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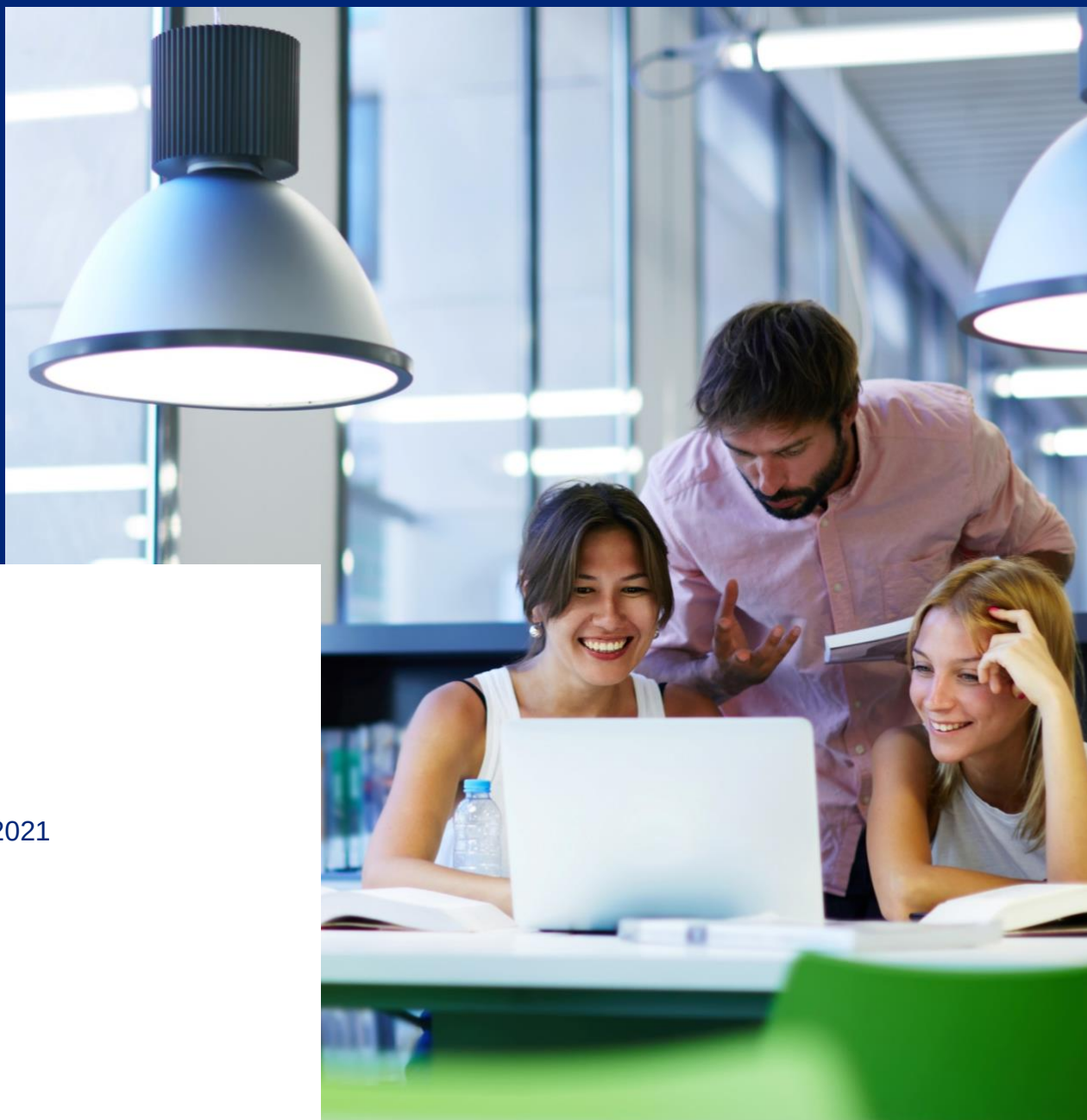
OUTCOME EVALUATION ON NURSE PRACTITIONER POLICY AND LEGISLATION IN THE AUSTRALIAN CAPITAL TERRITORY



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AUTHOR NOTE

This outcome evaluation satisfies Objective 1.3 of the Nurse Practitioner Professional Practice Project, sponsored by the Australian Capital Territory (ACT) Office of the Chief Nursing and Midwifery Officer. This evaluation, along with a nurse practitioner (NP) workforce and employer survey, will inform a broader consultation document for targeted stakeholders.

ACKNOWLEDGEMENT OF COUNTRY

ACT Health acknowledges the Traditional Custodians of the land, the Ngunnawal people. ACT Health respects their continuing culture and connections to the land and the unique contributions they make to the life of this area. ACT Health also acknowledges and welcomes Aboriginal and Torres Strait Islander peoples who are part of the community we serve.

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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 2100 NPs holding the NMBA endorsement, 54 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 Labour 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 Medicare Benefits Schedule (MBS) and Pharmaceutical Benefits Scheme (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.

