. (2017). *Nurse practitioners in the Australian Capital Territory in 2017: A review* [Report]. ACT Government.

Anderson, D., Gardner, G., Ramsbotham, J., & Tones, M. (2009, Jun-Aug). E-portfolios: developing nurse practitioner competence and capability. *Australian Journal of Advanced Nursing, 26*(4), 70-76.

Andrews, K. (2003, 28 March). *Media release: A new strategy for community care*

Australian Government. (2003). *Productivity Commission submission to the review of pricing arrangements in residential aged care* [Submission]1 74037 121 6). Productivity Commission. https://www.pc.gov.au/research/supporting/aged-care-pricing

Australian Government. (2018). *Eligible nurse practitioners questions and answers*. Department of Health. Retrieved 28 March from http://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda-nursepract

Australian Government. (2021). *Medicare Item Reports*. Services Australia. Retrieved 20 January from http://medicarestatistics.humanservices.gov.au/statistics/mbs_item.jsp

Australian Health Practitioner Regulation Agency. (2021). *Legislation*. AHPRA. Retrieved 07 November from http://www.ahpra.gov.au/About-AHPRA/What-We-Do/Legislation.aspx

Australian Nursing and Midwifery Accreditation Council. (2015). *Nurse Practitioner Accreditation Standards*. ANMAC.

Buchan, J., Twigg, D., Dussault, G., Duffield, C., & Stone, P. W. (2015, Jun). Policies to sustain the nursing workforce: an international perspective. *International Nursing Review, 62*(2), 162-170. https://doi.org/10.1111/inr.12169

Budzi, D., Lurie, S., Singh, K., & Hooker, R. (2010, Mar). Veterans' perceptions of care by nurse practitioners, physician assistants, and physicians: a comparison from satisfaction surveys. *J Am Acad Nurse Pract, 22*(3), 170-176. https://doi.org/10.1111/j.1745-7599.2010.00489.x

Carryer, J., & Adams, S. (2017). Nurse practitioners as a solution to transformative and sustainable health services in primary health care: A qualitative exploratory study. *Collegian, 24*(6), 525-531. https://doi.org/10.1016/j.colegn.2016.12.001

Carryer, J., Gardner, G., Dunn, S., & Gardner, A. (2007, Oct). The core role of the nurse practitioner: practice, professionalism and clinical leadership. *J Clin Nurs, 16*(10), 1818-1825. https://doi.org/10.1111/j.1365-2702.2007.01823.x

Carryer, J., & Yarwood, J. (2015). The nurse practitioner role: Solution or servant in improving primary health care service delivery. *Collegian, 22*(2), 169-174. https://doi.org/10.1016/j.colegn.2015.02.004

Cashin, A., Theophilos, T., & Green, R. (2016). The internationally present perpetual policy themes inhibiting development of the nurse practitioner role in the primary care context: An Australian–USA comparison. *Collegian*. https://doi.org/10.1016/j.colegn.2016.05.001

Centers for Disease Control and Prevention. (2011). *Developing an effective evaluation plan* [Workbook]. CDC. https://www.cdc.gov/obesity/downloads/cdc-evaluation-workbook-508.pdf

Centers for Disease Control and Prevention. (2021). *Logic models: CDC approach to evaluation*. CDC. Retrieved 28 January from https://www.cdc.gov/eval/logicmodels/index.htm

Chapman, M., Johnston, N., Lovell, C., Forbat, L., & Liu, W.-M. (2016). Avoiding costly hospitalisation at end of life: findings from a specialist palliative care pilot in residential care for older adults. *BMJ Supportive & Palliative Care*. https://doi.org/10.1136/bmjspcare-2015-001071

Chiarella, M., Currie, J., & Wand, T. (2020, Apr). Liability and collaborative arrangements for nurse practitioner practice in Australia. *Aust Health Rev, 44*(2), 172-177. https://doi.org/10.1071/AH19072

Coleman, J. (2015). *Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill* (51, Issue 36-2). New Zealand Government. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/00DBHOH_BILL63296_1/health-practitioners-replacement-of-statutory-references

College of Registered Nurses of Nova Scotia. (2016). *Nurse practitioner-sensitive outcomes* [Summary Report]. https://albertanps.com/wp-content/uploads/2017/12/NP-Sensitive-Outcomes-2016-Report.pdf

David, D., Britting, L., & Dalton, J. (2015, May-Jun). Cardiac acute care nurse practitioner and 30-day readmission. *J Cardiovasc Nurs, 30*(3), 248-255. https://doi.org/10.1097/JCN.0000000000000147

Delamaire, M., & Lafortune, G. (2010). Nurses in Advanced Roles: A Description and Evaluation of Experiences in 12 Developed Countries. *OECD Health Working Papers, 54*, 107. https://doi.org/10.1787/5kmbrcfms5g7-en

Ebener, P., Hunter, S., Adams, R., Eisenman, D., Acosta, J., & Chinman, M. (2017). *Getting to outcomes: Guide for community emergency preparedness*. RAND Corporation. https://www.rand.org/pubs/tools/TL259.html

Forbat, L., Liu, W.-M., Koerner, J., Lam, L., Samara, J., Chapman, M., & Johnston, N. (2020). Reducing time in acute hospitals: A stepped-wedge randomised control trial of a specialist palliative care intervention in residential care homes. *Palliat Med, 34*(5), 026921631989107-026921631989579. https://doi.org/10.1177/0269216319891077

Foster, J. (2010). *A History of the Early Development of the Nurse Practitioner Role in New South Wales, Australia* [Dissertation, University of Technology Sydney]. Sydney, NSW. https://opus.lib.uts.edu.au/handle/10453/20243

Francis, K., & Chapman, Y. (2018). *ACT Health strategic plan for the requirement of nurse practitioners within the Australian Capital Territory* [Report]. ACT Government.

Gagan, M., & Maybee, P. (2011). Patient satisfaction with nurse practitioner care in primary care settings. *Australian Journal of Advanced Nursing, 28*(4), 12-19. https://www.ajan.com.au/archive/Vol28/28-4_Gagan.pdf

Gardner, A., Gardner, G., Coyer, F., Gosby, H., & Helms, C. (2019). *The nurse practitioner clinical learning and teaching framework: A toolkit for students and their supervisors*. CLLEVER2 Research Consortium. https://doi.org/10.6084/m9.figshare.9733682.v2

Gardner, A., Gardner, G., Coyer, F., Henderson, A., Gosby, H., & Lenson, S. (2014). Educating Nurse Practitioners: Advanced Specialty Competence, Clinical Learning and Governance [Type]. Australian Government. http://www.olt.gov.au/system/files/resources/ID12-2182_Gardner_Report_2014.pdf

Gardner, A., Helms, C., Gardner, G., Coyer, F., & Gosby, H. (2020). Development of nurse practitioner metaspecialty clinical practice standards: A national sequential mixed methods study. *Journal of Advanced Nursing*. https://doi.org/10.1111/jan.14690

Gardner, G., Carryer, J., Dunn, S., & Gardner, A. (2004). *The nurse practitioner standards project: Report to the Australian nursing and midwifery council* 095806976X). Australian Nursing and Midwifery Council.

Gardner, G., Carryer, J., Gardner, A., & Dunn, S. (2006). Nurse practitioner competency standards: Findings from collaborative Australian and New Zealand research. *International Journal of Nursing Studies, 43*(5), 601-610. https://doi.org/10.1016/j.ijnurstu.2005.09.002

Gardner, G., Gardner, A., Middleton, S., & Della, P. (2009). *The nurse practitioner research toolkit*. https://eprints.qut.edu.au/72604/1/72604.pdf

Gardner, G., Gardner, A., & Proctor, M. (2004, Jul). Nurse practitioner education: a research-based curriculum structure. *J Adv Nurs, 47*(2), 143-152. https://doi.org/10.1111/j.1365-2648.2004.03073.x

Haines, H. M., & Critchley, J. (2009). Developing the nurse practitioner role in a rural Australian hospital - a Delphi study of practice opportunities, barriers and enablers. *Aust J Adv Nurs, 27*(1), 30-36. https://www.ajan.com.au/archive/Vol27/Haines.pdf

Helms, C. (2017). *Consensus on a Specialist Clinical Learning and Teaching Framework for Australian Nurse Practitioners* [Dissertation, Australian Catholic University]. Canberra, ACT.

Helms, C. (2021). *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey* [Report]. ACT Government.

Helms, C., Crookes, J., & Bailey, D. (2015, Apr). Financial viability, benefits and challenges of employing a nurse practitioner in general practice. *Aust Health Rev, 39*(2), 205-210. https://doi.org/10.1071/AH13231

Helms, C., Gardner, A., & McInnes, E. (2017, Feb). Consensus on an Australian Nurse practitioner specialty framework using Delphi methodology: results from the CLLEVER 2 study. *J Adv Nurs, 73*(2), 433-447. https://doi.org/10.1111/jan.13109

Jennings, N., Lee, G., Chao, K., & Keating, S. (2009, Jun). A survey of patient satisfaction in a metropolitan Emergency Department: comparing nurse practitioners and emergency physicians. *Int J Nurs Pract, 15*(3), 213-218. https://doi.org/10.1111/j.1440-172X.2009.01746.x

Joanna Briggs Institute. (2007). *National evaluation of nurse practitioner-like services in residential aged care services* [Report](1-74186-541-7). Commonwealth of Australia.

Johnson, G. (1988). Rethinking incrementalism. *Strategic Management Journal, 9*(1), 75-91.

Johnston, C. (2016, 12 December). *A day to celebrate our Nurse Practitioners* [Media Release]. https://www.cmtedd.act.gov.au/open_government/inform/act_government_media_releases/meegan-fitzharris-mla-media-releases/2016/a-day-to-celebrate-our-nurse-practitioners

Johnston, N., Lovell, C., Liu, W. M., Chapman, M., & Forbat, L. (2016, Aug 3). Normalising and planning for death in residential care: findings from a qualitative focus group study of a specialist palliative care intervention. *BMJ Support Palliat Care*. https://doi.org/10.1136/bmjspcare-2016-001127

Kennedy, A. (2016). ACT election: Labor promises walk-in clinic in Canberra's north as Liberals offer multicultural boost. *ABC News*. Retrieved 21 January 2020, from https://www.abc.net.au/news/2016-10-09/act-election-labor-promises-health-canberra-liberals/7916308

KPMG. (2018). *Cost benefit analysis of nurse practitioner models of care*. Australian Commonwealth Department of Health.

Kuipers, P., Harvey, D., Lindeman, M., & Stothers, K. (2014). Aboriginal and Torres Strait Islander health practitioners in rural areas: Credentialing, context and capacity building. *Rural And Remote Health, 14*(2897), 1-6. https://www.rrh.org.au/journal/article/2897#cite_note-1

Lindbloom, C. (1959). The science of 'muddling through'. *Public Administration Review, 19*, 79-88.

Maier, C., Aiken, L. H., & Busse, R. (2018). *Nurses in advanced roles in primary care: Policy levers for implementation* [Report](OECD Health Working Papers, Issue 98). Organisation for Economic Cooperation and Development.

Maier, C., Barnes, H., Aiken, L. H., & Busee, R. (2016). Descriptive, cross-country analysis of the nurse practitioner workforce in six countries: size, growth, physician subtitution potential. *BMJ Open, 6*(e011901). https://doi.org/10.1136/ bmjopen-2016-011901

Maier, C. B. (2015, 2015/12/01/). The role of governance in implementing task-shifting from physicians to nurses in advanced roles in Europe, U.S., Canada, New Zealand and Australia. *Health Policy, 119*(12), 1627-1635. https://doi.org/http://dx.doi.org/10.1016/j.healthpol.2015.09.002

Marlow, L. (1996). *Nurse practitioner project stage 3 : Final report of the steering committee* (NB 96-0027, Issue 0731007743). NSW Department of Health. http://nla.gov.au/nla.cat-vn2596835

Masso, M., & Thompson, C. (2014). Nurse practitioners in NSW 'Gaining Momentum': rapid review of the nurse practitioner literature [Type]. University of Wollongong.

Masso, M., & Thompson, C. (2017). Australian research investigating the role of nurse practitioners: A view from implementation science. *Collegian, 24*(3), 281-291. https://doi.org/10.1016/j.colegn.2016.04.003

Medicare Benefits Schedule Review Taskforce. (2020). *Taskforce findings - Nurse practitioner reference group report* [Report]. Australian Government. https://www.health.gov.au/resources/publications/taskforce-findings-nurse-practitioner-reference-group-report

New Zealand Government. (2020). *Nurse practitioners in New Zealand*. Ministry of Health. Retrieved 28 January from https://www.health.govt.nz/our-work/nursing/nurses-new-zealand/nurse-practitioners-new-zealand

NSW Government. (1993). *Nurse practitioner review Stage 2* ((NB) 93-120, Issue 0731005056). Department of Health. http://nla.gov.au/nla.cat-vn2907472

NSW Health. (2021). *Patient reported measures*. Agency for Clinical Innovation. Retrieved 15 January from https://aci.health.nsw.gov.au/make-it-happen/prms

Nurse Practitioner Reference Group. (2018). *Report from the Nurse Practitioner Reference Group to the Medicare Benefits Schedule Review Taskforce*. Australian Government. https://www1.health.gov.au/internet/main/publishing.nsf/content/BEB6C6D36DE56438CA258397000F4898/$File/NPRG%20Final%20Report%20-%20v2.pdf

Nurse Practitioners New Zealand. (2021). *Frequently asked questions*. College of Nurses Aotearoa. Retrieved 27 January from https://www.nurse.org.nz/npnz-nurse-practitioners-nz.html

Nursing and Midwifery Board of Australia. (2016). *Safety and quality guidelines for nurse practitioners*. Austrailan Health Practitioner Regulation Agency. Retrieved 10 October from http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations/Safety-and-quality-guidelines-for-nurse-practitioners.aspx

Nursing and Midwifery Board of Australia. (2020a). Nurse Practitioner Standards for Practice [Type]. Australian Health Practitioner Regulation Agency. https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

Nursing and Midwifery Board of Australia. (2020b). *Registrant data*. https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

Nursing Council of New Zealand. (2018). *Reports and workforce statistics*. NCNZ. Retrieved 8 August from http://www.nursingcouncil.org.nz/Publications/Reports-and-workforce-statistics

O'Keefe, E., & Hoitink, S. (2013). Cosmetic nursing: Pioneering a cosmetic, skin rejuvenation and aesthetic nursing model of practice. *Australian Nursing Journal, 21*(2), 36-37.

Parker, J., Faulkner, R., Dunt, D., Long, H., & Watts, J. (2000). *Evaluation of eleven Phase 1 demonstration projects* (Victorian Nurse Practitioner Project, Issue 0731161912). Victorian Government.

Pearson, A., Nay, R., Ward, C., Lenten, L., & Lewis, M. (2003). *Evaluation of sixteen Phase 2 demonstration projects* (Victorian Nurse Practitioner Project, Issue 0731161793). Victorian Government.

Porter, M., & Lee, T. (2013). The strategy that will fix health care. *Harvard Business Review, 91*(10), 50-70. https://hbr.org/2013/10/the-strategy-that-will-fix-health-care

Professional Standards Authority. (2015). Right-touch Regulation *Revised* [Type]. PSA. http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=12

SA Government. (1999). *Nurse practitioner project report* (NUPRAC Project, Issue 0730890376). SA Health. http://nla.gov.au/nla.cat-vn105663

Scanlon, A., Perera, C., Gonzalvo, G., & Fabinyi, G. (2015). Development of a Nurse Practitioner led Carpal Tunnel Syndrome clinic. *Australian Journal of Advanced Nursing, 32*(3), 41-47.

Schwartz, S. (2019). *Educating the Nurse of the Future - Report of the Independent Review into Nursing Education* [Report]. Australian Government. https://www.health.gov.au/resources/publications/educating-the-nurse-of-the-future

Solomon, D. H., Fraenkel, L., Lu, B., Brown, E., Tsao, P., Losina, E., Katz, J. N., & Bitton, A. (2015, Dec). Comparison of Care Provided in Practices With Nurse Practitioners and Physician Assistants Versus Subspecialist Physicians Only: A Cohort Study of Rheumatoid Arthritis. *Arthritis Care Res (Hoboken), 67*(12), 1664-1670. https://doi.org/10.1002/acr.22643

Stasa, H., Cashin, A., Buckley, T., & Donoghue, J. (2014, Mar). Advancing advanced practice - clarifying the conceptual confusion. *Nurse Educ Today, 34*(3), 356-361. https://doi.org/10.1016/j.nedt.2013.07.012

Victorian Government. (1999). *The Victorian nurse practitioner project: Final report of the taskforce*. Policy Development and Planning Division. http://www.dhs.vic.gov.au/pdpd/vnp/nurseprac.pdf

Victorian Government. (2004). *Victorian nurse practitioner project: Report of the nurse practitioner implementation advisory committee*. Department of Human Services.

Wall, S., Scudamore, D., Chin, J., Rannie, M., Tong, S., Reese, J., & Wilson, K. (2014, Apr). The evolving role of the pediatric nurse practitioner in hospital medicine. *J Hosp Med, 9*(4), 261-265. https://doi.org/10.1002/jhm.2162

Wand, T., White, K., Patching, J., Dixon, J., & Green, T. (2012). Outcomes from the evaluation of an emergency department-based mental health nurse practitioner outpatient service in Australia. *Journal of the American Academy of Nurse Practitioners, 24*(3), 149-159. https://doi.org/10.1111/j.1745-7599.2011.00709.x

Appendix A: Recommendations and Outcomes from Previous Nurse Practitioner Reviews in the ACT

Key[1]:	
Recommendation Met	
Recommendation Partially Met	
Recommendation Not Met	

Year	Report Title	Objective(s)	Recommendations	Progress to Date and Comments
2002	The ACT NP Project (ACT-NPP)	1. Investigate the safety, feasibility, and efficacy of the NP as a new level of health service in the ACT health system.	1. There be recognition of the NP as defined in this report, as a legitimate and autonomous member of the healthcare team. 2. The steering committee be reconvened to oversee the implementation of the role of the NP in the ACT. 3. The Nurses Board of the ACT be the approved body to regulate the use of the title 'nurse practitioner'. 4. The Nurses Act 1998 be amended to protect the NP title. 5. The use of the NP title be limited to those authorised to practise. 6. The scope of practice, as determined by clinical protocols, and medication formulary for the specific NP model be determined by a local multidisciplinary team that includes at least one medical clinical specialist and at least one advanced practice nurse.	In sum, this review achieved its aims. This was one of several National demonstration projects across Australia, whose outcomes culminated in the first iteration of *the National Competency Standards for the Nurse Practitioner*[2], which were then endorsed and published by the Australian Nursing and Midwifery Council in 2006[3]. Standards arising from this research have served as the foundation for the regulation of the nurse practitioner (NP) role, and the accreditation of NP academic programmes. To date, many of the recommendations from this report have been actioned or made redundant through legislative change. For example, the *Health Practitioner Regulation National Law* (ACT) *Act 2010* provides title protection for the NP role. However, much of the current legislation either acknowledges nurses but does not specifically mention nurse practitioners, or only mentions medical practitioners, which precludes an NP from working to their full scope of practice. For

[1] This is an *approximate* guide to whether recommendations from various reports were enacted or not. Some items have been marked as 'met' because they are no longer relevant given the current context of NP practice in the ACT.

[2] Gardner, G., Carryer, J., Gardner, A., & Dunn, S. (2006). Nurse practitioner competency standards: Findings from collaborative Australian and New Zealand research. *International Journal of Nursing Studies, 43*(5), 601-610.

[3] Australian Nursing and Midwifery Council [ANMC]. (2006). National Competency Standards for the Nurse Practitioner. Canberra, ACT.

			7. The diagnostic services relevant to the scope of practice for specific NP models be determined by a local multidisciplinary team and be included in the model's clinical protocols. 8. The range of referrals to general practitioners, medical specialist and allied health practitioners for specific NP models be determined by a local multidisciplinary team and be included in the model's clinical protocols. 9. The medication formulary be reviewed for validation by an expert panel external to the local team, and that this expert panel include a pharmacist, at least one medical clinician and at least one advanced practice nurse. 10. The scope of practice as determined by clinical protocols for the specific NP model be endorsed by the Nurses Board of the ACT. 11. The validated medication formulary for the specific NP model be endorsed by the Nurses Board of the ACT. 12. The Nurses Board of the ACT establish processes to review the scope of practice and medication formulary for NP models on renewal of NP registration.	example, the *Births, Deaths and Marriages Registration Act 1997* only allows a medical practitioner to sign a death certificate. Much of the remaining gaps in legislation exist because of definitional issues surrounding who is authorised to issue a 'medical certificate, perform a 'medical examination', or provide treatment.

