Health Workforce Australia
Expanded Scopes of Practice Program
Evaluation Progress Report 1

Centre for Health Service Development
March 2013
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### Abbreviations

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<th>Description</th>
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<td>CHSD</td>
<td>Centre for Health Service Development, University of Wollongong</td>
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<tr>
<td>ECP</td>
<td>Extended Care Paramedic</td>
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<td>ED</td>
<td>Emergency Department</td>
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<tr>
<td>ESOP</td>
<td>Expanded Scopes of Practice Program also referred to as the Program</td>
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<tr>
<td>APEN</td>
<td>Expanded Scope of Practice – Advanced Practice in Endoscopy Nursing (referred to as APEN projects)</td>
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<td>PED</td>
<td>Expanded Scope of Practice – Physiotherapists in the ED (referred to as PED projects)</td>
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<tr>
<td>NED</td>
<td>Expanded Scope of Practice – Nurses in the ED (referred to as NED projects)</td>
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<tr>
<td>ERP</td>
<td>Expanded Scope of Practice – Extending the Role of Paramedics (referred to as ERP projects)</td>
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<td>GP</td>
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<td>HWA</td>
<td>Health Workforce Australia</td>
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<td>ICP</td>
<td>Intensive Care Paramedic</td>
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<td>PCP</td>
<td>Primary Contact Physiotherapist</td>
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<td>Program</td>
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<td>SAAS</td>
<td>South Australian Ambulance Service</td>
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<td>VIRIAF</td>
<td>Victorian Innovation and Reform Impact Assessment Framework</td>
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1 Key messages

The Centre for Health Service Development (CHSD), University of Wollongong, was appointed in June 2012 to undertake the program evaluation of the Health Workforce Australia - Expanded Scopes of Practice (HWA-ESOP) program. Health Workforce Australia (HWA) currently funds 26 organisational projects across Australia. Several organisations have more than one implementation site.

The focus of this first evaluation progress report is the set-up phase; it is consequently formative – providing a view of the progress and development of the four sub-projects:

- Advanced Practice in Endoscopy Nursing (APEN)
- Physiotherapists in the Emergency Department (PED)
- Nurses in the Emergency Department (NED)
- Extending the Role of Paramedics (ERP)

In summary:

- The set-up phase has been successfully completed by all funded projects, which are now up and running (Mersey Hospital in Tasmania elected to discontinue their APEN project in September 2012, due to recruitment and medical supervision issues).
- All project teams have commenced their training pathways. Several projects have long training trajectories for their Expanded Scope of Practice (ESOP) practitioners continuing until December 2013; this may limit the capacity to evaluate the full impact of these roles.
- The program evaluation framework and associated evaluation tools are finalised and data collection is in progress. Challenges are emerging with completeness of data sets and the capacity of sites to extract this information.
- Balancing local and national evaluation requirements has required the co-operation of project teams, the national evaluation team and external research institutions. Approximately 50% of projects are implementing additional local evaluation activities; if all projects comply with the national evaluation requirements they should generate acceptable evidence of project impact.
- Sub-projects (APEN and PED) with lead sites have demonstrated a more streamlined approach to the project set-up phase with less duplication than sub-projects without a lead site.
- HWA’s program governance processes are working effectively with Project Advisory / Reference Groups, clinical advisors and the national evaluation team working collaboratively.
- The sub-project workshops organised by HWA have brought people together and contributed to the development of effective working relationships with project teams and other stakeholders.
- Project teams have worked consistently to communicate information about their respective Expanded Scope of Practice roles throughout their organisations; this has required constant repetition and reinforcement.
- The time taken to set-up and prepare the projects for implementation has been underestimated, predominantly for projects with lead responsibilities and / or organisations new to the Expanded Scope of Practice role. Future projects should include a 6 – 12 month set-up period depending on the context of implementation, particularly if the development of training resources is necessary.
- Sustainability will be challenging as not all projects have secured permanent funding, and this is an issue that has to be addressed from the commencement of the project.
- Project risks relating to the set-up phase have been managed effectively to date.

The next evaluation progress report will focus on the training and implementation phase of the sub-projects.
2 Executive summary

The HWA-ESOP program is part of a work plan implementing the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015. It was instigated to address known areas of workforce shortage in the Australian health system by expanding the scopes of practice of nurses, physiotherapists and paramedics. Innovative models of care delivery have been developed by State and Territory health authorities. These models have the potential to improve the patient journey, reduce waiting times and ease pressure in areas of high demand, such as Emergency Departments (EDs), by equipping health professionals with skills and experience to extend their existing roles. There is a need to implement and evaluate these models systematically and to assess whether they are suitable for wider (national) roll-out and the conditions under which they are most likely to succeed.

Within each sub-project there are a number of implementation sites, and two sub-projects (APEN and PED) also have lead sites providing guidance and support to implementation sites. In total, 26 organisations have received funding under the HWA-ESOP program. As national evaluator of the program, CHSD’s role is to assist sites with planning and carrying out their evaluation activities, to monitor evaluation outcomes and to collect, organise and synthesise evaluation data from the program as a whole, to inform future policy and practice. In this report, we describe our work in relation to the set-up phase of the Program.

Our review of each of the HWA-ESOP sub-projects has generated a range of findings, many that are common across the program. The synthesis of major lessons learned at the program level that pertain to the set-up phase are provided in relation to the six key elements of the program evaluation framework.

Program delivery – What did you do?

- The Request for Proposals (RFPs) needs the input of clinical experts and advisors during their development. Early appointment of clinical advisors would allow them to be involved in preparation of the RFP and project review and selection. This would avoid the incorrect use of terminology, particularly relating to advanced practice, which generated unnecessary confusion amongst professional bodies and concerns that some clinicians could be working outside their scope of practice.

- States and jurisdictions should also be engaged during the RFP process to ensure that the funded initiatives complement other workforce innovation projects; they have a key role in sustainability of the project in the medium to longer term.

- All RFPs need to clearly state the case for change, including the aims of the funding round and evidence for the recommended model of care and intervention.

- The models of care developed for nursing projects must align with accepted position classifications for varying professional designations, for example, if autonomous practice is central to the role then a Nurse Practitioner is required.

- The models of care developed for several physiotherapy and nursing projects included significant barriers from the outset. For example, prescribing issues were already being addressed through HWA through the Health Professionals Prescribing Pathway project. A thorough review of potential legislative and industrial issues prior to implementation may have identified which regulatory arrangements in which jurisdictions might allow flexibility and supported early inter-jurisdictional action.

- During the set-up phase, sub-projects with lead sites have demonstrated a more streamlined approach to getting started and less duplication than sub-projects without a lead site. However lead sites need to be identified first so that the RFP process allows implementation sites to apply for project funding with a clear understanding of the model of care and associated training and implementation requirements and what they are signing up for including the ‘fit’ of the model of care for their organisation.
If external evaluators are engaged, they need to commence earlier and possibly during RFP development. This would reduce the confusion between local and national evaluation requirements and improve understanding of the expectations of HWA for projects’ involvement in data collection and evaluation. This might also facilitate more streamlined ethics approval processes.

Early design of the evaluation framework, data collection methods and the associated program evaluation tools would streamline the ethics application process for project sites. The RFP should alert project teams to the likely requirement for ethics approval and the potential time required to prepare the application and gain approval.

Guidelines need to be provided to projects submitting RFPS to assist in the development of their budgets as many projects underestimated project management, training, equipment and evaluation costs. HWA should specify the investment expected in project management, as project teams that invested less have been slower to progress and less responsive to HWA timelines.

Projects consistently identified that there was not enough time allowed for the set-up phase of the project and for organisations without any experience of expanded scopes of practice, a 6 – 12 month lead time was preferred. This ‘pre-implementation period’ would maximise opportunities within the project.

Project teams require diverse skill sets to effectively manage all aspects of project development, training, implementation and evaluation. Rarely were all skills found within an individual which meant that project officers had to find assistance within or outside their organisation. Smaller organisations have fewer specialist resources.

Program impact – How did it go?

Organisations with a receptive context for change have demonstrated greater agility and adaptability during the set-up phase, particularly in their ability to address problems as they arise.

Recruiting the right people for the Expanded Scope of Practice roles has influenced early perceptions of other members of the health care team, for example, highly competent, experienced and known practitioners who have worked in the organisation and have a positive reputation and track record. In many instances their personal drive and enthusiasm has increased acceptance of the roles. Service models need to be transferable and sustainable at the service level.

Project teams need a structured approach to change management in workforce innovation projects as ad hoc or reactive responses leaves too much to chance. Whilst project teams are practical at addressing barriers as they arise the approach is usually reactive. Expertise in managing change varies significantly across project teams.

The experience of project teams to date suggests that workforce innovation requires an incremental approach to change, where organisations build on their previous experience and progress step by step.

Project teams with established relationships with key stakeholders found consultation and engagement easier; organisations where a senior leader visibly championed the project demonstrated improved acceptance of the role and model of care.

For most projects the introduction of a new model of care and scope of practice requires approval through the local organisational processes. These timeframes can be outside the control of project teams who are competing for access on busy agendas.

Clinical advisors need to visit project sites with the HWA project manager early in the set-up phase. This provides a safeguard for HWA and also provides clinical support and expert advice for project teams. The initial site visit could ideally include a member of the national evaluation team to ensure that all parties are starting with a common understanding of project requirements. This ensures consistent messages and reduces the time impost of site visits for project teams. This would also support role clarity between the project manager, clinical advisor and national evaluation team. Subsequent site visits need to be coordinated to avoid
duplication and overlapping visits as when data collection is required by the national evaluators, there is a need for independent site visits. As lead sites were also conducting site visits in the first months of the projects, this frequently meant that project teams hosted more than three visits in the set-up phase.

- A series of workshops were planned with the first workshop occurring within three months of projects being funded. These need to be paced across the life of the program with clear aims and alignment with the major project phases. For example, the first workshop appropriately focused on project set-up issues but probably also needed to include more about the models of care and proposed training pathway particularly for projects without lead sites. The second workshop addressed training, capacity development and implementation issues as well as strategies for project sustainability and generalisability. The third workshop could focus on lessons learned, project achievements, evaluation methods and data collection, final report development and dissemination.

- Several projects have been designed in a way that results in the Expanded Scope of Practice clinician implementing the new model of care in their organisation at the same time they are being trained in the role. This means that many clinicians will not be working to full scope for a considerable part of the implementation period. The majority of projects will barely have 12 months of implementation. This short implementation period reduces the likelihood of being able to generate robust data, demonstrate and measure the contribution of the projects to changes in key performance indicators and embed practice changes.

Program sustainability – Can you keep it going?

- Whilst all project Funding Agreements include the requirement for project teams to commit to continuing the Expanded Scope of Practice role, in reality most projects will need to secure funding for this to happen. Timing for this is crucial as most organisations require business cases submitted at least 18 months prior to expenditure being incurred. However projects will not have any evidence of their impact until implementation is completed and their final report is submitted.

- Helping project teams develop strategies to improve project sustainability needs to occur in the set-up phase, for example, this may be ensuring key decision-makers are included in the membership of steering committees or are provided with regular information on early wins.

- Entry requirements for the Expanded Scope of Practice roles must reflect the skills and qualifications required; however this needs to be balanced with increasing access to the pool of potential candidates. Restrictive entry criteria reduce the sustainability of the role and capacity to roll-out the model of care nationally and needs to be balanced with mitigating risk.

- Training models need to be affordable, accessible, demonstrate competency and that clinicians are ‘fit for purpose’. They need to be structured in accordance with adult learning principles, including capacity for recognition of prior learning. Ideally they generate a qualification (or part of a qualification) that is nationally recognised. Training models must be sustainable and appropriately documented.

- These Expanded Scope of Practice roles should be integrated into the broader health care team; when other health professionals can see how the role interfaces with other clinical roles and contributes to the care continuum, professional respect and recognition increases, which in turn supports sustainability.

Program capacity – What has been learnt?

- A basic aim of the HWA-ESOP program is to build capacity in nurse endoscopists, physiotherapists and nurses working in the ED and paramedics. Training has presented particular challenges when sub-projects did not have lead sites and / or inconsistency in the models of care being implemented. The more variation in models of care across implementation sites, the greater the risk for HWA.

- Project teams that are responsible for training must supply a documented training pathway, which includes learning outcomes, course outlines, assessment methods and appropriate learning resources.
Developing training pathways and supporting resources is time consuming and requires specialist expertise. To implement training on a national basis requires infrastructure; the capacity to transfer this training and mechanisms for assessment and recognition.

Many project teams responsible for training did not anticipate the work involved in designing the training pathway and resources. For some teams a significant investment has been needed to develop and document the competencies required by the Expanded Scope of Practice role and how these will be assessed.

Project teams have already identified that circumstances change as implementation progresses, and as the confidence of the Expanded Scope of Practice clinicians and acceptance by the surrounding health care team increases, boundaries can be flexed and the scope of practice extends. This means that vigilance is needed to ensure clinicians are equipped with the right skill set and that clinical governance processes keep pace with these changes.

For some project teams training has predominantly been finished however new needs may emerge as implementation progresses. There needs to be a review cycle so these emerging needs are identified and additional training can be supplied.

**Program generalisability – Are your lessons useful for someone else?**

A range of lessons have been learned about the set-up phase of this program. Sub-projects with common models of care appear likely to be easier to implement on a national basis as there are a broader range of implementation sites and experiences. Staged approaches may offer better opportunity for success.

Incremental roll-out is potentially more manageable where a fixed number of sites are funded at any one time.

Some of the models implemented have occurred in such specific contexts that they are unlikely to be suitable for replication unless the next organisation has similar pre-conditions.

Several sites are yet to show an awareness that their project needs to be packaged in a way that lends itself to national replication. During the set-up phase project teams are focused on 'doing' rather than planning for wider generalisability.

**Program dissemination – Who did you tell?**

Several project teams were relying on a public launch of their project to generate community interest and potential engagement. This did not occur in a timely way due to delays in Ministerial announcements and this affected stakeholder engagement.

During the set-up phase most dissemination has occurred internally within the project organisations with a focus on informing internal stakeholders about progress and early achievements.

Several project teams have developed information resources for consumers, to disseminate information about the Expanded Scope of Practice role and what this means for their care.

Limited national dissemination has occurred which is appropriate for this phase of the program. However several opportunities will present later in the year (such as the national HWA conference and annual professional conferences) so a coordinated approach will be needed.
3 Introduction and background to the HWA-ESOP program

3.1 Overview

The Centre for Health Service Development (CHSD), University of Wollongong, was appointed by HWA in June 2012 to undertake the evaluation of the Health Workforce Australia - Expanded Scopes of Practice (HWA-ESOP) program. This is the first of three evaluation progress reports on the HWA-ESOP program. The reporting period extends from the engagement of the national evaluation team in late June 2012 through to 28 February 2013. The focus of this first report is on the set-up phase; it is consequently formative – providing a view of the progress and development of individual projects and the sub-projects.

The HWA-ESOP program is part of a work plan implementing the National Health Workforce Innovation and Reform Strategic Framework for Action 2011-2015. It was instigated to address known areas of workforce shortage in the Australian health system by expanding the scopes of practice of nurses and allied health professionals. Innovative models of care delivery have been developed by State and Territory health authorities. These models have the potential to improve patient outcomes, reduce waiting times and ease pressure in areas of high demand, such as Emergency Departments (EDs), by equipping health professionals with skills and experience to extend their existing roles. There is a need to implement and evaluate these models systematically and to assess whether they are suitable for wider (national) roll-out and the conditions under which they are most likely to succeed.

Four sub-projects have been funded under the HWA-ESOP program. Each will implement and evaluate models of expanded scope of practice:

- Advanced Practice in Endoscopy Nursing (APEN)
- Physiotherapists in the Emergency Department (PED)
- Nurses in the Emergency Department (NED)
- Extending the Role of Paramedics (ERP)

Within each sub-project there are a number of implementation sites, and two sub-projects (APEN and PED) also have lead sites providing guidance and support to implementation sites. In total, 26 organisations have received funding under the HWA-ESOP program.

3.2 Aim of this report

As national evaluator of the program, CHSD’s role is to assist sites with planning and carrying out their evaluation activities, to monitor evaluation outcomes and to collect, organise and synthesise evaluation data from the program as a whole, to inform future policy and practice. In this report, we describe our work in relation to the set-up phase of the Program. Specifically, we report on:

- the development of an evaluation framework for the HWA-ESOP program
- the compilation of a compendium of data requirements and evaluation tools, for use by implementation sites
- evaluation support provided during the set-up phase
- the progress of each sub-project during the set-up phase
- reflections on the emerging risks and lessons learned at the program level

We also bring together information from site visits, workshops, progress reports and other sources to provide a baseline description of the sub-projects and implementation sites. Our initial observations regarding alignment of project objectives, project management, barriers and enablers faced by project teams, stakeholder engagement and sustainability strategies are provided.
begin to draw some lessons from this phase of the Program; summarise project and evaluation risks and conclude with recommendations for HWA to consider for future project implementations.

### 3.3 Project implementation sites

HWA currently funds 26 organisational projects across Australia. Several organisations have more than one implementation site. The APEN and PED sub-projects were set-up with two lead sites whereas the NED and ERP sub-projects only consist of implementation sites. A full list of projects and their respective funding allocation is included as Appendix 1. For convenience a summary of the project sites is provided in Table 1 below.

<table>
<thead>
<tr>
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<th>Organisation</th>
<th>Project Site</th>
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<td>1.Brisbane Metro South Health Service</td>
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<td>5.Southern Health</td>
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<td>PED</td>
<td>6.Alfred Health</td>
<td>The Alfred Hospital</td>
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<td>7.Southern Health</td>
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<td>10.Central Australian Hospital Network</td>
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<td>13.Gold Coast Hospital and Health Service</td>
<td>Robina Hospital</td>
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<td>14.Southern Adelaide Local Health Network</td>
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<td>NED</td>
<td>15.South Eastern Sydney Local Health District</td>
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<td>17.Illawarra Shoalhaven Local Health District</td>
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* In subsequent evaluation progress reports, Southern Health will be referred to as Monash Health, reflecting a name change announced on 8 March 2013.

Several changes have occurred since the projects were selected and for various reasons. Funding was originally allocated to an additional APEN project based at Mersey Hospital in Tasmania. Difficulties in recruiting a trainee nurse endoscopist, managing the demands of project
management and securing adequate medical mentoring and supervisory input led to this site withdrawing from the HWA-ESOP program.

The Alfred Hospital approached HWA to extend the PED initiative to Sandringham Hospital to improve the management of patients suitable for primary contact physiotherapy in the ED and to strengthen the sustainability of the model within Alfred Health. Originally implementation was planned at Ballarat Base Hospital but the availability of additional funds from the Victorian Department of Health has allowed the fuller inclusion of this facility in the program.

Murrumbidgee Local Health District had hoped to implement the NED model of care across the entire Local Health District; however the costs and logistics involved led to a review of this approach and the selection of five localities deemed the most suitable implementation sites. One of the NED organisations, Eastern Health, initially planned to introduce their mental health model of care in three project sites; however a review of service utilisation showed that the highest number of mental health presentations was occurring at Box Hill Hospital and Maroondah Hospital, consequently implementation at Angliss Hospital is currently on hold.

The key change for the ERP sub-project has been the decision by Ambulance Tasmania to change the location for project implementation to Launceston. This decision was made as there was stronger stakeholder engagement and staff support in this locality. As the set-up phase is now completed further major changes are not anticipated.
4 Development of the evaluation framework and compendium of data requirements and evaluation tools

4.1 Development of the evaluation framework

The evaluation framework is one of three key components to be delivered by the national evaluators of the HWA-ESOP program. Its purpose is to support sub-projects and lead / implementation sites in their evaluation efforts and to ensure a national approach to building an evidence base for demonstrating the effectiveness of the program as a whole. Specifically, the evaluation framework sets out to:

- define data sources, including information that can be gleaned from existing data collections and new, one-off evaluation activities
- demonstrate the evaluation logic (that is, how the data sources contribute to the overall evaluation objectives)
- describe stakeholder engagement and consultation activities, and the respective roles of the national evaluation team and funded organisations in contributing to the evaluation of the sub-projects and overall program.

These goals are based on the Request for Quotation (RFQ) and contract requirements provided to the national evaluators.

Development of the evaluation framework was a major focus for the national evaluation team during the reporting period. As required, a draft framework (Version 1.0) was submitted to HWA at the end of July 2012. This was reviewed by HWA staff and other key stakeholders, resulting in an amended draft (Version 2.0). Following a period of extensive consultation with lead and implementation sites, through teleconferences, meetings and site visits, negotiated changes were made. Staff of funded organisations, and sub-project clinical advisors, had further opportunity to provide feedback on the draft evaluation plan at the four sub-project workshops in August and September 2012. In addition, the evaluation framework was presented to the three Project Advisory / Reference Groups for their input. Officers of HWA continued to comment and advise on successive versions of the document. A third draft (Version 3.0) was submitted to HWA on 31 October 2012 and, following further amendments, finalised on 25 November 2012.

The evaluation strategy, framework design and methods are described in detail in the HWA-ESOP Evaluation Framework, Version 3.0 (Thompson et al., 2012a). The document sets out evaluation requirements at the national, sub-project and site level across the four thematic areas: economic evaluation, implementation evaluation, training evaluation and national implementation requirements. These four components focus on:

- economic impacts, for example on patient flow, cost and quality of care;
- implementation strategies, including differences and similarities across sites, change management and acceptability to providers and consumers;
- the effectiveness of training programs, including selection and recruitment issues, delivery, resources, retention / completion and assessment;
- factors likely to influence the wider (national) implementation of successful ESOP initiatives, including legislative and policy barriers, industrial relations and regulatory requirements and anticipated benefits for workforce costs and quality.

The approach is based on an evaluation framework that CHSD has used previously in several national program evaluations. Evaluation concepts are defined, and the evaluation logic is unfolded in terms of a series of questions, several are linked to the program’s objectives and others address broader issues about the impact of the program and its place in the Australian health system.
4.2 Compendium of data requirements and evaluation tools

The national evaluation team has worked closely with stakeholders to develop and define a set of Key Performance Indicators that are relevant and realistic for each sub-project. Details of these can be found in the HWA-ESOP Evaluation Framework, Version 3.0 (Thompson et al., 2012a). The Key Performance Indicators have been designed to cover a set of essential evaluation elements, identified in the RFQ, namely: changes in workforce capacity and productivity; impacts on patient safety; efficiency and effectiveness (including cost-effectiveness); and sustainability. In addition, elements of the CHSD evaluation framework have been incorporated to ensure comprehensive coverage of all important indicators relevant to the implementation and impacts of the HWA-ESOP program.

Detailed information about how the Key Performance Indicators are to be measured is provided in the Compendium of Data Requirements and Evaluation Tools (Thompson et al., 2012b). The evaluation tools have been designed to support the collection of the data and information required for implementation of the evaluation framework, so could not be finalised before HWA’s acceptance of the evaluation framework. The national evaluators have worked with stakeholders to identify useful data items that can be extracted from routine data sets to provide acceptable, relevant indicators of safety and quality. These naturally contain clinical content specific to each sub-project. The Compendium is also designed to support common approaches to evaluation across the four sub-projects. Most, if not all, sites will need to collect data on issues such as:

- patient experiences and satisfaction
- experiences of ESOP staff
- impacts of ESOP on the wider health-care team, planning and management
- change management and sustainability
- stakeholder partnerships.

Recognising these common needs, the national evaluation team created a set of tools that can be used by any site, with several customised for each sub-project. As well as ensuring that data can be more easily compiled and compared across sub-projects, the Compendium supports those ESOP staff that have limited experience in conducting evaluations, and / or have limited time to spend in creating or sourcing tools. Where possible, tools were adapted from existing, validated instruments identified in reviews of the evidence. In other cases, the tools were developed by the national evaluation team. The Compendium introduces each tool, explains its source and how it is to be used, and provides guidance on data collection and analysis.

Stakeholder consultation on the document is ongoing and revisions are made on the basis of feedback and the experience of implementation. The Compendium will be a resource that can continue to be used by HWA for future programs.
4.3 Evaluation support

4.3.1 Telephone and email contact

An important aspect of the national evaluator’s role is providing ongoing support and guidance to ESOP staff at lead and implementation sites in the conduct of their own evaluation activities. As part of this role, national evaluation team members are available as a point of contact for telephone and email queries, as well as taking part in mutually agreed teleconferences. Telephone contact began with members of the national evaluation team contacting each of the 26 organisations prior to the first series of workshops in August-September 2012. These telephone calls were to ‘break the ice’ and introduce the evaluation team members that would be the primary and secondary contact for each sub-project. Introductions between the project team and national evaluation team members occurred, the project team provided a brief overview of their proposed initiative and brief explanations were provided about the role of the national evaluation team, with reassurance that this would be explained further at the first sub-project workshop.

All subsequent telephone and email activities were recorded in a communications log, where they are coded for type of contact, duration, content and other information in order to keep track of the support provided.

During the current reporting period, the national evaluation team were involved in 15 teleconferences: 13 with project teams or personnel at sub-project sites, and two with HWA personnel. The duration varied from 15 to 80 minutes (most 50-60 minutes) and the topics covered included project management issues (e.g. set-up phase of the sub-projects) and evaluation support (e.g. feedback on the evaluation framework and compendium, discussions regarding data specifications).

Multiple telephone calls were received from ESOP sites, usually lasting between 30-40 minutes. Most of these dealt with ethics applications, particularly during August and September 2012. Later in the reporting period, ESOP staff called to provide feedback on the evaluation framework and tools, and discuss project issues such as change management.

In addition to receiving calls, national evaluation team members also initiated numerous telephone calls to sites. Again, most of these dealt with ethics applications, providing follow-up and support following earlier discussions. Other topics included the proposed evaluation tools, project status and local evaluation plans, and lessons learned to date.

Finally, national evaluation team members also provided written support to staff at ESOP sites in the form of long emails often with supporting files attached. Most correspondence has related to the topic of ethics, but also addressed queries regarding evaluation tools and their use and data extraction issues.

To date, the evaluation team has received most direct contact from the PED and NED sub-project teams.

4.3.2 Workshops

HWA has organised a series of workshops throughout the life of the HWA-ESOP program. The PED and NED sub-projects have had two workshops, the first in August / September 2012 and the second in February 2013. The APEN sub-project had their first workshop in September 2012 and their second workshop is scheduled for April 2013. The ERP sub-project had their first workshop in September 2012 and the second workshop is scheduled for July 2013.

These workshops have been well attended and feedback has highlighted the important networking opportunity they provide to all teams. They have proved an effective way of introducing sites to new knowledge and to each other. This is particularly important for the sub-projects without a lead
The first workshop focused on ‘setting up for success’ with an aim of ensuring project teams had the information they needed to understand the expectations of HWA and their contractual requirements, their participation in the national evaluation, the role of lead and implementation sites (where relevant) and some of the change management and stakeholder engagement challenges they may face and strategies to address these.

The second workshop for the NED and PED sub-projects aimed to provide space to pause and reflect on progress to date in establishing and planning the projects, commencing implementation of the agreed models of care, training issues and lessons learned from the set-up phase. At the request of project teams, sessions were also presented on financial sustainability, particularly developing a business case for ongoing funding (a key sustainability issue for most projects) and the production of the project toolkit and guideline development (a major deliverable required for each sub-project). The next steps in the evaluation process were briefly covered and project teams presented information on their progress to their peers and members of the relevant Project Advisory / Reference Group, with presentations covering:

- Model of care
- Training pathways and competencies
- Recruitment criteria
- Clinical governance around the ESOP role
- Early achievements
- Embedding the roles as ‘business as usual’.

Attendance at the workshops represents a significant investment in time and resources for both HWA and the project teams. Consequently clear objectives, incorporating participant feedback, should guide the agenda.

### 4.3.3 Site visits

National evaluation team members conducted site visits to every lead and implementation site between the first and second workshops. The vast majority of these visits were completed before the end of December 2012, and the remaining visits occurred during February 2013. At the same time HWA maintained a schedule of site visits and on occasion these visits overlapped with the national evaluation team with some project teams receiving up to three visits in the first six months of the HWA-ESOP program. It may be more effective to coordinate initial site visits to include the evaluation team, clinical advisor and HWA officers.

Site visits provide a vital opportunity to meet ESOP staff face-to-face in their usual working environments, and to learn about the contexts in which the HWA-ESOP workforce innovations are being implemented. National evaluation team members gain a valuable appreciation of the real-world barriers and enablers that influence program outcomes. These meetings also help to build positive, supportive relationships with program participants.

Around two to four hours were allowed for each site visit, longer for more remote sites. To ensure that all important issues were covered, discussions were guided by a standard agenda (see Appendix 2). National evaluation team members were able to obtain detailed information on how the models of care were being implemented, and to gain a greater understanding of barriers and enablers in the local setting. Evaluation issues were also discussed, including: local evaluation plans and tools; the use of the Compendium; routine data collection systems and the potential for extracting a standard set of items to use as quality and safety indicators. ESOP staff members were encouraged to consider several issues including: change management approaches, consumer engagement and to plan for sustainability. Potential risks were highlighted and risk management strategies reviewed.
National evaluation team members took detailed notes during the site visits, which were later written up under the key themes of the visit and kept as a record and resource for follow-up and reporting. Project teams were always welcoming and made every effort to accommodate the national evaluation team, the visits have been characterised by an open and transparent approach to discussing and resolving evaluation issues.

4.3.4 Progress reports

HWA have established a routine progress reporting process for all project teams. The PED, NED and APEN project teams have each provided project plans and two progress reports whilst the ERP project teams have lodged an implementation plan and one progress report.

The national evaluation team and HWA collaboratively developed a template for these progress reports, in an effort to standardise the information provided by project teams and reduce repetition and simplify the process. The reports provided to date have been reviewed by both the national evaluation team and HWA and have been of variable quality. This may be a reflection of the time available, skill set within project teams or a reflection of the structure of the template. Several project teams queried the need to produce progress reports regularly, particularly if their sub-project had a lead site. HWA has instituted a comprehensive review process of progress reports for the ERP sub-project and this should be extended to all sub-projects.

Appendix 3 includes a summary of the responses from project teams to a series of statements that relate to different aspects of their project. Project teams were asked to rate these statements using a seven-point Likert scale to reflect the situation with their project during the current reporting period. These responses are used as an early warning system for each sub-project and to flag where project teams may be encountering obstacles to progress.

4.3.5 Project Advisory / Reference Groups

Each sub-project has an external advisory or reference group made up of experts including key stakeholders, clinical leaders and members of national representative organisations. These groups meet at least three to four times annually to review the progress of the sub-project, monitor risks and discuss other business. The national evaluation team has participated in all Project Advisory / Reference Group meetings since engagement.

The terms of reference of the APEN, PED and NED Project Advisory Groups include project governance, providing guidance to HWA on the direction of the sub-projects, helping identify critical success factors, and establishing and maintaining communication networks to assist the coordination of the sub-projects with other reform activities. These groups also advise on many aspects of the sub-projects, such as stakeholder engagement, workforce expansion pathways, data collection, methodology and risk management, and aim to encourage the development of “champions” to drive wider implementation of successful initiatives. The terms of reference of the ERP Paramedic Reference Group are somewhat narrower, covering governance, guidance on project direction, and advice on data collection, methodology and risk management.