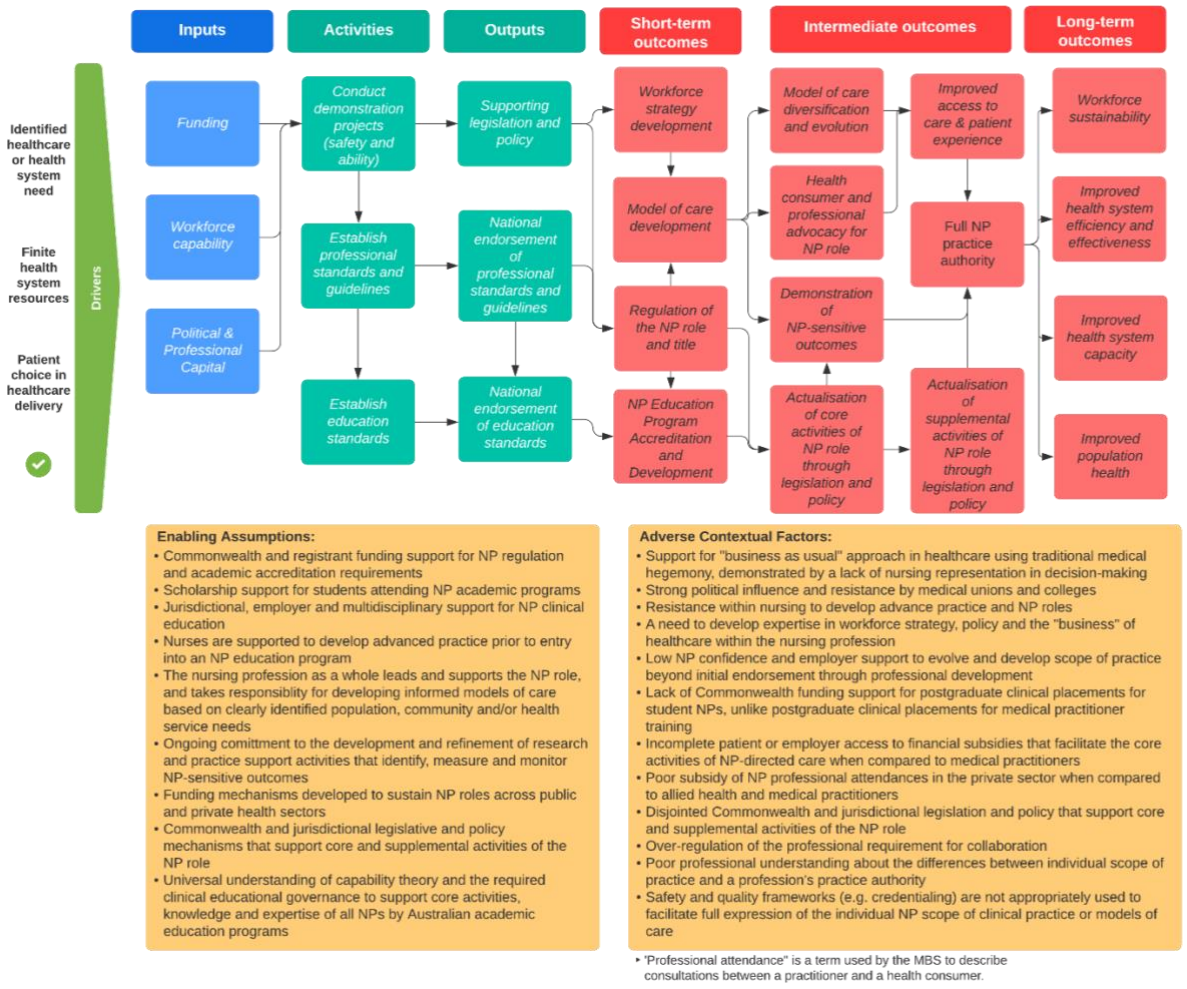
The 2017 review into NP practice was innovative, in that it recommended changes that would remove the restrictive governance framework used to authorise NP clinical practice within the Territory. From the perspective of clinical governance, this review recommended the NP role be "normalised" and in line 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
- 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, 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 rates of annual MBS utilisation from NP-directed services since 2010 (Australian Government, 2021), and decreasing rates of 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 reflect 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* (ACT) or the *Road Transport (Driver Licensing) Act 1999* (ACT). 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
- 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 NPs, 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* (Commonwealth), 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 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.

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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'.	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 20063. Standards arising from this research have served as the foundation for the regulation of the nurse

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.

			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. 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	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 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.

			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. 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 continuum of aged care services, namely the acute,	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 case management	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*

		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.	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	*Health (Collaborative Arrangements for Nurse Practitioners) Determination 2010* (C'wealth), as well as other agreements, 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.

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

			the Clinical Practice Guidelines and Medication Formularies. 7. The Australian Government support the work towards the establishment of an agreed generic national scope 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	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 endorsement7. 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 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

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.

				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 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.	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

			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 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	to larger 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*

			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 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	*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 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.

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

			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; 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;	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; 5. That there are realistic, achievable and individual key performance indicators established at the outset of NP position development;	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

		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 the aged care NP role in the context of Australian health.	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;	from 3/month to 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

			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.	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 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 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.	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 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	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 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

			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 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	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

			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 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.	successfully enact the role. There are a few that have done so, and their work is published in the peer-reviewed and grey literature. 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

			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	programs across the States and Territories.

			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	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

			Emergency Department staff.	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 – 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	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. 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

			Health, all employers and NPs in private practice.	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. 6. The Australian College of NPs provide an individualised career planning and support service.	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.