			13. A 'grandparenting' process be established to enable the wound care NP, the sexual health NP and the mental health consultation–liaison NP who participated in the ACT trial to register as NP with the Nurses Board of the ACT. 14. The minimum educational level for registration as NP be at a master's level. 15. The Nurses Board of the ACT be responsible for accrediting master's courses for NP education. 16. The accreditation requirements include a curriculum with a strong and substantial clinical focus that builds upon the intellectual competencies of the advanced practice nurse, including education and experience in a clinical specialty and research practice. 17. ACT Health provide financial support for subsequent evaluation of regulation processes and research into NP practice. 18. The Australian Nursing Council draw upon the educational findings of the ACT Nurse Practitioner Trial to advance progress towards a national standard for nurse practitioner education. 19. When the Master of NP course becomes available at the University of Canberra, the university	

			recognise as meeting the requirements for this award the nurses who participated as NPs in the ACT Nurse Practitioner Trial and who meet the prescribed prerequisites. 20. It is recommended that the NP have adequate professional indemnity insurance cover to practice within the full scope of their role. 21. It is recommended that remuneration for the NP be commensurate with their knowledge, skills and educational attainment, and that this level of remuneration be consistent across the ACT. 22. The following acts be amended to enable the NP to function in the role: a. Nurses Act 1988 b. Drugs of Dependence Act 1989 c. Poisons and Drugs Act 1978 d. Mental Health Act 1962 e. Mental Health (Treatment and Care) Act 1994 f. Prostitution Act 1992 g. Public Health Act 1997 h. Sexually Transmitted Diseases Act 1956. 23. The following acts be amended to include the title 'nurse practitioner':	

			a. Birth (Equality of Status) Act 1988 b. Children and Young People Act 1999 c. Children Services Act 1986 d. Guardianship and Management of Property Act 1986 e. Health Regulation (Maternal Health Information) Act 1998 f. Juries Act 1967 g. Magistrates Court Act h. Remand Centres Act 1976 i. Transplant and Anatomy Act 1978 j. Tuberculosis Act 1950.	
2005	The ACT Aged Care NP Pilot Project (ACT-ACNPPP)	1. Identify models of care that would enhance the quality of aged care service and delivery of health care for elders in our communities. 2. Identify the scope of practice of the aged care NP models. 3. Identify the impact of aged care NP services in the ACT on health care outcomes specifically in relation to access and clinical effectiveness. 4. Investigate aged care NP models according to the dimensions of the role and the scope of practice with particular emphasis on assessment and clinical leadership. 5. Identify the potential for improvement in coordination and linkages. 6. Investigate to what extent there is a shared scope of NP services across the	1. The aged care NP role should provide a flexible service that is responsive to the health needs of the aged care population, facilitating equitable access to timely health assessment, intervention and referral, and promoting best practices in aged care nursing. 2. The aged care NP role works within a 'transboundary' model of care (where appropriate), to provide integrated, flexible and coordinated care across the continuum of acute, community and residential aged care, regardless of whether the client is located in the public or private sector. 3. To facilitate communication, consultation, liaison and consistency	In sum, this review achieved its aims. Despite the positive outcomes demonstrated from this project, most of the recommendations from the ACNPPP were only partially realised. The strategic rollout of NP-directed services in ACT aged care facilities never fully eventuated, and has been largely replaced with models using teams of advanced-level registered nurses and medical practitioners, such as the GRACE and RADAR teams. Access to the MBS/PBS was provided to aged care NPs and other clinical specialty areas within the private sector in 2010 through the *Health Insurance Act 1973* (C'wealth) and the *National Health Act 1953* (C'wealth). However, the *National Health (Collaborative Arrangements for Nurse Practitioners) Determination 2010* (C'wealth), as well as other agreements,

		continuum of aged care services, namely the acute, community, transitional and residential aged care sectors, and to what extent specific skills are required to enable a NP to deliver appropriate and responsive care in individual settings. 7. Contribute to the growing body of knowledge about the impact of the aged care NP role on the Australian healthcare environment. 8. Explore mechanisms for improving access to general practitioners for clients in residential aged care facilities in the ACT.	in case management the aged care NP should have, where possible, authority and legitimate access to client information. The NP should also have the ability to practice within a range of different aged care settings. 4. The aged care NP model of care should complement the health care team utilising a collaborative multidisciplinary approach to care for the elderly. Aged care NPs provide nursing care, supporting the work of other health care providers and not replacing them. 5. The aged care NP model of care should be supported by an agreed set of clinical practice guidelines, and medication formulary that describes the scope of practice for the aged care NP. 6. The ACT Government, as represented by ACT Health, endorse for use within the ACT the Clinical Practice Guidelines and Medication Formularies. 7. The Australian Government support the work towards the establishment of an agreed generic national scope	instruments, and authorisation processes at the national and jurisdictional level have impeded full patient access to the MBS/PBS. For example, a NP who might be working in aged care cannot initiate a PBS-subsidised prescription for the slowing of Alzheimer's disease, or initiate MBS-subsidised medical imaging with computerised tomography of the brain to assist with the diagnosis. Work relating to a national scope of practice and education standards for NPs has been completed through the NMBA's *Nurse Practitioner Standards for Practice* (2014)[4], ANMAC's *Accreditation Standards for Nurse Practitioner Programs* (2015)[5], and the metaspecialty framework published by Gardner et al. (2019)[6]. However clinical practice guidelines (CPGs) are no longer relevant to the NP role, as they fell out of favour when they were found to inhibit practice unnecessarily once NPs achieved endorsement[7]. These CPGs were extensive documents that outlined processes in care, as well as medication and diagnostic formularies. They were overly prescriptive and were found to go beyond guideline-informed care to *protocolised* care. Nursing as a profession has evolved and we now see advanced level nurses using such CPGs to help them expand and guide

[4] Nursing and Midwifery Board of Australia [NMBA]. (2014). *Nurse practitioner standards for practice*. Australian Health Practitioner Regulation Agency [AHPRA]. Melbourne.
[5] Australian Nursing and Midwifery Accreditation Council [ANMAC]. (2015). *Accreditation standards for nurse practitioner programs.* ANMAC. Canberra.
[6] Gardner, A., Gardner, G., Coyer, F., Gosby, H., & Helms, C. (2019). *The nurse practitioner clinical learning and teaching framework: A toolkit for students and their supervisors.*doi:10.6084/m9.figshare.9733682.v2
[7] Carryer, J., Gardner, G., Dunn, S., & Gardner, A. (2007). The capability of nurse practitioners may be diminished by controlling protocols. *Australian Health Review, 31*(1), 108-115.

			of practice for NPs that incorporate evidence based clinical guidelines. 8. Clinical practice guidelines for the aged care NP should be developed collaboratively (utilising the best available current evidence) by a multidisciplinary team that includes medical, nursing, and allied health experts. 9. The leadership aspect of the aged care NP role not only incorporates the clinical aspects of care such as expert knowledge, skill and clinical decision-making but also incorporates the application of research into every day practice. 10. The aged care NP supports the work of other registered nurses and care workers, they should not replace the role or function of these care staff within an organisation or aged care setting. 11. Findings of the ACT-ACNPPP regarding the positive potential impact of the aged care NP on reducing the rates of hospital admission of aged care clients through the timely assessment, intervention, coordination and case management of clients in consultation with the multi-disciplinary team (particularly general practitioners), provide the basis for further investigation of	their clinical practice, whilst enabling them to the supply of medicines, and the requesting of diagnostic tests. The purpose of NMBA endorsement is so that NPs can work independently, without such structured processes governing their care. They are individually accountable to the regulator for their care, whereas CPGs largely make the nurse accountable to the employer. Thus, such guidelines are not necessary and NP credentialing has instead been the focus of public agencies. Well-published barriers to practice have confused the clinical role of the NP. Such barriers have forced NPs to use extensive workarounds for core aspects of their clinical roles (i.e. prescribing, diagnosing, requesting, and interpreting diagnostic tests and referring to medical and allied health specialists). These workarounds cause duplication and inefficiency of care, role uncertainty, and unrealised cost savings within both public and private sector roles. Employers want NP clinicians but as NPs develop within their roles, their *Standards for Practice* require they contribute to the larger profession in the domains of leadership, research, education, and support of systems. Twenty years on, health consumers and professionals alike are still asking what NP is and what they do. These experienced NPs are required to act in a higher capacity by contributing to larger

			the impact of this new level of nursing service. 12. The potential impact of aged care NP positions be complemented and extended by the amendment of current legislation and procedures to provide access to Medicare Provider Numbers and the PBS. 13. To enable the aged care NP to successfully enact their role, local authorities and agencies establish procedures and activate mechanisms to facilitate prescribing of medications, ordering of clinical investigations and referrals to other health care professionals. 14. The Nursing and Midwifery Office of ACT Health, in collaboration with the National Nursing and Nurse Education Taskforce, and the Australian Nursing and Midwifery Council (ANMC) facilitate the attainment of national consistency for nurse practitioner developments. 15. A nationally consistent minimum data set be established to provide data and further evaluate cost effectiveness, client and health professional satisfaction, efficacy of the aged care nurse practitioner	projects, presentations, committees, and discussions. However, this causes conflicts with employers who need clinical staff to run the day-to-day operations. This conflict is more easily managed by other professions, such as medical practitioners, who frequently hold co-joint appointments with academic institutions and have enterprise bargaining agreements that enable higher-level duties as they progress up the ladder of their profession. In addition, medical practitioners generally have teams of nursing and allied health staff to assist with their clinical loads, so they can take part in such duties. Nurse practitioners have no such support. To date, no publicly available national minimum dataset is available to evaluate cost effectiveness, client and health professional satisfaction, service delivery models or efficacy of NP roles. The primary reason for this is a lack of funding to establish such datasets and was a major recommendation from KPMG's *Cost Benefit Analysis of Nurse Practitioner Models of Care* (2018)[8] report, which had been funded by the Commonwealth Department of Health. It was hoped the MBS/PBS data could in part, be used for such purposes. However, this data is not publicly available and is very blunt in its approach to examining NP practice. It only tracks professional attendances with NPs. It does not examine with any granularity the types of procedures, treatments, or conditions that are

[8] KPMG. (2018). *Cost benefit analysis of nurse practitioner models of care.* Australian Commonwealth Department of Health.

			role, client safety and health care outcomes. 16. The aged care NP be provided with agreed prescribing rights within the PBS. 17. For an aged care NP to be able to function at their full potential across sectors, they need to be able to refer to other health professionals and to order diagnostics, within their scope of practice, under MBS, so older people will not be financially disadvantaged. 18. The 'Nurse Practitioners in the ACT—The Framework' (ACT Government 2002) document should be the model that facilitates the establishment of aged care NP positions, providing guidelines for the practice environment. 19. The ACT Government through its agency ACT Health facilitates the procedural components to enable the enactment of the full implementation of the aged care NP role; including approval of draft clinical practice guidelines and medication formularies. 20. The ACT Government develops and further implements local policies and mechanisms that advise pharmacists of the medication	being treated by NPs, as it is with general practitioners and medical specialists. ACT Government has limited experience in developing NP-specific resources for health consumers, NPs and employers. These are currently being developed by the NP Professional Practice Project to assist both the public and private sector in better understanding and establishing NP roles.

			formulary from which the aged care NP can prescribe. 21. The ACT Government through its agency ACT Health, collaborates with the private sector to support the development of the aged care NP role. 22. Further funding is provided to enable research to be undertaken to clarify issues surrounding establishing roles, how leadership from NPs impacts the health sector, transition to practice, after hours service delivery, and how the role improves access to timely care.	
2007	Implementing the Nurse Practitioner in Aged Care (INPRAC)	1. Contribute to a national minimum data set (Joanna Briggs Institute) for Aged Care NPs 2. Pilot data collection strategies and collect baseline data for assessment of the impact on quality measures with emphasis on reasons for admission, length of stay, client satisfaction and other indicators that may be relevant; 3. Provide data to inform clinical support structures for newly licensed practitioners; 4. Identify potential barriers in health structures and systems that may impact on the ability of the NP to order pathology, imaging and other diagnostic tests and develop strategies to address this;	1. The Pharmaceutical Benefits Scheme prescriber numbers and Medical Benefits Scheme provider numbers are made available to authorised NPs; 2. That organizations, line managers and overarching boards are fully informed of the role of the NP prior to implementation; 3. That further research and investigative studies are conducted to continue to monitor the cost savings resulting from decreased admission to acute services; 4. That the position description for the NP and the related client-base is negotiated and clearly articulated, prior to the commencement of the role;	This research project served as an extension to operationalise the NP role from the ACT-ACNPPP above, and was co-funded by the Commonwealth and Territory health departments. It was unique in that it examined outcomes relating to NP practice models across both the public and private health sectors. The INPRAC report provides useful insights and achieved its research aims. Importantly, it demonstrated significant health systems savings and PROMs associated with NP roles in the aged care sector. For example, the report identified that NP interventions in a residential aged care model were able to decrease falls in at-risk populations by 24% over the study period. In addition, the incidence of chronic wounds declined from 4/month to 0/month, and pressure injuries reduced from 3/month to

		5. Identify potential barriers in the structures and systems that may impact on the ability of the NP to implement prescribing rights and develop strategies to address these; 6. Identify health benefits associated with NP assessment, intervention or referral in aged care contexts; 7. Identify further legislative changes that may be required to allow the NP to function in the extended role, especially in relation to Schedule 8 medicines; 8. Develop local protocols and policies for the effective implementation for NP prescribing, ordering pathology, imaging and diagnostic tests; 9. Identify aspects of clinical intervention, leadership and acculturation during the transition period following endorsement to practice as NPs; 10. Provide data on the extent and character of the evolving role of the NP in aged care; 11. Identify and develop formalised supervision/mentorship strategies to support new NPs; 12. Identify the potential for improved integration, coordination, and linkages with existing services across the acute, community and residential aged care sectors; and 13. Contribute to the growing body of knowledge regarding the impact of	5. That there are realistic, achievable and individual key performance indicators established at the outset of NP position development; 6. That there is regular opportunity for performance review, by both the NP and the manager, at initially close intervals in order to provide ongoing assessment of the boundaries and parameters around the scope of the role; 7. That NP positions are legitimised, from a management and organisational perspective, and that this is conveyed to all members of the multidisciplinary team and other appropriate health professionals, including those that may be external to the employing organization; 8. That a strategic plan be developed for the ongoing professional, clinical and organizational development of the NP role; 9. That the Nursing and Midwifery Office, ACT Health continue to explore the possibility of a larger, statistically relevant, study regarding the delay to treatment commencement as a result of NP inability to obtain PBS and MBS prescriber and provider numbers; 10. That future NP positions have clearly defined service areas and geographical boundaries;	1/month during the study period. In a separate tertiary hospital-based aged care NP model, the actions of one NP (who was not legislatively allowed to practice to her full scope of practice), resulted in a health systems savings of $442,750 over the course of one year. Data from INPRAC was used in a much larger national project, whose final report was published in 2007. That project was coordinated by the Joanna Briggs Institute (JBI) and titled *National Evaluation of Nurse Practitioner-Like Services in Residential Aged Care Services.* It analysed data from several different jurisdictions that were implementing the NP role in aged care. What is most striking about the JBI project is that it suffered from significant issues relating to its methodology. For example, even though the JBI project aimed to examine NP-related practice and outcomes, INPRAC was the only contributor that used NPs, whereas the remaining jurisdictions used advanced practice nurses who had not undertaken or completed their NP training. Lastly, INPRAC was significant in that it observed significant adverse outcomes arising from delays in care provision. Those delays in care provision were attributed to the fact that NPs in the community-based aged care sector had no access to MBS/PBS items to subsidise core care activities, or were unable to undertake supplemental activities required of their roles due to legislative restrictions. These

		the aged care NP role in the context of Australian health.	11. That memorandums of understanding are developed, between area health services and private sector NPs to enable access to professional resources; 12. That mentorship is developed and encouraged for future NPs; 13. That future data collection methodologies are designed to accurately capture a greater range of NP core interventions; and 14. That interprofessional learning is available, by way of clinical support teams, to provide NPs with support, guidance and knowledge exchange opportunities in an ongoing manner.	unnecessary delays occurred because NPs were then required to source general practitioners or medical specialists to fulfill duties relating to core or supplemental NP duties (e.g. prescribing, requesting examinations, etc.), but this was not always logistically feasible in a timely manner. It is thought this observation, in addition to findings from the ACT-ACNPPP, were instrumental in pushing forward the Commonwealth's 2010 MBS/PBS reforms.
2007	Evaluation of the NP Framework	14. Undertake an evaluation of the Framework in terms of application across the ACT, impact and benefits using both quantitative and qualitative research methods. 15. Determine the effectiveness of the Framework package. 16. Determine the satisfaction of organizations and individuals interested in creating NP positions with the Framework. 17. Conduct a brief review and comparison with similar documentation from other States and Territories. 18. Identify and provide recommendations to the NP Project Team on improvements required prior	15. Reduce the size and content, simplify and make it [the Framework] more concise. It should be generic, not ACT Health and acute care centric; and able to be used by NPs in the public and private sectors. 16. Incorporate flowcharts where possible. 17. Change the document to a digital form with direct links to other key documents and websites. Ensure it is easily printable. Regularly update ensuring appropriate document control of versions maintained. 18. The key role of the Multidisciplinary Advisory Groups [MAG] should be emphasised and	This evaluation provided an opportunity to refresh the governance framework for NP positions across both the public and private sectors. In sum, the review was successful in achieving its aims. At the time, NPs across both the public and private sectors were required to submit a business case and matching clinical practice guidelines for approval by the Director General or their delegate before they were authorised to prescribe medicines or independently request diagnostic imaging or pathology tests. Such requirements for clinical practice guidelines or business cases are recommended, but no longer required in the private sector. Credentialing processes used in the public sector have now replaced the requirement for clinical practice

		to second and subsequent editions of the Framework documentation. 19. Within a quality context, report on the usability and clarity of the documentation from a consumer's perspective. 20. Finalise and deliver a report on the evaluation of the Framework to the Project Manager.	each Advisory Group remain in place for the duration of the NP service. The MAG could be the health service team with which the NP works, and members of the services be consumers. 19. Include references on consumer participation, for example websites and clearing houses. Include guidance on how to consult and liaise with Health Care Consumers ACT. 20. The formulary section needs updating to reflect changes to the regulation of medicines in the ACT. 21. Provide more guidance for NPs on the development of their formulary. 22. In conjunction with the Chief Pharmacist of the ACT develop a process for informing pharmacists, both public and private, on NP dispensing and how to access the approved NP clinical practice guidelines/formulary. 23. Ensure the Framework provides information to health service organisations on how to develop organisation-specific policies and procedures on the management of internal and external NP prescribing. 24. Include information on the credentialing process for NPs who	guidelines, and business cases for NP positions are approved through the usual processes in the public sector. Many of the changes did not produce any palpable change in the authorisation process, but most of the hurdles imposed by this framework was eventually repealed with changes to the *Health Act 1993* and the *Medicines, Poisons and Therapeutic Goods Act 2008.* Currently, no strategic policy exists for establishing or growing NP services across the ACT or Nationally. Due to the legislative and policy complexities surrounding NP practice, some pharmacists are still uncertain on what an NP can and cannot prescribe. The Australian College of Nurse Practitioners report that pharmacists are sometimes requesting that an NP submit their "collaborative agreement" or formulary to prove they are working within their scope of practice, even though this is not required. Many health service organisations, despite wanting NP services, are still uncertain about what is required to successfully enact the role. There are a few that have done so, and their work is published in the peer-reviewed and grey literature.

			apply to work with health facilities in the ACT. 25. Provide more in-depth information on options on professional indemnity where scope of practice may vary across different work situations and locations. 26. Develop short, concise, evidence-based complementary Framework documents in digital form which inform and guide, and are easily printed. 27. Ensure any future Framework "template" documents are in an accessible format so they can be easily downloaded and directly entered into. 28. Develop an ACT policy and a strategic planning framework for the development of NP services, that 'add value' to existing health services. 29. Provide more information on how to develop 'transformational' services outside the traditional models of health service, including outside ACT Health, and how to access other funding options to support these. 30. Develop a stronger focus and inclusiveness of consumers. Develop consumer-focussed information handout sheets to	Professional indemnity is determined by the insurer, but in most cases the insurer themselves are not aware of the true scope of practice of the individual NP and what they might require to adequately cover for their practice. There is no published guidance for NPs on what level of cover is required, for example, for NPs involving high levels of surgical procedures in their work. Access to an nursing adviser with specific expertise in NP-related policy and practice has been sporadic in the ACT. An NMBA-accredited and ANMAC-endorsed NP program through the University of Canberra never eventuated. Currently there are 15 accredited NP programs across the States and Territories.

			raise awareness of NP services and roles. 31. Simplify and streamline the "Approval of Positions" documentation requirements and process, particularly taking into the consideration the needs of non-government organisations. 32. Simplify and streamline the "Services Business Case" documentation requirements and template, particularly taking into consideration the needs of non-governmental organisations. 33. Simplify the Scope of Practice and Clinical Guidelines document and template, particularly taking into consideration the needs of non-governmental organisations. 34. Provide continued access to a NP advisor who provides guidance on the requirements of the business case and scope of practice documents, and who can assist with and facilitate the complex process of approval. This may not be required if process and documents were significantly simplified. 35. Develop a simple marketing strategy which includes activities and tools to market the NP to consumers, health service	

			managers, and other health professionals in the service team. 36. Develop a business performance measure to monitor the timeliness of the approval process of applications for NP services submitted to the Delegate. Monitor and report on this. 37. Raise the awareness and profile of the ACT-based NP master's course.	
2011	Independent Evaluation of the Nurse-led ACT Health Walk-in Centre	1. Conduct an evaluation of the first 12 months of nurse-led Walk-in Centre (WiC) operation, including an examination of: a. Patient access; b. Quality and appropriateness of care provision; c. Impact on other health services; and d. Cost effectiveness.	This evaluation report did not provide formal recommendations for the WiC model of care, but simply reported on outcomes. Key areas identified for improvement by the ACT Health Directorate, in response to this evaluation, related to: • Optimal WiC location; • Documentation methodology for waiting times; • Provision of training and ongoing education support for nurses; • Clinical decision support software; • Model of care and use of protocols; and • Relationship with the Canberra Hospital Emergency Department staff.	Overall, the nurse-led WiC has excellent capacity in meeting its aims of fulfilling an unmet health care need in the community, meeting demand for health care services, developing an innovative strategy to recruit and retain a professional multidisciplinary workforce, and relieving pressure on the public hospital system. The evaluation identified that it increased patient access to care, and that care was of a high quality and appropriate. The model was cost-effective when compared to ED occasions of service, but more expensive than a standard general practitioner consult. The evaluation clearly identified there was little differentiation between the scope of practice of the NP and an advanced practice nurse in the WiC model of care, and this was a core issue impacting upon the effective and efficient use of this highly skilled workforce. At the time of the evaluation, NPs practiced to the same protocols that APNs did, which severely limited their ability

				to manage conditions within the NP's employed scope of practice. Overall, the evaluation achieved its aims. However, the section describing cost effectiveness did not draw meaningful or realistic comparisons with the costs of care provision in general practices. This was mainly because the authors did not appear to account for MBS procedural items (e.g. suturing, plastering, etc.) used in general practices. Comparisons on procedural items would have been helpful due to the quantum of such services provided in the WiC. Publicly-available comparative data from general practices in the ACT would have greatly enhanced this section.
2017	NPs in the Australian Capital Territory in 2017: A review	1. Examine the strengths and weaknesses of the governance structures controlling NPs practising in the ACT.	1. The role of NPs in the ACT is 'normalised' to be in line with that of other health professionals, with the clinical governance arrangements for NPs the responsibility of employers. 2. All employers have robust clinical governance systems in place for all health professionals (including NPs) working in the service. 3. ACT repeal most regulations relating specifically to NPs and dismantle current Standard Operating Procedures. 4. ACT Health provide guidelines for all employers on employer obligations including the establishment of appropriate clinical governance arrangements for all health services	This review was transformational, as it initiated legislative reforms that removed labour-intensive authorisation processes experienced by both public and private sector NPs. The review sought to "normalise" the role within the health sector. In sum, this review achieved its aim. The review triggered the legislative reforms to the *Health Act 1993* that allowed employers and NPs to be responsible for their own credentialing processes. Unfortunately, the review did not have its full effect due to the fact there was no policy officer assigned to assist in the transition process, and only officially occurred since mid-October 2020.