The national evaluation team has worked to establish productive, collaborative relationships with the four Project Advisory / Reference Groups. During the current reporting period, national evaluation team interactions with these groups centred around consultation on the evaluation framework. Much useful feedback was received on the draft framework and incorporated into the final version. For example, the safety and quality indicators for the ERP sub-project were reviewed and compared with Australian and international literature and current best practice, to ensure they provide a high level of credible evaluation evidence.

Project Advisory / Reference Group members also raised some specific, additional evaluation questions. These suggestions were discussed with HWA and in most cases were agreed to be within the scope of the evaluation. Where these questions were deemed out of scope, they were
noted as issues with the potential to affect sub-project outcomes or sustainability. For example, the current evaluation is unable to assess the effectiveness of clinical simulation training for endoscopy nurses, or to investigate alternative hypotheses such as the role of resource allocation in reducing endoscopy waiting lists.

The professional expertise available to the HWA-ESOP program through these Project Advisory / Reference Groups has also proved valuable in guiding implementation. For example, the combined PED and NED Project Advisory Group noted a need to clarify the roles and scope of nurses in order to comply with professional registration requirements. This Project Advisory Group noted legislative requirements for prescribing as a potential barrier for these sub-projects.

4.3.6 Clinical advisors

HWA has engaged a clinical advisor for each sub-project. The role of the clinical advisor is to assist HWA with professional and implementation issues. From our observations the role has been adapted to meet the needs of each sub-project, e.g. the clinical advisor to the NED projects has provided importance guidance about clinical governance, industrial, training and professional nursing matters. Whereas the clinical advisor to the ERP projects has had direct involvement in training and mentoring of implementation sites as well as advising on stakeholder engagement issues. In all sub-projects the clinical advisor has attended workshops. They are all members of the relevant Project Advisory / Reference Group and frequently act as an important conduit of information between this group and HWA.

The national evaluation team has found interaction with the clinical advisors highly beneficial and this has included on a needs basis:

- joint site visits;
- collaborative planning for workshop sessions and;
- telephone and face-to-face discussions to seek advice on professional issues.

4.3.7 Additional consultations

The national evaluation team has participated in additional consultations with several academic units / departments that have established working relationships with project teams. These consultations have primarily addressed how to align the data collection requirements of the national evaluation with other research activities that were either planned or already in progress. For example:

- The PED project team based at The Canberra Hospital and ACT Health has a long association with the International Centre for Allied Health Evidence at the University of South Australia.
- The NED project team based at Royal Prince Alfred Hospital has collaborated and published widely over several years with Professor Kate White from the Sydney Nursing School, University of Sydney.
- The ERP project team from St John Ambulance in Darwin have formed a contractual arrangement with Edith Cowan University in relation to the delivery of the Extended Care Paramedic training program.

HWA also has specialist advisors and members of the national evaluation team have had the opportunity to meet with Professor Jim Buchan, a leading expert in human resources and workforce strategy, and health sector planning\(^1\).

4.3.8 Victorian Department of Health

The Victorian Department of Health has a strong interest and history in supporting workforce innovation and reform. In 2011, the Sector Workforce Planning Unit in the Department of Health engaged PricewaterhouseCoopers to develop an overarching evaluation framework for use when monitoring and determining the success of health workforce innovation and reform. The evaluation framework was developed to align with the national Impact Assessment Framework (IAF) developed by HWA. The Victorian Innovation and Reform Impact Assessment Framework (VIRIAF) is tailored to the specific needs of Victorian workforce innovation projects\(^2\). In addition, the Victorian Department of Health has provided funding to a number of health services to implement a Primary Contact Physiotherapy (PCP) model of care between 2006/07 and 2008/09, which culminated in ‘Review of Primary Contact Physiotherapy Services’ with a final report issued in August 2010.

The Victorian Department of Health has co-funded several of the ESOP projects, specifically the PED initiatives at:

- Casey Hospital
- Dandenong Hospital
- St Vincent’s Hospital Melbourne
- Ballarat Base Hospital

It has a longer term goal of implementing advanced musculo-skeletal physiotherapy roles in emergency, orthopaedics and neurosurgery across Victoria and sees this collaborative project as an important strategic step in piloting the methodology and building the platform to roll-out a sustainable model using advanced musculoskeletal physiotherapy to support service provision in areas of high demand\(^3\).

Similarly the Department has a longer term goal of implementing advanced nurse endoscopist roles across Victoria so has co-funded the Victorian project sites in the APEN sub-project:

- Austin Health
- Alfred Health
- Southern Health
- Western Health

It has established a Steering Committee that meets monthly for the APEN and PED sub-projects.

The additional funds provided to these Victorian projects have in most instances supplemented the available project management resources and supported travel costs for project teams to attend the HWA workshops. Whilst this has been a welcome contribution for these projects this has generated some issues for the evaluation:

- Understanding the impact of these additional project management resources on project implementation in comparison with project sites in other States and Territories that have not received additional resources
- Working with the additional layer of governance created through the Department’s involvement and ensuring that the integrity of the evaluation framework is maintained nationally, and;
- Ensuring effective two-way communication between the Department, HWA, project sites and the national evaluation team.

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3 Victorian Department of Health (2012) Draft Terms of Reference Steering Committee, issued by HWA.
4.4 Reflections and lessons learned

The process of developing the evaluation framework and compendium and working with HWA through a collaborative approach to supporting project teams over the past eight months has generated several observations that may influence project design and development processes in the future.

- **Timely engagement of external evaluators:** The time taken to issue the final draft of the evaluation framework and supporting compendium made it difficult for some project teams to finalise their ethics applications. Project teams that submitted early ethics applications before the final version of the evaluation framework and compendium were released may have had to submit amendments to their ethics applications. (The current status of ethical approval for each project team is provided in Appendix 4). HWA appropriately sought wide consultation from multiple stakeholders to ensure the evaluation framework was accepted and supported; this generated three drafts of the document and took approximately three months but delivered an improved product. This situation has something of the ‘chicken and egg’ argument about it, as it is through working with project teams and observing directly the context that lead and implementation sites operate in, that the most important refinements to the evaluation framework were made. In future large programs like the HWA-ESOP program, the evaluation team needs to be engaged early and ideally at least three months prior to the start date for the project teams. However early interaction with project teams will also need to occur to inform the evaluation methodology.

- **Evaluation responsibilities:** During the first series of workshops it became clear that there was a degree of confusion with some project teams about their responsibilities for evaluation. This ranged across the complete spectrum from project teams thinking that all aspects of the evaluation would be managed by the external evaluators and consequently they had made no budget provision for local evaluation activities through to project teams having negotiated external support prior to receipt of their funding. This was despite all RFP documentation and project Funding Agreements referring to the evaluation of the broader HWA-ESOP program. The lesson learned is not to assume that everyone interprets project documentation in the same way and that the understanding of project requirements is clarified early in the contract negotiation phase.

- **Pre-existing academic partnerships:** Many of the funded organisations had pre-existing relationships with other academic partners and a number were already involved in locally based research initiatives. Several teams had extensive previous experience in evaluation and wished to employ tools and methods that they or their organisation had used previously. This has required a balancing act between local preferences and national evaluation requirements, with all parties showing a genuine willingness to find workable compromises. It is important to openly discuss any concerns about intellectual property, particularly for researchers already working with the project teams. There needs to be clear documentation about how the local and national evaluation roles fit together and a mechanism to resolve professional differences.

- **Multiple communication channels:** Regular contact with HWA, the national evaluation team and project teams has been essential. Inevitably some project teams will have higher needs than others. Sub-projects with lead sites have had greater potential to streamline communication with the lead site providing a focal point for contact and a natural dissemination point to share resources amongst teams. The workshops have also provided a useful forum for face-to-face contact and the building of personal relationships and rapport – networking between project teams has consistently been reported as the most useful aspect of every workshop. Multiple channels of communication provide a mechanism to respond, reinforce and repeat key messages.
- **Frequency of workshops:** As discussed in section 4.3.2 two further workshops are planned for the remainder of this year for three sub-projects in addition to the final combined workshop scheduled for March 2014. In consultation with project teams, consideration could be given to combining workshop 3 and 4 for the APEN, PED and NED sub-projects due to the pressures of data collection, final report preparation and site visits in the fourth quarter of this year.

- **Use of site visits:** Project teams received at least one site visit from the national evaluation team during the course of the set-up period, these visits were to assist sites prepare for the local and national evaluation and to gather data. HWA also conducted up to two site visits per project team during the same period, for the purpose of monitoring project progress and risks, ensuring compliance with Funding Agreements and trouble-shooting if necessary. In the set-up phase visits between HWA and the national evaluation team overlapped on occasion. This did not always work as the agendas of both visits were quite different. The number of visits for some projects was challenging. The national evaluation team will conduct longer site visits toward the end of this year because of data collection activities. It is important that future site visits from all parties are coordinated and scheduled to minimise the impost on project teams.

- **Frequency of project progress reports:** All sub-projects provide regular progress reports. The majority of project teams have found the progress report template helpful. Several project teams have said that they find the quarterly reporting cycle (for three of the sub-projects) too onerous. Progress reporting may be more meaningful if it is linked to key project phases with a focus on depth and breadth as opposed to frequency. It has also been suggested that where a sub-project has lead sites and the same model of care is being implemented, that it is repetitive to have every project team provide a report. The lead sites could provide one integrated progress report that incorporates the associated implementation sites.

- **Role of clinical advisors:** The input of the clinical advisors and Project Advisory / Reference Groups has been valuable during the set-up phase. The diverse expertise of the members has assisted HWA to address a range of issues and provided important guidance about professional boundaries, industrial and legislative barriers. For example, these experts have assisted in generating solutions for sub-project problems and influenced thinking about the clinical governance and training processes for projects. The role of the clinical advisor has not always been clearly explained to project teams and there needs to be a mechanism for feedback from the Project Advisory / Reference Groups to project teams when relevant.

**In summary:**

- The evaluation team needs to be engaged at least three months prior to the commencement of the funded project teams.
- The local and national evaluation responsibilities should be clearly documented in the RFP and clarified during negotiations about the Funding Agreement. Test assumptions about project and evaluation responsibilities early to ensure ‘everyone is on the same page’.
- Early and open discussion should occur with researchers already working with project teams.
- Multiple channels of communication are needed in the set-up phase: email, telephone contact, face-to-face meetings and workshops. Lead sites provide a focal point for the dissemination of information.
- Sub-project workshops require clear objectives with the agenda guided by participants. Consider combining workshop 3 and 4 for the three sub-projects APEN, PED and NED.
- Site visits to project teams need to be coordinated to reduce the impost on project teams.
- The progress reporting cycle should align with key project milestones and phases e.g. set-up and recruitment phase; training and implementation phase; and the evaluation and sustainability phase.
- Each clinical advisor should have a role description that is shared with project teams at the start of the program and includes communication from the relevant Project Advisory /
Reference Group to project teams as appropriate. The first workshop provides an opportunity to introduce the clinical advisor and outline the role.
5 The project set-up phase: Advanced Practice in Endoscopy Nursing (APEN)

The data sources for this section of the progress report include all documentation received from project teams to date; for example, project plans and progress report 1 and 2 for the APEN sub-project. This information has been synthesised with findings from the site visits conducted by HWA, clinical advisors and the national evaluation team as well as the records of communication with project teams.

As HWA has all individual project documentation this information is provided at the sub-project level and addresses the common themes and issues that have collectively arisen.

5.1 Project description

The APEN sub-project responds to the national trend of increasing demand for endoscopy due to the implementation of the national bowel cancer-screening program. There is a resulting need to enhance the capacity and capability of the workforce to cope with this demand (The Cancer Council Australia and Australian Government Department of Health and Ageing 2006; Quality Working Group for the National Bowel Cancer Screening Program 2008)4,5. The sub-project aims to implement an innovative model of expanded scope of practice for nurse endoscopists. Traditionally medical officers have performed endoscopies. There is not a mature model of advanced practice in nurse delivered endoscopy developed within Australia, progress is occurring, hence the establishment of two lead sites. There are well-established models and training programs in the UK (Williams et al, 2009)6. The two lead organisations are also implementation sites and in turn are supporting five implementation sites.

According to the RFP documentation, the objectives of this sub-project are to:

- Identify an innovative model of extended scope of practice for nurse endoscopists that demonstrates improved productivity in terms of waiting times for an endoscopic procedure
- Implement a new workforce role on a national basis with consideration of national training and scope of practice guidelines
- Establish a national training program for nurse endoscopists
- Facilitate the redesign of the workforce to match the changing needs and demands of the service and not the determination of professional boundaries
- Develop toolkits and implementation guidelines including requirements to support national implementation.7

Clinical advisors and members of the APEN Project Advisory Group have identified concerns about some of the terminology used in these objectives and in relation to the sub-project. For example, the use of the terms extended / expanded / advanced should be defined, as this has been a source of confusion amongst stakeholders. Adding additional responsibilities to the role of a registered nurse does not equate with advanced practice and may be better reflected by the phrase ‘maximising the scope of practice’. The National Nursing and Nursing Education Taskforce

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released a discussion paper on ‘Specialisation and Advanced Practice – A Select Analysis of the Language of Specialisation and Advanced Nursing and Midwifery Practice in 2006’. This paper notes:

‘Nursing and midwifery regulatory authorities describe expanded roles as an extension of advanced practice and different to specialist practice, with extended practice recognised as that of the nurse practitioner’.

The five organisations that HWA has funded to implement APEN projects include:

- Logan Hospital (a lead and implementation site)
- Austin Health (a lead and implementation site) that operates endoscopy units at both the Austin and Heidelberg Repatriation Hospitals
- Southern Health whose project is based at Monash Medical Centre
- Alfred Health whose project is based at the Alfred Hospital
- Western Health whose project is based at Western Hospital but with potential for training lists to be provided at Sunshine Hospital and / or Sunbury Day Hospital.

5.2 Model of care

Each lead site is implementing the same nurse endoscopist training pathway and is developing a model of care suited to their organisational context. The principal differences relate to the scope of practice of the nurse endoscopist. At the end of the training pathway it is anticipated that nurse endoscopists will perform competent diagnostic colonoscopy (working towards proficiency) on patients that meet ASA I and ASA II criteria (American Society of Anaesthesiology Classification, I and II either mild or no disease), within a defined practice scope, in a delegated role. During the course of the training, the nurse endoscopists will function in a similar model of care as they will also work in other parts of the gastroenterology service and may contribute to outpatient services and multi-disciplinary clinics for patient review and follow-up. The nurse endoscopists will work in collaboration with the endoscopy team and participate in multi-disciplinary team meetings, journal club meetings and pathology meetings etc.

Both lead sites have considerable experience with the nurse endoscopist role with Logan Hospital recruiting personnel who have previously worked in this role in the UK. Austin Health has recently trained a nurse endoscopist, and this staff member commenced his own endoscopy lists in late January this year. Austin Health has also successfully implemented a similar advanced practice role - nurse cystoscopists. The role of the nurse endoscopist is new to all other implementation sites.

Logan Hospital, on completion of the HWA funded training pathway for Nurse Endoscopists plans to implement a model of care that is based on a nurse practitioner (candidate) model, with wider scope for autonomous practice. The nurse practitioner will work collaboratively and function autonomously within the gastroenterology-endoscopy service in a fully integrated role. They will perform endoscopy and related health care functions within a broad scope of practice including: advanced patient assessment; interpretation of diagnostic interventions and pathology, differentiating diagnoses; establishing management plans, including selection and prescription of appropriate medication and direct referrals to other health care professionals.

The Austin Health model of care, being implemented by all Victorian APEN project sites, is based on an advanced practice nurse model with the nurse endoscopist undertaking protocol driven

9 The nurse endoscopists employed in each of the project sites are ‘trainee nurse endoscopists’ for brevity they are referred to as nurse endoscopists throughout this report.
activities within a defined practice scope in a delegated role (i.e. under the direct supervision and delegated authority of a senior medical officer). The nurses are also completing the HWA funded training pathway for Nurse Endoscopists. Organisational drivers have informed which model these project sites have adopted (refer to Figure 1). In Victoria, concerns about future nurse workforce shortages have created concerns about overspecialisation.

**Figure 1 Training pathway to support models of care**

Throughout the implementation period it is important to capture the full spectrum of activity undertaken by the nurse endoscopist including participation in multidisciplinary meetings, research and clinical consultations. These additional activities need to be defined as part of the intended model of care across all sites i.e. there needs to be clarity about what the nurse endoscopist role entails. The role of the nurse endoscopist is expected to incrementally expand over time.

### 5.2.1 Project scope

**Logan Hospital** is located in a fast growing and large suburban area between Brisbane and the Gold Coast in South East Queensland. Logan Hospital has grown from a 48-bed community hospital in 1990 to a busy metropolitan hospital with over 360 beds. The hospital emergency department is the third busiest in Queensland with over 60,000 presentations a year\(^\text{11}\). The hospital has a well-established Endoscopy Unit with two endoscopy suites. In 2010/2011 there were 3,477 endoscopic procedures provided. The Gastroenterology Nurse Coordinator responsible for Brisbane South for the Queensland Bowel Cancer Screening Program is based at Logan Hospital.

**Austin Hospital and Heidelberg Repatriation Hospital** are co-located and two of three facilities that constitute Austin Health. Both hospitals are located in Heidelberg, 20 minutes northeast of Melbourne’s city centre. The Austin Hospital was re-developed in 2005 and has approximately 400 acute beds. Heidelberg Repatriation Hospital became part of Austin Health in 1995. The Surgery and Endoscopy Centre at the Austin Hospital contains two endoscopy rooms and there are also two endoscopy rooms in the Surgery Centre at Heidelberg Repatriation Hospital. At Austin Health (a National Bowel Cancer Screening Program pilot study site and provider), there

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has been a significant increase in the number of colonoscopies undertaken, with a 53% increase since 2008.

There are several APEN implementation sites within Melbourne. **The Alfred Hospital** is a major tertiary referral hospital located in close proximity to the Melbourne CBD. It has established gastroenterology and endoscopy services with two rooms used for endoscopic service within the day procedure unit. **Western Health** currently provides a direct access endoscopy service from two facilities: **Western Hospital** based in Footscray and **Sunshine Hospital** in Melbourne’s outer west. Western Hospital does not have a dedicated endoscopy unit with the two rooms used for endoscopy located within the same day surgical unit. **Monash Medical Centre**, based at Clayton is part of **Southern Health**. Monash Medical Centre is a 640-bed teaching and research hospital with a new endoscopy suite with two functioning endoscopy rooms. The funding provided by HWA has assisted with the fit-out of a third endoscopy suite, opening in April 2013.

### 5.2.2 Recruitment and staffing

The lead sites collaboratively developed the position descriptions and recommended entry criteria and key attributes of nurse endoscopist candidates. Logan Hospital was successful in recruiting two nurse endoscopist trainees to fill 1.4 FTE positions, one already an endorsed nurse practitioner and the other a nurse practitioner candidate. These positions were established at the Queensland classification of a nurse grade seven, nurse practitioner candidate.

Austin Hospital coordinated the recruitment process for all Victorian sites. A wide range of recruitment strategies were employed including: placement of an advertisement in the Journal of the Gastroenterological Nurses College of Australia (GENCA); use of the Austin Health Nursing Distribution List; promotion of the role at relevant conferences and use of the Victorian public hospitals Director of Nursing network.

The first round of advertising attracted 16 applicants for four positions; each is funded as a 0.8 FTE. Interview panels included both implementation site and lead organisation representation namely project lead, project manager, and medical lead from Austin Health, plus a representative from each of the Victorian sites. Three offers were made with one subsequently withdrawn, as the candidate was unable to commit to the full requirements of the project. Nurse endoscopists were appointed to Alfred Health and Western Health with positions readvertised for Austin Health and Southern Health. All positions were appointed at the Victorian classification of a level five clinical nurse consultant. After a second round of advertising all nurse endoscopist positions were filled.

Selection criteria included a Bachelor of Nursing Science (or equivalent) with at least five years of experience post their graduate nurse year. This included a minimum of two years in endoscopy (ideally candidates had at least three years full time experience in the gastroenterology specialty with at least two of these in endoscopy). The desirable criteria included a post-graduate course in gastroenterology. The lead sites agreed to be flexible about this requirement to broaden the pool of applicants, if a candidate did not have this post-graduate qualification they could supplement their experience by completing a foundation module in gastroenterology (under-graduate level) prior to commencing the training pathway. These criteria will be mandatory post completion of the HWA project.

In addition to their clinical competencies, trainees required additional attributes. The lead sites felt that candidates needed particular qualities to manage the challenging conversations that may arise with their peers, have the confidence and ability to promote the role and the experience and knowledge to ensure the role is embedded in safe practice.

### 5.2.3 Training pathways

The training program is common to both models and will extend from November 2012 through to December 2013. This is a critical factor to recognise, as the nurse endoscopists cannot be
expected to achieve optimum productivity prior to acquiring the requisite skills and experience. As the project funding ends in May 2014, this long training trajectory will impact on evaluation findings.

The two lead organisations have worked together in developing a training program designed to meet the needs of the trainees, but with elements applicable to medical staff training. Logan Hospital has prepared a wide range of high quality documentation about the training pathway, educational modules and related assessment methods. The training uses a combination of methods, for example: self-directed learning packages, face-to-face instruction, skill development through simulation and medical supervision.

The training framework outlines the:
- practice scope;
- entry criteria;
- clinical governance parameters;
- clinical knowledge;
- skills training;
- supervised practice;
- assessment;
- recognition of training in gastrointestinal endoscopy, and;
- evaluation.

Theory modules were sourced from the University of Hull, UK, successful completion of these will result in a Graduate Certificate qualification. Each implementation site manages the orientation and introduction of the nurse endoscopist to their local organisation. The skills training component of the program has been adapted from recent research conducted by an interdisciplinary group of scientists from the University of Queensland and the Queensland Health Clinical Skills Development Service. The first phase of face-to-face training occurred from 3-5 December 2012 and was attended by five trainees (two from Logan Hospital, one from Alfred Health, one from Southern Health and one from Western Health). Each of the five trainees has since completed the colonoscopy e-learning package and passed the related assessment. An orientation workshop was provided for nurse endoscopist trainers / medical leads on 22 January 2013 at Logan Hospital. The next face-to-face training occurred from 23-25 January 2013. The theoretical component commenced in late January 2013. Nurse endoscopists have been allocated one to two dedicated lists per week (patient numbers vary from 3 – 6 according to the implementation site); all have now commenced their training lists.

An important training issue emerged during the set-up phase - the documentation of the nurses’ training needed to equate to the information kept for medical endoscopists’ training. Medical trainees utilise a logbook system online through the Conjoint Committee for the Recognition of Training in Gastrointestinal Endoscopy, however this was not available to the nurse trainees. Logan Hospital investigated various options identifying that the iTeMS for Health log book system provided an appropriate e-portfolio for trainees. This e-portfolio will capture the information required for the project evaluation and for the eventual certification of the training of the nurse endoscopist12.

The development of the training framework and sourcing of the necessary educational resources and equipment to support this framework has been time consuming and a significant focus of the set-up phase. It has required a collaborative effort from many individuals and organisations. There have been high costs in sourcing several resources and equipment e.g. training materials from the University of Hull.

The training pathway is scheduled for completion by 31 December 2013 with the project ending on 31 March 2014. No further detail is provided about the training program and its implementation as this will be the focus of the second evaluation progress report.

5.2.4 Clinical governance

A requirement of this project is a systematic approach to maintaining and improving the quality of patient care within each implementation site. Project teams have reviewed their existing clinical governance processes to ensure safety and quality is appropriately addressed. Most projects have established working groups to support with implementation tasks and a Steering Committee to oversee the project. For example, Alfred Hospital’s Steering Committee includes the medical director of endoscopy, another consultant, an anaesthetist, theatre educator and the endoscopy manager. All project teams are using the existing clinical governance structures within their organisations to manage risk. These mechanisms ensure that the nurse endoscopist has appropriate clinical and professional line management. The training pathway requires the supervising doctor to complete a ‘Direct Observation of Procedure or Skills’. This is an assessment tool designed to evaluate the performance of a trainee undertaking a practical procedure, against a structured checklist\(^\text{13}\). The trainee receives immediate feedback to identify strengths and areas for development. Some project teams have indicated they will use additional clinical audit processes. The clinical supervision and mentoring role are critical in building the confidence and skills of the nurse endoscopist.

The clinical supervision and mentoring provided by the supervising medical specialist is fundamental to maintaining patient safety and quality. For example, the nurse endoscopist at the Austin will do a list with the department head of colorectal surgery, and expects to receive supervision from four or five different doctors. At Western Health the nurse endoscopist will initially be supervised by the head of the endoscopy unit, however this may change over time. At the Alfred Hospital the nurse endoscopist will be supervised by at least two senior doctors, and at Southern Health several senior doctors will support the trainee.

5.2.5 Sustainability

During site visits, most project teams were able to identify strategies they were deploying during the set-up phase to improve the conditions for project sustainability.

These included:

- Employing all trainee nurse endoscopists on an ongoing basis (positions are permanent but at the end of the project may not continue at the grade of nurse endoscopist)
- Identifying other nurses interested in the training pathway (through a register of unsuccessful applicants), in the event of attrition or the ability to provide further training programs
- Considering the development of a transition training pathway for implementation sites with interested personnel who did not yet meet the nurse endoscopist training entry requirements
- Using existing clinical governance processes within the implementation sites to support the nurse endoscopist
- Identifying early policy changes that may need to be introduced to support the role, for example, the patient consent process for nurse endoscopists
- Promoting inter-professional education opportunities, for example, Austin Health will apply the training program to nursing and medical staff
- Working with universities to develop an equivalent course that can be delivered post project (the University of Queensland already has a post-graduate certificate in nursing with a gastroenterological nursing specialisation). The development of a post-graduate course

specific to nurse endoscopy would require additional funds; it would ideally be available through flexible delivery

- Lobbying for external recognition of the nurse endoscopist-training program, for example recognition of the training program will facilitate the transition of nurse endoscopists to other organisations.

### 5.3 Progress in achieving objectives

The objectives for each sub-project were specified in the RFP documentation issued when proposals were first sought, these objectives were replicated with only slight amendment in the Funding Agreements developed for each project team. Each project has listed their objectives in their first progress report so they are not re-stated here.

Project documentation has been reviewed by HWA to ensure that:

- Project objectives align with program objectives
- Projects have in place strategies to address each objective
- Projects are making progress against their objectives i.e. projects are doing what they said they would do.

The focus for the national evaluation team during the set-up phase has been to ensure that:

- Local project evaluation plans align with project objectives and the national evaluation requirements.

The major strategy has been developing the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools that together provide a blueprint for project teams to follow to encourage consistent data collection methods that support both local and national evaluation requirements across all sub-projects. The Key Performance Indicators (KPIs) in the Evaluation Framework were developed with the input of all project teams through reviewing the performance measures included in their project plans and then asking them to critique the proposed sub-project KPIs at the first workshop. Most project teams have identified particular issues of interest to their organisation that they intend to monitor, for example, the lead sites are interested in the implications for nurse endoscopist training and development when the position is structured as a nurse practitioner role compared with an advanced practice nursing role.

During the initial site visit project teams were asked to identify the existing information systems and data collections available within their organisation. All project teams were asked to confirm their capacity to identify patients seen by the nurse endoscopist within their patient information systems. Potential challenges with the extraction of data and ethical approval to release this data to the national evaluation team were also discussed. Project leads were asked to identify the relevant contact people that the national evaluation team should work with to obtain data required over the life of the project.

The national evaluation team developed a data specification to assist project teams and to improve data consistency across each sub-project. The Austin project team assisted with producing a Gantt chart specifying the frequency and timing of data collection, who is responsible for collection and / or analysis and how each data source and evaluation tool maps back to the agreed KPIs within the Evaluation Framework.

Across all APEN projects there has been adequate progress in achieving key objectives. During the set-up phase attention has been directed to defining the model of care, recruitment related actions (including position description development, resolution of selection criteria etc.), procurement of equipment and resources, and development and commencement of the training pathway.
The focus of the national evaluation team has been about establishing constructive working relationships with all project teams, addressing questions relating to ethics approval issues and identifying early issues with data access and availability and reviewing existing evaluation tools.

The first or baseline data submission is due from project teams by 31 March 2013. This early submission aims to establish which sites have missing data elements and to streamline data collection processes for the subsequent data submissions due on 31 October 2013 and 30 April 2014. It also allows the national evaluation team to refine the data specification based on what items are commonly available and feasible to provide. All APEN project teams have advised of difficulties in providing certain data items and it is unlikely that any project site will be able to supply all items on the data specification. There is general consensus that the prospective data collection relating to the activities of the nurse endoscopists will be more straightforward because of the availability of the online log book system (e-portfolio) and the motivation of the trainees to record and capture relevant data items. The baseline data provides a basis for comparing changes in the activity of the endoscopy unit over the course of the implementation period. The national evaluation team will continue to work with lead sites to refine the data requirements as the limitations of the baseline data submitted by each implementation site are identified.

The training pathway is fully developed and training has commenced, the program appears to be of high quality and is comprehensively structured with appropriate training resources and a formative and summative assessment process.

The lead sites have considered both local and national evaluation strategies however this has not been a high priority for the other Victorian implementation sites at this stage. As projects move into the implementation phase closer attention will be needed to ensure local evaluation questions are being addressed and data collection processes align with those outlined in the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools.

5.4 Project management observations

These project management observations relate to the APEN sub-project. Dwyer et al\textsuperscript{14} (2004, p.20) have produced a framework, adapted from work by Belassi and Tukel\textsuperscript{15} (1996), which categorises project management success factors. This framework proposes four main categories of direct determinants of project success:

- **Commitment**: Is the organisation serious; is there a vision for the project and commitment to see it through? Is there commitment to manage the impact on stakeholders and partners?
- **Plan and design**: Is the project plan feasible, with achievable goals, strategies that can work good decision-making structures and outcomes that can be sustained?
- **Resources**: Are skilled people, enough money and the right material resources organised?
- **Project team**: Does the project teamwork well; is it able to manage the change required by the project and to communicate effectively with stakeholders?

Additional underlying factors that influence project success relate to the sector and organisation:

- **Sector** refers to the broader organisational context in which the organisation (and their project) sits.
- **Organisation** refers to the characteristics of the organisation including strategic directions, leadership, the organisational structure, and culture and people management practices also influence project management.


This framework is used to summarise the project management observations relating to the APEN sub-project.

### 5.4.1 Commitment

All project teams, particularly those from lead sites, have demonstrated a strong commitment and vision for the initiative. The lead sites have worked actively to support the implementation sites. This has been underwritten by their signed Funding Agreement, which specifies a project completion date of 30 May 2014. The best evidence of commitment is the quantum of ‘in-kind’ resources invested by every project team. The project teams are working within their own organisations to engage key stakeholders, particularly the Chief Executive Officer and senior medical and nursing personnel. Engagement with external stakeholders is occurring through participation with the representatives on the Project Advisory Group and other professional networks. Only one implementation sites does not have a functioning Steering Committee.

### 5.4.2 Plan and design

All project teams have produced a project plan. A couple of the implementation sites found the template cumbersome and time consuming. Generally, it is felt that the external reporting requirements of this project are greater than what was expected and that there is a level of replication between the lead and implementation sites. It was suggested that it might be more efficient if a separate report was not required from each implementation site. State and Territory Departments need to be involved in the planning phase to ensure that projects align with Departmental policy guidelines.

Progress reports received to date vary in the quality and level of detail; however objectives and strategies are consistent with the sub-project objectives. The decision-making structures set-up by project teams within their organisations appear to be working well and there is good co-operation between lead and implementation sites. Despite some delays with recruitment of nurse endoscopists and filling project management positions, all projects are progressing satisfactorily.

### 5.4.3 Resources

Several APEN projects have identified resource constraints. For example Alfred Health needs an additional list to support the project as budget provision was only made for one trainee list per week. Logan Hospital is in the difficult position of having unfunded training lists.

The Victorian Department of Health has made additional funding allocations to all Victorian APEN project teams. These funds are primarily to assist with project management and travel costs (the latter to support workshop attendance and participation in training activities). There is a differential level of investment in project management across the implementation sites. There appears to be a view that the lead sites have received additional funding ‘to lead’ so should also coordinate most administrative project functions. One implementation site, that has received additional funding from the Victorian Department of Health for project management support, is still relying on a senior manager with a full-time role to absorb the project management responsibilities. This is unsustainable and is impacting on the achievement of project milestones. This project team has also experienced several changes in key personnel within their organisation which has been challenging in securing executive leadership.

One or two project teams do not have ready access to data and evaluation support staff and have expressed concern about the additional administrative work generated by the project for the local endoscopy manager. The APEN sub-project is seen as having moderate to high support needs for the evaluation.
5.4.4 Project team

Each lead and implementation site has established a project team. These usually consist of a medical lead / senior consultant, the nurse manager of endoscopy, project manager / officer and nurse endoscopist with other members co-opted as needed. Project teams working most effectively have established a strong two-way communication process with their executive sponsor, which has assisted in addressing any barriers to progress as they occur. Those teams meeting frequently appear to have generated greater momentum and engagement within their organisation.

Both lead sites appointed full-time project managers and would not have been able to manage the set-up phase without this resource. The presence of a full-time person in this role has ensured consistency of communication.

5.4.5 Sector

All project teams have reported disruptions in the broader health sector. These range from the announcement of funding cuts through to Ministerial changes. Queensland Health cut funding that had previously been provided for training lists at Logan Hospital. The increasingly limited funding available from most State Health Departments is already raising concerns about the sustainability of the nurse endoscopist role in the longer term.

During the project set-up phase Queensland Health has devolved to District Health organisations. The political reality of managing changes in workforce roles has already provided front-page news in Melbourne’s ‘Sunday Age’ newspaper. Each State and Territory health system has a life of its own and these differences need to be managed during the implementation of a national workforce innovation program.

5.4.6 Organisation

All project teams have identified the importance of a supportive Chief Executive Officer and senior executive as a key success factor. This leadership from the top sends a strong message to the wider workforce and professional groups about the level of interest in the nurse endoscopy role.

Most project teams do not have structured communication plans, however they have reported on their approach to stakeholder engagement in their regular progress reports. Projects need to be implemented in organisations that have a receptive context for change. The APEN sub-project is characterised by senior medical and nursing staff who are change agents within their own organisations and genuinely see the opportunities for better patient care when all members of the health team work to their full scope of practice.

5.5 Stakeholder engagement strategies

Through the project progress reports all APEN project teams have provided evidence of stakeholder engagement. Stakeholders generally appear to be classified as internal to the organisation or external. The most frequently cited internal stakeholders include: internal personnel (including members of the organisation’s executive, the nurse endoscopists and supporting clinical staff based in the endoscopy unit or related clinical areas). Austin Health made an up-front investment in managing the medical politics of implementation in metropolitan Victoria and liaised with Directors of Endoscopy Units early in the RFP process.

External stakeholders appear to have been engaged as required for the development and delivery of the project. These have included representatives from professional organisations, local universities, Medicare Locals, State Health Departments, medical experts and trainers, and web technology providers. Some teams have utilised presentations at conferences and presentations.
to external organisations. Logan Hospital provided opportunities for team members to present at three conferences.

The development of training resources as a way of working with diverse stakeholders has been mentioned by several projects. This has included providing ‘train the trainer’ and staff training opportunities. Logan Hospital engaged with the University of Queensland, Queensland University of Technology and Griffith University to facilitate training development and the implementation of a pilot training project. The Austin Hospital also engaged with the Alfred Hospital and the Gastroenterological Society of Australia (GESA) to provide a ‘train the colonoscopist trainer’ workshop.

Introducing trainees to external stakeholders and networking opportunities has occurred. Meetings and workshops to facilitate the introduction of trainees to external stakeholders were conducted by several projects. There was also much activity relating to consultation with and updating of external stakeholders through committee and advisory group meetings and forums. Southern Health and Alfred Health have had high level executive support and engagement right from the RFP process. Media coverage was provided for the nurse endoscopist trainee collaborative at the Austin Hospital with trainee photos included in the HWA December edition of ‘Insights’.

Mechanisms that project teams have used to facilitate stakeholder engagement have focused on meetings, workshops and technologies such as email and teleconferences to update stakeholders. Meetings were the most common way of bringing stakeholders together. These included: steering committee meetings, advisory board meetings and staff meetings. Networking opportunities were provided through forum meetings, workshops and conferences. Clinical placements were also used. Austin Hospital negotiated several clinical placements to promote the role of the nurse endoscopist and to establish learning opportunities. Staff training and information sessions as well as the development of internal information and ‘Frequently Asked Question’ documents have also been implemented by several projects.

Consumer engagement does not appear to be a priority for the projects at this time with no instances of consumer engagement noted by any of the projects. This may be an area for consideration in the future. The APEN Project Advisory Group includes experienced consumer advocates.

5.6 Barriers

Through project progress reports and during site visits, project teams reported on barriers they faced during the set-up phase of the ESOP-HWA program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The barriers identified by the APEN project teams are presented under the following sub-headings:

- Role clarification
- Recruitment and training
- Communication and stakeholder engagement
- Resource issues
- Legislative and policy issues
- Evaluation issues

5.6.1 Role clarification

Two quite different issues emerged in relation to role clarification. The first related to the patient’s understanding that the nurse endoscopist is in a training role. There is a concern that patients may refuse treatment if they are informed that the practitioner performing the procedure is in a training role. There needs to be clear communication with patients that the nurse endoscopist is
already a qualified and experienced registered nurse who has undertaken specific training in endoscopy. Patients must provide informed consent and this has meant that all project teams have had to review patient consent and information processes.

The second issue related to role confusion between the lead sites and HWA about the nurse endoscopy role at a broader level. This issue took some time to work through, sites agreed that all nurses would complete the same training pathway however differences in role would be reflected in the development of local models of care designed to suit individual organisational needs. Some project teams felt that contract negotiations were prolonged with HWA because of confusion about intellectual property and other contractual obligations. These issues did not impact adversely upon the timeframes for project implementation and development of the training program.

5.6.2 Recruitment and training

APEN project teams identified delays in recruitment as a barrier they had to overcome during the set-up phase. These delays varied from problems in identifying appropriately trained clinical staff suitably skilled for the nurse endoscopist role, to difficulties in securing an identified project management resource. The project teams agreed that the Victorian lead site, Austin Health, would coordinate recruitment of the nurse endoscopists on behalf of the other Victorian implementation sites. Whilst other project teams were included in this process this did extend the timeframe for recruitment. This became particularly problematic for trainees without postgraduate studies in this specialty, as they were required to complete foundation studies in gastroenterology ahead of the formal training program commencing in January.

A transition pathway was identified as one way of addressing recruitment barriers, particularly for applicants with potential but not all entry requirements. This could be managed through sites that received multiple expressions of interest.

Initially some implementation sites did not want to commit to a permanent position for the nurse endoscopist and this was seen as a major barrier to sustainability. The lead sites felt this may dissuade potential applicants from applying, particularly those currently in senior roles or with ongoing employment. By offering a permanent position it demonstrated the organisation’s commitment to the role beyond the life of the project.

The trainee nurse endoscopists accepted the position aware that they must complete a comprehensive and lengthy training program. A couple of trainees advised that they did not fully understand the scope of the training requirements when they applied for the position. Whilst their employer meets all training costs the trainees have a substantial study load that has to be completed in addition to their 0.8 FTE clinical role. The nurse endoscopists are routinely assessed throughout the training pathway and must achieve competency in all modules of study. This ESOP role requires trainees to balance an intensive program of study with the implementation of a new model of care, frequently in a new organisation. This ‘trifecta’ of stressors may act as a barrier for future candidates.

The theoretical modules used in the training pathway have been adopted from the University of Hull in the United Kingdom. Whilst these are working well there are differences between Australian and European endoscopy practices which mean that some content is not relevant to the Australian context.

Several APEN project sites project that the nurse endoscopist will take 18 months to complete the 300 endoscopies (100 colonoscopies and 200 gastroscopies) required as part of their training requirements. Normally trainee registrars take about two years to complete the endoscopy-training program. When fully trained it may be possible for nurse endoscopists to do more lists than an equivalent trainee registrar because they will have more flexibility than physicians who have a wider range of other responsibilities. The Project Advisory Group also identified the need
for the training pathway to have an exit point in the event of trainees not completing the full program of study (this is an issue that is important for national scalability).

5.6.3 Communication and stakeholder engagement

Project teams agreed that there needs to be an on-site clinical champion to assist with managing the complex and influential stakeholders involved in endoscopy.

Some clinicians have advised of potential concerns from registrars that the introduction of nurse endoscopists could impact on access to training lists for these medical officers. This is not considered to be a significant risk to the sub-project; it does however require ongoing communication with registrars.

It was felt that whilst there is a high level of support from the medical officers involved in the project and most consultants within the endoscopy units of implementation sites, more generally there is antipathy towards the project from specialists who see no value in the process of training nurse endoscopists. There would be great concern if there were any suggestion that a trained nurse endoscopist was intending to practice in a private capacity outside the public hospital system.

It was noted by one site that improved communication and engagement from all sites was required to increase the level of understanding about training, program objectives and requirements at the Victorian implementation sites. Another site has experienced a lack of stakeholder engagement due to the resignation of key executive stakeholders. As new executives are appointed they need to be engaged and brought up to date on the project plan to minimise delays to decision making processes and maintain support for the project.

5.6.4 Resource issues

A barrier raised by implementation sites in relation to resources has been about Austin Health’s role as the ‘fund-holder’ for all Victorian sites. Unlike the other ESOP sub-projects, where all project Funding Agreements are directly between the project site and HWA, all Victorian APEN project teams have a sub-contract with Austin Health. It is Austin Heath (as a consortium) that has the Funding Agreement with HWA. Logan Hospital as the other lead site has a Funding Agreement with HWA. Whether this is a real or perceived barrier has not yet been determined, however a couple of sites have expressed concern and frustration at perceived delays in the transfer of funds to their organisation. This has been particularly difficult when procuring equipment. Contrary to this view Austin Health has found that their role as fund-holder has been critical in their ability to ensure implementation sites achieve project milestones and that consistent implementation of the model of care and training pathway is achieved. Both lead sites confirmed that the absence of a ‘contingency fund’ held by HWA to assist with any unexpected project costs was a barrier to making project improvements.

If a project site recruited a nurse endoscopist without a post-graduate qualification in gastroenterology nursing they had to meet the costs of purchasing the foundation module developed by the University of Hull (UK), approximately $2,500. Several project teams saw the cost of simulation equipment to assist with training related to tip control and colonoscope insertion as prohibitive (over $7,000) as they had not budgeted for this in their initial proposal.

The more significant barrier relating to resources is the projected impact of the training requirements on usual throughput. Western Health advised that a medical specialist normally does six to eight endoscopies during a session. This number will decrease to approximately four during the first year of the training and will therefore result in an overall decrease of this unit’s throughput. This will in turn impact on waiting lists. The Alfred Health project site has tried to mitigate this impact by running one new list for the nurse endoscopist in addition to her providing support for one of the medical specialist’s lists.
Other resource issues identified included delays to training sessions and assessments. This was mainly due to a lack of availability of medical personnel and anaesthetic staff to supervise the training sessions, limited access to simulation equipment and delays in the fit-out of one of the endoscopy suites in one facility. Logan Hospital is also facing difficulties because of a strict Queensland Department of Health policy that prevents the roll-over of external grants from one financial year to the next. As HWA is providing full project funding by 30 June 2013, due to restrictions on their ability to enter into contracts beyond this point, a work around solution is needed for the Logan project team.

All project teams felt that the timeframe for project set-up was too short as the amount of work needed in this initial project phase was excessive. The ‘politics’ both within and outside organisations relating to the nurse endoscopist role require sensitive handling and a significant investment in ongoing liaison and consultation. Lead sites also felt that not involving them in the selection of the implementation sites they would work with introduced an unnecessary barrier. Project teams agreed that the provision of a budget template or guideline would have improved project costing estimates. Calling for expressions of interest from both lead and implementation sites at the same time created problems in working through project budgets as implementation sites had to estimate a range of costs, particularly as the training pathway had not been developed and the associated costs of training were unknown for both lead and implementation sites.

5.6.5 Legislative and policy issues

The principal legislative and policy barriers that have arisen in the set-up phase relate to the development of the role, the workforce and funding implications of a nurse practitioner model and the need for a nationally agreed terminology in relation to advanced practice nursing roles. Lead sites agree that there needs to be a nationally accredited course for nurse endoscopist training. State Health Departments have advised to keep as light a ‘regulatory’ touch as possible on the project in this early development phase.

The potential for development of a nurse sedationist role has arisen in several forums (including the APEN Project Advisory Group). Doctors currently administer sedative medications during endoscopy. It was confirmed that during the course of the HWA-ESOP APEN program, nurses would not be trained in giving sedation.

5.6.6 Evaluation issues

The major barriers to evaluation that have arisen relate to the availability of data and the complexity of local ethics approval processes.

5.7 Enablers

Through project progress reports and during site visits, project teams reported on enablers they faced during the set-up phase of the HWA-ESOP program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The enabling factors identified by the APEN project teams are presented under the following sub-headings:

- Collaborative development
- Project management support
- Expanded scope of practice clinicians

5.7.1 Collaborative development

Whist there has been some tension between lead sites in the set-up phase; this has not prevented a collaborative approach to the many tasks that have needed to be completed. The lead project
teams have supported each other through recruitment, training, equipment procurement and ethics application processes.

Lead organisations initially planned to collaboratively produce a regular newsletter for dissemination to all implementation site contacts, subject to HWA approval. It was to include key dates, project updates, focus on trainees and sharing experiences and lessons learned. Other pressures have prevented this from being realised however it is likely to be a positive enabler of collaboration in the future.

The contribution of the Victorian Department of Health to project resources and governance, through coordinating regular steering committee meetings, has also been identified as a positive enabler of collaborative development. Project teams reported that the assistance provided by the national evaluation team, particularly the Compendium of Data Requirements and Evaluation Tools, was valuable.

Logan Hospital felt that being both a lead and implementation site allowed them more control over the development and implementation of the project and that being able to focus on only one implementation site for the first roll-out of this initiative improved the likelihood of success. Their pre-existing relationship with the Queensland Health Clinical Skills Development Service has been extremely positive. The Clinical Skills Development Service is an international leader in the development and provision of simulated clinical, teamwork and communication training.

There also appear to be efficiencies for Austin Health by this lead site having all implementation sites within the same State. Austin Health has also benefitted from their previous experience in establishing a nurse endoscopist position. The existence of a ‘pre-formed’ consortium made it easier to engage several hospitals in the Austin Consortium proposal. The leadership of this workforce innovation by clinical teams as opposed to State Department of Health personnel was also identified as a positive enabler of this role change.

5.7.2 Project management support

Logan Hospital has commented on the dynamism of their project team and that this has been a key success factor to date. The support at all levels throughout their organisation from the personnel in the Endoscopy Department, senior executives at Brisbane Metro South Health Service and including the Director-General of Queensland Health is also identified as a positive enabling factor.

Austin Health as a lead site has instituted regular meetings and teleconferences with all Victorian implementation sites. Austin Health has also provided practical support through coordinating recruitment for these sites. As the lead they have streamlined the ethics approval process by taking responsibility for preparing the National Ethics Application Form and including all implementation sites, removing the need for site-specific applications.

The additional funding provided by the Victorian Department of Health to the APEN project teams (approximately $65,000 per implementation site) will strengthen the potential for success if it is invested in improved project management processes. The role of the Victorian Department of Health in supporting the APEN workforce reform amongst Victorian sites is evidenced by their contribution of approximately $350,000. They have expected attendance at fortnightly and now monthly project steering committee meetings, which has introduced an additional layer of governance to the sub-project.

Alfred Health, Western Health and Southern Health all found the initial workshop organised by HWA a useful way of getting all project teams together and that scheduling this early during the set-up phase was helpful.
5.7.3 Expanded scope of practice clinicians

The nurse endoscopists recruited are motivated and energetic and have approached every challenge to date with enthusiasm. The Victorian trainees have set-up a Facebook page (closed group) and use SMS and email to communicate regularly and support each other.

There is concern that there will be a bias in the evaluation as the APEN sub-project has recruited motivated people who are highly skilled as they are the first group to be trained. This has been the experience of all sub-projects to date, with the expanded scope of practice opportunity appealing to ‘early adopters’ of innovation. In addition to the technical requirements of the position, all project teams are working to develop the personal attributes of the nurse endoscopists particularly in relation to challenging communication scenarios.

5.8 Reflections and lessons learned

In their progress reports, sites were asked to provide their reflections on the project’s progress – specifically, the lessons they had learnt, changes that should be made, and their most important achievements. These responses were analysed for common themes and integrated with findings identified by HWA and the national evaluation team through site visits, additional project documentation and ongoing contact with the project teams. The results are described below.

5.8.1 Lessons

Participants were asked: “What have you learned from the implementation and evaluation activities to date?” Responses to this question fell into one of four main themes:

- Model of care
- Communication
- Timing and resources
- Training

Model of care

This sub-project commenced without a national overview of the model of care. Several sites felt that this should have been defined prior to release of the RFP. It would also have been easier to develop the training pathway first and then implement it. The pressure to commence training prior to the end of December 2012 made it impossible to think through all aspects of the training prior to recruitment of the nurse endoscopists and commencement of implementation.

Clear communication and delineation of project and organisational objectives is essential. Whilst differences of opinion between lead sites has proved challenging at times it has also provided opportunity for critical evaluation of the model of care and training pathway. It needs to be remembered that there may be more than one way to achieve goals and objectives.

In addition descriptors need to be developed for the role of lead and implementation sites, so that in the future lead sites have a checklist that identifies the features necessary in an implementation site for higher likelihood of success.

Communication

The presence of lead sites has streamlined implementation of the APEN projects. A more structured communication process is needed between lead and implementation sites that is explained in project Funding Agreements. This is because some sites are more responsive than others in meeting information requests and deadlines established by the lead sites. Across the sub-project there should be consistent key messages.

Workshop and steering committee meetings have been most valuable in setting the foundations for this project and establishing working relationships with all key partners (HWA, lead and
implementation sites, the national evaluation team and Victorian Department of Health). Ongoing investment is needed to maintain and foster relationships with key partners throughout the course of the project.

**Timing and resources**

A longer set-up phase was needed for lead sites, particularly for the recruitment and appointment of the trainee nurse endoscopists. States that wanted to develop a Consortia approach had little warning of the release of the RFP and this created time management issues as building these networks and gaining agreement from multiple services takes time.

Initial skills acquisition for the nurse endoscopists requires adequate time for hands on scope manipulation and practice. It may be prudent to extend the duration of the initial scope manipulation training and skills practice for nurse trainees.

The logistics of ensuring medical staff availability for training activities has been challenging, particularly over the New Year period. Future training programs will ideally work around this period with flexibility required from all parties.

There is a genuine need for each site to have a dedicated project officer. This ensures someone is aware of the project detail; the project is their main focus and they have the time and skills to meet reporting timeframes etc. It also provides a resource / point of contact person for the trainee. The allocation of funds by the Victorian Department of Health specifically for the funding of a project officer will assist in establishing this role within the current APEN project sites.

There is potential financial impact associated with increasing unfactored costs for academic and training expenses. When budget proposals were originally developed, travel related costs were factored into the budget as an excepted expense line, where academic and training requirements were not considered in the broader context of the project. For one site, the actual cost to date of these expenses is more than double what has been budgeted for the entire project period. This has necessitated a budget review – the overrun may have to be met by reducing investments in other budget line items.

**Training**

The future of the nurse endoscopist training pathway requires careful consideration for the nurse endoscopist role to be sustainable. This has not been the top priority during the set-up phase but as project teams move into implementation, the ongoing provision of training has to be discussed. This includes the issues of credentialing and professional accreditation, potential training sites and the opportunity to integrate endoscopy training for nurses, gastro-enterologists and surgeons and establish a national training pathway.

5.8.2 Changes

Responses to the question “Based on what you have learned, will you make any changes?” largely mirrored the themes identified in the previous section. The key message was the importance of frequent and open communication as well as a flexible approach to addressing barriers to project progress. This will be assisted by establishing a schedule for regular teleconferences at the outset of the project.

Once the lead sites had agreed that there would be common entry requirements and a common training pathway for nurse endoscopists this reduced conflict as it could then be determined by each site what model of care would be implemented at the end of the training pathway.

Developing and implementing a competency based training program is time consuming and resource intensive. The timing and duration of training activities needs to be carefully planned and reviewed after implementation to identify if any changes are warranted. Innovative projects often
throw up issues that have much bigger implications and extend beyond the project, for example, a national training solution.

An appropriate investment in project management resources during the set-up phase helps get project implementation sites on track. The project officer needs to be appointed at the beginning of the set-up period and retained throughout the life of the project. It is important to recruit project officers with the necessary project management skills. Frequently the project sites could identify clinical experts but it was often difficult to find an individual with the right mix of skills for the project officer position. Project teams should not assign this role to a busy clinician who already has a full-time role.

Back-up staff resources should be identified early during the set-up phase to support project implementation in the event of planned leave and unplanned absences. As each APEN project site (except for Logan Hospital) only has 0.8 FTE nurse endoscopist, any prolonged absence from this position will impact on patient throughput and project impact.

Providing greater support to project teams at the RFP stage with templates to guide the development of project budgets is likely to mitigate future cost over-runs. Additional work needs to be done to define the essential requirements for a lead or implementation site in the future.

5.8.3 Achievements

Participants were asked “What are the project’s most important achievements so far?” and provided responses as follows:

- Establishing common entry requirements and a clear understanding and direction for the training pathway that is compatible with different models of care
- Recruiting high calibre trainees to the nurse endoscopist positions in all APEN project sites
- Securing permanent appointments for the nurse endoscopists
- Recruiting project managers / officers to support implementation
- Developing an innovative, comprehensive and validated training program drawing on local and international expertise
- Implementing the first stages of the nurse endoscopist training program
- Maintaining the engagement and participation of senior medical staff with six attending the ‘train the trainer’ workshop in January 2013
- Solving problems when presented with major hurdles (e.g. trainee withdrawal at short notice)
- Improving infrastructure for training and delivery of endoscopy services at the project sites
- Improving access for specific patient groups
- Enhancing data collection and coding processes
- Broadening organisational support for the nurse endoscopist role
- Increasing awareness of the APEN sub-project and the nurse endoscopist role with external stakeholders
- Building networks and support between lead and implementation sites
- Observing a large and complex program being implemented on time and within budget
- Demonstrating the potential for use of advanced practice nursing roles.
6 The project set-up phase: Physiotherapists in the Emergency Department (PED)

The data sources for this section of the progress report include all documentation received from project teams to date; for example, project plans and progress report 1 and 2 for the PED sub-project. This has been synthesised with findings from the site visits conducted by HWA and the national evaluation team as well as the records of communication with project teams.

As HWA has all individual project documentation this information is provided at the sub-project level and addresses the common themes and issues that have collectively arisen.

6.1 Project description

This sub-project responds to the increasing number of presentations to Emergency Departments and the pressures on local systems from the newly implemented national four-hour rule (the National Emergency Access Target). The PED sub-project has two lead organisations (The Alfred Hospital in Melbourne and The Canberra Hospital / ACT Health Directorate - both sites currently have existing models in place) and are also implementation sites. There are a further nine implementation sites that are implementing a model from a lead site directly or adapting it as needed with the support of the lead site (thus there is a total of eleven project sites). Refer to Table 1.

According to the RFP documentation, the objectives of this sub-project are:

- To implement new workforce roles, on a national basis with consideration of national training pathways, by building on work already undertaken on extended scope of practice in physiotherapy roles;
- To facilitate the redesign of the workforce to match the changing needs of the service and not the determination of professional boundaries;
- To implement innovative roles that operate as standalone practitioners in the ED environment, with the scope to assess, order diagnostics, treat and discharge patients without intervention from a medical practitioner;
- To identify models of extended scope of practice for physiotherapists in EDs that demonstrate improved productivity by improving patient flow, decreasing waiting time for patients in the ED and meeting KPIs for triage times by category and for 4 hours waiting time;
- To support medical staff in the environment of recruitment issues and shortage of ED medical practitioners;
- To develop toolkits and implementation guidelines including consideration of training requirements and training programs to support national implementation.\(^\text{16}\)

The workforce issues for emergency medicine specialists arising from the combination of increased demand and stringent performance targets are well suited to strategies to develop innovative expanded scope of practice roles for the current workforce. In this sub-project there is a relatively straightforward time-based effectiveness indicator, in this case derived from the nationally mandated four-hour target. The model in place at lead sites is seen as relatively robust and to have succeeded in the metropolitan setting. Of particular interest is the adaptability of this model to regional and remote settings.

As for the APEN and NED projects the wording of these project objectives has generated some confusion, particularly the term ‘expanded scopes of practice’, which has a different connotation to

\(^{16}\) HWA Request for Proposals Extended Scope of Practice for Physiotherapists in Emergency Departments (Lead Organisations) HWA-RFP/2011/007 and HWA Request for Proposals Extended Scope of Practice for Physiotherapists in Emergency Departments (Implementation Sites) HWA-RFP/2011/008.
advanced practice. There is no consensus about the title for the expanded scope of practice role and this has the potential to generate confusion amongst project teams, their organisations and the broader physiotherapy profession. This is an issue for HWA to address and it is unlikely that the present diversity of views will be solved in the life of this sub-project.

The reference in the third sub-project objective to the expanded scope of practice physiotherapist operating as a ‘standalone practitioner’ in the ED environment with the scope to assess, order diagnostics, treat and discharge consumers without intervention from a medical practitioner generated most concern. It is recognised that physiotherapists working in private practice are able to perform a number of tasks that are not customarily performed by physiotherapists in the public hospital system. However, in most jurisdictions, physiotherapists in the ED do not currently discharge their patients without the involvement of a medical officer.

Throughout this section of the report the ESOP physiotherapist role will also be referred to as a primary contact physiotherapist (PCP) to distinguish the practitioner from other physiotherapists that may be working in the ED in the secondary contact physiotherapist role.

6.2 Model of care

There are two lead sites, each with their own model of care – the Alfred Hospital and the Canberra Hospital / ACT Health Directorate. Both lead sites are also implementing the PED model of care in their own organisations. The Alfred Hospital is lead to four implementation sites which encompass seven hospitals: within Alfred Health (at both the Alfred Hospital and Sandringham Hospital); Southern Health (Casey and Dandenong Hospitals); St Vincent’s Hospital Melbourne, which is in a partnership arrangement with Ballarat Base Hospital; and Alice Springs Hospital. The Canberra Hospital is lead to three implementation sites covering three hospitals (in addition to their own): Cairns Base Hospital, Robina Hospital and Flinders Medical Centre.

The implementation sites were assigned to a lead site by HWA. The logic behind this clustering was to try to group together States and Territories with similar legislative barriers or restrictions on the various elements of the expanded scope of practice role. For example, given Canberra Hospital’s intention to secure permission to inject local anaesthesia for digital ring blocks, it was identified that South Australia and Queensland were more likely to support injecting by ESOP physiotherapists then for example Victoria or the Northern Territory.

The lead organisations have an established model of expanded scope of practice musculo-skeletal physiotherapy service in place in the ED, undertaking, for example, the following tasks such as:

- Assessment of the patient
- Independent management of simple fractures
- Independent ordering and interpretation of x-rays
- Limited prescribing (dependent upon the legislative requirements of the State / Territory)
- Provision of local anaesthetic joint injections for relocation of small joints
- Direct onward referral or discharge of the patient

The lead organisations each have a training, lead and mentoring role with their respective project implementation sites who are implementing the model that is in place at their lead organisation (with local adaptation as necessary).

The model aims to support PCPs in their management of the full patient episode of care, by extending their competencies to areas such as prescribing, ordering and interpreting of diagnostic imaging. PCPs should be registered with the Australian Health Practitioner Regulation Agency (AHPRA) and work in a musculoskeletal (MSK) team environment.
All project implementation sites had either a primary contact physiotherapy service (five sites) and/or secondary contact physiotherapy service in their hospital’s ED prior this ESOP initiative (refer to Table 2).

### Table 2 PED project sites – primary and secondary contact physiotherapy services

<table>
<thead>
<tr>
<th>Project Implementation site</th>
<th>Primary Contact Physiotherapy (PCP) service prior to ESOP program</th>
<th>Secondary Contact Physiotherapy (SCP) service prior to ESOP program</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Alfred Hospital (Lead)</td>
<td>Yes - an existing ED PCP model of care in place since 2008.</td>
<td>Yes - an existing secondary care discharge planning physiotherapy service. (The primary contact physiotherapy service clearly stands separate to the secondary care discharge planning physiotherapy service and the roles are not interchangeable).</td>
</tr>
<tr>
<td>Sandringham Hospital</td>
<td>No</td>
<td>Yes - an existing ‘by referral’ system to see secondary contact patients. (The referrals are taken by a ward physiotherapist and are usually for mobility reviews and prescribing gait aids).</td>
</tr>
<tr>
<td>Casey Hospital</td>
<td>No</td>
<td>Yes - an existing ED secondary contact physiotherapy, focusing on admission prevention and MSK cases that are a lower priority.</td>
</tr>
<tr>
<td>Dandenong Hospital</td>
<td>Yes - an existing ED PCP model of care in place since 2010.</td>
<td>No</td>
</tr>
<tr>
<td>St Vincent’s Hospital</td>
<td>Yes - an existing ED PCP model of care in place since 2008.</td>
<td>Yes - ED secondary contact physiotherapy team from 8am to 12:30pm and seven days per week (Grade 1) servicing ED and the wider hospital on the weekends.</td>
</tr>
<tr>
<td>Ballarat Base Hospital</td>
<td>Yes - an existing ED PCP model of care in place since 2006 for 15 hours per week. From 2007 to 2012 combined the primary and secondary contact role. In October 2012 separated the primary and secondary contact roles as part of the ESOP project.</td>
<td>Yes - an existing ED secondary contact physiotherapy model of care in place since 2005 i.e. on-call to ED. From 2007 to 2012 combined the primary and secondary contact role. The secondary contact physiotherapist is now on call service for the ED from 8:30am to 3:30pm provided by the ward staff.</td>
</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>No</td>
<td>Yes - on-call service only to the ED for mobility assessment and back pain, mainly with the goal of preventing admissions.</td>
</tr>
<tr>
<td>The Canberra Hospital (Lead)</td>
<td>Yes - an existing musculoskeletal primary contact physiotherapist in ED since 2007. An extension of an existing PCP role in ED commenced in 2011.</td>
<td>Yes</td>
</tr>
<tr>
<td>Cairns Base Hospital</td>
<td>No</td>
<td>Yes - has had physiotherapist support in the ED since late November 2011. In the first 6 months of 2012 a secondary contact physiotherapist service was established in the ED with a dedicated presence based in the ED.</td>
</tr>
<tr>
<td>Robina Hospital</td>
<td>No</td>
<td>Yes - an existing ED secondary contact physiotherapy service.</td>
</tr>
<tr>
<td>Flinders Medical Centre</td>
<td>No</td>
<td>Yes - in 2009 a half-day service was started in the ED, and this went to a full time service in 2010 to include patients with back pain and simple fractures.</td>
</tr>
</tbody>
</table>

### 6.2.1 Project scope

**The Alfred Hospital** has a long history with primary contact physiotherapy roles, first implemented in 2008. Consequently the PED sub-project has built upon these experiences. The Alfred Hospital model includes a team based approach to service delivery with the ED PCP role integrated into the MSK team of the physiotherapy department (this provides access to a minimum of three to four appropriately experienced staff). Funding provided by HWA has allowed the Alfred Hospital to increase their existing PCP service to eight hours per day and seven days per week from 1 October 2012. An essential element of this model is the availability of senior, permanent staff to cover weekends.