			– public and private/NPs and other health professionals. 5. Transitional arrangements such as a moratorium or extensions of time are put in place while the outcomes of this review and any changes to the current policy position are considered. 6. A senior policy/project manager is appointed to manage the transition and support ACT Health, all employers and NPs in private practice.	Recommendation 2, that most regulations relating specifically to NPs be repealed, was ineffective and vague in its recommendation as there are a total of 81 acts, regulations, and instruments that continue to affect NP practice.
2018	ACT Health Strategic Plan for the Requirement of NPs within the Australian Capital Territory	1. Identify the current status and future NP requirements within the Territory against best/evidence-based practice models nationally and internationally. 2. Develop a strategic plan that outlines the expected benefits and the change activities required to meet the desired future state.	1. Develop and distribute information on the role of NPs that is inclusive of case studies profiling innovative practice models. 2. Develop a succession planning process that is inclusive of NP traineeships. 3. Develop and provide access to clinical service plans and job description templates. 4. Develop a systematic scheduled cycle of evaluation for all NP positions, including implementation fidelity to ensure effective functioning is sustained, and positive exemplars are in place to apprise establishment for future NP positions. 5. The ACT aligns with other States and Territories regarding access to PBS as per the reforms of 2010.	This review was somewhat vague and ineffectual in its recommendations. It was unsuccessful in achieving either of its aims. Some outcomes from this review have only recently eventuated, and not in full. The ACT public health system finalised a systematic scheduled cycle of evaluation for NP positions through credentialing in 2020. To the author's knowledge, the Walk-in Centres are the only service within the ACT public sector that are in the process of developing a succession planning program for NPs. A senior project adviser position to lead further NP policy work in the ACT began in October 2020, and resulted in the development and distribution of information about the NP role through the ACT Health Directorate's website.

			6. The Australian College of NPs provide an individualised career planning and support service.	

Consultation Paper

19 May 2021

Proposed Legislative Changes to Authorise Core and Supplemental Clinical Activities Performed by Nurse Practitioners

You are invited to provide feedback

The ACT Government Health Directorate is consulting on proposed changes to legislation that would enable a "right-touch" regulatory approach to Nurse Practitioners (NPs) working in the ACT. The proposed changes would authorise NPs working within their individual scopes of practice to perform core and supplemental activities that directly relate to their clinical roles.

We are seeking feedback on the identified issues and your responses to specific questions. The ACT Office of the Chief Nursing and Midwifery Officer (CNMO) has released background documents that can be used to inform your responses to this consultation. These are:

- *Results from the Australian Capital Territory Nurse Practitioner Workforce and Employer Survey*
- *Outcome Evaluation on Nurse Practitioner Policy and Legislation in the Australian Capital Territory*
- *Nurse Practitioners in the ACT: Frequently Asked Questions (FAQs) for Employers*
- *Nurse Practitioners in the ACT: FAQs for Nurse Practitioners*
- *Nurse Practitioners in the ACT: FAQs for Health Consumers*

Providing feedback

Feedback can be provided by completing and emailing the attached Word document with the subject line "NP Authorisation" to nmo@act.gov.au

Feedback is required by close of business on **30 June 2021**.

Publication of submissions

The Health Directorate will publish submissions on its website to encourage discussion and inform the community and stakeholders. However, we will not publish on its website, or make available to the public, submissions that contain offensive or defamatory comments, or which are outside the scope of the consultation.

Before publication of submissions, the Health Directorate may remove personally-identifying information including contact details. The view expressed in the submissions are those of the submitting individual or organisation and publication does not imply any acceptance of, or agreement with these views by the Directorate.

The ACT Government Health Directorate accepts submissions made in confidence. These submissions will not be published on the website or elsewhere. Submissions may be confidential because they include personal experiences or other sensitive information. Any request for access to a confidential submission will be determined in accordance with the *Freedom of Information Act 1982* (Commonwealth), which has provisions designed to protect personal information and information given in confidence.

Please let the ACT Government Health Directorate know if you do not want your submission published or want all or part of it treated as confidential.

All information collected will be treated confidentially and anonymity preserved in internal and published reports. Data collected will only be used for the purposes described above.

Your participation is entirely voluntary.

In providing feedback, we ask that you do not provide responses that identify you or other individuals.

If you have any questions, you can contact the senior project officer at the ACT Office of the CNMO at Christopher.Helms@act.gov.au.

Contents

Executive Summary

The ACT Health Directorate, through the ACT Office of the Chief Nursing and Midwifery Officer (CNMO), has undertaken a project to better understand the current ACT Nurse Practitioner (NP) workforce, their requirements, and the legislative and policy barriers that preclude NPs from working to their full potential in the ACT.

Outcomes from this project are anticipated to optimise the ACT NP workforce in meeting priority communities, including older persons, people with chronic and/or complex health needs, and marginalised and/or vulnerable populations. The project aims to facilitate the delivery of high-quality health services, deliver value by creating greater efficiencies in the health system, and better enable workforce flexibility to meet dynamic health system needs. These aims align with the ACT Health Directorate's strategic objectives[1] of:

- Healthy communities
- Safe, responsive, sustainable public health system,
- Trusted, transparent and accountable, and
- High performing organisation that values our people.

This consultation paper seeks feedback on proposed changes to legislation and policy that would enable *full practice authority* and "right-touch" regulation[2] of the ACT NP workforce. Right touch regulation enables proportionate, consistent, targeted, transparent, accountable and agile regulation of the health workforce. It uses the minimum regulatory force to facilitate efficient and effective healthcare delivery, whilst prioritising protection of the public. In this consultation, *practice authority* refers to all activities a *profession* is legislatively authorised to perform, whereas *scope of practice* refers to all activities an *individual* within that profession is both legislatively authorised to perform, and competent to do.

On the short term, this consultation paper seeks feedback from ACT health consumers, health professionals, professional bodies, employers, and regulators to progress work that will provide ACT NPs with the practice authority to:

- Authorise death certificates;
- Witness non-written health directions;
- Prescribe medicines that induce a medical termination of pregnancy;
- Authorise drivers licence medicals; and
- Authorise workers' compensation certificates.

Over the medium-term, it is proposed that language in ACT legislation relating to healthcare and Australia's nationally-regulated health practitioner workforce be systematically reviewed to align with contemporary approaches to right-touch regulation. A review would facilitate legislation that assures the right healthcare professional is able to provide the right care at the right time for health consumers in the ACT.

---

[1] ACT Government. (2019). *ACT Health Directorate Strategic Plan: 2020-25*. Canberra, ACT. https://health.act.gov.au/sites/default/files/2020-09/ACTH%20Strategic%20Plan%202019%20LR.pdf

[2] Professional Standards Authority [PSA]. (2015). *Right-touch Regulation Revised* [Report]. PSA. http://www.professionalstandards.org.uk/docs/default-source/publications/thought-paper/right-touch-regulation-2015.pdf?sfvrsn=12

What is a Nurse Practitioner?

A NP is a registered nurse (RN) regulated by National law[3] through an endorsement process established by the nursing regulatory authority, the Nursing and Midwifery Board of Australia (NMBA). The NMBA establishes registration, endorsement, education, and practice standards for Australian nurses and midwives. The NMBA also establishes safety and quality guidelines for the nursing and midwifery professions. Currently, there are over 2000 NPs endorsed to practice across all Australian states and territories, with 54 listing their principal place of practice as the ACT. Nurse practitioners practise in over 50 different specialty areas, and are found across both the public and private healthcare sectors in every Australian jurisdiction.

Nurse Practitioners practise independently and collaboratively through an extended clinical nursing role. The NP role reflects that of an RN working at an advanced level of practice, but whose specific focus is on the provision of expert clinical care. This care includes the practice authority to independently and collaboratively perform the following *core activities*:

- comprehensive and advanced health assessment;
- diagnosis and treatment of medical conditions;
- autonomous prescribing of medicines;
- requesting and interpreting diagnostic examinations (e.g. blood tests and medical imaging examinations); and
- independent referral to medical, surgical and allied health practitioners.

Nurse Practitioners, as a result of their advanced clinical practice, are expected to undertake *supplemental activities* as relating to their individual scopes of practice. Supplemental activities are required to reduce unnecessary duplication of care, improve systems efficiencies, and improve the overall experience of healthcare consumers as they intersect with the health system. For example, a supplemental activity might include the completion of official documentation, such as workers' compensation certificates or driver's license medicals arising from an NP providing a comprehensive assessment, diagnosis and treatment plan for an individual. Like core activities, supplemental activities facilitate the NP role and are enabled through legislation and/or policy. The net result of these core and supplemental NP activities is the delivery of safe, effective, and efficient health services to persons who may be marginalised and/or underserved. This includes communities such as the homeless, the aged, Aboriginal and Torres Strait Islanders, refugees and those living in rural and remote areas.

The ACT Nurse Practitioner Workforce

The ACT CNMO recently examined the ACT NP workforce and their practice requirements. It identified that ACT NPs do not have the practice authority to perform core and/or supplemental activities required of their employed roles. This has resulted in significant unintended safety and quality outcomes for ACT health consumers and their families. For

[3] *Health Practitioner Regulation National Law Act 2009* (Cth)
https://www.legislation.qld.gov.au/view/html/inforce/current/act-2009-045

example, a recent survey[4] of NPs revealed current ACT legislation prohibits NPs from providing woman-centred care by disallowing the prescribing of medicines that induce a medical termination of pregnancy before nine weeks' gestation, despite NPs having the capability to do so. This restrictive legislation has resulted in unnecessary duplication of care and increased out of pocket expenses for at-risk women in the ACT.

In another example, despite having an internationally-recognised[5,6] palliative care service using NPs in the ACT, NPs themselves are not legally able to sign death certificates. Under ACT legislation, a valid death certificate is required before a person may be moved from their place of death. This is a critical supplemental activity required of palliative care NP roles, but their inability to undertake this task has resulted in unacceptable delays when persons with a life-limiting illness have died at home. In some instances, several days have passed with a person lying in state in their home whilst waiting for a medical practitioner to sign a death certificate.

Such outcomes and inefficiencies arise from the inability of NPs to complete activities required of their roles, and result in adverse outcomes and increased health system expenditure. This consultation paper and the following project reports provide greater detail on these issues:

- *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey*
- *Outcome Evaluation on Nurse Practitioner Policy and Legislation in the Australian Capital Territory*

Nurse Practitioners in the ACT operate within robust governance frameworks that align an individual's clinical scope of practice with their employed roles. To improve the effective use of the ACT NP workforce, legislative authorisations are needed to enable core and supplemental activities that are within the scope of practice of individual NPs. These authorisations aim to reduce poor patient outcomes, unnecessary duplication of care, out-of-pocket patient costs, strain on public health services, and improve the clinical efficiency of the NP workforce.

Consultation Questions:
We invite you to provide feedback, with particular focus on the following areas:
(NOTE: ALL questions relate to NP practice authority. The core and supplemental activities highlighted below do not necessarily relate to an individual NP's scope of practice. Scope of practice is determined by NP competence, their employed role, and supporting governance frameworks.)

---

[4] Helms, C. (2021). *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey*. ACT Government.
[5] Johnston, N., Lovell, C., Liu, W. M., Chapman, M., & Forbat, L. (2016). Normalising and planning for death in residential care: findings from a qualitative focus group study of a specialist palliative care intervention. *BMJ Support Palliat Care*. https://doi.org/10.1136/bmjspcare-2016-001127
[6] Liu, W. M., Koerner, J., Lam, L., Johnston, N., Samara, J., Chapman, M., & Forbat, L. (2020, Feb). Improved Quality of Death and Dying in Care Homes: A Palliative Care Stepped Wedge Randomized Control Trial in Australia. *J Am Geriatr Soc, 68*(2), 305-312. https://doi.org/10.1111/jgs.16192

1. What benefits and/or issues would you envision if NPs had the *practice authority* to prescribe medicines for medical terminations of pregnancy (MToP) in the ACT before nine weeks' gestation?
2. What additional information, resources and/or restrictions to practice (if any) would be required to safely and effectively facilitate MToP practice authority for NPs in the ACT?
3. What benefits and/or issues would you envision if NPs had the *practice authority* conduct the following supplemental practice activities?
    a. Authorise death certificates;
    b. Witness non-written health directions;
    c. Authorise drivers license medicals; and
    d. Authorise workers' compensation and Comcare certificates.
4. What additional information, resources and/or restrictions to practice (if any) would be required to safely and effectively facilitate the practice authorities in 3(a-d) above for NPs in the ACT?
5. What benefits, issues and/or risks do you envision if the ACT were to explore omnibus legislation for NPs working in the ACT?

The following sections provide an overview of the consultation, as well as supporting information on the NP workforce. It then provides further information on practice authority and scope of practice issues faced by NPs working in the ACT. This information is provided to inform the reader as to the background and rationale for the consultation questions.

Overview of the Consultation

In April 2020, the ACT Office of the Chief Nursing and Midwifery Officer (CNMO) provided advice to the Minster for Health, Rachel Stephen-Smith MLA, on legislative and policy issues affecting NPs, in response to correspondence from the Australian College of Nurse Practitioners (ACNP). In response, the ACT CNMO initiated a project to better understand the current ACT NP workforce, their requirements, and the legislative and policy barriers that preclude NPs from achieving full practice authority in the ACT. The project aims to develop recommendations for legislative and policy change that ensures a "right touch" regulatory approach to the NP workforce, which maximises workforce potential and ensures sustainable NP contributions to the ACT health system.

The project has three primary phases. The first phase resulted in the completion of a workforce survey of NPs and their employers, to better understand the current issues affecting NP practice in the ACT. This phase was completed in January 2021 and the final report arising from the survey, *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey,* can be found on the ACT Government Nurse Practitioner webpage.

The second phase of the project resulted in the completion of an outcome evaluation that discussed significant projects relating to NP practice, policy and legislation in the ACT since 2002. This phase was completed in early February 2021 and the final report arising from the evaluation, *Outcome Evaluation on Nurse Practitioner Policy and Legislation in the Australian Capital Territory*, can also be found on the ACT Government Nurse Practitioner webpage.

The third phase of the project is this consultation process, whose insights will be used to develop final recommendations to the ACT Government. Those recommendations will relate to proposed changes to legislation that better enable NP clinical practice in the ACT.

Overview of Nurse Practitioners

A NP is a registered nurse (RN) who has been endorsed by the Nursing and Midwifery Board of Australia (NMBA) to practise independently and collaboratively through an extended clinical nursing role[7]. The NP role reflects that of an RN working at an advanced level of practice[8], but whose specific focus is on the provision of expert clinical care. This care includes the practice authority to independently and collaboratively perform the following *core activities*, as relevant to all nurse practitioners:

- comprehensive and advanced health assessment;
- diagnosis and treatment of medical conditions;
- autonomous prescribing of medicines;
- requesting and interpreting diagnostic examinations (e.g. blood tests and medical imaging examinations); and

[7] Nursing and Midwifery Board of Australia. (2014). *Nurse Practitioner Standards for Practice*. http://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Codes-Guidelines/nurse-practitioner-standards-of-practice.aspx

[8] Nursing and Midwifery Board of Australia. (2020). *Fact sheet: Advanced nursing practice and specialty areas within nursing*. Melbourne: Australian Health Practitioner Regulation Agency

- independent referral to medical and allied health practitioners.

There are several key documents published or approved by the NMBA that enable the education, regulation and practice authority of NPs nationally. These include:

- Registration Standard: Endorsement as a Nurse Practitioner (2016)
- Nurse Practitioner Standards for Practice (2021)
- Nurse Practitioner Accreditation Standards (2015)
- Registered Nurse Standards for Practice (2016)
- Code of Conduct for Nurses (2018)
- Decision-Making Framework for Nursing and Midwifery (2020)
- Code of Ethics for Nurses (International Council of Nurses, 2012)
- Safety and Quality Guidelines for Nurse Practitioners (2016)

Australia legislated title protection for NPs in 1998[9], and the first two NPs were authorised to practice in New South Wales in 2000[10] in the areas of rural and remote practice and emergency care. The national endorsement awarded by the NMBA identifies those RNs who have achieved additional qualifications, experience and specific expertise for independent practise, which meets recognised standards and guidelines.

In addition to national regulatory requirements, NPs have contextualised state and territory, as well as employer authorisation processes[11] that are required for clinical practice. Jurisdictional requirements have historically concerned themselves with authorisations relating to the *Medicines, Poisons, and Therapeutic Goods Acts* and *Regulations*, however named. Over the past twenty years those requirements have changed nationally to acknowledge the autonomous nature[12] of NP prescribing practice, as seen with medical practitioners. Currently, Tasmania is the only remaining jurisdiction that requires a separate authorisation process to allow autonomous NP prescribing[13].

In the ACT, NPs were once required to undergo Territory-wide authorisation processes to not only prescribe medicines, but to comprehensively describe the individual's clinical scope of practice through 'clinical practice guidelines'. Those guidelines detailed which diagnostic tests the NP could request, care pathways, as well as the medical conditions they could independently manage. In addition, before an NP was authorised to practice a supporting business case was required for approval by the ACT Government or their delegate[14]. These

---

[9] New South Wales Government. (1998). Nurses Amendment (Nurse Practitioners) Act (No. 102). Sydney, NSW: Commonwealth of Australia.

[10] Foster, J. (2010). *A History of the Early Development of the Nurse Practitioner Role in New South Wales, Australia*. (Doctor of Philosophy), University of Technology, Sydney, NSW.

[11] Australian Commission on Safety and Quality in Health Care. (2015). *Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners* [Report](NSQHS Standards, Issue December). ACSQHC.

[12] Health Workforce Australia. (2013). *Health professionals prescribing pathway* [Report]. Health Workforce Australia.

[13] Department of Health. (2020). *Nurse practitioner authorisation to prescribe scheduled substances* [Guideline]. Tasmanian Government.

[14] Berrill, J. (2007). *Nurse practitioners in the Australian Capital Territory: The framework evaluation*. ACT Health.

authorisation requirements became increasingly problematic and burdensome as NPs and their employers actualised their roles across both the public and private health sectors, particularly in generalist areas of practice such as aged care and primary health care. A report[15] commissioned by the ACT Office of the CNMO highlighted the need to align NP authorisations with other Australian jurisdictions, who had "normalised" the NP role by removing legislative authorisation provisions for NPs that were above and beyond other regulated health professions. In response, legislative changes to the *Health Act 1993* were approved in 2019, which aligned authorisation requirements for NPs with other regulated health practitioners in the ACT.

Currently, there are over 2000 NPs endorsed to practice across all Australian states and territories, with 54 listing their principal place of practice as the ACT[16]. Nurse practitioners practise in over 50 different specialty areas[17], and are supported by six empirically-derived metaspecialties[18] (*See Table 1*). The metaspecialty framework[19] is used by students in NP academic education programs and endorsed NPs to broadly describe and develop their individual scopes of practice.

Table 1: The Australian Nurse Practitioner Metaspecialties

Metaspecialties
• Primary Health Care • Emergency and Acute Care • Ageing and Palliative Care • Child and Family Health • Mental Health Care • Chronic and Complex Care

Nurse Practitioner academic programs are independently accredited[20] at the Master's level and are informed by capability theory, which enables NPs to evolve their practice to meet novel and dynamic population needs[21]. As individual NPs clinically mature in their experience and expertise, they are expected to expand their practice after endorsement using the NMBA's *Decision-Making Framework*.

---

[15] Adrian, A. (2017). *Nurse practitioners in the Australian Capital Territory in 2017: A review* [Report]. ACT Government.

[16] Nursing and Midwifery Board of Australia. (2020). Nurse and Midwife Registrant Data (June). Melbourne, VIC: Australian Health Practitioner Regulation Agency.

[17] Gardner, A., Gardner, G., Coyer, F., Henderson, A., Gosby, H., & Lenson, S. (2014). *Educating Nurse Practitioners: Advanced Specialty Competence, Clinical Learning and Governance* [Report]. Australian Government. http://www.olt.gov.au/system/files/resources/ID12-2182_Gardner_Report_2014.pdf

[18] Gardner, A., Helms, C., Gardner, G., Coyer, F., & Gosby, H. (2020). Development of nurse practitioner metaspecialty clinical practice standards: A national sequential mixed methods study. *Journal of Advanced Nursing, 77*(3), 1453-1464. https://doi.org/10.1111/jan.14690

[19] Gardner, A., Gardner, G., Coyer, F., Gosby, H., & Helms, C. (2019). *The nurse practitioner clinical learning and teaching framework: A toolkit for students and their supervisors* [Toolkit]. CLLEVER2 Research Consortium. https://doi.org/10.6084/m9.figshare.9733682.v2

[20] Australian Nursing and Midwifery Accreditation Council. (2015). *Nurse practitioner accreditation standards.* ANMAC. https://www.anmac.org.au/standards-and-review/nurse-practitioner

[21] Gardner, G., Dunn, S., Carryer, J., & Gardner, A. (2006, Sep-Nov). Competency and capability: imperative for nurse practitioner education. *Aust J Adv Nurs, 24*(1), 8-14. https://www.ncbi.nlm.nih.gov/pubmed/17019819

Nurse Practitioners and Scope of Clinical Practice

Practice authority refers to all activities a *profession* is legislatively authorised to perform, whereas *scope of practice* refers to all activities an *individual* within that profession is both legislatively authorised to perform, and competent to do[22]. Like medical practitioners and other regulated health professionals, a nurse's individual's scope of practice is always more narrowly defined than their profession's practice authority.

An NP's scope of clinical practice involves much more than the core activities described in the preceding section. A broad definition of the NP scope of practice was established by the Australian Nursing and Midwifery Council (ANMAC)[23] and is summarised below:

The scope of practice of the NP builds upon registered nurse practice enabling NPs to manage episodes of care, including wellness focused care, as a primary provider of care or in collaborative teams. As part of this care, NPs use advanced, comprehensive assessment techniques in the screening, diagnosis and treatment of client conditions by applying best available knowledge to evidence-based practice. NPs can independently request and interpret diagnostic imaging and pathology tests, prescribe therapeutic interventions including the autonomous prescription of medicines, and independently refer patients to healthcare professionals for conditions that would benefit from integrated and collaborative care. They accomplish this using skilful and empathetic communication with health care consumers and health care professionals. NPs facilitate patient-centred care through the holistic and encompassing nature of nursing. Finally, NPs evaluate care provision to enhance safety and quality within healthcare. Although clinically focused, NPs are also expected to actively participate in research, education and leadership as applied to clinical care.

Some NPs operate in discrete specialty areas within larger multidisciplinary care teams (e.g. a Diabetes NP working within a tertiary hospital) and some may operate as primary healthcare providers serving in communities to supplement access to health services (e.g. a Primary Healthcare NP working in sole practice or in a regional, remote or isolated area).

An individual NP's approved clinical scope of practice is determined by their employer and the NP's individual competence[24]. For example, credentialing standards used by public sector

---

[22] Nurse Practitioner Schools. (2020). *Scope of Practice vs Practice Authority.* Nurse Practitioner Schools. Retrieved 13 January from https://www.nursepractitionerschools.com/faq/scope-of-practice-vs-practice-authority/

[23] Australian Nursing and Midwifery Accreditation Council. (2014). Consultation Paper 2: Review of the nurse practitioner accreditation standards (p. 7). Canberra, ACT: ANMAC.