The PCP service is new for **Sandringham Hospital** who prior to the HWA initiative had a secondary contact physiotherapy service available in the ED. There have been slight adaptations of the lead site model to suit the context of service delivery at this facility.
Southern Health had an existing PCP model running at Dandenong Hospital and operating Sunday to Wednesday for ten hours per day from 8am to 6pm. The one Full Time Equivalent (FTE) PCP is permanently funded by Dandenong Hospital; this was possible through the transfer of funds from an ED Registrar position. There is no change planned to this existing service however Southern Health has introduced an ED soft tissue review clinic at this facility in partnership with the orthopaedic team (through access to the Victorian Department of Health funding). This model has been expanded and implemented at Casey Hospital and operates seven days per week from 9:30am – 6pm drawing patients from the fast-track triage list. There are 1.4 FTE PCPs plus a project manager (0.6 FTE which includes an allocation of 0.1 FTE for the clinical lead role as well). The project team has reported that it has been a significant change process to introduce the lead site’s model of care and they are working to develop a team-based approach across the two Southern Health implementation sites.

St Vincent’s Hospital Melbourne has had an existing ED PCP model of care in place since 2008. Through the PED sub-project, the model has been expanded to provide longer hours of service, treat a wider range of patients and formalise training policies. The service is now available from Monday to Saturday from 9:30am to 7:30pm. The additional HWA funds have made it possible for St Vincent’s to reduce their reliance on casual staff for weekend cover with the PCPs now providing services on Saturdays. Sunday services are still provided by casual staff from 9:30am to 6pm.

St Vincent’s originally invited Ballarat Base Hospital to observe and learn from the PED sub-project but has since contributed $43,000 from HWA funds to assist Ballarat Base Hospital as an implementation site. Ballarat has also obtained funding from the Victorian Department of Health for a project manager position (0.2 FTE for one year). Like St Vincent’s, Ballarat had a physiotherapist in the ED for some years, although this functioned as both a primary and secondary contact role. These roles have now been separated, and the PCP position extended to cover 30 hours / week Monday, Tuesday and Thursday from 8:30am to 5pm and Friday from 9am to 3pm. The project team are introducing a three-month trial of weekend cover from April to June 2013. Due to funding constraints and potential conflicts with other ED roles (e.g. plaster technicians); the scope of the PCP role is more constrained at Ballarat than at some of the other implementation sites. However, the PCPs will be able to order and interpret x-rays and manage the episode of care in collaboration with medical officers.

The PCP model is new to Alice Springs Hospital. Until October 2012, physiotherapists were on-call to the ED for mobility assessment and back pain, mainly with the goal of preventing admissions. A secondary contact physiotherapist will still be available to back up the PCPs working in the ED. Three PCPs are covering 2.0 FTE positions with support from another member of the physiotherapy team on some weekends. The PCPs are part of the hospital physiotherapy team that consists of 8.5 FTE positions. The high prevalence of patient co-morbidities (e.g. a high incidence of renal problems) makes implementation more complex at this site. Nevertheless, there is support from the hospital’s pharmacy director and leadership and training will be provided for PCPs to administer pain relief (however no other drugs will be administered and no prescribing will be allowed by the PCP). Alice Spring Hospital is considering establishing an outpatient based soft tissue review clinic to support the role of the PCP in the ED. They may deviate slightly from their lead site’s training model in that it is not feasible for PCPs to travel to Monash University for the pharmacology module, which is provided weekly, and not in a block session. The site is looking to the Centre for Remote Health (linked to Flinders University) for an alternative source of training.

The Canberra Hospital in conjunction with the ACT Health Directorate has a long involvement in PCP roles and has been implementing an expanded scope of practice role for physiotherapists in the ED since 2007. Within this role senior MSK physiotherapists assess, treat and diagnose patients attending the emergency department with musculoskeletal complaints. An initial scoping project (in July 2008) highlighted inefficiencies in the primary contact position that could be reduced by extending the scope of practice for this position. This led to the project team designing
a new role to include tasks such as limited prescribing, independent management of simple fractures and independent interpretation of x-rays. The evidence-base produced by the Canberra team suggested that these changes would positively impact upon key performance indicators including length of stay and triage targets and also relieve the ED Doctors for more complex cases. The Canberra Hospital has been able to recruit an ESOP physiotherapist in training and a part-time project officer to support the ongoing development and implementation of the PCP role in this hospital and associated implementation sites. As Canberra Hospital has several PCP roles in other clinical areas there are skilled and experienced staff to support the ESOP physiotherapist in training.

**Cairns Base Hospital** has had a secondary contact physiotherapist located in the ED since early 2012. There is an allied health team based within the ED, which includes the physiotherapist, occupational therapist and a social worker. HWA funds have been used to establish a dedicated seven-day a week service operating ten hours per day from 8am to 6pm. It is initially functioning as a hybrid primary and secondary contact service until training is further advanced. This is because the team have one highly experienced PCP and another physiotherapist at the level of HP4 who is undergoing PCP training. PCP services were not established at Cairns so the model of care is evolving in accordance with local needs.

**Robina Hospital** based within the Gold Coast Hospital and Health Service, has not previously had any form of PCP service in the ED; however secondary contact services have been available. From October 2012 the PCP service has been provided five days per week from Monday to Friday 9:30am – 6pm. From the end of January 2013 a weekend roster commenced with the service remaining at five days per week from Sundays to Thursdays. It is planned to implement a seven days a week service from June 2013. As Robina only has funding for one PCP at this stage it has been difficult to develop a team-based approach. The PCP is of course part of the hospital physiotherapy team and is working collaboratively with other team members in the ED.

**Flinders Medical Centre** commenced a part-time PCP service in the ED in 2009, which was extended in July 2010 (a total of 1 FTE PCP only). Initially this role focused on patients with back pain and simple fracture (MSK conditions). The role has evolved over time and with HWA funding from October 2012 the service increased to 1.4 FTE PCP positions, which are shared by three personnel. The service now operates seven days per week from 8am to 4pm. The PCP primarily works with two groups of patients in the ED, those classified as ‘minor trauma’ and ‘trauma other’.

A summary of the main elements of the expanded scope of practice physiotherapy model of care is provided in Table 3.

### Table 3 Proposed changes to scope of practice for the PED sub-project

<table>
<thead>
<tr>
<th>Expanded scope of practice elements</th>
<th>Summary of progress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Imaging: X-ray</td>
<td>Most sites can already initiate X-rays and will be working towards interpreting the X-rays.</td>
</tr>
<tr>
<td>Other imaging: e.g. ultrasound, CT scan</td>
<td>There is minimal change proposed with initiating and reporting on other imaging such as ultrasounds and CT scans, with only two sites reporting that they will be able to order an ultrasound (one of these also can order a CT scan with consultant sign off).</td>
</tr>
<tr>
<td>Pathology</td>
<td>At this stage, only one site reports that they are investigating whether it is possible for PCPs to order pathology (Alice Springs Hospital).</td>
</tr>
<tr>
<td>Plastering</td>
<td>Some sites are reporting that they currently plaster or splint with other sites working towards this skill. There are a few sites that will not be including this in their scope of practice, mainly as these sites employ plaster technicians.</td>
</tr>
<tr>
<td>Providing pain relief / analgesia</td>
<td>Approximately five sites are working towards providing pain relief / analgesia, with one site currently able to provide a single dose of over the counter analgesia (The Alfred team) with the remainder of sites unable to undertake this expanded role at this stage.</td>
</tr>
<tr>
<td>Injections of local anaesthesia</td>
<td>Several sites are working towards giving injections of local anesthesia (such as ring blocks for finger dislocations).</td>
</tr>
<tr>
<td>Certification: sick leave and work cover</td>
<td>Most sites are either already providing, or are working towards providing sick leave certificates or certifications of attendance. Work cover certificates are not being provided, though one site reports they will be completing the Work Cover documents for the medical staff to sign, and another site reports they currently provide Work Cover certificates (Flinders Medical Centre).</td>
</tr>
</tbody>
</table>
| Role in discharge: without         | Several sites are working towards preparing discharge summaries and letters for GPs. One site reports that they...
6.2.2 Recruitment and staffing

All PED project teams have successfully recruited to project management and clinical positions. Most PED projects received multiple applications for the PCP positions, predominantly internal. Several sites were slower to secure project management positions with this responsibility falling to allied health personnel with existing full-time roles.

Each PED project managed its own advertising and recruitment process with lead sites providing samples of position descriptions. Most project teams had to customise the position description to fit local requirements, for example, Alice Springs Hospital has a policy that no position can be advertised with more than ten selection criteria. For several project teams navigating internal human resource processes was challenging; even though the project manager could show that the positions would be funded from an external grant, there were barriers like caps on staff establishment numbers and delays in placing advertisements.

Whilst the selection criteria varied slightly amongst PED projects, all PCP positions required the physiotherapist to have a tertiary degree in physiotherapy and AHPRA registration, evidence of relevant clinical experience (usually a minimum five years) and a Masters qualification (preferably in MSK physiotherapy and/or a clinically relevant field); or be able to demonstrate that they comply with the Australian Physiotherapy Association experiential pathway.

6.2.3 Training pathways

The two lead sites have each developed a training pathway. The Alfred Hospital has developed an in-house training program that incorporates a range of clinical education modules from external organisations. The process has evolved over the current project period and it has been identified that clinicians should practice in a supervised capacity for three to four months prior to assessment against the competency standards. The competency standards have been developed collaboratively with the input of clinical leads from all Victorian based PED project sites. Each month the group has worked on the competency standards for a different component of the training pathway e.g. radiology, lower limb, upper limb and differential diagnosis. The standards recognise that competency is a combination of knowledge, skills and attributes. There has been a considerable investment in documenting and formalising the education, training and competency packages. The Victorian Department of Health provided approximately $12,000 to fund a physiotherapist from Southern Health with experience and qualifications in workplace training, competency development and assessment. The development of these workplace competencies and related assessment methods has been intensive and time consuming given the short set-up phase for the PED projects. It is unlikely that this would have been possible in this timeframe without the collaborative approach of sites and the additional funding. Southern Health had been working in this field for 18 months and had considerable experience in the use of competency frameworks to support role development for allied health professionals.

An ongoing challenge for The Alfred project team is assessment of competence, particularly discriminating between different levels of experience in the ESOP role e.g. the difference in competency expected between an advanced practice physiotherapist and a physiotherapist with MSK experience. Further work is in progress to explicitly document what evidence is required to support a decision of competence and who is an appropriate assessor. The education and training resources cover radiology, pharmacology, pathology, differential diagnosis, fracture and
wound management. A trial relating to prescribing practices is proposed. PCPs complete an electronic clinical log and professional portfolio.

The Canberra Hospital / ACT Health project team provided each of their implementation sites with a training resource. This has previously been developed in collaboration with the International Centre for Allied Health Evidence at the University of South Australia. The ESOP physiotherapy training pathway addresses recruitment, training, credentialing and implementation. The training phase commences when it has been determined that the practitioner meets the institutional requirements to practice as a PCP as per a credentialing tool. The PCP enrolls in a formal program of study at the University of Canberra (Graduate Diploma of Extended Scope Physiotherapy). To support the clinical skills development of the PCP a clinical supervisor or mentor is identified. The credentialing phase continues as the University studies progress and includes a period of supervised practice of the extended scope tasks with assessment of competence against criteria in a clinical skills log book. When this pathway is completed the PCP reaches the implementation phase as they have reached the requirements of an extended scope physiotherapist. The Graduate Diploma is conducted over a one year period with a total of four weeks required in Canberra across the year. The residential study sessions are supported with online modules.

No further detail is provided about the training program and its implementation, as this will be the focus of the second evaluation progress report.

6.2.4 Clinical governance

HWA has clearly articulated through the initial RFP documentation and subsequent Funding Agreements signed with PED lead and implementation sites, an expectation that project teams will ensure appropriate safety and quality (including clinical governance arrangements) have been established. All project teams outlined their approach to clinical governance in their Project Plan and have provided additional information in their progress reports.

There is a good awareness of the importance of a strong clinical governance framework. Most projects are using their steering committee for this purpose. Cairns Base Hospital has access to an online automated system for credentialing medical officers and will apply this system to the ESOP roles in allied health. PED project teams are working with the existing clinical governance mechanisms within their organisations such as clinical care review committees, patient safety and quality officers and systems for recording and reporting incidents and complaints. All project teams are monitoring patient safety and quality data and most are involving their steering committee in reviewing this data. In several organisations, the steering committee has also provided a mechanism to engage concerned clinicians. For example, one project team invited an orthopaedic consultant concerned about the capacity of the PCP to order and interpret imaging. This committee routinely discusses cases of missed fractures in patients whose x-ray has been reviewed by ED clinicians. The willingness of the PCP to be included in this process has assisted in allaying the consultant’s concerns. The support of medical staff within the ED through mentoring and supervision of the PCP is a key feature of the model of care.

The clinical log books and associated documentation that explains the practical assessment tasks that the PCP works through have been very useful in demonstrating to other members of the health care team the ‘appropriateness’ of the scope of practice. Protocols and clinical guidelines are an important tool for ensuring ESOP clinicians operate within their scope of practice. Several project teams are using peer review of clinical cases as a quality improvement mechanism.

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There appears to be limited documentation relating to referral pathways in several implementation sites. As the ESOP model of care includes referral to other out-patient clinics within the organisation (and for some projects to consultants) these need to be communicated explicitly.

6.2.5 Sustainability

During site visits, all PED project teams were able to identify strategies they were deploying during the set-up phase to improve conditions for project sustainability.

These included:

- Using multi-disciplinary team language in explaining the ESOP model of care and explaining how it is embedded in team based care
- Advocating for the permanent appointment of one or more of the ESOP physiotherapist positions recruited through this initiative
- Ensuring strong links between the ESOP physiotherapy positions and the broader MSK physiotherapy team, physiotherapy department and ED
- Working with medical mentors to address supervision issues
- Providing education about the PCP role and the management of MSK conditions to nurses and junior medical officers as well as secondary contact physiotherapists working in the ED
- Investigating opportunities for development of a training pathway for less experienced physiotherapists to allow them to work toward a PCP role in the future
- Assessing the potential for complementary ESOP roles in outpatient clinics (understanding that critical mass will be needed to sustain the model in the longer term)
- Embedding the role of allied health within the culture of the ED
- Developing a business case to sustain the model in the longer term
- Involving State and Territory Departments of Health to support the implementation of the ESOP role.

6.3 Progress in achieving objectives

The objectives for each sub-project were specified in the RFP documentation issued when proposals were first sought, these objectives were replicated with only slight amendment in the Funding Agreements developed for each project team. Each project has listed their objectives in their first progress report so they are not re-stated here.

Project documentation has been reviewed by HWA to ensure that:

- Project objectives align with program objectives
- Projects have in place strategies to address each objective
- Projects are making progress against their objectives i.e. projects are doing what they said they would do.

The focus for the national evaluation team during the set-up phase has been to ensure that:

- Local project evaluation plans align with project objectives and the national evaluation requirements.

The major strategy to achieve this has been developing the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools that together provide a blueprint for project teams to follow to encourage consistent data collection methods and tools that support both local and national evaluation requirements across all sub-projects. The Key Performance Indicators (KPIs) in the Evaluation Framework were developed with the input of all project teams through reviewing the performance measures included in their Project Plans and then asking them to critique the proposed sub-project KPIs. Most project teams have identified particular issues of interest to their organisation that they intend to monitor, for example, several PED projects are
interested in the effectiveness and replicability of the two different training pathways; others have
instituted additional research projects to monitor patient outcomes such as changes in levels of
pain and functional status after treatment by a PCP. Several project teams have long-standing
relationships with other Universities and the HWA-ESOP program represents one more stage in
an established body of research. Other project teams have established new relationships for the
purpose of securing research and evaluation support.

During the initial site visit project teams were asked to identify the existing information systems
and data collections available within their organisation. All project teams were asked to insert a
‘flag’ within their patient information systems to enable easy identification of patients that would be
seen by the PCP. Both lead sites developed tools to guide their respective implementation sites in
collecting data relating to the change in scope of practice for the PCP. This has been invaluable in
streamlining the data collection process.

The national evaluation team developed a data specification to assist project teams and to
improve data consistency across each sub-project. A Gantt chart was produced specifying the
frequency and timing of data collection, who is responsible for collection and / or analysis and how
each data source and evaluation tool maps back to the agreed KPIs within the Evaluation
Framework. Project leads were asked to identify the relevant contact people that the national
evaluation team should work with to obtain the quantitative data required over the life of the
project.

The focus of the national evaluation team has been about establishing constructive working
relationships with the project leads; addressing questions relating to ethics approval issues and
identifying early issues with data access and availability and reviewing existing evaluation tools.

The first or baseline data submission is due from project teams by 31 March 2013. This early
submission aims to establish which sites have missing data elements and to streamline data
collection processes for the subsequent data submissions due on 31 October 2013 and 30 April
2014. It also allows the national evaluation team to refine the data specification based on what
items are commonly available and feasible to provide. All PED project teams have been diligent in
their efforts to provide the necessary data, however it is unlikely that all PED sites will be able to
supply all data items. The national evaluation team will continue to work with lead sites to refine
the baseline data set.

Most PED projects have access to data and evaluation support staff. Several project managers /
project officers have extensive experience in data extraction and analysis. Consequently these
projects are seen as having a higher level of capability in addressing the evaluation requirements
compared with other sub-projects.

In summary all PED projects are on track in addressing their objectives and are making good
progress.

6.4 Project management observations

These project management observations relate to the PED sub-project. Dwyer et al18 (2004, p.20)
have produced a framework, adapted from work by Belassi and Tukel19 (1996), which categorises
project management success factors. This framework proposes four main categories of direct
determinants of project success:

- Commitment: Is the organisation serious; is there a vision for the project and commitment to
  see it through? Is there commitment to manage the impact on stakeholders and partners?

Sydney.
• **Plan and design**: Is the project plan feasible, with achievable goals, strategies that can work good decision-making structures and outcomes that can be sustained?

• **Resources**: Are skilled people, enough money and the right material resources organised?

• **Project team**: Does the project teamwork well; is it able to manage the change required by the project and to communicate effectively with stakeholders?

Additional underlying factors that influence project success relate to the sector and organisation:

- **Sector** refers to the broader organisational context in which the organisation (and their project) sits.

- **Organisation** refers to the characteristics of the organisation including strategic directions, leadership, the organisational structure, and culture and people management practices also influence project management.

This framework is used to summarise the project management observations relating to the PED sub-project.

### 6.4.1 Commitment

All project teams have demonstrated a strong commitment to seeing the project through to its conclusion. A signed Funding Agreement that specified a project completion date of 31 December 2013 has underwritten this. However, all project teams have provided significant additional in-kind contributions over and above the HWA funds. The project teams are genuinely working to manage the impact on stakeholders and partners with an open and collaborative approach to engaging other members of the ED and physiotherapy team.

During several site visits, project teams spoke about the level of commitment required to address all obstacles during the set-up phase. This is perhaps best summed up by one project officer who said:

> ‘You’ve really got to have a passion to make this work!’

The best evidence of commitment is the quantum of ‘in-kind’ resources invested by every project team. Several PED sites commented that they had no idea when they submitted their RFP that such a significant level of ‘in-kind’ support would be needed. This has included the input of senior managers to assist with implementation barriers, the contribution of data and information staff and quality improvement personnel as well as the use of scarce research resources to support local evaluation plans.

### 6.4.2 Plan and design

All project teams have produced a project plan which includes realistic objectives and strategies. The PED project teams are predominantly highly skilled, well organised and motivated. They have effective decision-making structures in place and are demonstrating good capacity to identify and address project risks.

The lead sites have played a key role in supporting their implementation sites. The inclusion of lead sites has been an important design feature of this sub-project and it is unlikely that implementation would have proceeded in such a timely way without their input.

Lead sites have provided varying assistance depending on the needs of implementation sites and the project management style of the lead team, for example: support with developing project plans and progress reports and securing ethics approval. The other often cited benefit of the leads has been that their experience has helped other implementation sites avoid pitfalls during the set-up phase.
The arrangement that developed between St Vincent’s Hospital Melbourne and Ballarat Base Hospital is a product of history and St Vincent’s initial interest in being a lead site with a regional partner. St Vincent’s has primary responsibility for supporting Ballarat however the Alfred (as the lead site) also has a role. When the decision was made to fund Ballarat this project design issue should have been reviewed as it has generated some role confusion. The good working relationships between the project leads have reduced the impact of this issue over time.

All project teams have identified the imperative of demonstrating the performance and financial benefits to their organisation if the ESOP role is to be sustained.

6.4.3 Resources

All PED projects have reported a high level of investment in project management during the set-up phase. Most project sites have engaged a project manager / officer position with the position ranging from 0.2 FTE to 0.6 FTE for most implementation sites. Lead sites have supplemented this role ‘in-kind’ with significant contributions from existing PCP staff and allied health managers. It has been suggested that project teams should be directed in their Funding Agreements to allocate a minimum of 0.5 FTE project manager for the first 3 – 6 months.

Several sites have discussed the difficulties of implementing a major change like the ESOP role without previous project management experience. There is always a tension with projects implemented within busy departments as to who picks up the clinical load in the absence of the clinician deployed on project management tasks.

6.4.4 Project team

The project teams that have functioned best have included PCP personnel that are already known within the organisation. The benefit of having a resource that is familiar with the model of care and can respond to questions from other clinicians should not be understated.

Project teams that incorporate a diverse range of skills are better equipped to deal with the many and varied issues that arise in the set-up phase. The PED project teams did take some time to form and establish but are now working effectively across all lead and implementation sites.

Project teams need a central point of communication for consistency of message and timely response. The establishment of good project management mechanisms such as regular team meetings and monitoring and review processes has been observed.

6.4.5 Sector

The broader health system is characterised by constant change, particularly at the State and Territory level. Ministerial reshuffles and structural reorganisations of State and Territory Health Departments have occurred since the PED projects commenced. This is a fact of life for those who work in health care and project teams have shown resilience by adapting as necessary.

The involvement in the PED sub-project by the Victorian Department of Health has been an advantage for the Victorian project teams. The Department’s engagement has not only provided practical assistance through the provision of additional funds and coordination and oversight, but has signalled an interest in the sustainability of the PCP role in the longer term.

6.4.6 Organisation

Several project teams have reported major changes within their organisations that have the potential to impact upon the PED project. These vary from physical redevelopment and relocation of the ED through to changes in senior executives and ED clinicians. The Alfred has experienced a transformational change in the management of the triage process within its ED. From 14
November 2012, the hospital has removed the previous triage process. From this date there is no triage nurse and all patients are being seen by a consultant within ten minutes of arrival and allocated to one of three areas: resuscitation, assessment and fast-track. The ED consultants now have admitting rights where previously the relevant specialty team would assess the patient in ED and decide if an admission was required and / or the specialty team would accept the patient. The physiotherapist is based within the consultant led assessment team, which includes the consultant, registrar and nurse practitioner. As there is only one physiotherapist available if they are needed to treat a patient they are unable to contribute as part of the assessment team. In the past the PCP was based in fast-track and after the patient was triaged by the triage nurse, the physiotherapist would ‘pull’ the patient from the triage board and commence treatment. Whether these operational processes remain in place remains to be seen however this change is expected to impact the ESOP project evaluation data.

Two other PED project teams have identified the need to work with existing organisational committees. For example, Casey Hospital has engaged with their Work with Medication Safety Committee to try to progress their thinking about the role of PCPs in prescribing in the ED.

Very few projects have documented communication plans to guide their interactions with internal and external stakeholders. Whilst progress reports identify activities that are being undertaken to assist with managing change, the model of change management underpinning these activities is not described.

6.5 Stakeholder engagement strategies

All projects have provided evidence of stakeholder engagement, as reported in project progress reports. During the set-up phase, stakeholder engagement occurred mostly internally, although there were some good examples of external stakeholder engagement. Internal stakeholders include local organisational personnel such as executive / management staff, clinicians and committee members. Project teams at Southern Health (Casey Hospital) and St Vincent’s Hospital Melbourne have worked closely with information technology personnel, recognising that their support is integral to project data collection and evaluation requirements. St Vincent’s Hospital Melbourne also reported value from engaging with the Redesigning Care project officer and GP Liaison Officer.

External stakeholder engagement has been undertaken by several projects. External stakeholders were engaged for a variety of reasons, such as consultation, learning and project development and external support. Flinders Medical Centre worked hard to engage external stakeholders through discussing research opportunities with Flinders University, and attempting to engage various professional bodies.

There were few examples of engagement using mass media. Several facilities have disseminated information about the ESOP project within their organisation. For example, St Vincent’s Hospital Melbourne sent an article about the project to all staff, and the Robina Hospital team had an article published in the Gold Coast Hospital and Health Service newsletter.

Mechanisms for engaging with stakeholders have focused mainly around meetings and consultation sessions. Steering committee and advisory meetings are in place and reportedly functioning well, in addition to consultation and liaison meetings. Workshops and information sessions have been used in several projects particularly to introduce the project to external stakeholders, broader members of staff and / or management from different departments. Several project teams are routinely using updates via email and teleconference. The development of documents, such as the ‘model of care’ and ‘service outline’ were used by the team at Flinders Medical Centre as a means of gaining input from personnel based in the ED, physiotherapy, occupational therapy and other clinical areas.
Consumer engagement has been limited to date however the Alfred Hospital project team has sent expressions of interest to consumers registered with Alfred Health for consumer participants / representatives to be involved in the project in early 2013. The Robina Hospital team have been able to tap into a well-developed consumer engagement process within the Gold Coast Hospital and Health Service. A previous consumer of ED services at Robina Hospital, who is experienced in working with patients, is a valued member of the project Steering Committee. This consumer representative has also volunteered to assist as needed in exploring patients’ experiences of the expanded scope of practice physiotherapy service\(^\text{20}\). The project team at Alice Springs Hospital has initiated contact with the Aboriginal Liaison Officers based at the hospital seeking their input on patient survey tools and issues of cultural appropriateness.

All project teams are effectively managing stakeholders with no insurmountable difficulties noted to date. A couple of project teams have reported some resistance from orthopaedic services and the advice and experience of lead sites has been useful in addressing this issue.

### 6.6 Barriers

Through project progress reports and during site visits, project teams reported on barriers they faced during the set-up phase of the program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The barriers identified by the PED project teams are presented under the following sub-headings:

- Role clarification
- Recruitment and training
- Communication and stakeholder engagement
- Resource issues
- Legislative and policy issues
- Evaluation issues

#### 6.6.1 Role clarification

St Vincent’s Hospital Melbourne mentioned delays in clarifying the respective roles of lead and implementation sites as a barrier to the project during the start-up phase. At Cairns Base Hospital, the PED project is facing competition for eligible patients from nurse practitioners and doctors who require clinical experience. This means fewer patients will be available to the ESOP physiotherapist in training, and also has the potential to strain relations between ED staff, and create confusion for patients and referring health professionals. Other sites have also identified the problem of medical staff taking responsibility for patients in the ED that clearly had MSK conditions. Ongoing explanation is needed to help ED staff be clear about the role of the PCP and the difference between the primary and secondary contact physiotherapy roles. Several PCPs commented on their surprise at having to constantly repeat information about their role and the project in the first months of commencing in the ED.

#### 6.6.2 Recruitment and training

Many projects experienced delays in recruitment. In some cases this was a flow-on effect due to lack of engagement with the project at higher levels in the organisation (Alice Springs Hospital). In other cases the processes involved in recruitment proved unexpectedly time-consuming (Southern Health) or complex (Flinders Medical Centre), or it was difficult to attract suitably qualified applicants, a problem compounded by existing staff shortages (Ballarat Base Hospital). The Cairns Base Hospital noted that delays in recruiting a project officer to the lead site (Canberra Hospital / ACT Health) had implications for implementation sites such as delays in the availability of resources. At Southern Health, planned leave by a key staff member coincided with the

project’s initiation and several people shared the role temporarily. The resulting delays in recruiting and the development of a service model made it more difficult to engage stakeholders and progress to the next stages, including development of resources and needs analysis.

Training issues also presented barriers, particularly for the implementation sites. Those associated with the Canberra Hospital / ACT Health lead site were unprepared for the costs and time associated with the required training model, a Graduate Diploma course delivered by the University of Canberra. All the implementation sites linked to this lead site have noted this as a problem. For example, Robina Hospital was concerned that not all the ESOP recruits will meet the entry criteria for the course, and has requested recognition of prior qualifications and also possible entry via alternative routes (e.g. equivalency of experience). The project team at Flinders Medical Centre has noted the pressures upon the ESOP clinicians who are studying the Graduate Diploma, trying to establish the new model of expanded scope within the ED, providing hands-on clinical services and meeting the mentoring and clinical supervision requirements of the program. The cost of the training was not fully understood when project teams submitted their RFP and therefore not included in the project budget. In addition to the course fees, there are significant travel and accommodation costs for clinicians based outside Canberra and the expense of backfilling the clinical role for this training period. The project team at Flinders Medical Centre estimate a cost of around $45,000 for two clinicians to complete the Graduate Diploma within the 12-month implementation period.

These barriers are not unique to the Canberra Hospital / ACT Health lead site as the Alice Springs Hospital project team have identified similar difficulties in attending the pharmacology module organised by their lead site, The Alfred. This is because the module is not offered in an intensive mode and requires periodic attendance over several weeks.

6.6.3 Communication and stakeholder management

A variety of communication issues have been raised by PED projects. At Flinders Medical Centre, communicating about the project and the changes it involves has proved a challenge simply because of the scale of task: there are more than 200 nursing and medical staff working in the ED. At Cairns Base Hospital, the challenge has been to maintain contact and communication among ESOP trainees now that a seven-day roster has been instituted. This barrier is being addressed by scheduling regular project meetings. At St Vincent’s Hospital Melbourne, project implementation has necessitated changes to information technology systems and therefore liaison with these staff has been critical to ensuring access to the necessary software and processes.

A lack of communication from a key training provider – the University of Canberra – has proved a barrier for some sites. Cairns Base Hospital reports that information was not provided in a timely manner about confirmation of enrolment or the timing of residential components. Local regulations mean that two months’ notice is needed for approval of travel, therefore the lack of course information had the potential to delay training. Further, course outlines and materials were needed before decisions could be made about the capacity of ESOP personnel to deliver the model of care, and local agreements about medical imaging, supervision and a research proposal were also delayed.

All projects reported how time consuming they found liaison and communication, as this needed to occur at so many levels during the set-up phase.

6.6.4 Resource issues

The delays in getting resources to project implementation sites have been previously addressed. This was compounded by the lead sites commencing at the same time as implementation sites. This created pressure particularly for The Alfred project team, as they had not previously developed the full range of documentation and resources required by implementation teams.
Project leads were on occasion frustrated by the resistance of implementation sites to aspects of the model of care recommended by the lead site. Often this was a result of organisational custom and practice or resources. The provision of guidelines about the expectations in relation to funded clinical hours and project management resources would have addressed this barrier.

At least two project teams reported concerns from consultants that establishing a PCP service in the ED would increase presentations once word got out about ‘free’ physiotherapy treatment. This was a myth that had to be debunked early in the set-up phase.

Several project teams raised the competition for space in the ED. In the case of Alice Springs Hospital the opening of a newly redeveloped ED is imminent and will address this problem. Often the PCP would have an allocated room only to find that a medical officer was using this space.

**6.6.5 Legislative and policy issues**

During the set-up phase project teams identified a range of legislative and / or policy barriers to implementing aspects of the ESOP model of care. Impediments to prescribing were commonly reported with project teams understanding that this is part of a much bigger issue, nevertheless some project teams, such as Flinders Medical Centre are investigating local models and Robina Hospital and Cairns Base Hospital are seeking the assistance of Queensland Health in addressing this barrier. Several project teams report an inability to provide over the counter analgesia to patients within the ED.

Several project teams have come up against barriers to ordering imaging. For Cairns Base Hospital this appears to be a radiation safety issue. Radiation Health is the Queensland government's radiation safety agency. It has state-wide policy, licensing and legislative responsibility for radiation health standards and radiation safety. Radiation Health is a unit within the Division of the Chief Health Officer. It administers Queensland's Radiation Safety Act 1999 and the Radiation Safety Regulation 2010. Casey Hospital has experienced some reluctance to the PCP ordering ultrasound, CT scan and MRI; this is most probably related to billing issues as the hospital receives reimbursement from the Commonwealth if a consultant orders these tests in an outpatient clinic.

**6.6.6 Evaluation issues**

Several project teams raised issues relating to local and national evaluation requirements. One project team expressed confusion about the role of the national evaluation team and concerns about the intellectual ownership of data and evaluation findings. Another project team was unaware of the local evaluation responsibilities referred to in the project Funding Agreements.

Most project teams required support and assistance with the ethics approval process. Frequently local experts provided conflicting advice, which may have been due to a lack of familiarity with evaluation proposals as opposed to research proposals. Southern Health has very strict ethical guidelines about access to paediatric data. As Casey Hospital has a high number of paediatric presentations to their ED this created particular problems in securing ethics approval. All project teams demonstrated great determination and tenacity in pursuing their ethics applications and at the time of this review all project teams have submitted ethics applications and the majority have received ethical approval.

The challenge of measuring the ‘readiness or capacity for change’ within the funded organisations has also been identified as an issue during the set-up phase.

**6.7 Enablers**

Through project progress reports and during site visits, project teams reported on enablers they encountered during the set-up phase of the ESOP program. This information was collated into a
series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The enabling factors identified by the PED project teams are presented under the following sub-headings:

- Collaborative development
- Project management support
- Stakeholder engagement
- Expanded scope of practice clinicians

6.7.1 Collaborative development

The support provided by consultants, particularly a medical champion and ongoing collaboration and discussion with diverse practitioners about the proposed workforce model improved the decisions made about clinical hours of service delivery and the allocation of clinical as well as non-clinical time.

Working with other project teams either in the development of competency standards or through co-operating in joint research initiatives has been positive. The previous experience of lead sites and the provision of the training pathway, resources and educational modules has aided implementation and reduced duplication. The involvement of senior managers has provided useful guidance and a management perspective on model of care and staffing issues.

All implementation sites identified the benefit of regular communication and sharing of information and insights. Cairns Base Hospital instituted a weekly teleconference with Robina Hospital and Flinders Medical Centre to support the PCPs and allow them to debrief together about their clinical experiences.

The commencement of the Victorian project Steering Committee in conjunction with the Victorian Department of Health facilitated increased communication and strategic planning. As did the workshops organised by HWA to bring together project teams, the national evaluation team and other stakeholders. The onsite workshops provided by lead sites offered an opportunity to engage with the immediate implementation site project teams, as well as their wider stakeholders.

6.7.2 Project management support

The ability to recruit an experienced project manager and strong team support from other members of the ED and physiotherapy departments has been identified as an enabler by the majority of project teams. The funding provided to Victorian sites by the Victorian Department of Health to assist with project management has been welcomed and created some envy amongst other jurisdictions.

Allocating dedicated project management resources for the first six months of the project helps set the project up for success. Project teams felt that implementation sites would fare better with at least three months lead time prior to implementation. With project staff in place in the lead up period there are likely to be less delays in decision-making, clinician recruitment and ethics approval. One project site observed that traditionally physiotherapists can be very clinically focused and it is difficult to get the right mix of project management and clinical experience in the one person. This makes it necessary to ensure a project team with a diverse skill mix supports the project manager.

6.7.3 Stakeholder engagement

All project teams identified stakeholder engagement and support of the Chief Executive Officer and senior management team as enabling factors during the set-up phase. Early consultation with departments likely to be impacted by the ESOP role was useful. The development of a good
relationship between lead and implementation sites and a climate of openness and trust assisted in the set-up phase.

The pre-existing relationships that project team members had with internal and external stakeholders assisted communication, understanding and acceptance of the ESOP role. Where the physiotherapy personnel had an existing high level of trust with other departments (such as ED and orthopaedics), implementation of the model of care was easier.

Several project teams promoted ‘early wins’ in avoiding admissions for patients with back pain or lower limb injuries as a way of promoting the PCP role and gaining wider organisational support.

6.7.4 Expanded scope of practice clinicians

Many of the ESOP physiotherapists recruited were already working within their organisations and known to senior medical and nursing staff, which meant they had established relationships and credibility within the organisation. These personnel were able to quickly grasp the model of care and project objectives as many had previously worked in an ESOP role.

The enthusiasm and energy of the ESOP clinicians and their personal commitment to the project has also been identified as an enabling project factor. Many have exhibited a mature approach to working with ED personnel and have generated confidence through their clinical skills and willingness to work co-operatively with medical and nursing staff. On at least two occasions, PCPs have treated senior medical officers in the ED and picked up previously missed fractures.

At Casey Hospital the PCP is following the process for x-ray review used with new registrars and this has helped to instil confidence in other members of the medical team about this practice change. The PCPs at other project sites are adopting a similar approach to the medical staff in how they structure and communicate their clinical summary of a patient's condition to the ED consultant.

6.8 Reflections and lessons learned

In their progress reports, sites were asked to provide their reflections on the project’s progress – specifically, the lessons they had learnt, changes that should be made, and their most important achievements. These responses were analysed for common themes and integrated with findings identified by HWA and the national evaluation team through site visits, additional project documentation and ongoing contact with the project teams. The results are described below.

6.8.1 Lessons

Participants were asked, “What have you learned from the implementation and evaluation activities to date?” Responses to this question fell into one of five main themes:

- Clarity of project requirements and objectives
- Management and culture
- Communication
- Stakeholder engagement and support
- Time and resources

Clarity of project requirements and objectives

The majority of sites (seven of the nine) identified issues arising from not having a clear understanding of what the program involved. Many sites commented that there was a need for greater clarity around the evaluation process in regard to the roles and expectations of the various stakeholders in the collection of the data, the exact data items required and reporting process. Participants also commented that they were not made aware of the cost of the training program, and earlier explanation of this would have allowed them to develop a more appropriate budget.
Lead sites were concerned that implementation sites did not always have clear objectives, as their model of care was not based on that of the lead site. Implementation sites similarly commented that it would have been beneficial to their initial proposal if they had understood the lead site’s model from the outset. Other responses pointed to a varying level of understanding within a site and that this can be challenging when upper management has a different view of the project requirements.

HWA advertised the implementation sites before they chose the lead sites. The lead sites did not choose implementation sites however ACT asked to influence the allocation of implementation sites on the basis of a defined criteria; they were matched on the basis of similar legislative environments. The lead site needs to be consulted and included in the allocation of implementation sites otherwise projects can be de-railed in the set-up phase through re-negotiating the model of care. Implementation sites also need to know what they have signed up for especially as there may be a tension when people are working in implementation sites in the role already without the required post-graduate qualifications.

Lead sites need to commence at least six months prior to the start-up of implementation sites. This would allow more timely development of documentation and resources.

Management and culture

Most responses in this category related to lead-implementation site issues. Lead sites have gained an appreciation of the differences between organisations, for example in relation to: management, lines of seniority, culture, project stakeholders and allocation of resources. One participant commented, “change management takes time and is slower for some organisations”. An implementation site noted that geographical and specialty service level differences between the lead and implementation site was a barrier to implementing the lead site model. Another commented on the importance of developing standardised job descriptions, terminology and recruitment for the ESOP program.

The PCP and project lead need to understand the hierarchy within the ED. Selecting ESOP physiotherapists with experience in ED is advantageous, as they understand the importance of developing a rapport with consultants first and foremost and how this trickles down through the department. Personnel working in expanded scope roles need to show appropriate respect for ED personnel and proceed slowly. Often experienced PCPs would still make a point of seeking the advice and guidance of the consultant in the set-up phase to convey the message that they understood how things usually worked and respected the expertise of the medical officer. As the confidence of the medical officer in the PCP grows this respect is returned and the PCP is able to operate more autonomously. It appears that it is much easier to grow a primary contact physiotherapy service in an ED that has experienced a secondary contact physiotherapy service. This experience of having a physiotherapist in the ED sets up the pre-conditions for the more significant change associated with an ESOP role.

One lead site observed that more mature organisations are better able to think outside the square and be creative in their use of resources and rostering; this enables them to overcome resistance at multiple levels. To be successful organisations need someone to drive the project in each site. Ideally, this is a person with strong internal networks and a good reputation throughout the organisation.

Communication

There needs to be good communication within sites and between the lead and implementation sites particularly, clear communication of project objectives. Multiple mechanisms of communication are needed, and lead sites have used a combination of telephone calls, email, face-to-face workshops and meetings and monthly bulletins to communicate and coordinate project activities.
Communication can be streamlined when implementation sites only have to work with one lead organisation, the lead site should liaise with other key parties, such as educational providers, on behalf of implementation sites.

**Stakeholder engagement and support**

All project teams recognise the importance of stakeholder engagement and communication. Many reported that engagement should occur as early as possible in the project. One team described how they had been encouraged and supported by key stakeholders who had important input into the implementation and adaption of the model to meet the needs of their site.

A number of sites commented that stakeholders and management had been very positive and supportive of the initiative. One suggested that this support was due to a focus on improving the patient journey, rather than on an extension of roles. Another noted that having an established and well accepted ESOP service within the organisation minimised any barriers to implementation.

**Timing and resources**

In reflecting on what has been learnt during the set-up phase, most sites commented on the amount of time and resources involved. Many mentioned the need to develop clear and accurate timelines for implementation of the project. A number described unexpected delays, which affected their proposed implementation timelines, such as the ethics approval process. One site stated that ‘non-clinical’ time and resources required should not be underestimated, and another that even physiotherapists with ‘significant musculoskeletal training and experience require a large amount of time in the transition to the ED setting’. An earlier visit from the lead site and national evaluators may have allowed the earlier start of the local adaption and evaluation activities in one implementation site. It was acknowledged that the activities of set-up are time and human resource intensive but necessary to ensure credibility of the service from the start of implementation.

Two project teams emphasised the importance of investing resources in a training pathway for younger, less experienced staff so they can progressively build their skills and experience towards the ESOP role. This would assist with project sustainability and succession planning.

### 6.8.2 Changes

Responses to the question “Based on what you have learned, will you make any changes?” largely mirrored the themes identified in the previous section. The key message for the set-up phase was the allocation of more time earlier to clarify and understand the Funding Agreement, the evaluation framework, and the ethical requirements. A number of sites responded that they would ensure that stakeholder involvement and engagement occurred earlier in the process. Communication issues between lead and implementations sites should be addressed using clearly written guidelines regarding the objectives of the program.

The criteria for recruitment of the primary contact role should be reviewed, as physiotherapists with less than the ideal experience but the right attitude and commitment cannot currently be considered. It was suggested that the credentialing process needs further investigation with ongoing engagement with AHPRA and professional associations to achieve registration for ESOP practitioners. There may need to be a transition pathway for physiotherapists already qualified but without experience in the ESOP role. There will be an ongoing need for training, development and clinical supervision of physiotherapists in this role.

Implementation sites should be provided with guidelines to link the model of care to an indicative staffing profile to ensure that there are appropriate clinical hours and adequate resources to implement a team based approach. The provision of budget guidelines or an indicative budget would reduce the risk of underestimating staffing, travel, training and evaluation costs.
As noted previously lead sites should be maintained in future implementations but brought on at least 3 – 6 months earlier than other project teams to allow preparation of project documentation and training resources. The development of outpatient ESOP roles may complement the ESOP ED position and assist in building critical mass and sustainability.

Early identification of potential legislative and industrial barriers to expanded scope of practice changes would be advantageous with HWA taking the lead in this process.

6.8.3 Achievements

Participants were asked “What are the project’s most important achievements so far?” and provided responses as follows:

- Developing the project plan and project processes
- Obtaining local ethics approval for the project
- Analysing demand to work out the optimum hours for the PCP service
- Commencing the evaluation activities
- Developing training modules, education seminars, competency standards and guidelines
- Achieving in principle agreement to allow ESOP personnel to request medical imaging and prescribing
- Increasing resources and capacity including staff recruitment, classification of staff positions, and the creation of a PCP team
- Training of key staff, and the establishment of support structures such as steering and research committees
- Engaging stakeholders and benefiting from the support they provide for the projects’ model of care
- Implementing the ESOP service, including receiving compliments from consumers, and very positive feedback from ED consultants and broader staff
- Building the foundations for an integrated sustainable service
- Increasing the profile and recognition of the PCP role, leading to requests for involvement in wider department and organisational planning.
7 The project set-up phase: Nurses in the Emergency Department (NED)

The data sources for this section of the progress report include all documentation received from project teams to date, for example, project plans and progress report 1 and 2 for the NED sub-project. This has been synthesised with findings from the site visits conducted by HWA, clinical advisors and the national evaluation team as well as the records of communication with project teams.

As HWA has all individual project documentation this information is provided at the sub-project level and addresses the common themes and issues that have collectively arisen.

7.1 Project description

This sub-project also responds to the increasing number of presentations to Emergency Departments and the pressures resulting from the national four-hour rule. The aim of this initiative is to introduce expanded scope of practice to nursing roles to support medical practitioners and other members of the health care team to focus on consumers with higher triage categories.

The inter-professional, integration and partnership issues described in the physiotherapy sub-project are also relevant here. These include describing the challenges of successfully linking the ESOP work with existing State and Territory-based initiatives in clinical services redesign, which have been particularly strong in the areas of aged care and mental health, where managing the partnership arrangements between the new models and the wider system are crucial to the challenge of implementation and long term sustainability. This sub-project focuses on the priority areas of mental health, paediatrics and rural and regional implementation.

The multiple implementation sites selected, (thirteen project sites across eight organisations), are listed in Table 1.

According to the RFP documentation, the objectives of this sub-project are:

- To implement new workforce roles on a national basis with consideration of national training pathways, by building on work already undertaken on extended scope of practice nursing roles;
- To facilitate the redesign of the workforce to match the changing needs of the service and not the determination of professional boundaries;
- To implement roles that operate as standalone practitioners in the ED environment, with the scope to assess, order diagnostics, treat and discharge patients without intervention from a medical practitioner;
- To identify innovative models of extended scope of practice for nurses in EDs that demonstrate improved productivity by improving patient flow, decreasing waiting time for patients in the ED and meeting KPIs for triage times by category and potentially improving performance against 4 hours waiting time targets for triage categories 4 and 5.
- To support medical staff in the environment of workforce issues in relation to ED medical practitioners and to reduce workforce time constraints to allow a focus on higher level ED presentations (Australasian triage categories 1-3);
- To develop from these successful models toolkits and implementation guidelines including training requirements to support national implementation.21

Several stakeholders (including the clinical advisor) have identified concerns about some of this terminology. A clearer definition was needed for the terms expanded / extended / advanced prior

21 HWA Request for Proposals: Extended Scope of Practice for Nurses in Emergency Departments (Implementation Sites) HWA-RFP/2011/010.
to the NED projects commencing. As can be seen from the sub-project objectives the original documentation suggested that nurses would practice ‘as standalone practitioners in the ED’ however this is only possible for a Nurse Practitioner. Registered Nurses do not have the legal authority to diagnose and discharge patients, only Medical Officers and Nurse Practitioners currently have authority to operate autonomously. The third objective should be reworded to ‘...operate as interdependent practitioners in the ED environment with the scope to assess, refer for diagnostics, treat and discharge consumers in collaboration with a medical or nurse practitioner’.

It has also been suggested that with the fourth objective it would be prudent to remove the identification of triage categories 4 and 5 as clinicians have advised that triage category 4 can include patients with high morbidity and mortality and all patients of this triage category may not be an appropriate group for the NED project teams to assess and treat. It may be sounder for each project to work on the basis of presenting complaints.

7.2 **Model of care**

A wide range of different models of care are being implemented as part of the NED sub-project. With no lead site, the eight implementation sites are using a variety of strategies for workforce innovation in the ED, bound together by the common goal of improving efficiency while maintaining high levels of safety and quality. The models of care are summarised in Table 4.

7.2.1 **Project scope**

Three sites are targeting mental health patients. **Royal Prince Alfred Hospital (RPAH)** is a major metropolitan hospital with an existing Mental Health Nurse Practitioner (MHNP) who provides individual patient care in the ED and also runs a MHNP-led outpatient clinic. RPAH has recruited a team of mental health liaison nurses (at the level of Clinical Nurse Specialist), supervised by the MHNP, who will work with the ED team in managing mental health patients. The model of care includes assisting with information gathering and rapid assessment, managing difficult patients, and providing timely intervention to mental health patients as soon as possible after triage. At **Wollongong Hospital**, the role of the existing Clinical Nurse Consultants in the hospital’s ED and Psychiatric Emergency Care Centre is being expanded to their full scope of practice, supported by specialised training and education. The model of care includes the development of standing orders and brief interventions for people presenting with personality disorder, suicidal thoughts or self-harm. It will also streamline assessment of consumers who meet the entry criteria for the Psychiatric Emergency Care Centre. **Eastern Health** has appointed two Mental Health Nurse Practitioners (MHNPs), one is endorsed and one a candidate, to work across all two of its ED sites, providing training, mentoring and supervision to other ED staff as well as assessing and treating mental health patients and referring or discharging to other providers.

There is one metropolitan and two rural / regional sites focusing on increasing the skills and expanding the capacity of Registered Nurses in the ED to improve patient flow. **Prince of Wales Hospital (POWH)** is implementing review clinics and fast-track services to reduce waiting times and improve services for patients who may otherwise experience long delays or be “lost” to the system, i.e. did not wait for treatment and left prior to commencing or completing care. The focus is on lower acuity patients who customarily expect longer waiting times. **Murrumbidgee Local Health District (LHD)** is working with Registered Nurses to provide care for selected, non-life-threatening conditions (predominantly patients with triage category 4 and 5). This project team is implementing clinical pathways in rural ED or Urgent Care settings. Experienced Registered Nurses are undertaking additional study and will have their scope of practice extended to include management of common low-acuity presentations. At **Kilmore and District Hospital**, highly experienced Registered Nurses will receive targeted practical training and competency assessment in suturing, casting and immobilisation, and dealing with ear-nose-throat problems, and an online course qualifying them to take diagnostic X-rays.
Finally, there are two paediatric sites, both aiming to reduce ED waiting times and length of stay and enable the best use of medical and Nurse Practitioner resources for paediatric patients in higher triage categories. **Sunshine Hospital** will provide additional training for Registered Nurses to assess and treat paediatric patients who present with minor illness or minor injury (anticipated to be primarily patients in triage category 4 and 5). The care provided will be protocol driven and under the supervision of medical officers. The **Royal Children’s Hospital** in Melbourne is implementing criteria-led discharge pathways for three respiratory illnesses (asthma, bronchiolitis and croup) and gastroenteritis. All ED nurses have been trained to undertake this expanded scope of practice as part of their usual roles.

### 7.2.2 Recruitment and staffing

Several project teams are working with existing personnel (for example, Wollongong Hospital, Murrumbidgee Local Health District, Kilmore and District Hospital and the Royal Children’s Hospital, Melbourne). Others have used the funding allocation provided by HWA to recruit additional positions to work in the ESOP role. Those project teams who decided to recruit additional positions have all been successful in attracting suitable candidates. For several project teams (RPAH, POWH and Sunshine Hospital) most of these personnel came from within their own organisation, often re-locating from another part of the service. The Eastern Health team recruited two highly trained personnel from outside their organisation.

Table 4 below includes a summary of the project aims, scope and ESOP personnel recruited for the project.

**Table 4**  
**HWA-NED project aims, scope and personnel**

<table>
<thead>
<tr>
<th>Project site</th>
<th>Aims of project</th>
<th>Project scope</th>
<th>ESOP personnel</th>
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<tbody>
<tr>
<td>Royal Prince Alfred Hospital, Sydney, NSW</td>
<td>Work with ED colleagues to enhance psychosocial care for mental health patients; timely intervention as soon after triage as possible; provide specialised nursing care; assist in streamlining care across services; facilitate access to medical care for mental health patients; increase awareness of mental health issues in the ED.</td>
<td>Take part in rapid assessment and information gathering in medical emergency cases (e.g. overdose) and with difficult patients. In other cases, conduct mental health assessment, implement treatment plan, liaise with other members of ED team; conduct information gathering; refer patients to psychiatry services in conjunction with medical officers; refer to ED-based outpatient Mental Health Nurse Practitioner (MHNP) clinic; discharge in collaboration with senior medical staff and MHNP and / or psychiatry consultant.</td>
<td>3 FTE shared across four positions with two nurses part-time and two full-time. Mental Health Liaison Nurses (MHLN) working in team led by existing Nurse Practitioner (NP), Mental Health Liaison position, in ED. Team will cover morning and afternoon shifts, seven days / week.</td>
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<tr>
<td>Wollongong Hospital, Wollongong, NSW</td>
<td>Expand the role of the mental health ED Clinical Nurse Consultants beyond consultancy to include supervision, practice improvement, service innovation, education and training, leadership and coaching.</td>
<td>Includes the development of standing orders for mental health CNCs based in the ED and delivery of brief interventions for people presenting with personality disorder, suicidal thoughts or self-harm. Includes improved assessment of consumers who meet the entry criteria for the Psychiatric Emergency Care Centre. Care provided includes mental health assessment; care coordination; planning, delivery and evaluation of education and training; liaison and consultation with consultation-liaison psychiatry team; and communication with non-ED-based mental health staff especially acute community mental health teams.</td>
<td>5 FTE existing Clinical Nurse Consultants (CNCs) currently working in the Wollongong Hospital ED.</td>
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<tr>
<td>Eastern Health, Melbourne, VIC</td>
<td>Timely triage and service provision through access to expert assessment and management; support for other ED staff; better transfer to primary care; potential to divert some mental health patients from ED; mentoring, supervision and competency training to mental health clinicians in ED.</td>
<td>Psychiatric assessment and diagnosis; physical screen and assessment; treatment plan; medication management; prescription of medications as authorised; ordering diagnostic tests; training, supervision and consultation to ED staff; research and evaluation; referral to other services; discharge to existing specialist or primary care providers or referral to new services.</td>
<td>Two FTE Mental Health Nurse Practitioners (MHNP) appointed to work across two ED sites in Eastern Health (Box Hill and Maroondah Hospitals). One position is a NP (candidate) and the other is an endorsed NP. Shifts spread over seven days / week.</td>
</tr>
<tr>
<td>Project site</td>
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<td>Project scope</td>
<td>ESOP personnel</td>
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<tr>
<td>Prince of Wales Hospital, Randwick, NSW</td>
<td>The &quot;4th Door Safety Net&quot; project aims to reduce waiting times and provide high quality service for patients who have traditionally waited the longest in the ED. These patients are already in the medical system, and include those who leave against medical advice, do not wait for treatment, and those requiring observation, and subsequent review. The project provides a booked review clinic within the ED to reduce unplanned representations and improve patient management.</td>
<td>Focus on low-acuity presentations e.g. limb injuries, minor burns and scalds, management of wounds, removal of foreign bodies, ear-nose-throat problems, minor dental, soft-tissue infections, mild to moderate asthma, gastroenteritis, urinary tract infections, chest infections, minor rashes and allergic reactions, bites and stings. Extended Practice Nurses will take a clinical history, conduct a focused clinical examination, order diagnostic tests (e.g. pathology, radiology) and provide treatment, including medications as authorised and coordinate discharge planning.</td>
<td>1.6 FTE experienced Registered Nurses (RNs) who are undertaking post-graduate study and have been assessed by the Medical Officer and deemed competent to work collaboratively within this model of care.</td>
</tr>
<tr>
<td>Murrumbidgee Local Health District, NSW</td>
<td>Extend skills and knowledge of Registered Nurses. Implement clinical pathways in ED in rural settings. Reduce ED waiting times for non-life-threatening illness and injury by enabling timely assessment and commencement of treatment in the event that a medical officer is not present.</td>
<td>This project focuses on higher volume non-life-threatening presentations, e.g. non-specific eye irritation, ankles, wrist and limb injuries, wounds and simple lacerations; diarrhea and vomiting and simple urinary tract infections. Scope will depend on individual nurse’s level of training, illness / injury severity, legal requirements, input from medical officers and senior clinical staff.</td>
<td>This project is training existing nursing staff based in the five implementation sites: Wagga Wagga Base Hospital, Tumut District Hospital, Wyalong Hospital, Batlow Multi-purpose Service, Tumbarumba Multi-purpose Service</td>
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<tr>
<td>Kilmore and District Hospital, Kilmore, VIC</td>
<td>Improve local services and decrease need for transfer to a tertiary hospital elsewhere. Educate and support Urgent Care Nurses. Support local GPs in managing demands of ED on-call and private practice work.</td>
<td>Nationally accredited training which is transferable, leading to enhanced capability to provide urgent, necessary care. Patients able to receive timely treatment at KDH, increasing convenience and decreasing transfers out. Sustainability built into model.</td>
<td>Six Registered Nurses (RNs), all tertiary qualified and AHPRA registered, with minimum five years’ post-registration experience. (Positions were advertised internally, with 11 applicants. Selected candidates had 22-33 years’ experience, including 3-10 years at KDH.)</td>
</tr>
<tr>
<td>Sunshine Hospital, VIC</td>
<td>Decrease waiting times and ED length of stay, moving towards achievement of target triage times and 4-hour National Emergency Access Target. Increase availability of medical staff for managing paediatric patients in triage categories 1-3.</td>
<td>Focus on minor illness and injury, e.g. abdominal pain, gastroenteritis, asthma, croup, urinary tract infection, ear pain, bronchiolitis, minor burns and wounds, limb injuries, minor head injuries. Nurses will assess patients, investigate, commence treatment, order diagnostic tests, and coordinate referrals and follow-up of patients under clinical guidelines and with medical supervision.</td>
<td>2.5 FTE Registered Nurses have been recruited from existing ED personnel. This FTE allocation is filled by four nurses.</td>
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<tr>
<td>Royal Children’s Hospital, Melbourne, VIC</td>
<td>This project aims to reduce length of stay, whilst maintaining quality and safety for a specific cluster of common conditions. Redistribute medical and NP resources. Expand the scope of ED nurses leading to improved careers and staff satisfaction.</td>
<td>Eligible patients have their records marked, “For Criteria Led Discharge” at triage. The patient is then seen by the ED nurse, and if discharge within 12 hours is likely, the appropriate CLD patient pathway is applied. If there are any concerns, the nurse contacts a doctor or NP. When criteria for discharge are met, the nurse completes a CLD form, a discharge letter for the patient’s GP, and gives the parents a fact sheet before discharging the patient home (with sign-off from a senior Registered Nurse).</td>
<td>All ED nurses (approximately 100 personnel) have received training, completed competency assessment and are undertaking the expanded scope of practice role as part of their normal practice.</td>
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</table>
7.2.3 Training pathways

At the time of this report several NED project teams do not have a documented training pathway. Each project team has indicated they will adopt an approach that is suited to their project scope and organisational context. Where project teams recruited appropriately qualified staff for the role, the initial focus on training has been about orientating new personnel to the ED and the specific ESOP role they are undertaking (e.g. RPAH and Eastern Health). Wollongong Hospital has provided a two-day 'Coaching for Performance' workshop with follow-up coaching sessions as well as structured in-service sessions on mental health recovery within the ED and Psychiatric Emergency Care Centre. The Chief Psychiatrist is providing education about the application of the NSW Mental Health Act (2007). The CNCs are also completing Inter Personal Management Aggression Training. All mental health Clinical Nurse Consultants have attended a program run by the University of Wollongong on brief intervention for personality disorder. It is also planned to provide additional training to support the knowledge and skills of the CNC to participate in ongoing professional development of themselves and others and provide improved carer and family participation in the ED.

POWH has been successful in attracting experienced nurses who are studying and working towards NP endorsement. As they already have a high level of clinical experience and have previously worked in the ED for many years, these practitioners are receiving medical mentoring from a Fellow of the Australasian College of Emergency Medicine, with additional support from a CNC. The medical mentoring is fundamental and builds trust in the ESOP role. The ESOP clinicians provide case presentations – this is a deliberate strategy to emulate the senior medical officer and junior medical officer training model in place at the hospital.

Murrumbidgee LHD has invested considerable effort in developing self-directed e-learning packages that build upon the previous training of nurses. For example all Registered Nurses working in rural EDs or Urgent Care Centres are expected to have completed the First Line Emergency Care Course (FLECC). FLECC is a state-wide, standardised course offered across the rural Local Health Districts in NSW, it is a six-month program with both a theoretical and clinical component. It is currently co-ordinated by the Emergency Care Institute NSW that is located with the Agency of Clinical Innovation and reports to the NSW Minister of Health22. The Kilmore and District Hospital project team have developed a modular training program that uses products available from other Registered Training Organisations or Universities. This is being run on site or through e-learning methods. This includes a two-day course in suturing with assessment of clinical competency; a one-day casting and immobilisation workshop with an additional four days clinical competency development and supervision and a one-day Ear Nose and Throat (ENT) training workshop provided with training by Visiting Medical Officers using an ear-examination simulator. The ESOP nurses are also hoping to complete a ten-week online course, offered by the University of South Australia for remote and rural x-ray operators, that includes two days of practical assessment. There may also be opportunity for the ESOP nurses to complete a Certificate 4 in Training and Assessment (this is offered as a sustainability strategy to build a core of personnel capable of training others).