[24] Nursing and Midwifery Board of Australia. (2020). *Safety and quality guidelines for nurse practitioners.* Australian Health Practitioner Regulation Agency. Retrieved 19 February from http://www.nursingmidwiferyboard.gov.au/Registration-and-Endorsement/Endorsements-Notations/Safety-and-quality-guidelines-for-nurse-practitioners.aspx

employers[25] are commonly used by local committees to determine which medicines, interventions and diagnostic tests an employed NP is approved to prescribe, perform or request. That approval process is dependent upon the NP's employed role, and may result in differing scopes of practice for NPs working within the same specialty area and context of practice. For example, one NP working in public sector emergency department (ED) 'X' may be approved to request computed tomography (CT) scans whereas another NP in public sector ED 'Y' may be solely limited to requesting plain film x-rays. That is not to state NP 'Y' does not have the individual competence to safely and effectively request CT scans; it merely means their employed position does not require them to do so.

Financial Subsidies and their Impact on Nurse Practitioner Practice Authority

There is a widely held and incorrect belief that available Commonwealth patient subsidies for health care are what determines jurisdictional NP practice authority. This belief is most prevalent with available subsidies for specific diagnostic imaging tests (e.g. X-rays, ultrasounds and CT scans) and many medicines. Although these subsidies may influence how core activities are operationalised in NP clinical practice, they do not determine NP practice authority. This concept is important and relevant to this consultation, as practice authority relating to NP clinical practice has previously been limited in the ACT Legislature based upon this incorrect belief. This issue is further discussed in the section *Practice Authority to Provide a Medical Termination of Pregnancy* below. The following paragraphs in this section provide further detail on how the Medicare Benefits Scheme (MBS) and Pharmaceutical Benefits Schedule (PBS) relate to core activities that ACT NPs currently have the practice authority to perform within their individual scopes of practice.

Private sector NP clinical scope of practice is widely influenced by available patient subsidies offered by the Commonwealth for NP-directed care. For example, the MBS provides patient subsidies for professional attendances, diagnostic pathology, simple point-of-care testing, and limited diagnostic imaging tests when requested by an eligible NP in the private sector[26]. Many diagnostic imaging tests that are within an NP's authorised and approved scope of practice to request, such as CT scans and pelvic ultrasounds, are not subsidised by the MBS. Those tests are only subsidised when requested by a medical practitioner. This does not mean the imaging test is outside the NP's clinical scope of practice; it simply means the patient will be required to pay the full private fee for those imaging tests when requested by a NP.

Likewise, the PBS provides subsidies for limited medicines prescribed by an eligible NP, and has placed additional prescribing requirements for NPs on certain medicines before the Commonwealth will subsidise the costs of those medicines[27]. A lack of PBS subsidy does not preclude NPs from prescribing medicines they are authorised to prescribe. Therefore, current restrictions to the MBS and PBS mean that patients in the private community sector are

---

[25] Australian Commission on Safety and Quality in Health Care. (2015). *Credentialing health practitioners and defining their scope of clinical practice: A guide for managers and practitioners* [Report](NSQHS Standards, Issue December). ACSQHC.

[26] Australian Government. (2018). *Eligible nurse practitioners questions and answers*. Department of Health. Retrieved 28 March from http://www.health.gov.au/internet/main/publishing.nsf/Content/midwives-nurse-pract-qanda-nursepract

[27] Australian Government. (2010). *Nurse practitioner PBS prescribing*. Department of Health. Retrieved 28 March from http://www.pbs.gov.au/browse/nurse

required to pay the full cost for certain diagnostic imaging tests or medicines if they choose an NP as their healthcare provider. If a patient chooses to see a general practitioner, those same tests (MBS) or medicines (PBS) would be subsidised by the Commonwealth.

These financial disparities result in patients, who choose an NP as their healthcare provider, having increased out-of-pocket costs and taking longer to achieve their safety-net thresholds[28]. This is somewhat of a paradox, as NPs traditionally focus their care on populations and communities that are generally marginalised, vulnerable, and/or having a lower socioeconomic status[29]. Therefore, current funding mechanisms for patient subsidises through the MBS and PBS may serve as a mechanism to limit the clinical scope of practice for some NPs, as they do not want to financially disadvantage their clients. However, there are many clients that are seen by NPs who do not consider financial subsidy a barrier to safe and effective care, and prefer the NP continue to treat them as indicated by best practice guidelines. Some of these issues were highlighted to the Commonwealth through the recent MBS Taskforce Review[30], but recommendations to address these issues were not accepted by the Taskforce itself[31]. These recommendations are now being independently considered by the Commonwealth Minister for Health.

The private sector issues described above affect the clinical scope of practice of NPs working in the public sector, but through differing mechanisms. For example, the recent *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey* (2021) report highlighted concerns that many NPs in the ACT public sector are unable to prescribe subsidised medicines, initiate referrals to medical specialists, or request subsidised diagnostic tests in community-based settings. These limitations have severely limited the clinical scope of practice of NPs in the ACT, despite having the practice authority to perform such activities. These restrictions on clinical scope of practice are not related to NP authority or competency, but because of public hospital policies that are primarily designed to support medical practitioners, which do not account for NP clinical practice in the public sector. These issues are also compounded by current funding arrangements between the Commonwealth and Territory for publicly-subsided medicines[32], whether public hospitals make use of existing funding mechanisms for NP services through Tier 2 Non-Admitted Services[33], and policies that support how individual public hospitals pay for diagnostic testing requested by clinicians

---

[28] Australian Government. (2021). *Medicare safety nets.* Services Australia. Retrieved 19 February from https://www.servicesaustralia.gov.au/individuals/services/medicare/medicare-safety-nets

[29] Fiandt, K., Doeschot, C., Lanning, J., & Latzke, L. (2010, Sep). Characteristics of risk in patients of nurse practitioner safety net practices. *J Am Acad Nurse Pract, 22*(9), 474-479. https://doi.org/10.1111/j.1745-7599.2010.00536.x

[30] Nurse Practitioner Reference Group. (2018). *Report from the Nurse Practitioner Reference Group to the Medicare Benefits Schedule Review Taskforce* [Report]. Australian Government. https://www1.health.gov.au/internet/main/publishing.nsf/content/BEB6C6D36DE56438CA258397000F4898/$File/NPRG%20Final%20Report%20-%20v2.pdf

[31] Medicare Benefits Schedule Review Taskforce. (2020). *Taskforce findings - Nurse practitioner reference group report* [Report]. Australian Government. https://www.health.gov.au/resources/publications/taskforce-findings-nurse-practitioner-reference-group-report

[32] Australian Healthcare Associates. (2017). *PBS Pharmaceuticals in Hospitals Review* [Report]. Australian Commonwealth Department of Health. https://www.pbs.gov.au/reviews/pbs-pharmaceuticals-in-hospitals-review-files/PBS-Pharmaceuticals-in-Hospitals-Review.pdf

[33] Independent Hospital Pricing Authority. (2020). *Tier 2 non-admitted services classification*. Accessed 26 February from https://www.ihpa.gov.au/what-we-do/tier-2-non-admitted-care-services-classification

through "request and refer" numbers[34]. In sum, the current clinical efficiency of the publicly employed NP workforce in the ACT is not reflective of its true capacity, because they do not have access to sufficient funding and policy mechanisms that enable core activities required for their clinical scope of practice.

Practice Authority for Core Nurse Practitioner Activities

With respects to contextualised ACT legislation, NPs have full practice authority to conduct all previously described core activities. Key relevant legislation that enables those core activities are:

- *Health Practitioner Regulation National Law (ACT) 2010*
- *Medicines, Poisons and Therapeutic Goods Act 2008*
- *Health Act 1993*
- *Radiation Protection Act 2006*

However, practice authority is limited as relating to two core activities required for NP clinical practice in the ACT. The first relates to the ability of NPs to freely request diagnostic imaging examinations that are relevant to their individual clinical scopes of practice. The other limitation relates to the ability of NPs and other prescribers to prescribe certain medicines in the ACT.

In the NMBA's *Nurse Practitioner Standards for Practice* it is clear that an NP may request and/or interpret *any* diagnostic imaging test within their individual scope of practice. Provisions within the *Radiation Protection Act 2006* give NPs, as well as other regulated health practitioners, the practice authority to request diagnostic imaging test within their individual clinical scope of practice. However, the *Radiation Protection Act 2006* pt III div 3.1 stipulates that a person dealing with a regulated radiation source must take "reasonable steps" to ensure that a patient does not receive excessive exposure to ionising radiation. The division specifies this responsibility is not held by the practitioner dealing with radiation if the test has been requested by a *doctor*. The legislation is silent on other health practitioners who currently regularly request diagnostic imaging tests in the ACT, such as NPs, physiotherapists and other allied health practitioners. This has therefore raised concern with health professionals who deal with ionising radiation, as medico-legal responsibility for the consequences of ionising radiation exposure when requested by non-doctors is blurred. This has resulted in some radiologists refusing requests for diagnostic imaging when requested by NPs who are working within their individual scopes of practice. Steps to address this concern are on the forward agenda for the ACT Legislative assembly in 2021-2022.

With respects to the core activity of prescribing medicines, ACT legislation currently precludes NPs and other authorised prescribers from prescribing certain medicines in the ACT. For example, the *Medicines, Poisons and Therapeutic Goods Regulations 2008* limits the prescribing of certain medicines to medical specialists under Schedule 3, Appendix D. This includes the prescribing of specialist medicines for discrete medical conditions, such as oral isotrentoin for the treatment of severe cystic acne or clozapine for treatment-resistant

[34] Centre for International Economics. (2013). *Responsive patient centred care: the economic value and potential of Nurse Practitioners in Australia* [Report]. Australian College of Nurse Practitioners.

schizophrenia. In addition, the *Medicines, Poisons and Therapeutic Goods (Category Approval) Determination 2021* limits the prescribing of controlled medicines in specific circumstances, and for certain categories of patients for all prescribers in the ACT (*See Table 2*).

Table 2: Controlled Medicines and Categories Requiring Approval through Controlled Medicines Prescribing Standards

Controlled Medicines[1]	Patient Categories[1]
Morphine	Controlled medicine to treat a person with chronic (non-cancer) pain
Hydromorphone	Controlled medicine to treat a person with active malignancy or life limiting disease
Tapentadol	Controlled medicine to treat a person with drug-dependency
Buprenorphine	Controlled medicine to treat a person with a licensed indication or severe insomnia
Fentanyl	Psychostimulants for Attention Deficit Hyperactivity Disorder
Oxycodone	Psychostimulants for Binge Eating Disorder
Methadone	Psychostimulants for Narcolepsy
Alprazolam	1. A nurse practitioner working within their approved scope of practice can prescribe any of these controlled medicines, within the category limitations established by the *Medicines, Poisons, and Therapeutic Goods (Category Approval) Determination 2021*. In most instances prescribing is facilitated if there is an ATRG indication, and there is documented support by a medical specialist, drug and alcohol nurse practitioner and/or palliative care nurse practitioner. Refer to the *Controlled Medicines Prescribing Standards* for more information.
Flunitrazepam	
Dexamfetamine	
Lisdexamphetamine	
Methylphenidate	
Medical cannabis	
Sodium Oxybate	

For example, the *Determination* specifically authorises "palliative care nurse practitioners" and "drug and alcohol nurse practitioners" as prescribers who can prescribe controlled medicines for the treatment of drug-dependent persons with active malignancy or life-limiting disease.

Practice Authority to Provide a Medical Termination of Pregnancy

Currently, Part 6 of the *Health Act 1993* (ACT) precludes NPs from prescribing an abortifacient for the purposes of inducing a medical (non-surgical) termination of pregnancy (MToP) before nine weeks' gestation. In 2018, the *Health (Improved Abortion Access) Amendment Bill* was debated in the ACT Legislative Assembly. The original bill intended to improve access to MToP by including NPs with medical practitioners as authorised prescribers of the medicine that induces MToP. However, after debate in the Assembly[35] NPs were eventually excluded from the Bill based upon the incorrect conclusion that MToP was outside the scope of practice of NPs because they could not perform the required care without MBS or PBS subsidies. In addition, it was recognised that a separate approval process would be required by the Therapeutic Goods Administration (TGA) before NPs were authorised to prescribe the required medicine.

A recent ACT NP workforce survey[36] identified that a lack of access to MToP in an eligible patient resulted in significant costs for an at-risk woman, even though the NP had the competence and supporting governance frameworks to prescribe the medicine. This

[35] ACT Government, *Parliamentary Debates,* Legislative Assembly, 19 Septmeber 2018, 3.20.00 (Caroline LeCouteur, Member for Murrumbidgee) https://aod.parliament.act.gov.au/A73140

[36] Helms, C. (2021). Results from the Australian Capital Territory (ACT) *Nurse Practitioner Workforce and Employer Survey* [Report]. ACT Government.

particular issue is further complicated by the fact the company approved to supply the medicine to induce MToP has an approved Risk Management Plan (RMP) with the TGA. The current RMP asserts that only medical practitioners can undertake the requisite training before being authorised to prescribe the product[37]. The TGA itself does not regulate scope of clinical practice for regulated health practitioners. Changes to the *Health Act 1993* (ACT) would first be required before the RMP could be updated[38], and allow for NPs working within their scope of practice to prescribe this medicine.

Currently, no Australian jurisdiction has practice authority legislation that allows NPs working within their scope of practice to provide MToP before nine weeks' gestation[39]. Only medical practitioners, such as general practitioners and other medical specialists may provide MToP in Australia. Importantly, evidence to date in several international jurisdictions suggests that appropriately trained and supported NPs can safely and effectively provide MToP[40,41,42]. This has been recognised in New Zealand, where educational and regulatory standards closely approximate those of Australian NPs. Legislation in New Zealand has recently passed that allows NPs working within their scope of practice to provide MToP[43]. It is perhaps timely to consider revisiting this practice authority for NPs in the ACT, to better support transferable skills and expertise that aligns with the intent of the *Trans-Tasman Mutual Recognition Act 1997* (C'wealth).

Other legislative barriers relating to core NP practice activities in the ACT do not appear to be currently causing a significant effect on NP clinical practice. For example, the *Controlled Sports Act 2019* requires that pre-event medical clearances only be performed by a medical practitioner. Nurse Practitioners can independently assess and diagnose any medical condition within their scope of practice. In fact, the *Public Health Act 1997, Sex Work Act 1992,* and *Road Transport (General) Act 1999* specifically place the same level of responsibility and accountability arising from assessment and diagnosis of medical conditions on NPs as medical practitioners. However, results from the ACT NP workforce survey did not indicate comprehensive assessment and diagnosis relating to the *Controlled Sports Act 2019* was an immediate problem affecting the ability of NPs to undertake core activities required of their

---

[37] Therapeutic Goods Administration. (2012). *Registration of medicines for the medical termination of early pregnancy.* Retrieved 26 February 2021 from https://www.tga.gov.au/registration-medicines-medical-termination-early-pregnancy

[38] Therapeutic Goods Administration. (2019). *Risk management plans for medicines and biologicals: Australian requirements and recommendations.* Retrieved 17 March 2021 from https://www.tga.gov.au/book-page/what-rmp

[39] Marie Stopes Australia. (2020). *Nurse-led medical termination of preganncy in Australia* [Legislative Scan]. Marie Stopes International.

[40] Yarnall, J., Swica, Y., & Winikoff, B. (2009). Non-physician clinicians can safely provide first trimester medical abortion. *Reproductive Health Matters, 17*(33), 61-69. https://doi.org/10.1016/S0968-8080(09)33445-X

[41] National Academies of Sciences. (2018). *The Safety and Quality of Abortion Care in the United States.* National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK507233/

[42] Mainey, L., O'Mullan, C., Reid-Searl, K., Taylor, A., & Baird, K. (2020). The role of nurses and midwives in the provision of abortion care: A scoping review. *Journal of Clinical Nursing, 29*(9-10), 1513-1526. https://doi.org/https://doi.org/10.1111/jocn.15218

[43] New Zealand Parliament. (2021). Abortion Legislation Bill. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/BILL_89814/abortion-legislation-bill?fbclid=IwAR2DLd5xKgkJzh14KcdYViwGGqVII1Mkyi4GpIMJbHupvhw4B2G0EVxVALw

roles. This is likely because no ACT NPs were working with populations requiring assessment in accordance with the *Controlled Sports Act 2019*.

Consultation Questions:
An appropriately trained and authorised NP working within their individual scope of practice could safely and effectively provide MToP before nine weeks' gestation. They would be able to perform this activity irrespective of available subsidies through the MBS or PBS. However, NPs currently do not have the *practice authority* to provide MToP in the ACT.

Practice authority requires a change to the *Health Act 1993* (ACT) to include NPs with medical practitioners as authorised prescribers of medicines to induce a MToP in the ACT. An amendment to the RMP registered with the TGA would then be required to include ACT NPs as being eligible to undertake any required training to prescribe the required medicine.

1. What benefits and/or issues would you envision if NPs had the practice authority to prescribe medicines for medical terminations of pregnancy (MToP) in the ACT before nine weeks' gestation?
2. What additional information, resources and/or restrictions to practice (if any) would be required to safely and effectively facilitate MToP practice authority for NPs in the ACT?

Practice Authority for Supplemental Nurse Practitioner Activities

Nurse practitioners, as a result of their advanced clinical practice, are expected to undertake *supplemental activities* as relating to their individual scopes of practice. Supplemental activities are required to reduce unnecessary duplication of care, improve systems efficiencies, and improve the overall experience of healthcare consumers as they intersect with the health system.

Supplemental activities include the completion of required documentation arising as a result of an NP providing a complete episode of care. Like core activities (e.g. prescribing medicines, requesting diagnostic tests, etc.), supplemental activities facilitate the NP role and are enabled through legislation and/or policy. For example, as a result of assessing, diagnosing and providing therapeutic interventions for an illness that requires an absence from work, NPs in the ACT will commonly issue a 'sick certificate' that serves the purpose of a statutory declaration[44] for the patient's employer. The reason why NPs cannot provide a 'medical certificate' in this instance is because operational definitions in the *Fair Work Act 2009* (C'wealth) and *Workers Compensation Act 1951* (ACT) require that 'medical certificates' only be written by a registered medical practitioner. If an NP were to provide a 'medical certificate' it would amount to 'holding out', which is an offence under sections 116 and 118 of the *Health Practitioner Regulation National Law 2010* (C'wealth).

The aforementioned NP employer and workforce survey[45] demonstrated that NPs currently work in diverse areas of practice across the ACT. The survey suggested that legislative

[44] Australian Government. (2021). Statutory declarations. Attorney-General's Department. Retrieved 26 February from https://www.ag.gov.au/legal-system/statutory-declarations
[45] Helms, C. (2021). *Results from the Australian Capital Territory (ACT) Nurse Practitioner Workforce and Employer Survey* [Report]. ACT Government.

authorisations are needed for supplemental activities that are within the scope of practice for individual NPs, in order to reduce poor patient outcomes, unnecessary duplication of care, out-of-pocket patient costs, strain on public health services, and improve the clinical efficiency of the NP workforce. Such authorisations would provide NPs with the appropriate practice authority, but not necessarily be within the scope of practice of individual NPs. Table 3 below outlines the supplemental activities requiring legislative authorisation that significantly impact upon the current ACT NP workforce:

Table 3: Supplemental Activity Authorisations Currently Required for Nurse Practitioners in the ACT

Supplemental Activity	Relevant Legislation	Supporting Frameworks for Clinical Practice
Authorising death certificates[46]	• Births, Deaths and Marriages Registration Act 1997 and Regulations • Cemeteries and Crematoria Act 2003 and Regulations • Coroners Act 1997	• World Health Organisation. (1979). *Medical certification of cause of death: Instructions for physicians on use of international form of medical certificate of cause of death*. (4th ed.) WHO. https://apps.who.int/iris/handle/10665/40557 • Australian Bureau of Statistics. (2020). *Information paper: Cause of death certification in Australia*. ABS. https://bit.ly/3vgkeJA
Witnessing non-written health directions	• Medical Treatment (Health Directions) Act 2006	• Nurse Practitioner Standards for Practice • Registered Nurse Standards for Practice • Code of Conduct for Nurses • Code of Ethics for Nurses
Authorising driver's license medicals	• Road Transport (General) Act 1999 • Road Transport (Driver Licensing) Act 1999 and Regulations • Road Transport (Driver Licensing) Regulation 2000 • Road Transport (Alcohol and Drugs) Act 1977	• Austroads. (2017). *Assessing fitness to drive*. Austroads. https://bit.ly/3cnnQ3R
Authorising workers' compensation and Comcare certificates	• Workers Compensation Act 1951 and Regulation • Work Health and Safety Act 2011 (C'wlth) and Regulations	• Comcare. (2021). *Medical practitioners: Your role in an employee's rehabilitation*. Australian Government. https://bit.ly/3rG3QQA • WorksafeACT. (2021). https://www.worksafe.act.gov.au • NSW Government. (n.d.) *Workers compensation guide for medical practitioners*. State Insurance Regulatory Authority. https://bit.ly/30E6NoV

For example, the employer and NP workforce survey identified that common supplemental activities required by palliative care NPs are the ability to authorise death certificates and non-written health directions for those persons without advance care plans. Similar

[46] Some registered nurses employed in in the ACT public sector are able to declare "life extinct" in a deceased patient. A death certificate is an important legal document that officially notifies the Territory registrar of a death. It reports deaths that are not required by law to be reviewed by the Coroner and are required before a body can be moved from the place of death. A declaration of "life extinct" does not meet this requirement.

regulatory jurisdictions, such as Canada, New Zealand and the USA already allow NPs and other regulated health professionals other than medical practitioners to sign death certificates[47].

Likewise, NPs in the ACT have identified that an inability to authorise workers' compensation certificates, Comcare certificates, and driver's license medicals are a commonly-encountered patient requirement arising from their authority to undertake a comprehensive assessment. However, NPs in the ACT do not currently have the authorisation to perform these supplemental activities even though they may be a patient's primary healthcare provider, or have assessed and managed the complete episode of care relating to a workplace-based injury. This requires the NP to refer the patient to a medical practitioner, who duplicates the care provided by the NP in order to authorise the relevant certificate. This directly translates to increased out-of-pocket and health system costs. These restrictions to practice represent over-regulation of the nursing workforce, and are out of step with other countries that use an NP workforce with similar regulatory and educational requirements.