Sunshine Hospital has provided ESOP nurses with a one-day course covering gluing and wound management, x-ray ordering and nurse-initiated medications. The four-day Paediatric Foundation Program in general paediatrics was provided on site by the Royal Children’s Hospital, Melbourne. All nurses have completed competency-based assessments and receive clinical mentoring from the Paediatric Emergency Physician based in the ED. The Royal Children's Hospital, Melbourne has developed three self-directed e learning packages that cover: criteria led discharge, respiratory assessment and hydration assessment. Nurses complete pre-knowledge questionnaires and then undertake this competency-based training. Once this has been satisfactorily completed, nurses then can apply the criteria led discharge pathways with appropriate patients.

No further detail is provided about the training program and its implementation, as this will be the focus of the second evaluation progress report.

7.2.4 Clinical governance

HWA has clearly articulated through the initial RFP documentation and subsequent Funding Agreements signed with NED implementation sites, an expectation that project teams will ensure appropriate safety and quality (including clinical governance arrangements) have been established. All project teams outlined their approach to clinical governance in their Project Plan and have provided additional information in their progress reports.

All NED projects are using the established clinical governance processes within their organisations so that ESOP clinicians work under the same clinical governance structure. This includes ensuring ESOP nurses have clear lines of professional accountability; understand policies and practices relating to clinical governance and monitoring incidents and adverse events. Most projects have applied accepted frameworks or guidelines for ethical and responsible practice or appropriate practice guidelines (refer to Table 5).

### Table 5 Examples of standards and guidelines applied in NED projects

<table>
<thead>
<tr>
<th>Project site</th>
<th>Standards / Guidelines</th>
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| Royal Prince Alfred Hospital, Sydney, NSW | Local RPAH clinical guidelines and policies, including:
Protocol for patients potentially at risk who leave prior to formal disposition; and Guidelines for the management of behavioural emergencies in the ED. |
| The Wollongong Hospital, Wollongong, NSW   | Competencies explicitly tied to Australian Nursing and Midwifery Council competency standards (2006). CNCs are expected to ensure they receive regular clinical supervision. Nurses involved in co-joint training and performance management on the use of standing orders for medication and physical investigations. |
| Eastern Health, Melbourne, VIC            | Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) provides a common language and standard criteria for the classification of mental disorders; ED Mental Health Nurse Practitioner Formulary |
| Prince of Wales Hospital, Randwick, NSW   | Frameworks for ethical and responsible practice based on the Australian Nursing and Midwifery Council (ANMC) National Competency Standards for the Nurse Practitioner. Nurses utilise medication standing orders and be guided by hospital protocols for extended practice nursing in the ED. |
| Murrumbidgee Local Health District, NSW   | Model is based on the Rural Adult Emergency Clinical Guidelines developed by NSW Health. Training may be followed by standard competency assessment and credentialing. Nurses utilise medication standing orders for pain relief, symptom control and tetanus prophylaxis including IV fluid administration where indicated on clinical pathways. |
| Kilmore and District Hospital, Kilmore, VIC| Good Practice Guidelines for rural x-ray operators being developed by Victorian Department of Health (Kilmore project manager is on reference group). Online course is designed to meet licensing requirements for rural x-ray operators in Victoria. |
| Royal Children’s Hospital, Melbourne, VIC | Criteria-led discharge flow charts, standard forms and discharge letters to patients’ GPs, standard information sheets for parents to take home. The HWA project is one of three CLD pathway projects currently running at RCH. |
| Sunshine Hospital, VIC                    | Nurses will refer to medical staff for diagnosis, ongoing treatment and discharge. |

7.2.5 Sustainability

At least two project teams indicated that their project may not identify an alternative funding stream once the HWA grant expires. During site visits, most NED project teams were able to identify strategies they were deploying during the set-up phase to improve conditions for project sustainability.

These included:

- Building the model of care and practice changes into the roles of existing permanently funded positions
- Appointing new ESOP personnel to permanent positions within the organisation (in some cases positions were offered permanent employment but not necessarily at the grade of the ESOP role)
- Ensuring high level stakeholder engagement from senior hospital executives and ED clinicians
- Developing training programs with the capacity for replication should staffing changes occur
- Linking with higher education providers to promote research into the ESOP role
- Changing hospital policy to embed practice changes
- Using existing clinical governance processes within the implementation sites to support the ESOP nurses
- Promoting inter-disciplinary collaboration and providing education about the ESOP role to other members of the ED health care team.

7.3 Progress in achieving objectives

The objectives for each sub-project were specified in the RFP documentation issued when proposals were first sought, these objectives were replicated with only slight amendment in the Funding Agreements developed for each project team. Each project has listed their objectives in their first progress report so they are not re-stated here.

Project documentation has been reviewed by HWA to ensure that:
- Project objectives align with program objectives
- Projects have in place strategies to address each objective
- Projects are making progress against their objectives i.e. projects are doing what they said they would do.

The focus for the national evaluation team during the set-up phase has been to ensure that:
- Local project evaluation plans align with project objectives and the national evaluation requirements.

The major strategy to achieve this has been developing the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools that together provide a blueprint for project teams to follow to encourage consistent data collection methods and provide tools that support both local and national evaluation requirements across all sub-projects. The Key Performance Indicators (KPIs) in the Evaluation Framework were developed with the input of all project teams through reviewing the performance measures included in their Project Plans and then asking them to critique the proposed sub-project KPIs at the first workshop. Most project teams have identified particular issues of interest to their organisation that they intend to monitor, these primarily relate to patient waiting time and other measures associated with patient flow improvements.

During the initial site visit project teams were asked to identify the existing information systems and data collections available within their organisation. All project teams were asked to insert a ‘flag’ within their patient information systems to enable easy identification of patients that would be seen by the ESOP practitioner. Discussions also addressed potential challenges with the extraction of data and ethical approval to release this data to the national evaluation team. Project leads were asked to identify the relevant contact people that the national evaluation team should work with to obtain the quantitative data required over the life of the project.

The national evaluation team developed a data specification to assist project teams and to improve data consistency across each sub-project. A Gantt chart was produced specifying the frequency and timing of data collection, who is responsible for collection and / or analysis and how each data source and evaluation tool maps back to the agreed KPIs within the Evaluation Framework.

The focus of the national evaluation team has been about constructing working relationships with the project managers; addressing questions relating to ethics approval issues and identifying early issues with data access and availability and reviewing existing evaluation tools.
The first or baseline data submission is due from project teams by 31 March 2013. This early submission aims to establish which sites have missing data elements and to streamline data collection processes for the subsequent data submissions due on 31 October 2013 and 30 April 2014. It also allows the national evaluation team to refine the data specification based on what items are commonly available and feasible to provide. All NED project teams have been cooperative and diligent in their efforts to provide the necessary data. For smaller sites with limited data and performance resources, this has been very challenging. The unique nature of each NED project has led to the requirement for some project teams to develop special purpose data collection processes, for some teams these are manual as they are unable to add fields to existing hospital information systems. The majority of NED projects have decided they will base their local evaluation on the national evaluation requirements. Several projects, particularly those based in large teaching hospitals, are conducting additional data collection and research activities in parallel. NED projects with limited access to data and evaluation support staff (particularly those project teams based in rural and regional areas) are seen as having higher evaluation support needs.

In summary projects are on track in addressing their objectives however in the following months more attention is needed to ensure local evaluation questions are being addressed and data collection processes align with the national requirements outlined in the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools.

### 7.4 Project management observations

These project management observations relate to the NED sub-project. Dwyer et al.\(^23\) (2004, p.20) have produced a framework, adapted from work by Belassi and Tukel\(^24\) (1996), which categorises project management success factors. This framework proposes four main categories of direct determinants of project success:

- **Commitment**: Is the organisation serious; is there a vision for the project and commitment to see it through? Is there commitment to manage the impact on stakeholders and partners?
- **Plan and design**: Is the project plan feasible, with achievable goals, strategies that can work good decision-making structures and outcomes that can be sustained?
- **Resources**: Are skilled people, enough money and the right material resources organised?
- **Project team**: Does the project team work well; is it able to manage the change required by the project and to communicate effectively with stakeholders?

Additional underlying factors that influence project success relate to the sector and organisation:

- **Sector** refers to the broader organisational context in which the organisation (and their project) sits.
- **Organisation** refers to the characteristics of the organisation including strategic directions, leadership, the organisational structure, and culture and people management practices also influence project management.

This framework is used to summarise the project management observations relating to the NED sub-project.

#### 7.4.1 Commitment

All project teams have demonstrated a strong commitment to seeing the project through to its conclusion. A signed Funding Agreement that specified a project completion date of 31 December 2013 has underwritten this. The NED projects have all worked hard to manage the impact on

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stakeholders and partners. For the project teams at Murrumbidgee LHD and Kilmore and District Hospital there has been a particular focus on engaging GPs and other primary care providers. Whilst all organisations indicated a commitment to continuing their respective projects beyond the funding period, already several project teams have indicated that they are under pressure to justify any recurrent funding allocation.

7.4.2 Plan and design

All project teams have produced a Project Plan, which include predominantly realistic objectives, strategies and project milestones. A couple of project teams have not yet developed adequate training pathways for the project as a whole but have been reviewing the training needs of individual ESOP nurses. The best evidence of good project decision making processes has been the capacity of project teams to move forward without alienating stakeholders. Whilst every project team has faced obstacles they have addressed these to the best of their capability. It is too early to determine whether project outcomes can be sustained. A problem raised by the Project Advisory Group is that most of the NED projects are not implementing a truly expanded scope of practice role but are rather encouraging nurses to work to their full scope of practice. This does not mean that projects are not innovative for the organisation they are based within, however not all projects can be said to be genuinely innovative for the nursing profession.

7.4.3 Resources

The NED project teams have invested varying levels of effort and resources into project management. Most projects have not allocated adequate time for project management (often this is a function of limited resources rather than limited will). Several project teams have clearly benefited from close senior executive involvement and leadership.

The project teams that have had to develop ‘in-house’ training programs have struggled to balance the demands of this workload with other project tasks during the set-up phase. A couple of teams who developed e-learning packages had no previous experience in this area and had to co-opt either internal experts (if available) or external support.

7.4.4 Project team

Project sites with very small teams have struggled, as there were so many different facets to the project that a team with diverse skills was needed to make it work. Those teams with a project lead or manager that was well known and respected in the organisation have fared best whilst those teams with limited engagement and direct support from senior managers have fared worst during the set-up phase.

All projects have now implemented project management mechanisms such as regular team meetings and monitoring and review processes. Several project teams will need to review the project management resources they have budgeted for the later stages of project evaluation, as they appear to underestimate the volume of work associated with production of their final report and project toolkit.

7.4.5 Sector

Every project team has been affected by the constant state of flux in the health sector, for example, changes in Ministerial portfolios in the Victorian State Government have occurred since projects commenced. It appears that there is limited jurisdictional involvement by State Health Departments in any of the NED projects, the only exception being Kilmore and District Hospital because of interest in their intent to train nurses to take x-rays. The Victorian Department of Health through their ‘Better Skills Best Care’ pilot projects has previously trialled nurse x-ray in Lorne Community Hospital.
7.4.6 Organisation

Most project teams have already experienced staffing changes within their organisation that have impacted upon the NED project, for example, project sponsors leaving the organisation or project leads / managers being promoted into other roles.

The support of senior nursing and ED personnel has been critical for every project as this sends a message to the wider workforce about the level of interest in the ESOP model of care. All projects have included an outline of their intended communications management approach in their Project Plans. None of the progress reports provided to date provide any explicit information about the change management approach adopted by project teams. Several project teams work in organisations where there is no standardised project management processes or resources. All project teams have described their workplace cultures as receptive to change; often this acceptance is influenced by the reputation of the project lead / manager.

7.5 Stakeholder engagement strategies

Through the project progress reports all NED project teams have provided evidence of stakeholder engagement. Stakeholders generally appear to be classified as internal to the organisation or external. The majority of this engagement has been of an internal nature with internal personnel such as nursing staff, ED staff, clinical / medical staff and mental health staff.

Engagement of external stakeholders appeared to be less common but included organisations that could assist the development of the project and the promotion of the project. There were some examples of effective external stakeholder engagement including work done by Kilmore and District Hospital with an external training provider. The hospital engaged with the Benchmarque Group, Southern Cross Training, University of South Australia and other Registered Training Providers, to implement nationally accredited training relevant to expanding the scope of practice of emergency nurses.

Several project teams provided examples of their engagement with the media. For example the Murrumbidgee LHD provided advice of media releases aimed at promoting the ESOP initiative in the local implementation communities. Kilmore and District Hospital had an article about the project in the local newspaper, and an article that is to be published in the Benchmarque Group newsletter.

Projects have used various mechanisms to engage with stakeholders including meetings, information sessions, staff information and training sessions and site visits. The formation of steering committees and working groups have been popular ways of engaging critical internal stakeholders as they have provided an opportunity for departmental representatives to be involved in the project through regular meetings and other contact.

RPAH and Wollongong Hospital have each invited a psychiatry representative to be a part of the implementation committee / team to foster improved relationships. The project team at Wollongong Hospital initially encountered some communication difficulties, particularly with internal stakeholders. This led to the enlistment of additional senior management support and further consultation and reviews of project scope to ensure issues were addressed.

Consumer engagement has been undertaken using several strategies. These have included the inclusion of consumer representatives in working parties, dissemination of project information through posters and flyers and media opportunities and patient / service user surveys. Eastern Health has used a survey of service users to help guide the development of the next stages of the project. There has been mixed success with some of these approaches. The Royal Children’s Hospital noted that while an invitation to the Quality Department for a consumer representative to attend the working party was made, a consumer representative was not appointed despite of repeated requests.
7.6 Barriers

Through project progress reports and during site visits, project teams reported on barriers they faced during the set-up phase of the program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The barriers identified by the NED project teams are presented under the following sub-headings:

- Role clarification
- Recruitment and training
- Communication and stakeholder engagement
- Resource issues
- Legislative and policy issues
- Evaluation issues

7.6.1 Role clarification

There are no lead sites in the NED sub-project; all are functioning as implementation sites. A few projects expressed some confusion about the role of HWA and appear to have not fully understood the terms of their Funding Agreement, particularly the requirement to develop a training pathway and supporting materials or their responsibility for producing a toolkit to aid project replication.

Wollongong Hospital felt there was a lack of clarity in relation to the expectations and details within the Funding Agreement, as these did not align with the proposal that was originally lodged. It appears that the project site wanted to develop a model of care and trial its implementation whereas HWA was clear that it would only fund the implementation of a pre-existing model of care. This project team acknowledged that they should have given closer scrutiny to these changes and undertaken further negotiation prior to signing the Funding Agreement. This change in expectations has created challenges in setting up the model of care and has contributed to delays in the achievement of project milestones.

Several sites were unaware that they were responsible for conducting their local evaluation in addition to contributing to the national evaluation. One site advised they had received ‘mixed messages’ about evaluation requirements believing their local plan had been endorsed by HWA early in the set-up phase to subsequently find they were expected to contribute to national evaluation requirements.

7.6.2 Recruitment and training

RPAH, POWH and Sunshine Hospital all recruited high calibre ESOP practitioners relatively easily. Whilst Eastern Health experienced some delays they achieved their goal of two highly experienced mental health nurses both engaged in the NP training pathway. Projects working with existing personnel such as Wollongong Hospital and Royal Children’s Hospital, Melbourne did not have the pressure of securing clinical staff.

At least half of the NED project teams had difficulty in securing an appropriately skilled project officer. The reasons for this included the unexpected resignation of project personnel, staff moving out of the project team because of promotion or an inability to attract any project officer applicants.

Delays in filling some project team positions at Murrumbidgee LHD subsequently created pressures for the development of the education and training program. The project team recognised that a Clinical Nurse Specialist needed to be included in the team to assist with training program development and implementation. This specific expertise was needed to ensure appropriate documentation of clinical competencies and clinical pathways and a 0.5 FTE has been.
appointed. This project team also had difficulty in obtaining appropriate information technology support to develop and implement their online education program. In the end they had to outsource the design to a contractor and work hard to ensure their information technology department would upload the modules to the organisation’s intranet. An unexpected barrier for Murrumbidgee LHD was local policy that prevented staff from accessing YouTube on the Internet, as this was a major component of the online education package and had to be addressed.

In some project teams ESOP practitioners reported being overwhelmed by the training expectations. Whilst in another site, the project team had more staff than they could manage competing to participate in the training program developed for the ESOP practitioners.

7.6.3 Communication and stakeholder management

POWH reported difficulties in getting stakeholder buy-in for the inclusion of mental health patients needing low-medical risk clearance in their project scope. After ongoing negotiations a decision was made to exclude this patient group from the project scope.

Murrumbidgee LHD worked with their Executive Director of Medical Services to devise a plan to engage GPs in the smaller rural towns selected for project implementation. A decision was also made to include a supportive GP on the Steering Committee. Most GPs working in smaller hospitals in the LHD are remunerated through a ‘fee for service model’. Where GPs were concerned about income and expenses there was limited support for the project, GPs seeking more balanced lifestyles and less call-outs after hours were pleased to hear of the project and keen for it to proceed. A small number of GPs have raised concerns about medical responsibility, accountability and liability and these are still being worked through with the LHD Executive Director of Medical Services and the Murrumbidgee Medicare Local.

The Royal Children’s Hospital, Melbourne discussed issues relating to potential change fatigue within the ED due to the recent raft of changes that had occurred with the relocation of services to the new facility and ongoing changes to service delivery models in the ED. The project team addressed this by early communication about the ED Criteria Led Discharge project in the set-up phase. They also capitalised on the existing inpatient Criteria Led Discharge project and through linking the ED initiative to this, a known entity, improved stakeholder acceptance.

7.6.4 Resource issues

The most common barrier raised by implementation sites in relation to resources has been adequate time for the project set-up phase. Most project teams underestimated the time that recruitment and ethics approval processes would absorb. This problem was exacerbated for sites that did not allocate enough resources to project management with one project commencing with a project officer for two days per week. Other tasks affected by the short set-up phase include recruitment, policy development, establishment of clinical governance processes and education design tasks. Many of these tasks could have been managed prior to commencing implementation of the model of care with a longer lead-in period.

RPAH identified that the competing demands of the tight evaluation timeline and high clinical load for the project lead created pressures. Ensuring adequate non-clinical time for project leads would address this barrier.

POWH reported concerns about the time required to manually link records relating to patients presenting by ambulance as booked cases (or non-emergency transports to the ED). This difficulty in getting data that accurately captured the patient journey was one factor that influenced the team’s decision to reconsider the inclusion of these patients in their patient target group. This team also identified that considerable time and resources was required in the set-up phase to resolve data quality issues and develop automated reports to allow monitoring of the project.
The Kilmore and District Hospital project team found the lack of Doctors on-call overnight (from 22:00 hours to 08:00 hours) a significant barrier as the ESOP Registered Nurses cannot assess, treat and discharge patients independently within their current scope of practice. After discussions with the HWA Clinical Advisor, the project team approached local GPs to see if they would agree to receive calls from ESOP Registered Nurses overnight if relevant patients present. The Clinical Advisor to the NED sub-project advised the project team to approach the medical team at the Northern Hospital ED to see if they would receive telephone calls overnight.

Royal Children’s Hospital, Melbourne identified the timing of the project set-up phase as a barrier. The first workshop did not occur until August 2012 and this coupled with the time required to get ethics approval and develop training resources and the contract requirement for 12 months of implementation meant that training occurred in January 2013. This is a holiday period when staff are taking annual leave but because the new rotation of medical officers commenced in early February, the project team were left with few options.

7.6.5 Legislative and policy issues

No legislative barriers have been identified during the set-up phase; however several policy barriers have arisen. The policy of Murrumbidgee LHD not to allow staff to access YouTube has previously been explained. Sunshine Hospital found the internal policy and procedure process a barrier to getting acceptance of clinical protocols for the ESOP nurses. The Scope of Practice Committee and Pharmacy Utilisation Committee both requested a series of changes, however this ended up being a circular process with protocols moving between committees without a clear path for resolution. This has been very frustrating for the project team.

7.6.6 Evaluation issues

The major barrier that has arisen relates to the time taken and complexity for some sites in gaining ethics approval. Both Murrumbidgee LHD and the Royal Children’s Hospital, Melbourne reported receiving conflicting advice from internal ethics and research governance advisors.

7.7 Enablers

Through project progress reports and during site visits, project teams reported on enablers they faced during the set-up phase of the HWA-ESOP program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The enabling factors identified by the NED project teams are presented under the following sub-headings:

- Collaborative development
- Project management support
- Stakeholder engagement
- Expanded scope of practice clinicians

7.7.1 Collaborative development

Early consultation with ED medical and nursing staff and collaboration in the review and development of the model of care and patient pathways was consistently reported as critical to success. Involving ED personnel in joint problem-solving has helped project teams to overcome obstacles during the set-up phase and including other clinicians in the process of clinical guideline development worked well in improving ownership of the project and producing better guidelines.

Several project teams have found the support from other teams within their organisation a positive enabler during the set-up phase. Eastern Health found that the support provided by their Quality Planning and Innovation team about service redesign principles and tools to track care provision and practice change extremely helpful.
Wollongong Hospital found that access to the Professor of Mental Health Nursing for project advice and support was beneficial as was her ongoing commitment to participate in the Project Steering Committee. Kilmore and District Hospital found external training suppliers that genuinely wanted to support what they saw as an interesting model of care. Capital Radiology, a private provider of radiography services, offered to provide assistance and training to support the capacity of nurses to provide x-rays.

7.7.2 Project management support

Those project teams that secured an experienced project manager appear to have experienced fewer difficulties during the set-up phase. Where project managers were recruited with limited experience, project management training and the provision of templates (such as the Progress Report Template and Compendium of Data Requirements and Evaluation Tools) were essential.

7.7.3 Stakeholder engagement

All project teams mentioned good engagement from ED nursing and medical staff as well as executive support as an enabler of success.

POWH identified the importance of a senior medical sponsor for medical support to cope with the challenges arising in the early project stages. The way this team managed the competition within their ED for space was positive – they changed two rooms with single patient beds into a space with multiple reclining chairs, which appeased ED clinicians concerned about losing space in the Fast Track area.

Sunshine Hospital ran a series of six education sessions for all ED staff on various aspects of the project to inform and communicate the 130 plus nursing staff in the ED. They also cited the supportive culture within their department and flexible attitude of staff to change as factors contributing to project success.

7.7.4 Expanded scope of practice clinicians

Several projects identified the calibre of the ESOP clinicians as a key enabler of project success. Teams recruiting to new positions felt they were getting motivated and energetic personnel who were receptive to change and enthusiastic about the project challenges – true ‘early adopters’.

At RPAH the mental health nurse practitioner presence was already established in the ED and this assisted considerably in integrating the new ESOP clinicians within the ED structure. This project manager’s extensive previous experience in conducting program evaluation research and the partnership with a Professor from the Sydney Nursing School, the University of Sydney will contribute to a robust project evaluation.

RPAH, Eastern Health and POWH all recruited experienced personnel and noted that the more time that ESOP clinicians spent on the floor in the ED the lower the anxiety amongst other members of the health care team.

One team reported that including ESOP clinicians with other personnel from ED in a joint workshop to develop practice guidelines enabled common understanding of the scope of practice and increased confidence in the project generally.

7.8 Reflections on project progress

In their progress reports, sites were asked to provide their reflections on the project’s progress – specifically, the lessons they had learnt, changes that should be made, and their most important achievements. These responses were analysed for common themes and integrated with findings.
identified by HWA and the national evaluation team through site visits, additional project documentation and ongoing contact with the project teams. The results are described below.

7.8.1 Lessons

Participants were asked, “What have you learned from the implementation and evaluation activities to date?” Responses to this question fell into one of three main themes:

- Model of care
- Communication and stakeholder engagement
- Timing and resources

Model of care
For many of the NED projects the model of care including the nursing role, needed to be explained consistently to the existing nursing and medical staff. Communication of the model of care needs to be ongoing with any modification to the model and as new staff join the organisation.

The importance of clarifying the project requirements, including project roles and responsibilities, HWA’s expectations and the local project site’s evaluation responsibilities, was stressed by some projects. As was the need to define what constitutes advanced or extended practice for nursing roles.

In the set-up phase, competencies and processes need to be well established to support the implementation phase of the projects. A period of supernumerary time (up to a week) where all ESOP practitioners could be oriented together, and spend time working with the ED staff prior to implementation commencing fully would be preferable.

Models of care reliant on NPs may be limited by the availability of endorsed NPs; consideration needs to be given to the national agenda regarding NPs for these models to be successfully transplanted across other health services nationally. The lack of a clearly articulated State or National Supervision framework for the nursing workforce has necessitated at least one project to develop a framework locally to support the Nurse Practitioner role.

Communication and stakeholder engagement
Communicating the project aims and objectives to the key stakeholders, so that they have a clear understanding of the project, has assisted in securing support and commitment from stakeholders. Ongoing and regular communication with all stakeholders will be integral to maintaining local ownership of these projects. The support from key senior medical and executive staff has been crucial to the development of the nursing roles and the initial success of the project.

The delay in announcement of the funding has impacted upon the communication strategy for several project teams, as they were unable to announce the project formally. This meant that at local collaborative meetings the project team were unable to identify the funding source and provide any detail about the role and expected project impact. A marketing strategy has been required within one organisation to increase the knowledge of the role as new and emerging nursing roles may not be well understood within the medical and allied workforces.

Timing and resources
In reflecting on what has been learnt during the set-up phase, most sites commented on the amount of time and resources involved. The amount of time allocated to the set-up phase was not sufficient for most NED projects.

The NED projects all have different models of care and for some this was a newly created role whereas other projects already had pre-existing roles or services that the project would be building on. This meant for some sites there was not enough time to set-up the project before they had to
start implementation. These projects were consumed by the start-up tasks and this reduced the time available for internal and external stakeholder engagement at the project start.

Several project teams found the workload in the set-up phase much greater than anticipated. For some projects this was exacerbated by project officers who, though enthusiastic and dedicated, were new to project management. Project management requires communication and organisational skills as well as confidence to get the project up and running. The project officer may possess these skills or alternatively they have been provided by other staff in the organisation. One project teams used healthcare redesign methodology to assist in the systematic implementation of the project and found this greatly increased awareness of the many steps, processes, people, resources and depth of communication necessary to successfully achieve projects aims and objectives and ensure sustainability. Overall a longer time frame is needed for the set-up phase.

Ongoing opportunities to consolidate and implement education and training need to be available for ESOP nurses to be confident to implement their extended roles.

7.8.2 Changes

Responses to the question “Based on what you have learned, will you make any changes?” largely mirrored the themes identified in the previous section. The key message was the importance of being able to refine the project and make changes as issues arose and lessons were learned during the set-up phase. In the set-up phase the projects have been adapting and modifying their models of care to ensure the most effective outcomes. For example, one project adjusted the scope of their project (number of sites and pathways) and other projects have modified their activities based on preliminary data such as peak times for staff rostering. One project suggested to ‘start smaller and expand was the way to go’. A number of sites responded that they would ensure that stakeholder involvement and engagement occurred earlier in the process.

The NED projects are higher risk because of their diversity. In the future the Clinical Advisor should be involved at the point of project selection so that any concerns about scopes of practice included by project proposals can be identified.

Developing and implementing a competency based training program is time consuming and resource intensive. The timing and duration of training activities needs to be carefully planned and reviewed after implementation to identify if any changes are warranted. Frequently smaller organisations have limited resources to support ‘in-house’ program development.

Finally back-up staff resources should be identified early during the set-up phase to support project implementation in the event of planned leave and unexpected absences.

7.8.3 Achievements

Participants were asked “What are the project’s most important achievements so far?” and provided responses as follows:

- Establishing a clear model of care and gaining endorsement for its implementation
- Engaging and maintaining effective senior medical and executive staff support for the model of care
- Recruiting skilled and experienced nursing staff
- Developing and / or implementing the training programs
- Establishing clinical guidelines and pathways
- Increasing engagement with key stakeholders through membership of steering committees
- Unifying nursing, medicine and allied health to improve follow-up patient care
- Obtaining local ethics approval for the project
- Commencing data collection
- Maintaining energy and enthusiasm for project implementation.
8 The project set-up phase: Extending the Role of Paramedics (ERP)

The data sources for this section of the progress report include all documentation received from project teams to date; for example, implementation plans and progress report 1 for the ERP sub-project. This has been synthesised with findings from the site visits conducted by HWA and the national evaluation team as well as the records of communication with project teams and the Paramedic Reference Group (PRG).

As HWA has all individual project documentation this information is provided as a summary only with findings and recommendations addressing the common themes and issues that have collectively arisen at the sub-project level.

8.1 Project description

This sub-project will support the implementation and national transfer of key success elements identified from an existing Extended Care Paramedic (ECP) metropolitan model developed by the South Australian Ambulance Service (SAAS) at several sites across Australia. The capacity of sites to customise the model to meet local needs and conditions is likely to be particularly important as ambulance services are structured differently in most States and Territories. The paramedics participating in this initiative are expected to be at the level of an Intensive Care Paramedic. The academic level associated with this quantum of knowledge and problem solving abilities equates to a Graduate Diploma or equivalent25.

According to the RFP documentation:

‘Extended Care Paramedic’ is based on the description of a South Australian Extended Care Paramedic (ECP). It is an experienced paramedic at intensive care paramedic or equivalent level who has subsequently gained extra expertise in evaluation and assessment of complex clinical and social/environmental situations. The ECP has advanced problem solving and negotiating/communicating skills. ECPs work as an integrated part of a multidisciplinary care team, utilising their assessment, problem-solving and communication skills to ensure that the consumer receives the right care delivered in the right situation at the right time by the right members of the health care team.’

In summary this project will focus on extending the competencies and capabilities of paramedics (at South Australian ICP equivalent level) to provide, in collaboration with other health care professionals, emergency health care to consumers in their usual residence wherever appropriate. It aims to be complementary to the primary care delivered by the consumer’s usual General Practitioner. The ECP has the specific focus of providing alternative care pathways for patients and reducing unnecessary transport to hospital.

The objectives of this sub-project are to:

- reduce costs to the health system associated with ED presentations or early entry into aged care facilities that could be more effectively and appropriately managed in the patients’ usual place of residence, and involves the patients’ usual GP wherever possible;
- increase the capability and capacity of aged care and community health professionals to deliver quality care in the patients’ usual place of residence;
- minimise disruption to patients, their carers and family by providing high level care in their usual residence where appropriate;
- increase career pathways and retention strategies for paramedic professionals.

This project aims to support the national transfer and further implementation of critical elements of an existing Extended Care Paramedic model\(^{26}\).

There are five project implementation sites underway:
- ACT Ambulance (Canberra)
- Ambulance Tasmania (Launceston)
- St John Ambulance Northern Territory (Darwin)
- South Australian Ambulance Service (Mt Gambier / Limestone Coast)
- South Australian Ambulance Service (Port Lincoln / Eyre Peninsula)

### 8.2 Model of care

All project implementation sites are in essence delivering the same model of care however adaptations have been made to address the different contexts of each organisation and locality. For example, the South Australian sites are able to leverage off the experience of the Adelaide metropolitan service that has implemented the ECP role since the pilot project commenced in December 2008. However the rural location of both Port Lincoln and Mt Gambier has resulted in different project implementation challenges.

For all other project sites, the ECP model of care is a new initiative that has not previously been implemented in any of their organisations. The SAAS model provided a starting point for the other project teams however every implementation site has had to modify the model to suit their available workforce, organisational needs and local health service infrastructure and context.