The supplemental activities described in Table 3 above are required by NPs working within their individual scopes of practice in every Australian State and Territory. Currently, none of these jurisdictions provide NPs with the practice authority to authorise death certificates, non-written health directions, or driver's license medicals. Only two jurisdictions, South Australia and Queensland, allow NPs working within their scope of practice to authorise worker's compensation certificates. Reportedly Tasmania will be consulting with the public on the ability of NPs to authorise workers' compensation certificates in 2021. See Table 4 below for a summary of state-based practice authorities for NPs who authorise worker's compensation certificates:

Table 4: Workers' Compensation and Nurse Practitioner Practice Authority

	Queensland	**South Australia**
Year Practice Authority Granted	2010	2016
Relevant Legislation and Policy	• Workers' Compensation and Rehabilitation Act 2003 and Regulations • Workers' Compensation Certificate Protocol for Nurse Practitioners	• Return to Work Act 2014 and Regulations • Nurse Practitioner Work Capacity Certificates
Practice Setting Restrictions	• None	• Public or private emergency department contexts only.
Scope	• New injuries only • Minor injuries only	• New injuries only • No specification of severity
Restrictions	• Maximum duration 10 days • No ongoing certificates	• Maximum duration 7 days • No ongoing certificates

It is proposed that NPs in the ACT be given the practice authority to perform the four supplemental activities described in Table 3 above. This is because those activities have been highlighted by the current ACT NP workforce as commonly having significant adverse effects

[47] Millares-Martin, P. (2020). Death certification in England must evolve (Considering current technology). *Journal of Forensic and Legal Medicine, 69*(101882). doi: 10.1016/j.jflm.2019.101882

on patient safety and/or quality outcomes, or contributing to significant inefficiencies, due to their inability to authorise those activities. These same safety and quality concerns were identified by NPs in New Zealand. In order to address these concerns "omnibus legislation" was enacted, which provided New Zealand NPs with far-reaching practice authority. A New Zealand NP working within their scope of practice may issue death certificates, complete compulsory mental health treatment orders, carry out medical examinations ordered by a court, assess fitness to drive and authorise worker's accident and compensation certificates. This was accomplished by simply replacing the term "medical practitioner" with "health practitioner" in their legislation[48,49].

Nurse practitioners are increasingly working in public and private sector primary healthcare, where they may provide services as a patient's primary healthcare provider, or in partnership with a larger healthcare team[50,51,52]. A recent review of the ACT legislation suggests the extent to which current legislation inappropriately limits NP practice authority may be much more extensive than the supplemental activities listed above. There are currently 16 legislative instruments that provide practice authority for NPs in the ACT, but a further 63 that indirectly impact upon NPs to achieve their full practice authority. It is perhaps time to enable best practice legislation and policy in the ACT, by creating our own version of right-touch omnibus legislation. Such revisions would reflect contemporary regulation and clinical practice, which facilitates safe, effective, and innovative models of care using a highly expert and regulated health workforce.

---

[48] Coleman, J. (2015). *Health Practitioners (Replacement of Statutory References to Medical Practitioners) Bill* (51, Issue 36-2). New Zealand Government. https://www.parliament.nz/en/pb/bills-and-laws/bills-proposed-laws/document/00DBHOH_BILL63296_1/health-practitioners-replacement-of-statutory-references

[49] Nurse Practitioners New Zealand. (2021). *Frequently asked questions*. College of Nurses Aotearoa. Retrieved 27 January from https://www.nurse.org.nz/npnz-nurse-practitioners-nz.html

[50] Currie, J., Chiarella, M., & Buckley, T. (2019, Feb). Privately practising nurse practitioners' provision of care subsidised through the Medicare Benefits Schedule and the Pharmaceutical Benefits Scheme in Australia: results from a national survey. *Aust Health Rev, 43*(1), 55-61. https://doi.org/10.1071/AH17130

[51] Currie, J., Chiarella, M., & Buckley, T. (2016, Oct). Workforce characteristics of privately practicing nurse practitioners in Australia: Results from a national survey. *J Am Assoc Nurse Pract, 28*(10), 546-553. https://doi.org/10.1002/2327-6924.12370

[52] Helms, C., Crookes, J., & Bailey, D. (2015). Financial viability, benefits and challenges of employing a nurse practitioner in general practice. *Aust Health Rev, 39*(2), 205-210. https://doi.org/10.1071/AH13231

Consultation Questions:
Over the short-term, it is proposed that NPs in the ACT be given the practice authority to conduct the following supplemental practice activities, as relevant to their individual scopes of practice:

a) Authorising death certificates;
b) Witnessing non-written health directions;
c) Authorising workers' compensation and Comcare certificates; and
d) Authorising driver's license medicals.

Over the medium-term, it is proposed that language relating to "medical practitioners", "doctors", "medical certificates" and other synonyms be systematically reviewed within ACT legislation, so that omnibus legislation may be considered that better enables the practice authority of nurse practitioners. This would align with contemporary approaches to right-touch legislation and policy of a nationally-regulated health workforce.

3. What benefits and/or issues would you envision if NPs had the practice authority to conduct the above four supplemental practice activities (a-d) above?
4. What additional information, resources and/or restrictions to practice (if any) would be required to safely and effectively facilitate the practice authority to perform the above supplemental activities (a-d) for NPs in the ACT?
5. What benefits, issues and/or risks do you envision if the ACT were to explore omnibus legislation for NPs working in the ACT?

Conclusion

The NP workforce is one whose practice is well-established in Australia and internationally. There is a significant body of peer-reviewed research demonstrating the safety and ability of nurses to undertake the NP role in diverse areas of practice. They work in metropolitan to regional and remote areas of Australia, across both the public to private health sectors. They may work as stand-alone primary healthcare providers, but also work collaboratively within larger healthcare teams. They work in a multitude of specialty areas, and are highly regulated by the NMBA. After being established in Australian healthcare for over 20 years, they are recognised for their innovation, work with marginalised and vulnerable populations, and their ability to safely and effectively practise as independent practitioners who are fully accountable for their care.

Core activities of the NP role include the ability to independently, collaboratively and comprehensively assess, diagnose and treat conditions within their individual scopes of practice. This includes the ability to request and interpret diagnostic examinations, diagnose medical conditions, and autonomously prescribe medicines. Supplemental activities of the NP role are those that arise as an outcome of providing complete episodes of care. However, existing data from the ACT reveals NPs are encountering significant barriers in actualising their roles, because they lack the practice authority to perform core and/or supplemental activities relevant to their scopes of practice. They have not yet achieved their full potential in contributing to health system reform. It is now time to consider how right-touch regulation and policy can better facilitate core and supplemental activities required for NP roles within the ACT community. This will ensure a sustainable future workforce, improve systems

efficiencies and patient outcomes, and demonstrate effective stewardship of the healthcare system.

Nurse Practitioners in the ACT

Frequently Asked Questions (FAQ) for ***Employers***

This FAQ is written for Nurse Practitioner (NP) employers in the Australian Capital Territory (ACT). It's recommended you review the FAQs designed for Nurse Practitioners and Health Consumers for further information.

The ACT Office of the Chief Nursing and Midwifery Officer (ACT OCNMO) will update this information from time to time, as legislation and/or policy evolves in the ACT.

What's a Nurse Practitioner (NP)?

Nurse Practitioners are expert registered nurses (RN) that are endorsed by the national nursing regulator, the Nursing and Midwifery Board of Australia (NMBA). The title 'nurse practitioner' is protected by law and signifies the RN has extensive clinical experience and education. They can work independently within their roles to:

- Assess and diagnose medical conditions,
- Prescribe medicines,
- Request and interpret tests (e.g. imaging tests such as X-rays and ultrasounds, as well as blood tests), and
- Make referrals to a medical and/or allied health specialists.

You're able to identify whether your NP holds the NMBA endorsement by checking the national register. To find or request more information about NPs, we recommend you visit ACT Health's webpage or contact the Australian College of Nurse Practitioners.

What does an NP do?

Nurse practitioners work in many different areas, including specialty care (e.g. diabetes, palliative care, wound care, and mental health) to generalist care (e.g. Walk-in Centre, aged care, or primary healthcare NP). They may work as individual health providers with their own stand-alone clinics, or work within larger healthcare teams. They work in both the public and private health sectors.

Each NP has skills and expertise that are unique, and supplement those skills by collaborating with other health professionals to ensure you get the best possible care. For example, some can perform procedures like skin checks and suturing, whereas others are excellent at case management and the care of long-term health conditions. If you're unsure if your NP can do something for you – just ask! They will be more than happy to provide you with helpful advice.

I'm interested in *hiring* an NP. What key information should I know?

There are over 50 different specialty areas in which NPs practice[1]. Data published by the NMBA indicate there are just over 2100 NPs nation-wide[2], and emergency NPs are the most common specialty[3]. Approximately 75% of endorsed NPs currently work in the public sector. You may be fortunate and find a candidate immediately. However, many employers find their applicant pool is insufficient, or advertised positions generate interest from highly capable NPs in differing specialty areas who want to expand their roles into a new area of practice. Therefore, in order to attract the right candidate, we recommend you consider (as appropriate) the following:

- Include a statement in job advertisements that "experience in [a specific specialty area] is highly desirable, but not required for the right candidate who is willing to expand their practice through mentoring and a supportive work environment"; or
- Grow your own NP by supporting existing registered nursing staff into the NP role.

If a candidate does not have experience in the advertised area of practice, you need to carefully review the NP's *capability* and the *time* required to expand their practice to meet job requirements. You will also need to consider how applicable credentialing processes will be used to protect the public *and* facilitate the NP's growth into the role. Generally, this process

[1] Helms, C., Gardner, A., & McInnes, E. (2017). Consensus on an Australian Nurse practitioner specialty framework using Delphi methodology: results from the CLLEVER 2 study. *J Adv Nurs, 73*(2), 433-447. https://doi.org/10.1111/jan.13109

[2] Nursing and Midwifery Board of Australia. (2021). *Statistics*. https://www.nursingmidwiferyboard.gov.au/About/Statistics.aspx

[3] Middleton, S., Gardner, A., Gardner, G., & Della, P. R. (2011). The status of Australian nurse practitioners: the second national census. *Aust Health Rev, 35*(4), 448-454. https://doi.org/10.1071/AH10987

can take anywhere from three months to one year, depending on the requirements of the role and the NPs existing scope of practice. You should therefore decide if you have enough support in the workplace to help the candidate successfully transition.

NPs are able to independently expand their knowledge and skills into new areas, using the NMBA's *Decision-Making Framework for Nursing and Midwifery*. A good way of expanding the NP's practice is by starting them in their scope of practice comfort zone, with a mutually-agreed upon plan, milestones and timelines for expanding practice into different facets of their new practice area. This plan should include appropriate review and oversight by the employer and an experienced clinician mentor, who should be a medical practitioner or nurse practitioner.

Potential candidates can be screened for their NP endorsement on the register of practitioners, which is maintained by the Australian Health Practitioner Regulation Agency (AHPRA). It's important to note the NMBA no longer issues physical registration and endorsement certificates. The online register is the single point of truth relating to whether nurses are registered and/or are endorsed with the NMBA, and whether they have conditions or undertakings on their practice.

What key skills should any NP have upon endorsement?

All newly-endorsed NPs should be able to independently perform the following key skills within their scope of practice:

- Completing and documenting a comprehensive history and physical assessment;
- Formulating a differential diagnosis;
- Autonomously prescribing medicines using principles aligning with the Quality Use of Medicines;
- Autonomously and judiciously requesting and interpreting reports arising from diagnostic examinations;
- Independently determining the limits of their competence; and
- Collaborating with other health professionals through written referral and appropriate communication.

In addition, many NPs will have advanced specialty knowledge within a specific area of practise. As with other health professionals, there may be a transition period of up to six - twelve months while the newly-endorsed NP enters clinical practice.

I'm interested in *growing my own* NP. What key information should I know?

Whether you're growing an RN into an NP role, or helping an NP expand their practice into your desired role, there are a few key things you should know:

Growing RNs into the NP Role

An RN must demonstrate 5000 hours working at an advanced level of practice in the previous six years, and have successfully completed a Master's degree from an accredited Australian university before they are able to demonstrate the registration standard required for endorsement by the NMBA. In order to gain entry to an Australian Master of Nurse Practitioner program the RN must demonstrate the following:

- Current registration as a RN;
- A postgraduate qualification (Graduate Certificate or Graduate Diploma) in a clinical field relevant to the RN's intended clinical field; and
- A minimum of two years' full time equivalent (FTE) as an RN in a specified clinical field; and
- A minimum of two years' FTE working at an *advanced level of practice* in that same clinical field.

The determination of an advanced level of practice does not relate solely to, or require the ability to undertake technical procedural skills (e.g. suturing, plastering, insertion of contraceptive devices, etc.).

The demonstration of advanced practice requires the nurse demonstrate a high level of nursing practice across five domains: clinical care, optimising health systems, education, research and leadership. The ADVANCE Tool can assist nurses and employers to determine if the RN is working at an advanced level of practice. If not, it highlights areas for future professional development. Once enrolled in a Master of Nurse Practitioner course, the student should expect to graduate in 2-3 years, depending on the program and their progress.

Using Existing NPs and Growing them Into a New Role

NPs who are endorsed by the NMBA may use the *Decision-Making Framework for Nursing and Midwifery* to help make practice decisions relating to their intended scope of practice. In addition, the *Nurse Practitioner Clinical Learning and*

Teaching Framework uses the concept of "metaspecialties"[4] to help guide the development of clinical learning and teaching goals for NPs wanting to expand into different areas of clinical practice. Ultimately, scope of practice is jointly determined by the NP, their employer, and the intended requirements of the role. An NP going into a different area of practice must determine, in collaboration with their employer, what additional education, training, and clinical governance will be required to safely expand their clinical scope of practice.

What funding models support NP positions?

There are two primary funding models that support NP positions: public or private funding. Both funding models benefit from a needs assessment, development of a relevant business case, and consideration of supporting outcomes measures that will promote growth and long-term sustainability of NP roles.

Eligible NPs working in the private sector may obtain a Medicare provider number and use the Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (PBS) to help subsidise the cost of care provision. The MBS and PBS work to subsidise the costs of performing the core activities discussed above. Importantly, to be eligible for MBS and PBS support the NP is required to demonstrate one of four types of collaborative arrangements. Nurse practitioners working in the private sector, who do not use MBS or PBS subsidies in their clinical practice, are not required to demonstrate a collaborative arrangement.

Occasionally there are additional funding pools in the primary healthcare sector, including through non-governmental organisations and primary health networks when there are demonstrable gaps in service provision.

What clinical governance supports are needed for NP practice?

Generally, the clinical governance requirements for NPs are no different than for medical practitioners or other regulated health practitioners. If you are working with a new NP, or an NP expanding their practice into a new area, they will likely need more mentorship and/or supervision than an experienced NP. However, there are a few key governance considerations that may be relevant, depending on the NP's intended scope and context of practice:

- How can credentialing be used to not only protect the public, but assure the NP can work to their full scope of practice with minimal inefficiency?
- How does ACT legislation uniquely impact upon the NP's practice authority and their employed role?
- What referral and consultation pathways can patients and health professionals use to access the NP's services and vice versa?
- How will care escalation occur, and how might this be different from other regulated health practitioners within the health service?
- How will peer review occur and what nurse-sensitive outcomes measures should be used to measure performance?
- What level of private indemnity insurance does the NP require given the requirements of the employed role?

How much should I pay my NP?

This depends on whether the NP is employed in the public or private health sectors. The public sector has Enterprise Agreements that determine an employed NP's salary and work conditions in the ACT. Minimum work conditions for nurses employed in the private sector have been established by the Fair Work Commission through the Nurses Award 2010. Employers should note salary rates listed in the Award are far below that of public sector enterprise agreements. NPs in the private sector must determine their own salaries in negotiation with employers.

Can NPs write 'medical certificates' in the ACT?

NPs in the ACT must issue a 'sick certificate' for employees who are unwell and cannot attend their workplace. A sick certificate serves the purpose of a statutory declaration for the patient's employer. The reason why NPs cannot provide a 'medical certificate' is because the law requires that 'medical certificates' only be written by registered medical practitioners. There is no limit on the number of days an NP can write a sick certificate, but depends on the patient's illness and any relevant policies for your organisation.

[4] Gardner, A., Helms, C., Gardner, G., Coyer, F., & Gosby, H. (2020). Development of nurse practitioner metaspecialty clinical practice standards: A national sequential mixed methods study. *Journal of Advanced Nursing, 77*(3), 1453-1464. https://doi.org/10.1111/jan.14690

Can NPs fill out workers' compensation (including Comcare) or driver's license medical paperwork?

NPs can assess, diagnose, and treat work-related injuries within their individual abilities and employed roles. However, under ACT law, NPs workers' compensation (including Comcare) certificates must be authorised by a medical practitioner.

NPs working within their individual abilities and employed roles can assess a person's fitness to drive. However, under ACT law, Driver's License Medicals forms must be authorised by a medical practitioner.

Can NPs prescribe medicines subsidised by the government?

Many medicines are subsidised by the government through public hospitals or the Pharmaceutical Benefits Scheme (PBS). Generally, inpatient medicines and those supplied by public hospitals upon discharge are subsidised by the ACT government. Many medicines that are dispensed in community pharmacies are subsidised by the PBS.

Private Sector

NPs meeting requirements in the private sector, who are working within their abilities and employed roles, can obtain a prescriber number and write prescriptions that attract a PBS subsidy for specific medicines. Generally, any medicine listed on the PBS website will attract a subsidy if prescribed by a medical practitioner. The Commonwealth has determined that if a medicine prescribed by an NP does not attract a PBS subsidy, patients will need to pay the full private cost of that medicine. The cost of privately-prescribed medicines will not contribute to a patient's safety net threshold.

Public Sector

NPs working in community-based settings can obtain a prescriber number and write prescriptions for specific medicines that are covered by the PBS. NPs working in ACT public hospitals or in co-located outpatient departments cannot write prescriptions for medicines covered by the PBS. Prescriptions written by an NP working in public hospitals or co-located outpatient departments that are filled in community-based pharmacies will be required to pay the full, private costs of those medicines. Medicines prescribed by public sector NPs for inpatients or *supplied* in community-based clinics (e.g. Walk-in Centres) in public hospitals are subsidised by ACT Government.

Can NPs request tests that are subsidised by the government?

Many diagnostic pathology and imaging tests requested by NPs are subsidised by the government through hospitals or the Medicare Benefits Schedule (MBS). Generally, inpatient testing and those investigations performed by public hospitals are subsidised by ACT Government. Most tests that are performed in community-based laboratories or imaging services are subsidised by the Commonwealth through the MBS.

Private Sector

NPs meeting requirements in the private sector, who are working within their abilities and employed roles, can apply for a provider number and request diagnostic tests that attract a MBS subsidy. Generally, any *pathology* testing that attracts a subsidy when requested by a medical practitioner will be subsidised when requested by an NP. In addition, NPs in the private sector are able to perform a small selection of simple basic point-of-care tests for which patients receive an MBS subsidy.

However, not all *imaging* tests requested by an NP in the private sector will be subsidised by the MBS. Currently, an NP requesting these imaging tests will attract an MBS subsidy. If the patient chooses to see an NP for any other imaging tests they will be required to pay the full private cost of those imaging tests, even if within the scope of practice for that NP or subsidised when requested by a medical practitioner. The costs of privately-requested imaging tests will not contribute to the patient's safety net threshold.

.

I have a concern about the care my NP has provided. Who do I contact?

Nurse Practitioners, like other regulated health practitioners, are responsible for the care they provide. They adhere to national standards and guidelines. If you have a concern about the care your NP has provided, it is always best to first raise your concerns with the NP involved and follow organisational policy. If you do not feel comfortable doing so, then the following may assist:

1. Contact the ACT Human Rights Commission; or
2. Contact the Australian Health Practitioner Regulation Agency.

Nurse Practitioners in the ACT

Frequently Asked Questions (FAQ) for ***Health Consumers***

This information is for people who see a Nurse Practitioner (NP) in the Australian Capital Territory (ACT). The ACT Office of the Chief Nursing and Midwifery Officer (ACT OCNMO) will update this information if things change.

What is a Nurse Practitioner (NP)?

Nurse Practitioners are expert registered nurses (RNs). The title 'nurse practitioner' means the RN has extensive experience and education. They can:

- Assess and diagnose medical conditions,
- Prescribe medicines,
- Request and interpret tests (e.g. imaging tests such as X-rays and ultrasounds, blood tests), and
- Make referrals to a medical and/or allied health specialist.

You can check whether your NP is registered by checking the national register. To find or request more information about NPs, you can visit

- ACT Health's webpage, or
- contact the Australian College of Nurse Practitioners.

What does an NP do?

Nurse practitioners work in many different areas, including diabetes, palliative care, wound care, mental health, Walk-in Centres, and aged care. They may work in their own stand-alone clinics, or work within larger healthcare teams. They work in both the public and private health sectors.

Each NP has unique skills and expertise. For example, some can perform procedures like skin checks and stiches, and others are excellent helping you take care of long-term health conditions. If you're unsure if your NP can do something for you – just ask! They will be more than happy to give you helpful advice.

Can NPs write 'medical certificates' in the ACT?

NPs in the ACT can issue a 'sick certificate' for people who are unwell and cannot go to work. NPs cannot provide a 'medical certificate' because 'medical certificates' can only be written by registered medical practitioners. There is no limit on the number of days an NP can write a sick certificate for, it depends on your illness and the NP employer's policies.

Can NPs fill out my workers' compensation (including Comcare) or driver's license medical paperwork?

NPs can assess, diagnose, and treat many work-related injuries. However, under ACT law, workers' compensation (including Comcare) certificates must be completed by a medical practitioner (doctor).

NPs can assess a person's fitness to drive. However, under ACT law, Driver's License Medical forms must be completed by a medical practitioner.

Can NPs prescribe medicines subsidised by the government?

Many medicines are subsidised by the government through the Pharmaceutical Benefits Scheme (PBS). Generally, inpatient medicines and those supplied by public hospitals in the ACT are subsidised by the ACT government. Many medicines that are dispensed in community pharmacies are subsidised by the PBS.

Private Sector

NPs working in private health services can write prescriptions for specific medicines that are covered by the PBS. Generally, any medicine listed on the PBS website will be subsidised if prescribed by a doctor. If a medicine prescribed by an NP does not attract a PBS subsidy, you will need to pay the full cost of that medicine. The costs of private medicines will not contribute to your safety net threshold.

Public Sector

NPs working in community-based settings can write prescriptions for specific medicines that are covered by the PBS. NPs working in ACT public hospitals or in co-located outpatient departments cannot write prescriptions for medicines covered by the PBS. Any prescriptions written by an NP working in ACT public hospitals or co-located outpatient departments that are filled in community-based pharmacies will be at the full, private costs of those medicines. Medicines prescribed by public sector NPs for inpatients in public hospitals, or *supplied* in community-based clinics (e.g. Walk-in Centres) are subsidised by ACT Government.

Can NPs request tests that are subsidised by the government?

Many blood and imaging tests (e.g. X-rays and ultrasounds) requested by NPs are subsidised by the government through hospitals or Medicare. Generally, inpatient testing and those tests performed by public hospitals are subsidised by ACT Government. Many tests that are performed in community-based laboratories or imaging services are subsidised by Medicare.

Private Sector

NPs working in the private sector can request diagnostic tests that attract a Medicare subsidy.

Blood Tests: Generally, any blood test that attracts a subsidy when requested by a doctor will be subsidised when requested by an NP.

Imaging: Not all imaging tests requested by an NP in the private sector will be subsidised by Medicare. If an NP requests these imaging tests they will attract a subsidy. If you choose to see an NP for any other imaging tests you will have to pay the full private cost of those imaging tests. The costs of private imaging examinations will not contribute to your safety net threshold.

Public Sector

Imaging and pathology examinations that are requested by NPs that are completed in ACT public hospitals or health centres, are subsidised by ACT government.

I have a concern about the care an NP has provided. Who do I contact?

Nurse Practitioners, like other regulated health practitioners, are responsible for the care they provide. They must follow national standards and guidelines. If you have a concern about the care an NP has provided, it is always best to first raise your concerns with the NP involved. If you do not feel comfortable doing so, then the following may assist:

1. Contact the NP's employer; or
2. Contact the ACT Human Rights Commission; or
3. Contact the Australian Health Practitioner Regulation Agency.

Nurse Practitioners in the ACT

Frequently Asked Questions (FAQ) for ***Nurse Practitioners***

This FAQ is written for Nurse Practitioners (NP) who are new to the Australian Capital Territory (ACT), or who are newly-endorsed with the Nursing and Midwifery Board of Australia. It's recommended you review the FAQs designed for Employers and Health Consumers for further information.

The ACT Office of the Chief Nursing and Midwifery Officer (ACT OCNMO) will update this information from time to time, as legislation and/or policy evolves in the ACT.

We invite you to keep up-to-date with news relevant to NPs from the ACT OCNMO by signing up to our mailing list.

What's the difference between practice authority and scope of practice?

Practice authority refers to all the activities a *profession* is legislatively authorised to perform, whereas **scope of practice** refers to all activities an *individual* within that profession is both legislatively authorised to perform, and competent to do. NPs are independent and collaborative practitioners regulated by the Nursing and Midwifery Board of Australia (NMBA). Thus, you are fully responsible and accountable for your practice. An *employed* scope of practice is determined by yourself and your employer, as relevant to your employed role.

What authorisation process is required for public sector NPs?

NPs working for the public sector must undergo a formal credentialing process for approval of their employed scope of practice. Credentialing committees within the ACT public sector are delegated through a legislative instrument approved by the Minister for Health through the *Health Act 1993*. The purpose of credentialing is to not only protect the public, but facilitate practice so that individuals may work to their full scope of practice within their employed roles.

What authorisation process is required for private sector NPs?

Regulated health practitioners working in the private sector, inclusive of NPs, are **not** currently required to undergo a formal credentialing process for their employed scope of practice. However, they must still adhere to professional standards and guidelines for practice established by the NMBA, as well as local regulatory requirements. It is *highly recommended* that private sector employers establish contextualised credentialing processes relevant for all health practitioners, which is transparent and relevant to their context, profession, and area of practice.

Are there any specific requirements for independent NP clinics in the private sector?

Like other private sector employers in the health industry, NPs working in stand-alone NP clinics are required to adhere to local requirements, such as work health and safety laws. It is highly recommended you use the Australian Business License and Information Service when setting up your clinic to understand your requirements.

A unique requirement for stand-alone NP clinics in the ACT is that you must apply for an infection control license if you perform any skin penetration procedures in your clinical practice. This requirement does not apply to general practices who employ medical practitioners.

Can NPs write 'medical certificates' in the ACT?

NPs in the ACT must issue a 'sick certificate' for employees who are unwell and cannot attend their workplace. A sick certificate serves the purpose of a statutory declaration for the patient's employer. The reason why NPs cannot provide a 'medical certificate' is because operational definitions in the *Fair Work Act 2009* (C'wealth) and *Workers Compensation Act 1951* (ACT) require that 'medical certificates' only be written by a registered medical practitioner. If an NP were to provide a 'medical certificate' it would amount to 'holding out', which is an offence under sections 116 and 118 of the *Health Practitioner Regulation National Law 2010* (C'wealth). There is no limit on the number of days an NP can write a sick certificate, and is dependent on the patient's disposition and employer policy.

NPs may also authorise 'attendance' and 'carers' certificates for employers of patients through the statutory declaration process described above. These certificates are generally given when an employee misses work for a medical appointment, or who are well themselves but caring for an unwell family member.

Do NPs have the authority to authorise a workers' compensation (including Comcare) certificate?

NPs in the ACT have the practice authority to assess, diagnose, and treat work-related injuries within their employed scope of practice. However, under the *Workers Compensation Act 1951* (ACT) and *Work Health and Safety Act 2011* (C'wealth) NPs **cannot** authorise workers' compensation or Comcare certificates - they must be completed by a medical practitioner working within their scope of practice.

Do NPs have the authority to perform a medical termination of pregnancy (MToP)?

Currently NPs in the ACT **do not** have the practice authority to prescribe a medicine for the purposes of MToP under Part 6 of the *Health Act 1993* (ACT). Any health professional, other than a medical practitioner, who prescribes a medicine for the purposes of inducing a termination of pregnancy commits an offence under ACT legislation.

Do NPs have the authority to perform and authorise Driver's License Medicals?

NPs in the ACT have the practice authority to assess a person's fitness to drive within their employed scope of practice. However, under the *Road Transport (Driver Licensing) Act 1999* (ACT) NPs **cannot** authorise paperwork required as evidence by the ACT Road Transport Authority - it must be completed by a medical practitioner.

It is important to note *there is no mandatory reporting requirement* for practitioners if they identify a patient is unfit to drive. However, practitioners should note they are not civilly or criminally liable for assessing a patient and reporting, in good faith, a patient who may be unfit to drive.

Do NPs have the authority to authorise a death certificate?

Current NPs in the ACT **do not** have the practice authority to authorise a death certificate as required by the *Births, Deaths and Marriages Registration Act 1997*. Some registered nurses employed in the public sector *may* declare 'life extinct' in a person, but this is dependent upon local policy. Check with your health service for further information. The declaration of life extinct *does not* have the same legal ramifications as a death certificate.

Do NPs have the authority to witness a non-written health direction?

Under the *Medical Treatment (Health Directions) At 2006* (ACT), NPs and other health professionals **do** have the practice authority to witness non-written health directions, but one of the two witnessing professionals **must** be a medical practitioner. A NP **cannot** substitute for a medical practitioner for this purpose.

What diagnostic examinations do NPs have the authority to request and/or interpret?

An NP endorsed by the NMBA can request *any* diagnostic pathology or imaging examination within their scope of practice. Like medical practitioners, an NP may interpret *any* diagnostic pathology or imaging examination within their scope of practice.

Subsidy of diagnostic pathology or imaging through the Medicare Benefits Schedule (MBS) or other funding mechanisms does not relate to an NP's practice authority. However, an NP's employed scope of practice may limit which diagnostic examinations an NP may request and/or interpret.

What medicines do NP have the authority to prescribe in the ACT?

An NP endorsed by the NMBA can prescribe *any* S2, S3, S4 or S8 medicine within their employed scope of practice, **except** medicines used for the purposes of inducing a medical termination of pregnancy, or Appendix D Medicines in the *Medicines, Poisons and Therapeutic Goods Regulation 2008* (ACT).

There are Controlled Medicines Prescribing Standards for the prescribing of controlled medicines in the ACT that all prescribers *must* comply with.

Do I need a separate authorisation process for patients from NSW or other jurisdictions?

Authorisation to practice is not required for patients living in different States or Territories, as long as the care provided by the practitioner occurs within ACT borders.

In the case of telehealth services, all practitioners must adhere to legislation and policy in the jurisdictions in which the patient resides. This is particularly important as relating to the Medicines, Poisons and Therapeutic Goods Acts (however named).

GBC21/455

Portfolio: Health

Health Staffing Breakdown

- The ACT Government committed to hire at least 400 new clinical staff, including nurses, doctors and healthcare professionals, to provide more healthcare services as our city grows.
- The impact of 2020-21 and 2021-22 new initiatives (across the Health portfolio, including Calvary Public Hospital) shows progress towards this goal by the end of 2021-22 is programmed to be 344 FTE. However, this includes a significant number of COVID-19 related positions that will likely cease towards the end of the 2021-22 financial.
- Excluding these time limited positions, the number of health professional employees over the two financial years is approximately 257 FTE – 17 doctors, 194 nurses and 47 allied health, as below:

	Excl. non-ongoing initiatives*	**Incl. non-ongoing initiatives***
Doctors	17	24
Nurses**	194	250
Allied Health	47	70
Total	**257**	**344**

* such as COVID-19 response and vaccination program, as these staff are not expected to continue into 2022-23.
** Includes 90 FTE for the Nurse Ratio initiative, notwithstanding the 90 won't be employed for the full financial year. The annualised figure is 28 FTE.

Cleared as complete and accurate: 28/09/2021
Cleared for public release by: Executive Group Manager Ext:49869
Contact Officer name: Jean-Paul Donda Ext:49641
Lead Directorate: Health
TRIM Ref: GBC21/455

- The number of ACT Health Directorate (only) employees funded from 2021-22 new initiatives is 147 FTE, as below:

Initiative	FTE 2021-22
Introduction of nursing and midwifery ratios	1.5
COVID-19 Response	94.0
Patient Navigation Service (Empowering patients for better healthcare)	0.5
Implementation of ABM in the ACT Health System	2.0
COVID-19 Vaccination Program	41.5
Northside Hospital Development	7.6
Total	**147.1**

- The Budgeted and actual number of ACT Health Directorate (only) employees for the past three years were:

	2018-19	2019-20	2020-21	2020-22
Original Budget	557	603	683	829
Actual (Financial Statements)	539	584	713	n/a

GBC21/455

Portfolio: Health

HEA E02 - Improving our public health system – Introduction of nursing and midwifery ratios

	2021-22 $'000	2022-23 $'000	2023-24 $'000	2024-25 $'000	Total $'000
Nurses	4,081	14,238	14,625	15,023	47,967
Implementation team	292	592	600	608	2,093
Total Expenses	**4,373**	**14,830**	**15,225**	**15,631**	**50,059**
FTE	**28**	**93**	**93**	**93**	

Talking points

- The Government will deliver the first stage of a phased introduction of minimum nursing and midwifery to patient ratios at Canberra Health Services and Calvary Public Hospital Bruce, focusing on General Medical, General Surgical, Acute Aged Care and the Adult Mental Health Unit.
- At its peak, more than 90 additional nurses and midwives will be employed across our two public health faciliites.
- Ratios is a process of organising care of patients to mandated number of nurses and midwives every shift.
- Ratios mean that nurses and midwives have more time to spend with patients providing direct clinical care.
- The implementation team, an additional 3 FTE, will commence in the ACT Chief Nursing and Midwifery Office to implement, monitor and evaluate this program.
- The introduction of nursing and midwifery ratios was a 2020 Labor party election commitment.

Stephen-Smith 2021-22 ACT Budget

What plans does the ACT Government have to deliver better care across our hospital system?

- Investment in more nurses, doctors, allied health etc
- Nurse ratios
- New initiatives

Thank you, Madam Speaker.

Madam Speaker, the ACT Government committed to invest in least 400 new clinical staff including nurses, doctors and healthcare professionals, to provide more healthcare services as our city grows.

The impact of 2020-21 & 2021-22 new initiatives (across the health portfolio, including Calvary Public Hospital) shows progress towards this goal by the end of 2021-22 we will invest in an additional 344 staff. This includes a significant number of COVID-19 related positions that will likely cease towards the end of the 2021-22 financial. Excluding these time limited positions, the number of health professional employees over the next two financial years is approximately 257 staff – 17 doctors, 194 nurses and 47 allied health.

The ACT Government will hire more than 90 additional nurses and midwives across our health services as part of its commitment to provide better healthcare.

<u>Nursing and Midwifery Ratios</u>

The ACT Government has developed, in conjunction with the Australian Nursing and Midwifery Federation, the ACT Public Sector Nursing and Midwifery Framework.

This Framework provides the blueprint for processes that will be used in determining the right number of nursing and midwifery staff and skill mix to meet the service requirements within our public sector hospitals.

ACT Health Directorate, Canberra Health Services, Calvary Public Hospital Bruce, and the Australian Nursing and Midwifery Federation have been working collaboratively on preparing for the introduction on Nursing and Midwifery Ratios in early 2022.

A dedicated Ratios Implementation Team has been set up in the Office of the Chief Nursing and Midwifery Officer within ACT Health Directorate. This team is responsible for moving this important work forward. This team will be on the ground, working with clinicians, nursing and midwifery managers across both Canberra Health Services and Calvary Public Hospital Bruce providing support and advice on implementing the Nursing and Midwifery Ratios.
The team is well supported by a high-level Steering Committee comprising of senior executives from both health services, ACT Health Directorate and the Australian Nursing and Midwifery Federation.

This Government will continue its focus and investment into key infrastructure projects for ACT health facilities, to ensure our health system meets the growing need of our city. This includes the continuation of planning and design works for a new northside hospital, which will bring modern hospital services closer to the growing and ageing northside population.

As part of planning for the new Northside Hospital, we will invest in the delivery of essential infrastructure upgrades at Calvary Public Hospital Bruce,

to ensure the continued provision for safe and effective service for patients and staff.

Along with planning for a modern hospital, we are committed to the delivery of the Canberra Hospital Master Plan and will commence early works for a new multi-storey carpark at the Canberra Hospital. The Master Plan will deliver major expansion of the Canberra Hospital, which will deliver significant healthcare infrastructure, including new emergency, surgical and critical care facilities.

In 2021-22 we will focus on:

- investment in evidence-based harm minimisation responses to illicit drugs through programs for harm reduction approaches to drug use and dependence to reduce health, social and economic harms resulting from drug use. Investment will include a fixed-site pill testing service;
- leading the development of a co-design gender-focused peer-led health service with Non-Government Organisations and LGBTIQ+ stakeholders, and develop an implementation plan for the LGBTIQ+ Health Scoping Study to address health care concerns;
- implementing a new model of patient navigation to better coordinate care across the health system for people with chronic and complex conditions including a paediatric nurse liaison service;
- progressing the design of an activity based management system tailored to the needs of the ACT public health system to assist our capacity to respond to increasing demand for health services;
- expanding health system capacity through the expansion of the Canberra Hospital Intensive Care unit, delivering expanded care at the Canberra Hospital Emergency Department and more emergency surgery capacity.

ENDS

QUESTION: How will implementing Nurse/Midwife Ratios contribute to improving outcomes and our hospital system?

- Why nurse ratios work
- How this delivers on election commitments

Thank you, Madam Speaker.

The Government has committed to implementing Nurse and Midwife-to-Patient Ratios in the public health sector across the ACT.

Ratios is a process of organising care of patients to mandated number of nurses and midwives every shift.

Ratios mean that nurses and midwives have more time to spend with patients providing direct clinical care.

This improves patient safety and quality of care which increases patient satisfaction and health outcomes

Research shows that improved patient outcomes can result in financial savings.

Nurses and midwives enjoy greater job satisfaction because of these initiatives.

In consultation with the Australian Nursing and Midwifery Association, it has been agreed that the Nurse and Midwife-to-Patient Ratios will be implemented as a phased approach across both Canberra Health Services and Calvary Public Hospital Bruce.

Implementing the Nurse and Midwife-to-Patient Ratios will enhance Canberra Health Services and Calvary Public Hospital as being employers of choice.

Last week, I announced that there will be $50.1 million allocated over the next four years to recruit more nurses and midwives into our health system.

With this financial commitment, we anticipate implementing Nurse and Midwife-to-Patient Ratios and increasing nursing staff levels from February 2022.

Initially, the implementation of Nurse and Midwife-to-Patient Ratios will occur in the areas of general medical and surgical wards, adult mental health and in acute aged care.

An implementation team led by the ACT Health Chief Nursing and Midwifery Officer is collaborating with key stakeholders to embed communication, education and evaluation strategies as part of the Implementation Plan.

Planning for Phase Two of the implementation of the Nurse and Midwife-to-Patient Ratios will be incorporated into the next Enterprise Agreement negotiations.

Background

- In 2019, you endorsed the ACT Public Sector Nursing and Midwifery Staffing Framework.
- This Framework provides the policy support for the implementation of Nurse and Midwife-to-Patient Ratios.
- The Framework contains Schedule X which sets out the agreed minimum ratios across the public health services.
- Schedule X forms part of the ACT Public Sector Nursing and Midwifery Enterprise Agreement currently under negotiation.
- It is expected that Enterprise Agreement will be put to the vote soon.

Issues (not for distribution)

- The funding announced in this budget will employ nurses to meet the new ratios requirements. There will be no extra midwives employed in phase one.
- Once the Enterprise Agreement is signed, the Australian Nursing and Midwifery Association has an expectation that the mandated ratios will be implemented quickly.

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN21/2157**
CC:	Rebecca Cross, Director-General Cherie Hughes, A/g Deputy Director General	
From:	Jo Spencer, Executive Branch Manager, Communications and Engagement	
Subject:	Changes to the nurse recruitment campaign	
Critical Date:	09/12/2021	
Critical Reason:	To advise of changes to the nurse recruitment campaign	

Recommendation

That you note the 'Changes to the nurse recruitment campaign.

Noted / Please Discuss

Rachel Stephen-Smith MLA 2/1/22

Minister's Office Feedback

ACTHD and CHS to please jointly discuss how the work done for this campaign might be used to support a broader 'work in the ACT' health care workforce attraction campaign where we are not facing the time pressures of ratios that I understand partially drove CHS' decision to undertake its own recruitment. Please liaise with Ms Bransgrove about this. Thank you

Background

1. Nursing and Midwifery recruitment across the ACT public health system is always a challenge with a shortage of nursing and midwifery applicants a genuine issue both locally, and nationally.

2. From February 2022, new nurse/midwife to patient ratios will be introduced through the ACT public health system. Implementing the first phase requires the hiring of 90 additional nurses/midwives across the system.

3. Canberra Health Services (CHS) will need to recruit 53 new nurses and Calvary Public Hospital Bruce (CPHB) requires 37 new nurses with the majority in mental health nursing positions.

4. Nationally there are currently around 350,000 nurses disbursed across the jurisdictions. This increased by just 1.35 per cent in 2020. This represents a reduction in the annual increase from 3.29 per cent the previous year.

5. In discussions in November 2021, it was acknowledged that nursing and midwifery recruitment in Australia can be a challenge, and that it would be beneficial to develop a 'whole of system' recruitment strategy for the public health nursing sector, to enhance our chances of attracting new nurses and midwives to the ACT.

6. The Office of the ACT Chief Nursing and Midwifery Officer (CNMO) requested assistance from communications teams at ACT Health, CHS and CPHB. In collaboration, the three entities developed a combined recruitment strategy to be executed throughout 2022.

Issues

7. The intent for the campaign was to be as customer focused as possible to make sure it was reaching current and former nurses, including existing ACT nurses wishing to specialise or upskill; nursing and midwifery graduates; trainees; and students in Australia. The campaign did not extend to international candidates, given the uncertainty of COVID-19 ramifications on borders and limited international travel at this time. Importantly, the campaign centred around making it as easy and seamless as possible for the target candidates to:

    - Understand there are multiple opportunities across the health service in the ACT.
    - Have a single place to register interest and receive a package of information about the full scope of opportunities in the ACT.
    - Lodge an application or expression of interest.
    - There had been some early suggestion of joint interview panels, but this had not really progressed.

8. The campaign spoke to a range of professional benefits and opportunities for candidates, a strong emphasis on the advantages offered by the government's nurse/midwife to patient ratios commitment (only the third jurisdiction in Australia to implement), as well as the attractions of living and working in Canberra.

9. CHS subsequently indicated that it would prefer to commence its own recruitment campaign.

10. The ACT CNMO will continue to have an overarching monitoring and evaluation role for the ratios project via the steering committee. Operational responsibility and any recruitment action will sit with Karen Grace, Executive Director, Nursing Midwifery and Patient Support Services at CHS.

11. Calvary will now also be responsible for its own arrangements regarding ratios commitment and its recruitment campaign.

Consultation

Internal

12. The new arrangements were advised by ACT CNMO, Mr Anthony Dombkins. Communications Teams at CHS and CPHB have been advised.

External

13. ACT CNMO, Mr Anthony Dombkins has discussed the change to the nurse recruitment campaign with the Secretary of the Australian Nursing and Midwifery Federation.

Work Health and Safety

14. No Work Health and Safety issues are identified

Signatory Name:	Jo Spencer Executive Branch Manager Communications and Engagement	Phone:	X46568
Action Officer:	Angie Drake Senior Director Strategic Communication	Phone:	X48995

ACT Health Directorate

To:	Minister for Health	**Tracking No.: MIN22/175**
CC:	Rebecca Cross, Director General	
From:	Anthony Dombkins, Chief Nursing and Midwifery Officer	
Subject:	Implementation of Nurse/Midwife to Patient Ratios	
Critical Date:	31/01/2022	
Critical Reason:	The implementation of Ratios commences on 1 February 2022	

Recommendation

That you note the information contained in this brief.

Noted / Please Discuss

Rachel Stephen-Smith MLA 6/3/22

Minister's Office Feedback

Apologies for delayed formal sign-off but thank you for verbal updates and keeping my office in the loop on progress.

Background

1. A Memorandum of Understanding was signed on 19 August 2018 by Michael De'Ath (previous Director-General, ACT Health Directorate) and Matthew Daniel (Chair, Australian Nursing and Midwifery Federation (ANMF) - ACT Branch) to develop a ratios framework that could be implemented in the ACT Public Health Services.

2. "Ratios Framework" means a workload management system that includes agreed mandated minimum nurse/midwife ratios that consider the acuity, patient safety and workload in each designated clinical area. The completed Ratios Framework known as *ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework,* was endorsed by you on 21 November 2019.

3. The *ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework* contains a Schedule that sets out minimum nurse/midwife-to-patient ratios for ACT Health Services. This Schedule (*Schedule 10*) is implemented under the Nursing and Midwifery Enterprise Agreement (NMEA) which came into effect on 24 January 2022.

4. During the 2020 Election, the Government committed to the mandating of minimum ratios for nursing and midwifery staff at Canberra Health Services (CHS) and Calvary Public Hospital Bruce (CPHB).

5. As part of the negotiations for the current NMEA, parties agreed that the first phase of implementation of nursing and midwifery ratios at CHS and CPHB will focus on General Medical, General Surgical, Acute Aged Care and the Adult Mental Health Unit.

6. The first phase will be implemented over the next 12 months with the intention that other clinical areas will be addressed with future Enterprise Agreements.

7. Oversight and governance of the implementation of the Ratios Framework has been aligned to the ACT Chief Nursing and Midwifery Officer (CNMO). However, implementation responsibilities lie with CHS and CPHB.

8. The Office of the CNMO is leading the implementation of Nurse/Midwife Ratios in partnership with a Ratios Implementation Steering Committee as well as Implementation Working Groups at both CHS and CPHB which include all key stakeholders including the ANMF.

9. Nurse/Midwife Ratios implementation will commence in February 2022.

Issues

10. While most of the pre-implementation preparatory work has been completed through a Project Management Plan, formal consultations regarding Models of Care and Staffing/Rostering profiles have commenced with staff and the ANMF.

11. The Implementation of Nurse/Midwife Ratios will be a staged approach. This means that not all clinical areas identified for Phase One will implement ratios on 1 February 2022

12. The ongoing COVID-19 pandemic is impacting on nurse staffing at CHS and CPHB. This has resulted in resources being focused on dealing with the immediate CO 19 related issues which has delayed some aspects of Nurse/Midwife Ratios Implementation. It is not envisaged that this will impact the overall Implementation of Nurse/Midwife Ratios in the medium term.