The focus of the ECP model of care is on lower acuity patients who do not require emergency care and are usually classified as ‘non priority complaints’. Whilst these cases are not emergencies in the traditional sense of lights and sirens, they may be complex and require the ECP to apply advanced clinical reasoning. The ECPs will attend cases that are frequently classified as ‘sick person’ when the person may have multiple chronic conditions and present as generally unwell. Patients receive more tailored care and if needed, will be managed in collaboration with other health professionals. Each project team has identified the scope of practice for their ECPs through the development or adoption of Clinical Practice Guidelines. These guidelines reflect the previous experience of sites that have implemented the ECP model, the implementing organisation’s existing guidelines for paramedics and local population health needs and service development opportunities e.g. wound care including suturing and managing skin tears, assisting palliative care patients with break through pain, non-routine replacement of urinary catheters etc.

All project sites (with the exception of Port Lincoln) have procured and equipped a vehicle specifically for ECP use. Whilst SAAS provided standard guidelines on the recommended equipment, each site has revised this given local supplies and preferences. Engaging the ECPs in the equipping and set-up of the vehicle has been important in assisting their transition to working with a non-transport capable vehicle.

The ECP model of care offers a different career pathway for experienced paramedics and may assist in retaining highly skilled paramedics who are bored or burnt out by the emergency responder role and / or have an interest in providing more holistic care. Alternatively it also offers a means of challenging and engaging experienced paramedics based at small stations that may not see a high volume of emergency cases and are looking for ways to maintain their clinical skills.

Five elements of the model of care are briefly discussed in the following sections: project scope, recruitment and staffing, training pathways, clinical governance and sustainability.

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\(^{26}\) HWA Request for Proposals: Extending the Role of Paramedics RFP Number: HWA-RFP/2011/015.
8.2.1 Project scope

The ACT Ambulance project is based in an urban environment with the ECP team working within a 25km radius of Canberra. There is a major teaching hospital, The Canberra Hospital, and well developed primary care services such as a ‘Walk-In Centre’ for ambulatory patients. ECPs will not go to the three custodial facilities or police stations as they are all serviced by Justice Health who provides nursing and medical cover. The ACT has a higher socio-economic status generally and residents have good access to both public and private health care. ACT Ambulance is not part of the ACT Health Directorate but along with the ACT Fire Brigade, ACT Rural Fire Brigade and State Emergency Service forms part of the Emergency Services Agency, which is based within the Justice and Community Safety Directorate. The ECP model will operate in addition to the existing emergency response crews with the ECP team using a specially equipped vehicle that does not have patient transport capability. Patients will primarily be seen in their usual residence, which may include residential aged care facilities.

Ambulance Tasmania is basing their ECP initiative in Launceston. The ECPs will operate across a 50-75km radius from the city extending to the smaller outlying hamlets of Georgetown and Longford. Launceston General Hospital is a 300-bed public hospital that provides acute care facilities for residents of Launceston and the northern region of Tasmania: it has a newly redeveloped Emergency Department. There is one Medicare Local that encompasses the entire State. Like many regional areas in this State GPs are under pressure from increasing patient demands. Ambulance Tasmania lies within the Department of Health and Human Services. The ECP model will operate in addition to the emergency response crews with the ECP team using a specially equipped vehicle that does not have patient transport capability. Patients will be seen in their usual residence, including residential aged care facilities and potentially in outlying small primary care or community health settings when access to an ECP is appropriate.

St John Ambulance Northern Territory (SJANT) (a self-funding charitable organisation) provides ambulance services to Territorians on behalf of the Northern Territory (NT) government. This arrangement is administered through a five year contract. All emergency services communications are co-located with St John communications personnel working alongside Police and Fire Service communicators. Royal Darwin Hospital has 363 beds and is recognised as Australia’s National Critical Care and Trauma Response Centre. It is administered by The Top End Hospital (and Health) Services Board. The NT Medicare Local encompasses the entire Territory. The ECP service plans to operate in the greater Darwin region (within a 90km radius). The project will not provide services to the immigration detention centres within and on the outskirts of Darwin. Due to the demography of Darwin the ECPs will see a high proportion of indigenous cases with the ambulance service already engaged with Bagot Community (an Aboriginal community within Darwin that includes a health centre) and Danila Dilba Health Service (that provides primary care services in the Darwin and Yilli Rreung region). There is one GP Super Clinic in the NT and this is based at Palmerston. The ECP model will operate in addition to the emergency response crews with the ECP team using a specially equipped vehicle that does not have patient transport capability. Patients will be seen in their usual residence, including residential aged care facilities and a proportion of patients are likely to be homeless and treated in collaboration with crisis care accommodation, Aboriginal health services or even in the outdoor area they reside.

The South Australian Ambulance Service (SAAS) at a corporate level, ultimately reports through SA Health to the Minister for Health. SAAS has a regional office in Mt Gambier where one ECP project is based, the other project is being implemented in Port Lincoln. The Mt Gambier / Limestone Coast ECP project will operate within a 1.5 hour radius of Mt Gambier, extending to the regional communities of Millicent, Penola and possibly as far as Naracoorte. Mt Gambier Hospital is part of Mt Gambier and Districts Health Service and is co-located with Mt Gambier Community Health. Mt Gambier is the general hospital for the South East. Three smaller GP-supported hospitals (Millicent, Naracoorte and Penola) provide basic health services to local communities and feed into the general hospital for additional services. Mt Gambier Hospital
receives most of the high acuity cases as well as supporting the low acuity cases from the surrounding districts. The ECP crew will not provide emergency response and is supernumerary to the emergency crew. It will be tasked to appropriate cases through the Emergency Operations Centre based in Adelaide (this Centre takes 000 calls for the entire State). The ECP model will operate in addition to the emergency response crews with the ECP team using a specially equipped vehicle that does not have patient transport capability. Patients will mostly be treated in their usual residence, including residential aged care facilities, and may be based in smaller outlying regional communities with limited access to primary care.

**Port Lincoln** Hospital and Health Service is part of the Eyre and Western Health Services. The hospital includes a modern 50 bed complex complete with high dependency unit, renal dialysis and operating facilities. The ED operates 24 hours per day. In Port Lincoln the ECP paramedics will also operate as part of the emergency response crew and they are the only ECPs that will use a vehicle that has patient transport capability. The ECPs will operate in a 1.5 hour radius of Port Lincoln servicing the surrounding regional areas of the Eyre Peninsula. The ECP functions as a first and second responder and the model of care is integrated with the emergency response model. The primary method for case referral is through the Emergency Operations Centre. Patients will mostly be treated in their usual residence, including residential aged care facilities, and may be based in smaller outlying regional communities with limited access to primary care.

Table 6 below summarises some of the practice changes common to the five ECP project sites.

**Table 6 Common ERP sub-project practice changes and project sites' progress**

<table>
<thead>
<tr>
<th>Extended Care Paramedic model of care changes</th>
<th>Summary of progress all project sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>ECP patient flag</td>
<td>A fundamental element of the SAAS ECP model is the location of an ECP in the Emergency Operations Centre to flag ECP cases and ensure they are directed to ECPs in the field. Ambulance Tasmania has reviewed the relevant algorithms used by their Communications Centre so that a flag is raised for potential ECP cases. SJANT has based ECP expertise in their Joint Emergency Services Centre.</td>
</tr>
<tr>
<td>Clinical practice guidelines</td>
<td>All sites had existing CPGs used by other paramedics in their service and these in combination with the SAAS guidelines provided a starting point. There is now a customised set of ECP CPGs in four Australian States and Territories. The CPGs are a critical element of the ECP training pathway as they identify the additional clinical practices that ECPs perform and define the scope of practice.</td>
</tr>
<tr>
<td>Point of care testing</td>
<td>SJANT and SAAS Mt Gambier and SAAS Port Lincoln have the capacity to undertake point of care testing. This can be used for example to check electrolyte levels, troponin levels (the troponin test is a blood test that detects small degrees of damage to heart muscle) and INR - a test of blood clotting. ACT Ambulance Service and Ambulance Tasmania have not yet implemented point of care testing.</td>
</tr>
<tr>
<td>Provision of medications</td>
<td>Intensive Care Paramedics already have capacity to provide a wide range of medications when treating a person in an emergency response. The drug formulary used by ECPs is more extensive and review and approval by the appropriate clinical governance committee has been necessary in most sites. All project teams are implementing the ECP drug formulary.</td>
</tr>
<tr>
<td>Transport not required</td>
<td>ACT Ambulance Service, Ambulance Tasmania and SAAS all have clear policies in place that permit paramedics to determine if transport is not required; ECPs will therefore be able to refuse to transport a patient if this is unnecessary. SJANT is more likely to transport the patient if they insist on being taken to a hospital ED; this is largely because of the large indigenous population and high level of comorbidities seen in many patients.</td>
</tr>
<tr>
<td>Primary care referral</td>
<td>All project teams are working to establish primary care referral pathways appropriate to their local service delivery context. This is time consuming and requires well developed networks.</td>
</tr>
</tbody>
</table>

### 8.2.2 Recruitment and staffing

The recruitment for each ECP project was managed internally by the respective sponsoring organisation. Each project team had a copy of the SAAS position description for reference but this was customised by all sites to ensure it aligned with their own human resource practices and industrial classifications. Most project teams recruited Intensive Care Paramedics (ICPs) – the ICP qualification equates to a Graduate Diploma. There was a general view that ICPs, if available, had the best mix of skill and experience for this role. All ECP positions are supernumerary to the usual rostered crews.
All project teams have commenced their service with the primary source of patient referrals directed through their 000 communication system. SAAS has an ECP based in the Emergency Operations Centre 24/7 to assist with identifying cases suitable for ECP crews. As this Emergency Operations Centre covers the entire State of SA the projects in Mt Gambier and Port Lincoln have been able to utilise this service. The role of the clinician in the ACT Ambulance Service communications centre will change to manage referral of cases to the ECP. All sites are developing secondary referral processes that vary from emergency response crews arriving at a case and determining that it is suitable for the ECP, through to a system for two way referral from a specific group of primary care providers.

**ACT Ambulance** received approximately eight applications for four positions following an internal expression of interest with four personnel selected. They received one appeal that was managed through their usual human resource process. All ECPs are highly experienced and ICP trained and highly familiar with the operations of ACT Ambulance.

**Ambulance Tasmania** had a very short window in which to recruit their ECPs. This was a result of the strategic decisions to move the project location to Launceston early in the set-up phase and to utilise the SAAS training program which was due to start. The project team had approximately 48 hours to manage the selection process with two ECP candidates recruited from 16 applicants. Both ECPs are highly experienced and ICP trained, one is currently based within Launceston and the other re-located to Launceston to take up the ECP role.

**St John Ambulance Australia NT** decided to build the ECP role into their current staffing structure and convert the existing Station Officer role into an Extended Care Station Officer (ECSO). The Station Officer is rostered 24/7 and provides back up and support to general ambulance crews and assesses non-transport situations. As there are only ten ICPs in Darwin and approximately 100 paramedics across the Territory, the pool of ICPs that SJANT had to recruit from was too small. They widened their entry criteria to include qualified paramedics with a minimum of two years post-graduate experience. They received seven applications and recruited four ECPs with two recruits intensive care trained. The ECSO position represents a significant pay rise for a non-ICP but has a lot more operational responsibility, it was the belief of SJANT that the seniority associated with the ECSO position would improve patient recruitment and management. This meant a transparent and open recruitment process was highly important. SJANT are planning to do a second round of recruitment and training mid-year.

The **SAAS Mt Gambier** project team used a clear and detailed selection process based on the established merit-based selection processes of SAAS. They recruited three ECPs from a possible pool of eight ICPs based in Mt Gambier. The ECP scope of practice carries a higher degree of autonomy and responsibility than the ICP scope of practice. The decision and outcome requirements of the ECP role have a higher degree of risk over a longer time frame than standard ambulance practice with an expectation that the ECP will make autonomous clinical decisions that will encompass immediate treatment and transport options as well as ongoing treatment plans and referrals to other health services. All ECPs are currently based within Mt Gambier.

The **SAAS Port Lincoln** project team originally intended to recruit six ECPs but was only able to recruit two ECPs initially with a third currently undergoing training. As there were only six ICPs that were eligible to apply from within the region, the project team planned that should the available selection pool not produce any successful applicants, the application process would be opened up to eligible ICPs across the organisation. A second expression of interest was recently issued but did not attract any additional recruits. The combination of the first and second responder roles into the one position may have been a factor in the limited recruitment success as this combined role will inevitably have a higher utilisation rate than paramedic positions trained only as the first or emergency responder.

Table 7 provides a brief summary of the ECP recruitment outcomes and hours of operation established by project teams, during the set-up phase. Most project teams analysed the volume
and pattern of non-emergency calls over the 24 hours period and seven days of the week, prior to determining the ECP’s hours of operation. Several project sites estimated that approximately 20% of cases attended to by emergency response teams did not require transport. For example, in several locations overnight calls were less frequent with the afternoon and early evening the peak demand periods for non-emergency response.

Table 7  Summary of ECP recruitment outcomes and hours of operation

<table>
<thead>
<tr>
<th>ECP project</th>
<th>Qualification</th>
<th>Number of ECPs recruited</th>
<th>Hours of operation</th>
<th>Roster</th>
<th>ECP commencement</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Ambulance Service</td>
<td>ICP</td>
<td>4</td>
<td>10am – 10pm</td>
<td>ECPs work 7 days per week</td>
<td>14 January 2013</td>
</tr>
<tr>
<td>Ambulance Tasmania</td>
<td>ICP</td>
<td>2</td>
<td>10:30am – 10pm</td>
<td>ECPs work to an 8 day cycle; 4 days on and 4 days off</td>
<td>14 January 2013</td>
</tr>
<tr>
<td>St John Ambulance NT</td>
<td>Mixed</td>
<td>4</td>
<td>11am – 11pm</td>
<td>ECPs work to an 8 day cycle; 4 days on and 4 days off</td>
<td>13 March 2013</td>
</tr>
<tr>
<td></td>
<td>50% of ECPs are ICP trained</td>
<td>(Training 1 - 2 reserves)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SAAS Mt Gambier</td>
<td>ICP</td>
<td>3</td>
<td>7am – 7pm</td>
<td>ECPs work 7 days per week</td>
<td>31 December 2012</td>
</tr>
<tr>
<td>SAAS Port Lincoln</td>
<td>ICP</td>
<td>3</td>
<td>Day shifts 8am – 6pm</td>
<td>ECPs work a varied shift roster and may be available on either day or night shifts</td>
<td>31 December 2012</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(1 ECP still in training)</td>
<td>Night shifts 6pm – 8am</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.2.3 Training pathways

Two different approaches have been taken to training the ECPs. SAAS, because of their previous experience in conducting training for the metropolitan ECPs, offered to include ECPs from other project teams in their training program which commenced in October 2012.

ACT Ambulance, Ambulance Tasmania, SAAS Mt Gambier and SAAS Port Lincoln all participated in the training program developed and implemented by personnel from Educational Services, experienced ECPs and content experts working within SAAS. Significant clinical input was provided by Professor Hugh Grantham, from Flinders University. The face-to-face sessions occurred in Adelaide during mid-October 2012.

ACT Ambulance and Ambulance Tasmania both elected to take advantage of this opportunity and sent their ECPs to Adelaide to participate in the four week didactic training component. The SAAS program includes a series of clinical placements and period of mentoring with experienced metropolitan ECPs that extends for four weeks. ECPs from ACT and Tasmania returned to their local project sites for the clinical placement experience however were unable to benefit from mentoring from other ECPs as they are the first ECPs in their State and Territory.

The ACT Ambulance Service Education Unit developed ACT specific elements of training and coordinated the clinical placements that extended for a four week period at the conclusion of the four week didactic training period.

Ambulance Tasmania organised a six week period of clinical placements that extended from early November to mid December 2012. During this period three in-house training days occurred as well as an extensive range of community based placements including: community nursing, palliative care, community dementia care, aged care and GP clinics. A four day placement with Launceston General Hospital provided a diverse range of nursing, allied health and pathology experiences in addition to one day with the Diabetes Centre at Northern Integrated Health Centre.

Medical mentoring (an important component of the SAAS, ACT Ambulance Service and Ambulance Tasmania training programs will be addressed in Section 8.2.4 Clinical governance).
All SAAS candidates participating in the training pathway were expected to complete an examination and oral viva conducted by the clinical lead.

The ECPs from Mt Gambier and Port Lincoln followed this four week period of lectures with two weeks of clinical placements in Adelaide followed by two weeks of clinical placements in their local regional area. This was followed by a four week internship period which included a one week rotation with an experienced ECP in metropolitan Adelaide.

Some examples of clinical placements included: the Accident and Emergency Department of Mt Gambier Hospital, community nursing, palliative care, residential aged care and GP placements etc. The ECPs also spent several shifts with Nurse Practitioners in EDs in larger hospitals in central Adelaide. The ECP ‘Clinical Internship’ is a model of support and clinical development that aims to facilitate the ECP Intern towards professional clinical practice, a fundamental part of this approach to skill acquisition is the provision of clinical practice guidelines27.

**St John Ambulance Australia NT** pursued a different training approach as they had a pre-existing contract with Edith Cowan University (ECU) which included provision for the ECP training. The training was provided through a combination of distance education, in class teaching conducted in Darwin by ECU educators (during mid-December 2012) and clinical placements in WA before returning to Darwin for further placements. The course includes six modules and the program has been facilitated by ECU’s Paramedical Science program in partnership with SJANT. On completion of the unit assessments students are eligible to claim up to four units within the Master of Science (Paramedical Science) or to elect to be awarded a Graduate Certificate.

The students worked through six online learning modules and attended a two week intensive class room program. This was supplemented with 120 – 160 hours of clinical placement which included two weeks at Fremantle Hospital and where possible a further 1 – 2 weeks in a large GP clinic in Darwin and / or an Aboriginal health clinic where possible. Assessment occurred through compilation of a portfolio that included an assignment, two reflective case studies and the use of a clinical log to demonstrate competencies in several clinical domains.

All costs of training (including any associated travel and accommodation expenses) have been met by the ECP’s employing organisation. At the time of this report all project teams have completed their face-to-face training programs with several in the final stages of clinical placements and supervised medical mentoring sessions.

Clinical placements were consistently identified as a critical component of the training program, not just because of the practical experience and insights they provided but because of the contacts and relationships they generated.

Ambulance Tasmania provided an interesting insight when one ECP discussed a palliative care patient he was called to see after hours. As the ECP had spent a day during their clinical placement with local palliative care physicians, he was a known face and had also been given the mobile numbers of the physicians. The ECP was able to contact the relevant specialist directly and streamline the patient’s care. The ECP felt that the clinical placements had helped to build professional respect for the ECP role.

No further detail is provided about the training programs and their implementation as this will be a focus of the second evaluation progress report.

### 8.2.4 Clinical governance

Clinical governance has been defined by Phillips et al. (2010) as follows:

27 Internal documentation: ‘SAAS ECP Internship Portfolio’, provided by SAAS Mt Gambier project team.
Clinical governance is a systematic and integrated approach to ensuring services are accountable for delivering quality health care. Clinical governance is delivered through a combination of strategies including: ensuring clinical competence, clinical audit, patient involvement, education and training, risk management, use of information and staff management.28

HWA has clearly articulated through the initial RFP documentation and subsequent Funding Agreements signed with sites, an expectation that project teams will ensure appropriate safety and quality mechanisms (including clinical governance arrangements) have been established. All project teams addressed their approach to clinical governance in their Implementation Plan and have provided additional information in their first progress report.

The project teams have taken a similar approach to clinical governance for the ECPs. In the first instance they have built on the clinical governance policies, processes and practices already established within their organisation and where possible integrated the clinical governance requirements of the ERP project into existing organisational processes. For example all project teams work in organisations where retrospective clinical audits are routinely completed for a proportion of cases. As the project implementation proceeds several project teams have advised they are considering setting up additional ECP specific clinical governance mechanisms. These vary from ECP peer review of cases through to a clinical audit process that focuses on only ECP cases. Several project teams have clinical coordinators, clinical support officers and / or experienced operations managers that provide assistance and advice in the field 24 hours per day. In addition project teams have established a local clinical coordination / governance committee for the ECP project and most are also reporting to established Clinical Governance Committees within their organisations.

Across all project sites, investment in clinical practice guidelines adapted for the local context and clinical governance framework; has provided the foundation for the ECP model of care and defined the scope of practice. All jurisdictions had existing clinical practice guidelines for paramedics and whilst the SAAS clinical practice guidelines provided a useful starting point for ECP specific guidelines, these were adapted by other project teams to ‘fit’ the local operational context.

The medical mentor has a critical role in providing ongoing support and clinical supervision and if necessary telephone advice and back up for the ECP in the field. Ideally this clinician has experience in pre-hospital care. This is a fundamental aspect of clinical governance for this model of care. The approach adopted has depended on local resources with ACT Ambulance Service taking advantage of an existing relationship with the Capital Region Retrieval Service based in ACT for this support. Ambulance Tasmania has a Medical Director, General Practice and Primary Care who will assist with medical mentoring and has also liaised with local GPs to secure their supervisory support for ECPs. SJANT employs a medical director 2.5 days per week who provides this support as well as a medical advisor. The SAAS Mt Gambier project has been able to engage the Director of Emergency Medicine at Mt Gambier Hospital as a clinical mentor to the ECPs with the Medical Officer on duty in the ED available to provide emergency clinical advice. The SAAS Port Lincoln ECPs are supported by local GPs who provide clinical training and development and clinical liaison. It has been proposed that emergency clinical advice will be provided by the GP on call.

As all project teams are providing episodic care, a clear referral pathway is needed to ensure that patients requiring follow up have access to appropriate primary health care. The process for ECPs to arrange follow up appointments with GPs or other community providers and communicate details about the care they have provided, through discharge summaries, is unique to each site.

8.2.5 Sustainability

During site visits, all project teams were able to identify strategies they were deploying during the set-up phase to improve the conditions for project sustainability.

These included:

- Documenting their model of care and Clinical Practice Guidelines and developing in-house training to support the implementation of these Guidelines
- Securing adoption of these Clinical Practice Guidelines through existing corporate approval processes so they are embedded within the organisation and become ‘business as usual’ for ECPs
- Ensuring the ECPs were either permanently appointed or at the very least signing personnel to a contract that included provision for their continuation in a role at a similar level should project funding be discontinued
- Understanding what evidence senior executives would require to commit to appropriate ongoing funding and ensuring their local evaluation and/or national evaluation requirements addressed this
- Communicating widely and consistently within the organisation to generate ownership and buy-in of the ECP model of care
- Working to generate stakeholder engagement and community ownership of the ECP model through disseminating information about early wins, using available media, securing local clinical placements and establishing collaborative project structures
- Monitoring ECP satisfaction with the role and identifying a backup cohort in the event of attrition

8.3 Progress in achieving objectives

The objectives for each sub-project were specified in the RFP documentation issued when proposals were first sought, these objectives were replicated with only slight amendment in the Funding Agreements developed for each project team. Each project has listed their objectives in their first progress report so they are not re-stated here.

Project documentation has been reviewed by HWA to ensure that:

- Project objectives align with program objectives
- Projects have in place strategies to address each objective
- Projects are making progress against their objectives i.e. projects are doing what they said they would do.

The focus for the national evaluation team during the set-up phase has been to ensure that:

- Local project evaluation plans align with project objectives and the national evaluation requirements.

The major strategy to achieve this has been developing the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools that together provide a blueprint for project teams to follow to encourage consistent data collection methods and tools that support both local and national evaluation requirements across all sub-projects. The Key Performance Indicators (KPIs) in the Evaluation Framework were developed with the input of all project teams through reviewing the performance measures included in their Implementation Plans and then asking them to critique the proposed sub-project KPIs at the first workshop. Most project teams have identified particular issues of interest to their organisation that they intend to monitor, for example, the SAAS projects are both interested to know if the ECP role assists with reducing inter-facility transfers between smaller outlying community hospitals and larger regional centres like Mt Gambier and metropolitan Adelaide.
During the initial site visit project teams were asked to identify the existing information systems and data collections available within their organisation. All project teams were asked to insert a ‘flag’ within their patient information systems to enable easy identification of ECP patients. Potential challenges with the extraction of data and ethical approval to release this data to the national evaluation team was also discussed. Project leads were asked to identify the relevant contact people that the national evaluation team should work with to obtain the quantitative data required over the life of the project.

The national evaluation team developed a data specification to assist project teams and to improve data consistency across each sub-project. A Gantt chart was also developed specifying the frequency and timing of data collection, who is responsible for collection and/or analysis and how each data source and evaluation tool maps back to the agreed KPIs within the Evaluation Framework.

Across all ERP projects there has been a limited focus on both local and national evaluation requirements during the set-up phase. This is understandable given the pressures upon project teams to recruit their ECPs, procure and equip their vehicle, develop clinical practice guidelines and appropriate clinical governance processes and finalise the training pathway for the ECPs. The focus of the national evaluation team has been about establishing constructive working relationships with the project leads; addressing questions relating to ethics approval issues and identifying early issues with data access and availability.

The first or baseline data submission is due from project teams by 31 March 2013. This early submission aims to establish which sites have missing data elements and to streamline data collection processes for the subsequent data submissions due on 31 October 2013 and 30 April 2014. It also allows the national evaluation team to refine the data specification based on what items are commonly available and feasible to provide.

The majority of projects have decided that they will base their local evaluation on the national evaluation requirements. Some projects (particularly those with existing partnerships with academic institutions) are considering their capacity to implement additional local evaluation activities. One or two projects appear to have been overly ambitious in proposing to evaluate changes in patient outcomes and the impact of the ECP initiative on hospital attendance and/or admission reduction and reductions in patient length of stay. The unavailability of unique patient identifiers used by both ambulance and hospital services and the inability to link data sets significantly reduces the capacity to generate robust evaluation findings about downstream patient outcomes.

All ERP projects have resource constraints and none have ready access to data and evaluation support staff. Consequently these projects are seen as having high support needs for the evaluation.

The team at SJANT are implementing a new information system (SIREN) in the first quarter of 2013 which has already generated challenges in providing appropriate baseline data as information from the previous information system (Principal) is not fully compatible with the new system. The project teams need to extract data from several systems including their Computer Aided Dispatch System or Advanced Medical Priority Dispatch System, their patient/clinical information system (VACIS, SIREN or in some instances manually completed case cards that have to be entered into a spreadsheet to allow analysis of aggregate data).

In summary projects are on track in addressing their objectives however in the following months more attention is needed to ensure local evaluation questions are being addressed and data collection processes align with the national requirements outlined in the Evaluation Framework and Compendium of Data Requirements and Evaluation Tools.
8.4 Project management observations

These project management observations relate to the ERP sub-project. Dwyer et al.\(^{29}\) (2004, p.20) have produced a framework, adapted from work by Belassi and Tukel\(^{30}\) (1996), which categorises project management success factors. This framework proposes four main categories of direct determinants of project success:

- **Commitment**: Is the organisation serious; is there a vision for the project and commitment to see it through? Is there commitment to manage the impact on stakeholders and partners?
- **Plan and design**: Is the project plan feasible, with achievable goals, strategies that can work good decision-making structures and outcomes that can be sustained?
- **Resources**: Are skilled people, enough money and the right material resources organised?
- **Project team**: Does the project team work well; is it able to manage the change required by the project and to communicate effectively with stakeholders?

Additional underlying factors that influence project success relate to the sector and organisation:

- **Sector** refers to the broader organisational context in which the organisation (and their project) sits.
- **Organisation** refers to the characteristics of the organisation including strategic directions, leadership, the organisational structure, and culture and people management practices that also influence project management.

This framework is used to summarise the project management observations relating to the ERP sub-project.

8.4.1 Commitment

All project teams have demonstrated a strong commitment to seeing the project through to its conclusion. This has been underwritten by their signed Funding Agreement which specifies a project completion date of 30 May 2014 with a final financial report lodged on 14 July 2014. However, all project teams have provided significant additional in-kind contributions over and above the HWA funds. The project teams are genuinely working to manage the impact on stakeholders and partners with an open and collaborative approach to engaging local GPs, Medicare Locals, public and private sector health care providers and both internal and external organisational stakeholders.

8.4.2 Plan and design

All project teams have produced an Implementation Plan, these vary in the quality and level of detail provided however all plans include predominantly realistic objectives and strategies. The best evidence of robust project decision-making processes has been the capacity of project teams to move forward progressing recruitment, training, procurement of equipment, approval of clinical practice guidelines etc. It is too early to determine whether project outcomes can be sustained, for all project teams this is likely to hinge on demonstrations of the effectiveness of the project (particularly patient safety and quality), acceptability to staff and stakeholders and economic efficiency. All project teams have identified the imperative of demonstrating the financial benefit to the health system as the funding structures they work under show that the ambulance services will not benefit financially from this initiative as they are paid a higher rate per patient transported compared with a patient not transported.


8.4.3 Resources

All project teams have reported a high level of investment in project management during the set-up phase. This has been challenging as initially all project leads were trying to juggle the responsibilities of the ESOP project with their normal full-time role. After a couple of months, project teams recognised this was unsustainable and had to either identify additional resources (e.g. SJANT brought in an external consultant) or move out of their full-time operational role for a period (in the case of ACT Ambulance Service). Any site that tried to combine project management responsibilities with normal duties found this problematic because of the sheer volume of tasks that needed to be done in a very short timeframe.

8.4.4 Project team

Project sites with very small teams struggled as there were so many different facets to the project that a team with diverse skills was needed to make it work. One day the project lead would be dealing with procurement issues, the next could be occupied with addressing senior representatives of the local hospital or Medicare Local about the project objectives and subsequent days may require negotiations with industrial bodies, review of clinical practice guidelines or drafting of position descriptions. Project teams that appointed a full-time person in a coordination role appeared to have functioned best in the set-up phase with greater consistency of communication and responsiveness to demands from both HWA and the national evaluation team. The establishment of good project management mechanisms such as regular team meetings and monitoring and review processes has been observed.

8.4.5 Sector

Every project team has been affected by the broader health and emergency system context in which their organisation and project sits. Heraclitus was an ancient Greek philosopher whose doctrines focus on change, his quotation ‘The Only Thing That Is Constant Is Change’ whilst written in 500BC applies just as much to the HWA-ESOP program here and now31. For example, the NT Government changed in 2012 after an eleven year period of rule by one party. This in turn led to a restructure of the health system and a new operating environment with the establishment of two separate Health and Hospital Services, one in the Top End and the other in Central Australia, operated by Statutory Management Boards that will oversee service delivery32. In addition, both the ACT Government and Department of Health and Human Services in Tasmania have undergone major restructures in the past 12 months.

8.4.6 Organisation

The importance of a supportive Chief Executive Officer has been identified by all project teams as a key success factor. This leadership from the top has sent an important message to the wider workforce about the level of interest in the ECP model of care, it has also been important in navigating internal road blocks, for example with endorsement of clinical practice guidelines and protocols.

Three project teams have provided a communications plan (SJANT, SAAS Mt Gambier and SAAS Port Lincoln) which provides structure and transparency about the approach particularly to external stakeholder engagement. None of the project Implementation Plans or progress reports provided to date provide any explicit information about the change management approach of the project teams. Whilst their reporting clearly shows that adjustments and changes are being made as issues arise, and many activities are being undertaken that logically contribute to managing change, this appears to be occurring reactively rather than strategically.

Projects need to be implemented where organisational resources are based. In several instances there were pressures to implement the ERP projects in locations remote from the Ambulance Head Office. Where projects can resist this they should, as proximity to organisational resources (whether these are regional offices or head offices) improve prospects for effective project implementation as there is better access to support, medical mentoring and more efficient supervision.