13. The ANMF has undertaken to provide an amnesty from industrial action should ratios not be met until 1 July 2022. Reporting on compliance to mandatory ratios will commence in February 2022 and the ANMF will be monitoring progress closely.

14. Recruitment to some clinical areas, namely mental health services, remains challenging. Nurse/Midwife Ratio Workforce Plans at CHS and CPHB have been developed.

15. The current NMEA expires in December 2022. Planning for Phase 2 of Mandatory Nurse /Midwifery Ratios (specialty areas) will commence in early February 2022.

Financial Implications

16. Funding for this initiative is through HEA E02 – Improving our public health system – Introduction of nursing and midwifery ratios. $50.059M has been allocated till 2024-25.

Consultation

Internal

17. Jo Spencer, Executive Branch Manager, Communications and Engagement, ACT Health, Jacinta George, Executive Group Manager, Health Systems Planning and Evaluation Division.

Cross Directorate

18. The Implementation Steering Committee has representation from Narelle Comer, Director of Clinical Services Nursing and Midwifery, CPHB; Karen Grace, Executive Director, Nursing and Midwifery, CHS; Kalena Smitham Executive Director, People and Culture, CHS; Steve Linton, Director, Industrial Relations, People and Culture, CHS; Jim Tosh, Senior Manager, People and Culture, CHS; Cecilia Jones, Regional Director, People and Culture Calvary Care and Bernadette Panek, Senior Director, Industrial Relations, ACT Health.

19. The Steering Committee has representation from the ANMF - ACT Branch: Matthew Daniel, ACT Branch Secretary; Tom Cullen, Federation Legal Counsel; and Carlyn Fidow, Lead Organiser.

20. Consultation has also occurred with Raoul Craemer, Senior Director, Policy Design and Evaluation, Chief Minister, Treasury and Economic Development Directorate.

External

21. Matthew Daniel, ACT Branch Secretary; Tom Cullen, Federation Legal Counsel and Carlyn Fidow, Lead Organiser.

Work Health and Safety

22. Nil.

Benefits/Sensitivities

23. The potential benefits of the implementation of Ratios are:

- guaranteed level and skill mix of staff on each shift which improves management of the care environment;
- better patient outcomes;
- improves patient levels of satisfaction with care;
- reduction in length of hospital stays;
- reduced in-patient mortality;
- reduce staff fatigue and presenteeism and improves levels of job satisfaction which contributes to a sustainable workforce; and
- ratios has the potential to positively contribute towards the Safewards model.

24. Ratios Implementation is a partnership project between the CNMO, CHS, CPHB and ANMF with buy in from all organisations. The major sensitivity is the potential delay in implementation because of shortage of staff due to the impacts of COVID-19. This may cause concern with the ANMF.

Communications, media and engagement implications

25. There has been extensive work undertaken by the ACT Health communications team and communication units at CHS and CPHB as well as the ANMF, on developing a suite of consistent information on Ratios for use internally and externally. The implementation of ratios has the potential to generate media coverage.

Signatory Name:	Anthony Dombkins Chief Nursing and Midwifery Officer	Phone:	[redacted]
Action Officer:	Mark Gaukroger Manager, Ratios Implementation	Phone:	[redacted]

Minister for Health, Rachel Stephen-Smith
Economic priorities response speech

Madam Speaker, I would like to thank the Chief Minister for outlining the priorities of government for the year ahead.

As we face our third year of responding to the COVID-19 pandemic, we should acknowledge that as a community, and indeed as a public service, we have grown and become more resilient as we front up daily to an ever-changing environment.

Throughout the ebbs and flows of the pandemic, I can see the public service workforce, and indeed the broader community, preparing at every turn to embrace change, to swiftly pivot, to carefully re-evaluate and to thoughtfully re-focus their efforts where needed.

We are indeed a resilient and buoyant community and it is clear that despite the things that come hurtling our way, there are still a lot of other things that we need to just get on and do. And we do.

I am pleased to provide members some additional information with a particular focus on the work the ACT government is doing to promote the health and wellbeing of Canberrans.

Preventative and population health

We want Canberrans to enjoy the highest standards of health at every stage of life. We have one of the highest life expectancies in the country and can expect to live many of those years in good health.

The ACT Government is committed to maintaining these high standards of health and continues to invest in promoting positive health and wellbeing of Canberrans whilst also reducing the burden on our health system through early intervention and preventive health actions.

The Healthy Canberra: ACT Preventive Health Plan 2020-2025 sets the foundations for achieving this goal in partnership with the Canberra community.

The Plan includes a particular focus on creating healthy and supportive food environments for people to lead healthy and active lives across their lifespan. This is especially important within the first 1,000 days of a child's life, where we know that interventions can have the greatest impact.

The ACT government continues to invest in a range of programs that will help people to live healthier lives and prevent chronic disease before it begins.

The latest round of the *Healthy Canberra Grants* opened in early February 2022. These grants provide a total funding pool of $1.0 million and are focused on improving health outcomes from the earliest stages of children's lives.

Fresh Tastes is a free ACT Government service helping schools make healthy food and drinks a bigger part of everyday life for Canberra's kids.

Healthier Choices Canberra assists Canberrans to eat well, working with Canberra food businesses to make fruit, vegetables and water more appealing, accessible and available to the Canberra community.

Over 130 businesses are part of *Refill Canberra* which, in partnership with Icon water, allows people to refill their water bottles for free at a local business.

Over 50,000 children play organised sport outside of school in the ACT. As part of *Healthier Choices*, clubs pledge to take action to provide a healthier junior sport environment.

Gamechangers, a new initiative in 2022, will help local Canberra businesses partner with local junior sport clubs to create sponsorship relationships that no longer promote unhealthy food and drink to children playing sport.

The Kids at Play, Active Play program is a capacity building program designed to help early childhood educators feel confident to promote active play and teach fundamental movement skill to children aged three and up in early childhood settings.

It's Your Move supports high school students to innovate and lead health promotion projects in their schools.

The *Safer Baby Bundle* focuses on reducing smoking during pregnancy which includes the procurement of eight smokerlyzers for use in maternity services.

Work is also being undertaken to look at opportunities for the development of resources, teacher professional learning and a co-design approach to reduce the uptake of e-cigarettes by young people.

As we begin to work out what living with COVID-means, preventive health and addressing the factors that help people live healthy lives is even more important, and remains a high priority for this government.

Infrastructure investment and jobs created

Madam Speaker, significant investment into health facilities is continuing which in turn will stimulate the local economy and generate new jobs.

This investment includes a range of projects that will modernise and grow our health system so that it can continue to meet the needs of the growing and ageing Canberra community.

The Canberra Hospital Expansion project will deliver increased capacity across Canberra Hospital's adult intensive care, paediatric intensive care, surgical, coronary care and emergency services.

This project is the largest ever investment in healthcare infrastructure by the ACT Government.

The new facility will be constructed as an integrated building creating the heart of the hospital campus and will be connected to other hospital functions through public, clinical and logistical transfer links.

Building 5 and 24 have now been demolished which has enabled bulk excavation and piling to commence for the new Critical Services Building.

The Centenary Hospital for Women and Children Expansion Project has continued throughout the COVID-19 pandemic.

The project includes the construction of both new buildings and refurbishment components.

Already completed is the refurbishment of the Paediatric High Care Ward and a new administration building.

Four stages in the program are currently under construction including a new Adolescent Mental Health Unit and Day Service; a refurbished Maternity Assessment Unit, Ante-Natal Ward and Early Pregnancy Assessment Unit; and new Clinical Administration and Education Spaces.

The refurbishment of the Gynaecology Procedure Suite is planned for 2022; and refurbishment of the Neonatology Special Care Nursery will commence in 2023.

Construction of a new Cancer Research Centre at the Canberra Region Cancer Centre will bring together the knowledge and expertise of academics, clinicians, industry and health professionals who will work collaboratively to treat and care for Canberrans.

This investment will improve the quality of cancer care in the ACT through better specialist translational research and enable more rapid introduction of new treatments for our cancer patients.

Construction of a new outpatient medical imaging service at the Weston Creek Walk-in Centre will enable greater community access to common diagnostic medical imaging services, including ultrasound, x-ray and computed tomography (CT) from the one location.

This investment will help reduce community wait times for medical imaging services and enable more efficient scan times for the Canberra Hospital emergency department and inpatient service.

A project is underway to provide infrastructure upgrades at two residential drug and alcohol treatment facilities at Isabella Plans and Fadden.

An investment of $33 million will be made to a range of capital infrastructure and ICT upgrades on the Calvary Bruce campus to improve safety of staff and patients and to modernise critical infrastructure.

Consultation and design work is progressing on the $13.5 million eating disorder clinic that will create a holistic system of patient care.

Consultation and early design work will continue for the Northside hospital development and the Government has commenced recruitment for several critical roles.

Work is underway to investigate a new carpark at Canberra hospital to provide additional parking spaces in line with the Canberra hospital expansion.

A number of feasibility studies are currently underway to develop design options and guide the investment of a number of key projects.

This includes the delivery of a Northside Elective Surgery Centre at the University of Canberra Hospital precinct to boost elective day procedures that do not require overnight stay or care post operation.

This new service will complement the existing specialist rehabilitation and recovery services and the additional investment is expected to take pressure off our hospitals by delivering day procedures including ear, nose and throat, gynaecological, orthopaedic, ophthalmology and dental.

Feasibility will also be undertaken for the four new Health Hubs planned in the Inner South, Tuggeranong, West Belconnen and North Gungahlin that will provide a combination of walk-in and appointment-based services with a focus on prevention, early intervention and coordinated care for people with chronic illness.

Endoscopy suites at Canberra Hospital will be expanded and refurbished and are expected to deliver an additional 5,000 endoscopy procedures, meeting the growing need for diagnosis and detection of many conditions, including some cancers.

Jobs for Canberrans

Madam Speaker, building a new state-of-the-art critical services building is not possible without creating new jobs for Canberrans.

Through this key project, the Government is assisting to upskill workers, with the project to be delivered by a workforce of approximately 600 people - creating valuable jobs, employment and training opportunities for Canberrans.

Over 80% of the sub-contractors engaged on the construction of the Canberra Hospital Expansion project site to date are local ACT businesses.

Towards the end of March, approximately 100 form workers and concreters will arrive on site to start construction of the building's superstructure. This work will continue throughout the year.

Through the Connectivity Centre initiative, approximately 20 career seekers have been provided with prevocational and other support to get them ready for immediate employment as construction on the project ramps up.

Madam Speaker, the ACT Government has committed to hire at least 400 new clinical staff, including nurses, doctors and healthcare professionals, in order to provide more healthcare services as our city grows.

Across the Health portfolio, including Calvary Public Hospital, significant progress has been made towards this goal with 344 FTE positions employed by the end of June 2022. This includes a significant number of temporary COVID-19 related positions.

Excluding these time limited positions, approximately 257 FTE positions have been filled by health professionals over the last two financial years, made up of 194 nurses, 47 allied health professionals and 17 doctors.

The phasing in of nursing and midwife to patient ratios in the ACT public health system has commenced this month across Calvary Public and Canberra Hospitals.

Developed in consultation with the Australian Nursing and Midwifery Federation, the ratios guarantee more staff on the ward and ensure an increased skill mix on each shift to provide the best possible care for patients in our public health system.

The government has committed to an additional 90 FTE throughout 2022 with more than $50 million over four years invested to achieve this work.

ACT Health is delivering the Digital Health Record to roll out a single, real-time, person-centred and world class clinical health record across the Territory, employing approximately 100 staff and implementing significant improvements to healthcare through information technology.

The ACT Government has supported local construction businesses during severe COVID-19 disruptions with funding for key health infrastructure projects to provide immediate positive impacts to the local economy and lasting infrastructure benefits to the broader community.

Since the start of COVID-19 screwdriver ready phase 1,2 and 3 programs aimed at accelerating meaningful infrastructure projects and providing critical jobs to local traders and medium enterprises were fast-tracked;

Conclusion

Madam speaker, I want to express my thanks to those who continue to front up to do the work every day – and many nights – as they continue to respond directly to the COVID-19 pandemic.

And to those who front up every day – around the clock - to continue the important non-COVID work across our directorates that keeps our community healthy, supported, and protected and goes to making our health system, and our community stronger.

Thank you

Lowes, Shannon (Health)

From: Ellis, Catherine (Health) on behalf of ACT Health DLO
Sent: Monday, 21 February 2022 3:19 PM
To: Health Ministerial Liaison Officer
Subject: FW: Event proposal - ratios announcement

Importance: High

Categories: Area, Jas

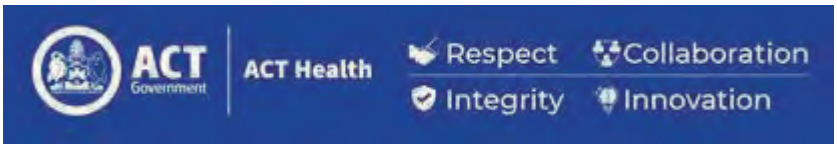
Hi Team

Can we please TRIM the below request for an event proposal to be developed on ratios.

I suggest Tony Dombkins and his team will be leading on this and need to liaise Greg Bayliss at Calvary regarding date and time options to put to MO.

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob: [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: McGregor-Dainton, Amy <Amy.McGregor-Dainton@act.gov.au>
Sent: Monday, 21 February 2022 2:28 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Cc: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: Event proposal - ratios announcement
Importance: High

Hi Cathy,

Can you please ask the relevant person to prepare an event proposal for a media stand-up – to be jointly held by Minster Stephen-Smith/ACT Gov and the Australian Nurses and Midwives Federation (ANMF) – at Calvary Public Hospital Bruce in the first or second week of March?

If health comms could coordinate with Greg Bayliss at Calvary (I have let him know that we're keen to do the stand-up and he was on-board) to come up with a couple of date/time options that Meg (health policy adviser) can put to the ANMF secretary, that would be great.

A media release will also be required, but I believe Talib has already drafted this.

Thanks,

Amy McGregor-Dainton

Strategic Communications Adviser - Office of Minister Rachel Stephen-Smith MLA
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2600
T: (02) 6205 7402 | M: [redacted] | E: amy.mcgregor-dainton@act.gov.au

ACT Government

Rachel Stephen-Smith MLA

Minister for Health
Minister for Families and Community Services
Minister for Aboriginal and Torres Strait Islander Affairs

Member for Kurrajong

Attachment A: ARRANGEMENTS BRIEF

FUNCTION:	Media announcement about the introduction of nurse/midwife to patient ratios
VENUE:	Calvary Public Hospital Bruce (CPHB), paved area outside main entry *Backup location in the case of rain will be available on the steps and portico adjacent to main entry (this area can be used without affecting public access)
HOST:	Name: Robin Haberecht, General Manager CPHB Mobile: [redacted]
DAY:	Thursday
DATE:	10 March 2022
TIME:	12.00pm
TIME COMMITMENT:	30 minutes
CATERING:	Not applicable
DRESS CODE:	Business attire
YOUR ROLE:	Speak to the media about nurse/midwife to patient ratios
WHERE TO PARK:	Level 1 or Level 2 of Calvary Hospital multi storey car park
WHO WILL MEET YOU:	Robin Haberecht will meet you at the main entry of the hospital
ADVISOR ATTENDING:	Amy McGregor-Dainton, Communications Adviser
AUDIENCE:	Media representatives TBA Robin Haberecht, CPHB General Manager

Rachel Stephen-Smith MLA - Arrangements brief

	Matt Daniel, Secretary, Australian Nursing Midwifery Federation, ACT Branch Anthony Dombkins, Chief Nursing and Midwifery Officer Calvary representatives Graduate Nurses (to be available for photos/vision)
VIPs:	Not applicable
PAST INVOLVEMENT:	You made a media statement in May 2021 about the new funding committed for nursing of $50.1 million over four years
SENSITIVITIES:	With the impacts of the pandemic on our health system the full effect of this nursing recruitment might not yet be felt consistently across the wards where ratios are being implemented, but we will continue to work towards ensuring the ratios are being met consistently
ORDER OF CEREMONIES	Minister to address the media Minister and others to be available for questions Robin Haberecht (CPHB) and Anthony Dombkins are available to speak or answer questions if required At the conclusion of these activities a group of recently employed (mainly new graduate) Calvary nurses and midwives will assemble for photo/media opportunity (please note these staff have not been prepared for media comment)
MEDIA:	A media release has been provided to your office
SOCIAL MEDIA ACCOUNTS	The ACT Health social media channels will post about this announcement.
OUTSTANDING REGULATORY ISSUES	There are no outstanding regulatory issues

Rachel Stephen-Smith MLA - Arrangements brief

TALKING POINTS

MEDIA DOORSTOP
NURSE AND MIDWIFE TO PATIENT RATIOS

THURSDAY 10 MARCH AT 12.00PM
LOCATION – CALVARY PUBLIC HOSPITAL BRUCE

The phasing in of nursing and midwifery ratios in the ACT public health system has started in February of this year as part of the ACT Government's commitment to providing better healthcare for Canberra and the region.

Nursing and midwifery ratios will improve our health system and deliver better outcomes for patients and a safer workplace for nurses and midwives.

Developed in consultation with the Australian Nursing and Midwifery Federation ACT the ratios guarantee more staff on the ward and ensures an increased skill mix on each shift to provide the best possible care for patients in our public health system.

The ratios began being phased in across selected wards at Canberra Hospital and Calvary Public Hospital Bruce from 1 February.

The COVID-19 pandemic had an impact on our health system that also affected the nursing recruitment drive to achieve consistent ratios across the wards; but we will continue to ensure that the ratios are met consistently.

Canberra Health Services and Calvary Public Hospital Brue have already recruited more than 50 full time equivalent nursing positions to help meet the incoming ratios.

Rachel Stephen-Smith MLA - Arrangements brief

The most recent ACT Budget committed $50.1 million over four years to recruit additional nurses across Canberra Health Services and Calvary Public Hospital Bruce as part of the first phase of nursing and midwifery ratios.

The minimum ratio for nurses or midwives to patients will depend on the clinical setting with the first phase of ratios agreed with the Australian Nursing and Midwifery Federation ACT to focus on General Medical, General Surgical, Acute Aged Care and the Adult Mental Health Unit.

Q&A

When did the phasing in of nursing and midwifery ratios start?

Phase 1 of the nursing and midwifery ratios began on 1 February 2022. The implementation of phase 1 across General Medical, General Surgical, Acute Aged Care and the Adult Mental Health Units is to be completed by 31 December 2022.

How many new nurses are needed to implement phase 1?

The ACT Government committed $50.1 million over four years to recruit 90 additional FTE nurses across Canberra Health Services and Calvary Public Hospital Bruce as part of the first phase of nursing and midwifery ratios.

How many have been recruited so far?

Canberra Health Services and Calvary Public have already recruited more than 50 full time equivalent nursing positions, with recruitment ongoing for more nurses to help meet the new ratios.

- Calvary has employed 10 FTE clinical nurses specifically to support ratios.
- Canberra Health Services has recruited 44 FTE to date (out of a budgeted 55 FTE).

The recruited FTE identified as specifically to help meet the nursing and midwifery ratios are in addition to the regular ongoing nursing and midwifery recruitment undertaken by both Canberra Health Services and Calvary Public Hospital Bruce.

Are we now meeting the ratios on the wards identified for phase 1?

The COVID-19 pandemic is still having a significant impact on staffing for both Canberra Health Services and Calvary Public Hospital Bruce.

This is proving to make full compliance with ratios across all shifts on all wards difficult as we begin implementation of phase 1.

Both Canberra Health Services and Calvary Public Hospital will continue to work towards the consistent meeting of ratios as the implementation of phase 1 continues.

Rachel Stephen-Smith MLA - Arrangements brief

MAP/TRAVEL DETAILS

MEDIA DOORSTOP
NURSE AND MIDWIFE TO PATIENT RATIOS

THURSDAY 10 MARCH AT 12.00PM
LOCATION – CALVARY PUBLIC HOSPITAL BRUCE

The Minister will travel using her own transport

It is customary for the Minister to park on Level 1 or Level 2 of the multi-storey car park and walk across to the Calvary main entry

At the main entry the Minister will be met by CPHB General Manager Robin Haberecht

Rachel Stephen-Smith MLA - Arrangements brief

MEDIA RELEASE

ACT Government

Media release

Rachel Stephen-Smith MLA
Minister for Health
Minister for Families and Community Services
Minister for Aboriginal and Torres Strait Islander Affairs

Member for Kurrajong

10 March 2022

Nursing and midwifery ratios begin

The phasing in of nursing and midwifery ratios in the ACT public health system has started this month as part of the ACT Government's commitment to providing better healthcare for Canberra and the region.

Developed in consultation with the Australian Nursing and Midwifery Federation ACT the ratios guarantee nursing and midwifery staffing levels on the ward and ensures the appropriate skill mix on each shift to provide the best possible care for patients in our public health system.

The ratios began being phased in across selected wards at Canberra Hospital and Calvary Public Hospital Bruce from 1 February.

ACT Minister for Health Rachel Stephen-Smith said despite the challenges of the COVID-19 pandemic both Canberra Health Services and Calvary Public Hospital Bruce had already recruited some of the new nurses required to help meet the incoming ratios.

"Nursing and midwifery ratios will improve our health system and deliver better outcomes for patients and a safer workplace for nurses and midwives," Minister Stephen Smith said.

"The COVID-19 pandemic has presented many challenges for our health system, but we are committed to continuing our efforts to implement these important nursing and midwifery ratios.

"Canberra Health Services and Calvary Public have already recruited more than 50 full time equivalent nursing positions, with recruitment ongoing for more nurses to help meet the new ratios".

"I understand that with the impacts of the pandemic on our health system the full effect of this nursing recruitment might not yet be felt consistently across the wards where ratios are being implemented, but we will continue to work towards ensuring the ratios are being met consistently."

Rachel Stephen-Smith MLA - Arrangements brief

The most recent ACT Budget committed $50.1 million over four years to recruit additional nurses across Canberra Health Services and Calvary Public Hospital Bruce as part of the first phase of nursing and midwifery ratios.

The minimum ratio for nurses or midwives to patients will depend on the clinical setting with the first phase of ratios agreed with the Australian Nursing and Midwifery Federation ACT to focus on General Medical, General Surgical, Acute Aged Care and the Adult Mental Health Units.

Statement ends

Media contact:
Jed Rainbow M [redacted] jed.rainbow@act.gov.au

Rachel Stephen-Smith MLA - Arrangements brief

SOCIAL MEDIA

The following post will be published on ACT Health's Facebook, Twitter and Instagram channels, tagging CHS, Calvary and the ANMF.

The ACT Government has commenced Phase 1 of nurse/midwife to patient ratios in the public hospitals - an important part of our commitment to providing better healthcare for Canberra and the region.

But what are ratios and what do they mean for staff and patients?

Ratios mean there is a mandated minimum number of nurses or midwives working on a particular ward, unit, or area in relation to the number of patients. Ratios vary with the needs of each ward and help improve healthcare outcomes for patients and working conditions for nurses and midwives.

Studies have found the benefit of nurse/midwife to patient ratios include:

- Improved critical response times
- Improved health outcomes for patients
- Decreased lengths of stay
- Improved working conditions for nurses and midwives and higher job satisfaction

Phase 1 of ratios is being introduced in the general medical, surgical wards as well as acute aged care and adult mental health units in @CanberraHealthServices and @calvarybruce.

For more information go to https://bit.ly/3Mk7c6i

@anmfactbranch

Lowes, Shannon (Health)

From: George, Jacinta (Health)
Sent: Thursday, 10 March 2022 2:18 PM
To: HSPE
Subject: FW: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March

Importance: High

OFFICIAL

AS I don't have source data, cleared as advice from Calvary

Thanks

Jacinta George
Executive Group Manager
Ph: (02) 5124 9403 (Executive Assistant)
[redacted]
Email:jacinta.george@act.gov.au
Health System Planning and Evaluation
Level 3, 2 Bowes Street Phillip ACT 2606
health.act.gov.au

From: LHN Coord <LHNCoord@act.gov.au>
Sent: Thursday, 10 March 2022 12:01 PM
To: ACT Health, Clinical Leadership <Clinical.Leadership@act.gov.au>; ACTHealthCorporate&Governance <ACTHealthCorporate&G@act.gov.au>; Canberra Health Services Ministerial <CHS.Ministerial@act.gov.au>; HSPE <HSPE@act.gov.au>; LHN Coord <LHNCoord@act.gov.au>
Cc: Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>; Stewart, Margaret (Health) <Margaret.Stewart@act.gov.au>; George, Jacinta (Health) <Jacinta.George@act.gov.au>
Subject: RE: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

Hi Team

Please see below response for clearance at a. and b. below:

1. How many new graduates have been recruited in this financial year – 18
    a. Enrolled Nurse - 11
    b. Registered Nurse - 7

Please note that this has not had Executive clearance.

Kind regards

Natasha

Natasha Westcott | **Coordination and Support Officer**
Local Hospital Network Commissioning | Health System Planning and Evaluation | ACT Health Directorate
Direct Email: Natasha.Westcott@act.gov.au
Phone: Via Microsoft Teams
Level 4, 6 Bowes Street Phillip ACT 2606
health.act.gov.au

From: Webster, Elizabeth (Health) <Elizabeth.Webster@act.gov.au> **On Behalf Of** ACT Health, Clinical Leadership
Sent: Thursday, 10 March 2022 10:09 AM
To: ACTHealthCorporate&Governance <ACTHealthCorporate&G@act.gov.au>; Canberra Health Services Ministerial <CHS.Ministerial@act.gov.au>; HSPE <HSPE@act.gov.au>; LHN Coord <LHNCoord@act.gov.au>
Cc: Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>
Subject: FW: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

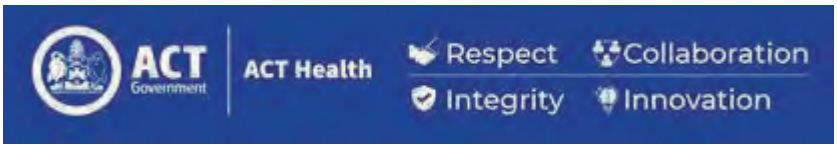
Morning All

The MO requested an urgent breakdown of what professions are in the graduate numbers (MO doesn't need the numbers broken down, just an indicator of what those numbers represent).

Question	ACTHD	CHS	CPHB	QEII	Total
How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022	18	0	154

Regards

Elizabeth Webster, Executive Officer
T: (02) 5124 9546 I **M:** [redacted] | **E:** Elizabeth.Webster@act.gov.au
Office of Professional Leadership and Education | ACT Health Directorate
Level 3, 2-6 Bowes Street, Phillip | GPO Box 825 Canberra ACT 2601
W: www.health.act.gov.au



From: Felding, Jasna (Health) <Jasna.Felding@act.gov.au> **On Behalf Of** Health Ministerial Liaison Officer
Sent: Thursday, 10 March 2022 10:03 AM
To: ACT Health, Clinical Leadership <Clinical.Leadership@act.gov.au>
Subject: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

Hi Elizabeth

The above ministerial has been returned from the Minister's Office seeking further information, please see below.

Would be grateful if this could be provided asap.

Kind regards

Jasna Felding| Ministerial Liaison Officer
Ph: 02 5124 9834| Email: Jasna.felding@act.gov.au
Office of Director-General / Ministerial & Government Services Unit | ACT Health Directorate
Level 5, 2-6 Bowes Street Phillip ACT 2606
health.act.gov.au

Work days: Monday - Thursday

From: Ellis, Catherine (Health) <Catherine.Ellis@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Thursday, 10 March 2022 9:57 AM
To: Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>
Subject: FW: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

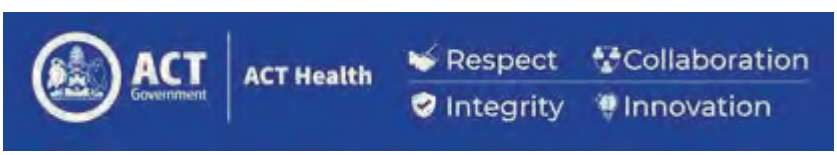
OFFICIAL

Hi Jas and Aiden

As discussed see below request for breakdown of grad data.

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob: [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Thursday, 10 March 2022 9:53 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: RE: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

Thank Cathy,

Can I just get a clarification for the new graduates with a breakdown of what professions are in those numbers (I don't need the numbers broken down, just an indicator of what those numbers represent).

Thanks,

Meg

From: Ellis, Catherine (Health) <Catherine.Ellis@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Thursday, 10 March 2022 9:07 AM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: RE: URGENT Advice by Email: Ratios Announcement - 10 March

OFFICIAL

Hi Meg

Please see below final update to include QEII data. Very minor change and not really impacting the overall total by much.

Question	ACTHD	CHS	CPHB	QEII	Total
How many nursing staff have been recruited in this financial year	1 ACTHD systems don't record beyond this granularity so we're unable to specify if they were a midwife or not.	535 This doesn't include graduates	171	4	711
How many midwifery staff have been recruited in this financial year		19	20	0	39
How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022	18	0	154
Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited	3 2 x HPO4 and 1 HPO3	154 Total number recruited in the 21/22 FY	21	0	178

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square

From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Wednesday, 9 March 2022 6:36 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: RE: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

Thanks Cathy! Really appreciate this coming together for the event 😊

From: Ellis, Catherine (Health) <Catherine.Ellis@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Wednesday, 9 March 2022 5:26 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: FW: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

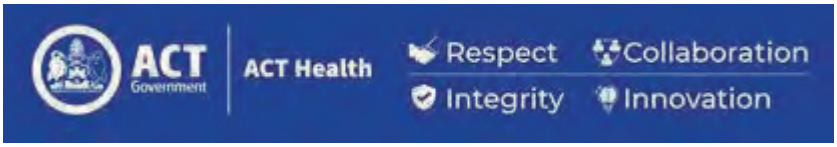
Hi Meg

Further updates to include CPHB, but I note QEII is not yet available. Unfortunately QEII data may not be available before COB today and noting this event is tomorrow, apologies in advance if I can't get that through to you.

Question	ACTHD	CHS	CPHB	Total
How many nursing staff have been recruited in this financial year	1 ACTHD systems don't record beyond this granularity so we're unable to specify if they were a midwife or not.	535 This doesn't include graduates	171	707
How many midwifery staff have been recruited in this financial year		19	20	39
How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022	18	154
Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited	3 2 x HPO4 and 1 HPO3	154 Total number recruited in the 21/22 FY	21	178

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob: [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Ellis, Catherine (Health) **On Behalf Of** ACT Health DLO
Sent: Wednesday, 9 March 2022 3:49 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: FW: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

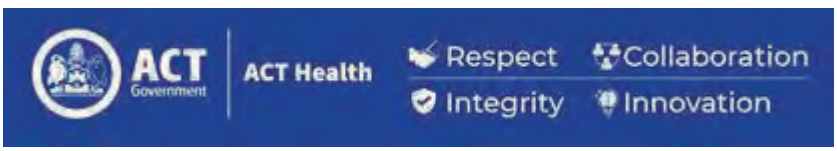
Hi Meg

See below information that we have available so far. The team are still chasing up CPHB and we will update as soon as we can.

Question	ACTHD	CHS	CPHB	Total
How many nursing staff have been recruited in this financial year	1 ACTHD systems don't record beyond this granularity so we're unable to specify if they were a midwife or not.	535 This doesn't include graduates		536
How many midwifery staff have been recruited in this financial year		19		19
How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022		136
Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited	3 2 x HPO4 and 1 HPO3	154 Total number recruited in the 21/22 FY		157

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Tuesday, 8 March 2022 5:37 PM

To: CHS DLO <CHSDLO@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: Ratios Announcement - 10 March
Importance: High

Hi Both,

Can I please get some figures about recruitment of staff in the following areas:

- How many nursing staff have been recruited in this financial year
- How many midwifery staff have been recruited in this financial year
- How many new graduates have been recruited in this financial year
- Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited

Can I please have this information by 3pm tomorrow if possible?

Thanks,

Meg Bransgrove
Senior Adviser
Office of Minister Rachel Stephen-Smith MLA
ACT Government
Email: meagen.bransgrove@act.gov.au
M: [redacted]
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2600

Lowes, Shannon (Health)

From: Waye, Jenny (Health) on behalf of Canberra Health Services Ministerial
Sent: Thursday, 10 March 2022 12:54 PM
To: ACT Health, Clinical Leadership; ACTHealthCorporate&Governance; HSPE; LHN Coord
Cc: Health Ministerial Liaison Officer; Macpherson, Katherine (Health)
Subject: RE: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March

Importance: High

Follow Up Flag: Follow up
Flag Status: Flagged

OFFICIAL

Hi Elizabeth

I understand that the figure provided in the table yesterday from CHS was for nursing graduates only.

CHS also has Midwifery graduates as follows:

- 18 graduates in 2021
- 19 graduates in 2022

Thanks

Jenny Waye | Ministerial Liaison Officer
Ph: 02 51249832| Email: CHS.Ministerial@act.gov.au
Government Relations | Canberra Health Services | ACT Government
Level 1, Building 28, Canberra Hospital| health.act.gov.au

Work days: Monday, Wednesday, Thursday and Friday
RELIABLE | PROGRESSIVE | RESPECTFUL | KIND

From: Webster, Elizabeth (Health) <Elizabeth.Webster@act.gov.au> **On Behalf Of** ACT Health, Clinical Leadership
Sent: Thursday, 10 March 2022 10:09 AM
To: ACTHealthCorporate&Governance <ACTHealthCorporate&G@act.gov.au>; Canberra Health Services Ministerial <CHS.Ministerial@act.gov.au>; HSPE <HSPE@act.gov.au>; LHN Coord <LHNCoord@act.gov.au>
Cc: Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>
Subject: FW: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

Morning All

The MO requested an urgent breakdown of what professions are in the graduate numbers (MO doesn't need the numbers broken down, just an indicator of what those numbers represent).

Question	ACTHD	CHS	CPHB	QEII	Total

How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022	18	0	154

Regards

Elizabeth Webster, Executive Officer
T: (02) 5124 9546 I **M** [redacted] | **E:** Elizabeth.Webster@act.gov.au
Office of Professional Leadership and Education | ACT Health Directorate
Level 3, 2-6 Bowes Street, Phillip | GPO Box 825 Canberra ACT 2601
W: www.health.act.gov.au

From: Felding, Jasna (Health) <Jasna.Felding@act.gov.au> **On Behalf Of** Health Ministerial Liaison Officer
Sent: Thursday, 10 March 2022 10:03 AM
To: ACT Health, Clinical Leadership <Clinical.Leadership@act.gov.au>
Subject: URGENT RFA - MIN22/392 - Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

Hi Elizabeth

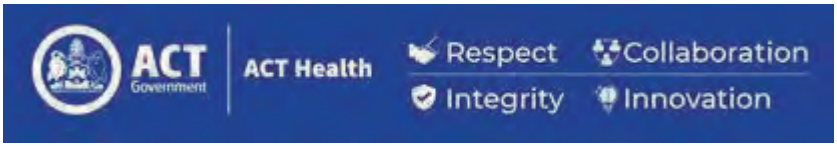
The above ministerial has been returned from the Minister's Office seeking further information, please see below.

Would be grateful if this could be provided asap.

Kind regards

Jasna Felding| Ministerial Liaison Officer
Ph: 02 5124 9834| Email: Jasna.felding@act.gov.au
Office of Director-General / Ministerial & Government Services Unit | ACT Health Directorate
Level 5, 2-6 Bowes Street Phillip ACT 2606
health.act.gov.au

Work days: Monday - Thursday



From: Ellis, Catherine (Health) <Catherine.Ellis@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Thursday, 10 March 2022 9:57 AM
To: Health Ministerial Liaison Officer <HealthMinisterialLiaisonOfficer@act.gov.au>

Subject: FW: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

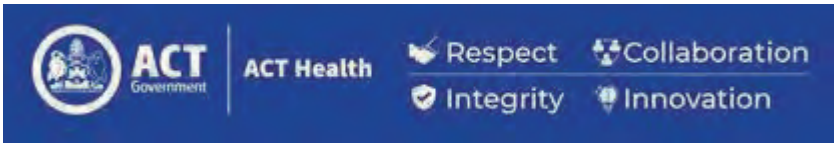
OFFICIAL

Hi Jas and Aiden

As discussed see below request for breakdown of grad data.

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob: [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Thursday, 10 March 2022 9:53 AM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: RE: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

Thank Cathy,

Can I just get a clarification for the new graduates with a breakdown of what professions are in those numbers (I don't need the numbers broken down, just an indicator of what those numbers represent).

Thanks,

Meg

From: Ellis, Catherine (Health) <Catherine.Ellis@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Thursday, 10 March 2022 9:07 AM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: RE: URGENT Advice by Email: Ratios Announcement - 10 March

OFFICIAL

Hi Meg

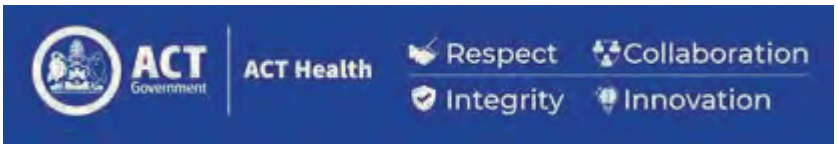
Please see below final update to include QEII data. Very minor change and not really impacting the overall total by much.

Question	ACTHD	CHS	CPHB	QEII	Total
How many nursing staff have been recruited in this financial year	1 ACTHD systems don't record	535 This doesn't include graduates	171	4	711

How many midwifery staff have been recruited in this financial year	beyond this granularity so we're unable to specify if they were a midwife or not.	19	20	0	39
How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022	18	0	154
Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited	3 2 x HPO4 and 1 HPO3	154 Total number recruited in the 21/22 FY	21	0	178

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob: [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Wednesday, 9 March 2022 6:36 PM
To: ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: RE: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

Thanks Cathy! Really appreciate this coming together for the event 😊

From: Ellis, Catherine (Health) <Catherine.Ellis@act.gov.au> **On Behalf Of** ACT Health DLO
Sent: Wednesday, 9 March 2022 5:26 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: FW: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

Hi Meg

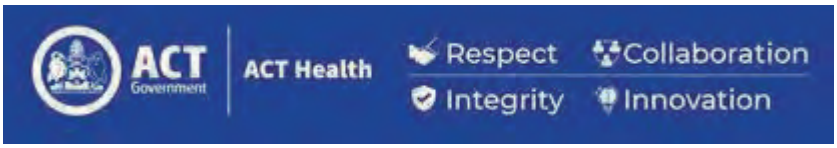
Further updates to include CPHB, but I note QEII is not yet available. Unfortunately QEII data may not be available before COB today and noting this event is tomorrow, apologies in advance if I can't get that through to you.

Question	ACTHD	CHS	CPHB	Total
How many nursing staff have been recruited in this financial year	1	535	171	707

	ACTHD systems don't record beyond this granularity so we're unable to specify if they were a midwife or not.	This doesn't include graduates		
How many midwifery staff have been recruited in this financial year		19	20	39
How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022	18	154
Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited	3 2 x HPO4 and 1 HPO3	154 Total number recruited in the 21/22 FY	21	178

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square



From: Ellis, Catherine (Health) **On Behalf Of** ACT Health DLO
Sent: Wednesday, 9 March 2022 3:49 PM
To: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Subject: FW: URGENT Advice by Email: Ratios Announcement - 10 March
Importance: High

OFFICIAL

Hi Meg

See below information that we have available so far. The team are still chasing up CPHB and we will update as soon as we can.

Question	ACTHD	CHS	CPHB	Total
How many nursing staff have been recruited in this financial year	1 ACTHD systems don't record beyond this granularity so we're unable to specify if they were a midwife or not.	535 This doesn't include graduates		536
How many midwifery staff have been recruited in this financial year		19		19

How many new graduates have been recruited in this financial year	12	124 This doesn't include the additional 23 to commence in May 2022		136
Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited	3 2 x HPO4 and 1 HPO3	154 Total number recruited in the 21/22 FY		157

Thanks
Cathy

Catherine Ellis | Directorate Liaison Officer | ACT Health Directorate
Mob: [redacted] | Email: ACTHealthDLO@act.gov.au
Office of Rachel Stephen-Smith | Minister for Health
Officer of Emma Davidson | Minister for Mental Health
Level 2, Legislative Assembly Building, Civic Square

From: Bransgrove, Meagen <Meagen.Bransgrove@act.gov.au>
Sent: Tuesday, 8 March 2022 5:37 PM
To: CHS DLO <CHSDLO@act.gov.au>; ACT Health DLO <ACTHealthDLO@act.gov.au>
Subject: Ratios Announcement - 10 March
Importance: High

Hi Both,

Can I please get some figures about recruitment of staff in the following areas:

- How many nursing staff have been recruited in this financial year
- How many midwifery staff have been recruited in this financial year
- How many new graduates have been recruited in this financial year
- Of the 257 FTE health professionals outlined in the 2021-22 ACT budget how many have been recruited

Can I please have this information by 3pm tomorrow if possible?

Thanks,

Meg Bransgrove
Senior Adviser
Office of Minister Rachel Stephen-Smith MLA
ACT Government
Email: meagen.bransgrove@act.gov.au
M: [redacted]
ACT Legislative Assembly, 196 London Circuit, Canberra, ACT 2600

SUBJECT: Nurse/Midwife to Patient Ratios – Timeline of Implementation

a. Work already done for Phase 1
b. Planning for future phases to implement ratios across our health sector

Thank you, Madam Speaker.

Implementation of Phase 1 of the Nurse/Midwife to Patient Ratios has commenced in 21 wards within Canberra Health Services and Calvary Public Hospital Bruce within a staged approach towards full implementation of Phase 1 by December 2022.

Madam Speaker, the journey to implementing ratios has been a considerable one. The concept was first explored back in 2018 when we began developing the ACT Public Sector Nursing and Midwifery Safe Care Staffing Framework. This document underpins the implementation of ratios within the ACT Public Health System.

A 'Ratios Framework' details a workload management system that includes mandated minimum nurse/midwife ratios that takes into account the acuity, workload, and patient safety elements in each designated clinical area. The implementation of Ratios began within clinical areas in February this year.

The ACT Chief Nursing and Midwifery Officer is overseeing the implementation of Ratios and is working in a partnership with the Australian Nursing and Midwifery Federation, the Ratios Implementation Steering Committee, and Implementation Working Groups at both Canberra Health Services and Calvary Public Hospital Bruce.

This approach supported the review of clinical services and human resource management to begin the implementation of ratios soon after the Fair Work Commission ratified the ACT Public Sector Nursing and Midwifery Enterprise Bargaining Agreement on 24 January this year. The Enterprise Agreement includes the Schedule 10 that defines the ratios.

This is a wonderful achievement and one that I am very proud of considering the challenges that have faced our health services during the COVID-19 pandemic.

Madam Speaker, in addition to undertaking the vast amount of administrative and clinical redesign required to implement ratios, our health services have

also recruited over half of the extra 90 full time equivalent nurses that are needed for ratios. This is to be applauded.

However, the work is not over Madam Speaker.

While continuing to reach the goal of fully implementing Phase 1 of ratios by December 2022, we are now also focusing our attention on Phase 2 of ratios.

Phase 2 will be included in the next Nursing and Midwifery Enterprise Agreement, which we will begin negotiating in the very near future. In this agreement, we will be looking at the possibility of implementing ratios into other specialty areas such as women's and children's health, critical care, perioperative areas, cancer, and some further mental health units. These will be determined in the next round of negotiations.

To better inform how we progress into Phase 2, we have been meeting with nursing staff from both hospitals to seek their comments and views on the implementation of Phase 1 of ratios.

The Executive of Canberra Health Services, Calvary Public Hospital Bruce and ACT Health Directorate have also met to consider and discuss the opportunities that will arise within the next bargaining phase of the enterprise agreement.

Madam Speaker, I am pleased with what we have achieved so far with the implementation of mandated nurse/midwife ratios within the ACT Health System. It will enhance our health service and is a positive outcome for both patients and nurses. I am looking forward to progressing this important initiative in the years to come.

END

SUBJECT: The importance of ratios

a. The benefits to welfare of staff

b. The benefits to patient care

Thank you, Madam Speaker.

It is with great pleasure that I inform the Assembly that the implementation of Nurse/Midwife to patient ratios has started across the ACT Public Health System.

This is an important milestone in the history of ACT health services as it will not only improve the quality and safety of care that our community receives but it will also improve the lives of our hardworking and dedicated nursing and midwifery workforce.

Madam Speaker, the implementation of mandated nurse to patient ratios into 21 of our general medical, surgical, and acute aged care wards, and our adult mental health units at both Canberra Health Services and Calvary Public Hospital Bruce, will greatly enhance the care that we provide within our health services.

The additional 90 full time equivalent nurses will provide more time for nurses to deliver clinical care and support for our patients.

Madam Speaker, research shows that ratios can have a significant impact on positive outcomes for patients with decreased hospital acquired incidents in the clinical area. Implementing mandated nurse/midwife ratios is not only good news for patients, it is also good news for the dedicated nurses who are working within our health care system.

Nurses can now come to work knowing that there are going to be enough nurses working on the floor to provide the care that their patients need. There will also be a dedicated team leader nurse on the morning and afternoon shifts who will be there to support nurses in their clinical role. They will know that on night duty, they will have the best nurse to patient ratio in the country.

It is stated that nurses who work within a mandated ratios system feel a greater sense of satisfaction about their work with more time to meet the individual needs of their patients. Ratios has the potential to decrease burn

out, with research denoting nurses are more likely to stay working in a health service that has mandated ratios implemented.

This is indeed good news.

END