8.5 Stakeholder engagement strategies

Through the project progress reports all ERP project teams have provided evidence of stakeholder engagement. Stakeholders generally appear to be classified as internal to the organisation or external. The most frequently cited internal stakeholders include: internal personnel (including members of the organisation’s executive, the ECPs and other paramedics and staff).

The focus for external stakeholder engagement has been with service providers that can influence the delivery of the project, such as: GPs and / or representatives of Medicare Locals and GP Super Clinics, residential aged care providers, pathology providers, medical mentors, local hospital personnel, representatives of the State or Territory health departments and members of Aboriginal community organisations. In addition project teams have engaged their local media to promote the community’s understanding of the role of the ECP and liaised with relevant unions to keep them informed, particularly in relation to recruitment processes. Most project teams have referred to the necessity for union consultation and engagement, with both SJANT and Ambulance Tasmania due to renegotiate enterprise bargaining agreements in the next 12 months. All projects identified the delay in announcement of the HWA funding as a frustration (and consequent inability of project teams to promote the new initiative publicly prior to the Federal Minister for Health’s announcement about the HWA-ESOP program). This was unavoidable and in spite of this two project teams were able to secure media interest with stories in their local newspaper about their ERP projects.

Project teams have established a variety of mechanisms for engagement, the most popular being steering committees or local clinical coordination committees that provide a practical means of engaging other service providers, stakeholder workshops, distribution of ECP fact sheets and clinical service updates, networking at conferences and the use of clinical placements as part of the ECP training pathway. Ambulance Tasmania invested three days in a ‘travelling GP road-show’ as a way of engaging GPs within the broader Launceston region. This was found to be enormously beneficial in generating interest and good will for the project. Both SJANT and Ambulance Tasmania have used their medical director to assist with GP liaison.

Approaches to consumer engagement have been limited and primarily two-fold: inclusion of consumer representatives in consultations and on occasion committees; and dissemination of project information through local organisations, flyers and the general media. Opportunities for the project teams to engage consumers in a more meaningful and substantial way should be a consideration moving forward.

Several project teams have found engagement of hospital and ED personnel difficult as they do not see themselves having a role in the project if patients are not transported. This may be a factor of ambulance services not being managed by the State or Territory Department of Health in various parts of Australia.

8.6 Barriers

Through project progress reports and during site visits, project teams reported on barriers they faced during the set-up phase of the HWA-ESOP program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The barriers identified by the ERP project teams are presented under the following sub-headings:
8.6.1 Role clarification

Three project teams identified barriers that relate to the ECP role and the implementation of the model of care. The SAAS project sites were faced with an established pre-conception about the role of the ECP based on the metropolitan ECP role operating for some years in Adelaide. The geography of Mt Gambier and Port Lincoln are distinctly regional and early in the implementation it could be seen that the country ECPs would have slightly different roles to their metropolitan counterparts. For example, they would cover a broader geographic area with the aim of reducing patient transfers from smaller outlying urgent care centres to the regional hospital. The relationship between the ECPS and GPs, particularly in Port Lincoln, is fundamental to the role and without GP engagement the ECP does not have appropriate clinical supervision or referral pathways. Ongoing education of staff about the difference in these roles has been needed with SAAS personnel (including the Emergency Operations Centre), regionally based ECPs and other employees of SAAS.

The ACT Ambulance Service and Ambulance Tasmania had no previous experience with the ECP role and had undertaken very limited planning about the introduction of this role prior to the HWA funding opportunity arising. This led to them being reliant on the scope of practice and policy framework previously developed by SAAS, even though SAAS was not identified by HWA as a lead site. When this documentation was not readily available in the format needed for review within their organisations this generated substantial additional work that these project teams had not expected. In hindsight SAAS needed to be alerted to this expectation much earlier and to have had a longer lead time to develop and document this material. Local modifications would still probably have been needed but this would have reduced duplication in development of clinical practice guidelines and supporting policy documents. Another barrier that was not identified early during the set-up phase was the time taken to get sign off when using existing organisational governance processes e.g. in Ambulance Tasmania clinical committees with wide external representation may only meet every few months and on a pre-determined schedule. This impacted on the time that some activities took such as the review and endorsement of Clinical Practice Guidelines.

Several project teams did not fully appreciate the work required to establish appropriate referral pathways for the ECPs. As the intention is to provide integrated care with the patient referred back to their GP or other appropriate primary health care services, the project teams needed documented and accepted referral pathways. Several pathways required referral by a registered health professional and provision is still being made to have these accessed by the patient’s GP or potentially the project’s medical mentor.

8.6.2 Recruitment and training

A couple of project teams identified delays in recruitment as a barrier they had to overcome during the set-up phase. These delays varied from problems securing internal approval for the ECP role and positions due to liaison with human resources, management and unions through to managing an appeal by an unsuccessful applicant. Not all sites received the volume of applications they were expecting, one site felt the requirement to complete a tertiary education program may have been a barrier for personnel used to working in what has historically been a Vocational Education and Training (VET) based sector. Another project team felt that because only Intensive Care
Paramedics could apply, this immediately limited the potential pool of applicants in rural and regional areas.

The importance of an open and transparent recruitment process based on merit was emphasised as the most effective way to generate a sizable pool of candidates and address employee scepticism about the entry requirements for the positions. As project implementation progresses, the requirement for ECPs to be ICP trained can be more fully explored as well as the implications for national scalability of tertiary education as opposed to in-house training programs.

All project teams have had to work with their Communications Centre clinicians and other communications staff to explain the most safe and efficient way to identify ECP cases. Barriers that have been addressed included changes to work practices and workflow in the communication centre as well as technical changes to the business rules in the Computer Aided Dispatch system or Advanced Medical Priority Dispatch System (AMPDS).

Barriers identified about the training of ECPs are not included in this report as this is the main topic for the second evaluation progress report.

8.6.3 Communication and stakeholder engagement

The majority of project teams identified barriers relating to communication and stakeholder engagement. At the simplest level this ranged from an inability to access contact details for GPs, lack of understanding about local health care needs, through to limited strategic networks and previous investment in relationships with external stakeholders. This meant that some project teams were starting very much at ground zero. In smaller rural localities a small number of GPs have seen the implementation of the ECP role as a threat to their income and are not overly supportive of the project. These barriers will need to continue to be addressed over time with project teams working with their Medicare Local, providing ongoing communication through information sheets, face-to-face consultation, meetings to establish stakeholder relationships and inviting GPs to take a role in relevant committees.

8.6.4 Resource issues

The major resource barriers identified by the ERP project teams have focused on isolation from Head Office and corporate resources; pressures to find accommodation for the ECPs and storage for their equipment in ambulance stations where space is already at a premium; and the availability of appropriate information technology to enable access to electronic medical records.

The absence of bulk billing GPs in some locations (such as Darwin, where bulk billing is only available at the GP Super Clinic, both in office and after hours) is also a barrier to patient referral and ongoing care.

The current structure of reimbursement for ambulance services is a barrier as in every State and Territory a higher fee is paid to the ambulance service for an emergency transport as opposed to the reimbursement for management of a lower acuity case (approximately 40% less than the emergency transport reimbursement).

Several project teams felt that the HWA funding allocation was inadequate for all costs – the higher salary of the ECP in some jurisdictions, cost of training, cost of procuring and outfitting a non-transport vehicle and cost of consumables were not always accurately estimated.

8.6.5 Legislative and policy issues

Both ACT Ambulance Service and Ambulance Tasmania identified legislative and policy barriers to the implementation of the ECP’s full scope of practice. Ambulance Tasmania identified pathology issues as carriage of blood products by the ECPs will require a change of legislation. For ECPs to
be able to prescribe an amendment is required to the Poisons Act 1971, which has occurred infrequently over the past decades.

Paramedics are not currently a registered profession and this is an issue of ongoing professional debate. Several project teams have raised this in the context of the ECP not being able to procure a Medicare provider number and charge for the service provided.

An example of a policy issue that has created a barrier during the set-up phase is the authority to use and store an extended range of pharmaceuticals (ECPs use a wider range of pharmaceuticals than other paramedics). In the ACT, this requires a recommendation from the ACT Ambulance Service Clinical Advisory Committee to the Chief Officer.

8.6.6 Evaluation issues

Whilst no ERP project teams identified any barriers relating to evaluation in the set-up phase, the issue of ethical approval for the local evaluation has proved challenging for some sites. This is because ambulance services do not have established Human Research Ethics Committees that they can readily access. Ambulance organisations that fall under the jurisdiction of the Department of Health should be able to access an appropriate committee; other organisations have relied on partnerships with academic institutions to assist with this process or the approval of their Chief Executive Officer. HWA and project teams are keen to disseminate their findings in the future, many journals require evidence of ethical approval of evaluation and research studies prior to publication.

Changes in accepted ambulance performance metrics need to be interpreted with caution. For example, crew utilisation rates are likely to provide a more useful indication of productivity improvements than the time spent per case by the ECP. Indicators such as 'Did Not Transport Rates' may increase however revenue generated by patient transports will decline. The benefits of releasing emergency crews to deal with higher acuity cases and the value added to the patient journey through streamlining of care are unlikely to be captured quantitatively. The experience of patients and impact of the role on other members of the health workforce are critical data elements best captured qualitatively.

8.7 Enablers

Through project progress reports and during site visits, project teams reported on enablers they faced during the set-up phase of the HWA-ESOP program. This information was collated into a series of spread sheets and thematically analysed with all issues then classified according to their primary focus. The enabling factors identified by the ERP project teams are presented under the following sub-headings:

- Collaborative development
- Project management support
- Stakeholder engagement
- Expanded scope of practice clinicians

8.7.1 Collaborative development

The support provided by SAAS to all other project sites has been identified as a key enabling factor. Whilst things didn’t necessarily ‘fit’ perfectly, the experience and resources of SAAS greatly assisted the other project teams who were not having to start from scratch and reduced duplication. All project teams spoke highly of the willingness of SAAS to share their knowledge, experiences and resources.

Another enabling factor is the collaborative approach that has developed amongst project teams, particularly amongst the ECPs who formed bonds during their face-to-face training (with four of the
The ECPs have set-up a ‘Dropbox’ online to allow them to share files and resources.

The workshop facilitated by HWA at the beginning of the set-up phase allowed project teams to network. Many of the participants were already known to each other from previous professional experiences and/or conference events. There is a high level of co-operation and sharing between project teams.

The contribution by existing committees within the respective ambulance services has also enabled a collaborative approach to the clinical oversight of the ECP initiative as has the contribution of Medical Directors.

### 8.7.2 Project management support

Strong team support from other paramedic staff and members of the ambulance service has been identified as an enabler for two projects. This has encouraged the project team and assisted them to deal with any pockets of resistance within the organisation.

The introduction of the SIREN electronic patient management system at SJANT has been identified as key enabler of more effective project management as it will provide access to data and information that was previously only available on manually recorded case cards.

Site visits by the evaluation team and the provision of a suite of common evaluation tools was also identified as beneficial by several project teams.

### 8.7.3 Stakeholder engagement

All project teams identified stakeholder engagement and the support of external groups and agencies as an enabling factor during the set-up phase. At a practical level this engagement has facilitated clinical placements for ECPs, ensured appropriate medical mentoring (particularly where access to ED based salaried medical officers are available) and involvement of a wider group of organisations on steering committees. The pre-existing relationship with Universities and external clinical experts has greatly assisted the training process.

Project teams have also demonstrated an awareness of local and national developments that can support project implementation, for example, the Australian Government ‘healthdirect’ initiative.

### 8.7.4 Expanded scope of practice clinicians

The ECPs that have been selected are seen by most project sites as an enabling factor, for through their interaction with patients, other paramedics and members of the health care team they are building support for the role. All candidates participated in face-to-face training and clinical placements that necessitated their absence from home over an extended period. Their willingness to participate and determination to make things work has undoubtedly contributed to progress in this early project phase. It appears that the paramedics attracted to this opportunity are innovative people who can problem solve and have the ability to apply their advanced clinical skills to situations that do not always require a routine solution.

As the ECPs are supernumerary to the existing emergency crews when the ECP takes a case this releases the emergency crew. In localities where the ambulance executive team have been concerned about high demand, the capacity of the ECP to assist has been viewed positively.

### 8.8 Reflections and lessons learned

In their progress reports, sites were asked to provide their reflections on the project’s progress—specifically, the lessons they had learnt, changes that should be made, and their most important
achievements. These responses were analysed for common themes and integrated with findings identified by HWA and the national evaluation team through site visits, additional project documentation and ongoing contact with the project teams. The results are described below.

8.8.1 Lessons

Participants were asked “What have you learned from the implementation and evaluation activities to date?” Responses to this question fell into one of four main themes:

- ECP model of care
- Communication
- Stakeholder engagement and support
- Timing and resources

ECP model of care
The model in South Australia is well developed to meet the needs and the structure in SAAS. However, this model required significant modification to meet the local needs of other States and Territories particularly in terms of clinical governance requirements. This included the development of policies, documentation of the scope of practice and clinical governance elements. The acceptance of the ECP scope of practice requires the authorisation of a number of health professionals, including clinical and paramedic specialists. For approval to be obtained policy and procedural documentation is needed that covers all aspects of the extended role. It therefore took more time to mobilise organisational support and manage the consultation and review process.

Communication
The absence of a local champion and project management resources at the SAAS Port Lincoln project site has impacted upon the project’s set-up phase. Whilst there have been advantages in sharing project management resources across both SAAS project sites, it has been harder to generate momentum and engagement without a dedicated resource. When all project team members are at capacity with their workload and someone goes on leave there is not the capacity to absorb this workload and this can impact on one or both project sites.

Stakeholder engagement and support
Most project teams did not have the necessary relationships and partnerships established with external stakeholders to support the project set-up phase. Relationships take time to develop and for this capability to function effectively relationships and procedures need to be in place prior to project implementation with key stakeholders such as pathology providers, pharmaceutics suppliers, medical consumable companies, primary health care providers such as community nursing, palliative care and GPs.

Prior relationships with educational institutions speeded the development and delivery of the ECP training program for both SJANT and SAAS. Resources need to be invested in documenting the training pathway, resources and assessment methods for national replication.

Timing and resources
The biggest challenge for all projects is the development time required to effectively set-up an ECP initiative. A period of six months has proved unrealistic for a jurisdiction without prior experience of the ECP model of care. Most project teams felt that a more realistic timeframe would be 12 months to identify, develop and comprehensively address the full scope of works associated with the ECP program.

The short time frame from project approval to implementation only allowed a very short time for external communications to occur; and the delay with the formal announcement had a large impact on timings for external communication.
The short set-up phase has placed stress on internal requirements including the purchase of acceptable equipment, accommodation and storage needs, and procurement and set-up of a suitable vehicle. The acquisition of equipment has been problematic and further exacerbated around the Christmas Season, resulting in a number of delays.

8.8.2 Changes

Responses to the question “Based on what you have learned, will you make any changes?” largely mirrored the themes identified in the previous section. The key message was the importance of flexibility and the ability to make incremental changes as issues arose and lessons were learned during the set-up phase. For example not all elements of the model of care were ready to be implemented from ‘Day 1’. It is also anticipated that the project will evolve during the period of the implementation, as and when further consultation is held with other health care professionals.

Back-up staff resources should be identified early during the set-up phase to support project implementation in the event of planned leave and unexpected absences. The relatively short period of implementation and limited additional ECPs for implementation of the model, mean that any staff absences are likely to impact significantly on project success. The ambulance services in smaller jurisdictions appear to be lean organisations with limited capacity to redeploy personnel and resources.

8.8.3 Achievements

Participants were asked “What are the project’s most important achievements so far?” and provided responses as follows:

- Building the foundations for the ECP role in the respective State or Territory
- Recruiting and training the ECP personnel within the first six months or so of operation
- Developing improved medical mentoring and clinical supervision arrangements
- Collaborating with other States and Territories to develop project resources
- Providing additional training and development opportunities for paramedics
- Strengthening local, regional and State based primary care networks and relationships
- Improving engagement with medical professionals
- Increasing professional recognition and respect for paramedics
9 Emerging risks

9.1 Project risks

There are a number of actual and potential risks that have emerged since the start of this Program. Some of the emerging risks identified by the projects were also listed as barriers. For this section risks have been included if they have occurred i.e. actual risks and if they have the potential to impact on the next phase of the Program. The process of risk management for each sub-project is managed by the HWA Liaison Officer. The national evaluation team supports this risk management process by informing HWA of project risks as they are identified.

It is important to understand the constraints on innovative practice in terms of legislation, credentialing, clinical guidelines, local protocols and resource requirements in order to ascertain the conditions under which implementation is most cost-effective and national roll-out is most likely to succeed.

9.1.1 Human resources and workload issues

Among the most common risks identified by HWA-ESOP projects is the problem of the small number of staff actually available to implement the expanded scopes of practice effectively. This risk has two elements: recruiting appropriate clinicians to begin with and then addressing the impact of unplanned resignations or absences.

Many projects highlighted difficulties with staff recruitment. In some cases, preliminary project activities took longer than expected; leading to delays in advertising positions e.g. Alice Springs Hospital (PED), Logan Hospital (APEN). At Flinders Medical Centre (PED), the process of recruitment was complicated by a local cap on staffing positions (despite the new position being funded by HWA). Other sites discovered that when they advertised and interviewed, there were few suitable candidates for the available positions. For example, mental health nurse practitioners are in high demand, leading to recruitment challenges for the Eastern Health site (NED). Some, such as Austin Hospital (APEN), concluded that it was better not to recruit than to appoint underqualified applicants. This project team also noted that in order to attract suitable candidates, trainee positions needed to be made into permanent appointments.

Loss of recruits is another risk faced by at least one of the sites so far, albeit for a positive reason with a primary contact physiotherapist for the Casey Hospital project (PED) achieving entry into a Graduate Medicine program. As many projects have only received funding to recruit one or two additional personnel, any absence impacts immediately on patient contact hours. Retention is a potential risk for all sub-projects in which intensive training is provided during the set-up phase, such as the APEN and ERP sub-projects. The lack of formal recognition of expanded scopes of practice roles by various professional bodies is a potential threat to sustainability of all sub-projects.

A number of other risks also fall under the broad area of human resources and workload issues. Sites have had to make decisions about the best times to deploy ESOP personnel, based both on availability of staff and on demand for services. Most sites do not have ESOP personnel available 24 hours a day, seven days a week, and therefore need to identify peak demand periods, change rosters and constantly review workload data e.g. Limestone Coast (ERP). Due to funding constraints, the St Vincent's Hospital site (PED) uses casual staff on Sundays but the site has identified a need to implement additional monitoring and clinical governance measures to ensure they are meeting standards for primary contact physiotherapists. Other sites have had to manage perceptions that ESOP represents an increased workload for some personnel e.g. Wollongong Hospital (NED), Port Lincoln (ERP). There is also a risk that ESOP staff could be diverted into other tasks and away from their new duties. For example, the physiotherapist appointed to the ED at Flinders Medical Centre replaced a previous role which dealt mainly with hospital avoidance cases in this setting. As there is now no-one performing this role, there is a risk that the ESOP...
physiotherapist could be called upon to deal with patients who fall outside the musculo-skeletal focus of the current project. All of these identified risks have the potential to reduce the impact of the HWA-ESOP program by diluting the ‘dose effect’ of the ESOP role and reducing efficiency and productivity.

A common risk identified across the four sub-projects is that of professional isolation of the ESOP practitioner. As there is such a small number of these positions in each organisation unless they are integrated into a broader team they can be marginalised and underutilised. This will lead to attrition and the loss of a significant investment in training and also potentially derail momentum already generated within the organisation for this workforce change.

9.1.2 Training issues

Cost of training, delays in commencing training and time management (i.e. juggling training with working in the ESOP role) have been highlighted as potential risks. At the Port Lincoln site (ERP) on the Eyre Peninsula, newly recruited staff members have not progressed as quickly as expected through the training phase, leading to delays in full implementation. PED implementation sites led by the Canberra Hospital did not factor into their budgets the travel costs and course fees associated with completion of the required Diploma-level course at the University of Canberra. Until ESOP physiotherapists undertake the course, they will not be qualified to commence the full range of duties and therefore the changes in scope of practice may be incremental with impacts on efficiency and productivity. Project teams have worked to mitigate this risk by recruiting highly experienced musculo-skeletal physiotherapists where possible. In the case of one NED project, no paid study leave is available to allow nursing staff to attend face-to-face training. Participants have agreed to undertake the training in their own time; however, this is a threat to the sustainability of the project as future recruits may not be so generous.

9.1.3 Stakeholder engagement issues

Projects have identified numerous risks associated with the need to build working relationships with key stakeholders. If important individuals or organisations refuse to engage with HWA-ESOP sub-projects and sites, implementation may be delayed or blocked. For example, local GPs are key stakeholders for the ERP projects and failure to gain their acceptance and cooperation has been identified as a major risk. In addition, scope extensions need to be endorsed by clinical advisory committees. Powerful individuals can either facilitate or obstruct implementation. Many projects have highlighted the need for clear, frequent communication and marketing of the innovations to all stakeholders, including staff members who are not directly involved but whose workloads might be affected, clinical leaders and quality managers, allied health practitioners, and the broader community. The importance of effectively engaging State and Territory jurisdictions as key stakeholders has been highlighted particularly in relation to addressing legislative barriers and supporting sustainability.

9.1.4 Change management issues

Changes to organisational systems, resources and cultures are required in order to facilitate implementation of the HWA-ESOP program. Any delays or difficulties in making these changes may have adverse effects on site and sub-project outcomes. For example, several of the ERP projects have highlighted the importance of having ambulances properly equipped and set-up ready for the ECPs. A delay in the completion of a new endoscopy suite is a risk for implementation and evaluation at Southern Health (APEN). The purchase of equipment needed for hands-on training and supervised practice at Logan Hospital (APEN) was made more complex by local funding arrangements and rules about sources of capital expenditure. IT support was needed at the Murrumbidgee Local Health District sites (NED) to facilitate installation of education modules and changes to policies were required in order to open access to YouTube so that trainees could view educational videos.
The risk generated by competing training needs of medical students, junior medical officers, nurse practitioners and ESOP clinicians has arisen in several project sites. Some members of the health care team may be unwilling to relinquish patients suitable for primary contact physiotherapy, due to their own need to gain valuable experience in treating such patients. At least one site has noted that having a detailed implementation plan is the key to addressing issues that may threaten the viability or impact of projects.

The sites and sub-projects are also vulnerable to risks that exist beyond the control of the individual organisation. Legislative requirements limit the scope of certain practitioners in varying jurisdictions, particularly affecting the ability of ambulance officers and physiotherapists to prescribe medication. Implementing standing orders for medication is one way in which such risks can be addressed e.g. Robina Hospital and ACT Health (PED). In some areas, ESOP clinicians have no authority to order or interpret pathology tests e.g. ACT Ambulance Service (ERP). Clinical governance issues have also been identified as potential risks to implementation. Expanded scopes of practice may require new protocols or clinical guidelines which need to be ‘signed off’ before ESOP staff are authorised to implement new models of care. If these prove contentious or are not approved, services are likely to be limited to existing scopes of practice.

The HWA-ESOP program is not operating in isolation, and inevitably some of the sites will encounter difficulties related to concurrent, possibly conflicting initiatives in the health system. For example, four observation beds have been opened in the ED at Royal Children’s Hospital, with some overlap in the target patient population for the NED project at that site. Planned changes in the role of the ED at Robina Hospital may have impacts on this PED implementation site. A review of mental health service provision in the region has led to a period of change and restructuring of mental health services at Wollongong Hospital, with potential effects on the NED site there. As well as creating problems for implementation, concurrent initiatives also have the potential to affect evaluation outcomes because it may become more difficult to distinguish and measure the effects of the HWA-ESOP initiatives and their particular contribution to changes in performance measures.

Finally effective engagement with State and Territory health departments is likely to be a key contributor to the sustainability of these expanded scopes of practice workforce roles. Whilst collaboration is now occurring with the Victorian Department of Health, largely in response to their funding contribution and establishment of a Steering Committee, resulting in regular meetings between HWA, implementation sites and the Victorian Department of Health. A similar process would be beneficial in other States and Territories.

9.2 Evaluation risks

Many of the risks to implementation also present problems for evaluation of the HWA-ESOP program. True impacts on efficiency, effectiveness and productivity may be masked by delays in recruitment, staff turnover, workload issues and time management problems. The cost and time required to complete training may affect the sustainability of the projects.

There are a number of other risks specific to the evaluation activities. Of these, perhaps the greatest challenge is engaging sub-projects and sites in the spirit of the evaluation, as well as encouraging them to adhere to the letter of the evaluation requirements. While most sites understand that evaluation is an integral part of the HWA-ESOP program and are willing to play their part, there are differing views on the best way to achieve the desired outcomes. Some, particularly sites where expanded scopes of practice have been in use for some time, wish to use their existing systems and expertise, including their own evaluation tools, in order to maintain continuity with an ongoing program of research. Others simply are reluctant to change long-standing organisational preferences and practices. This presents barriers to the collection of a consistent, comparable data set across all sites. In some cases, sites can be persuaded to collect additional data items to cover key aspects of the evaluation beyond their own existing evaluation methods. However, this added burden is not always acceptable and the risk remains that
complete data may not be available for comparison across sub-projects for all Key Performance Indicators.

Limitations of administrative data sets also present a challenge for evaluation. At some sites, standard data collections are not able to provide all the items required to assess patient safety, quality and efficiency indicators. At other sites, the data are available but are not able to be extracted automatically, and manual data extraction may prove too costly and time consuming. Again, these limitations present a risk to the collection of a complete and comprehensive data set for the evaluation of the HWA-ESOP program. The national evaluation team is continuing to work with individual sites to address these risks as they emerge.

Several other evaluation risks have been identified across the four sub-projects. Some sites lack funding for project management support, which means evaluation activities will have to be carried out by clinical staff on top of their usual duties. Other sites lack software resources and expertise in data analysis.

Finally, there are risks of attribution and contribution, that is, the extent to which any changes observed by the evaluation are due to the HWA-ESOP activities. In the view of the national evaluation team, the HWA-ESOP program fits within a model where it is reasonable to measure ‘contribution’ rather than ‘attribution’. This task is complicated by the extent of other, concurrent changes in the health system. Notably, the national four-hour target for ED is a motivating factor for change in hospital systems across the country. Several project teams have noted that their organisations have multiple projects in train to address the national emergency access target (NEAT) requirements. A related issue is whether the HWA-ESOP projects will provide a sufficient “dose” for their effects to be detectable above the noise of normal variations in service demand and operational capacity. For example, the PED projects may prove extremely beneficial for those patients directly affected, but it may be difficult to demonstrate statistically significant improvements in productivity and ED waiting times generally. In this respect, projects that aim to make relatively simple, broad-based changes, such as the Criteria-Led Discharge initiative at the Royal Children’s Hospital which involves all 100 nurses working in this ED, may be better able to produce supportive data than more targeted projects in which a few, intensively trained staff are serving a fairly select group of patients. This will not necessarily mean that one approach is better than the other; simply that one is better able to demonstrate results.

Summary
As the evaluation unfolds, additional risks may be identified that will need to be controlled through the collective contribution of the national evaluation team and major stakeholders. Project risks relating to the set-up phase have been managed effectively to date:

- Recruitment and retention of suitable candidates is a major challenge for projects. Making trainee positions permanent appointments is one strategy that has been used to attract high-quality applicants and reduce this risk.
- Workload issues such as rostering at times of peak demand is necessary to maximise the anticipated efficiency and productivity gains of projects.
- Time, course fees and travel associated with training courses represent a major impost on some project teams. This risk can be addressed by improvements to the RFP process and the provision of guidelines for project budget development. It will be important to consider these requirements and their potential impact on the viability and sustainability of expanded scopes of practice.
- Clear, frequent and early communication with stakeholders has addressed some of the risks associated with failure to engage with innovative practices and changes to protocols and guidelines.
- Resource issues, including availability of clinical mentors, purchasing of equipment and access to suitable work spaces, have the potential to affect the productivity of ESOP personnel. Providing longer set-up phases may mitigate this risk for future projects.
- Changes to legislative requirements are needed to facilitate expansion of scopes of practice in some areas, particularly in relation to prescribing medication, ideally HWA can progress this issue in parallel with project implementation.

- Powerful individuals and organisations can block innovation by resisting change to protocols and practices or by refusing to endorse new clinical guidelines for expanded scopes of practice. Project teams’ early identification of these stakeholders and engagement of senior leaders in their organisations has helped with managing this risk.

- Other, concurrent initiatives in the health system can complicate implementation and also raise issues around attribution of effects in the evaluation of HWA-ESOP program. Identifying and documenting these initiatives is the first step in managing their impact on projects.

- Ongoing engagement with State and Territory Health Departments is likely to be a contributor to the ongoing sustainability of the expanded scopes of practice roles.

- Despite negotiation and compromise efforts by the national evaluation team and sub-projects, it is likely that some key indicators will not be collected by all sites. Limitations in the administrative data sets and technology capabilities at some sites present further challenges to the collection of a comprehensive, consistent set of data across the HWA-ESOP program. The national evaluation team is working with sites experiencing these issues.

- The innovations implemented under the HWA-ESOP program may prove beneficial to individual patients yet these improvements may not be detectable at the larger scale of organisational productivity and cost-effectiveness. There is a risk that small effects may be lost in the noise of normal variability.
10 Reflections and lessons learned at the program level

The preceding review of each of the HWA-ESOP sub-projects has generated a range of findings, many that are common across the program. This section aims to synthesise the reflections and major lessons learned at the program level that pertain to the set-up phase.

10.1 Program delivery – What did you do?

- The Request for Proposals (RFPs) needs the input of clinical experts and advisors during their development. Early appointment of clinical advisors would allow them to be involved in preparation of the RFP and project review and selection. This would avoid the incorrect use of terminology, particularly relating to advanced practice, which generated unnecessary confusion amongst professional bodies and concerns that some clinicians could be working outside their scope of practice.
- States and jurisdictions should also be engaged during the RFP process to ensure that the funded initiatives complement other workforce innovation projects; they have a key role in sustainability of the project in the medium to longer term.
- All RFPs need to clearly state the case for change, including the aims of the funding round and evidence for the recommended model of care and intervention.
- The models of care developed for nursing projects must align with accepted position classifications for varying professional designations, for example, if autonomous practice is central to the role then a Nurse Practitioner is required.
- The models of care developed for several physiotherapy and nursing projects included significant barriers from the outset. For example, prescribing issues were already being addressed through HWA through the Health Professionals Prescribing Pathway project. A thorough review of potential legislative and industrial issues prior to implementation may have identified which regulatory arrangements in which jurisdictions might allow flexibility and supported early inter-jurisdictional action.
- During the set-up phase, sub-projects with lead sites have demonstrated a more streamlined approach to getting started and less duplication than sub-projects without a lead site. However lead sites need to be identified first so that the RFP process allows implementation sites to apply for project funding with a clear understanding of the model of care and associated training and implementation requirements and what they are signing up for including the ‘fit’ of the model of care for their organisation.
- If external evaluators are engaged, they need to commence earlier and possibly during RFP development. This would reduce the confusion between local and national evaluation requirements and improve understanding of the expectations of HWA for projects’ involvement in data collection and evaluation. This might also facilitate more streamlined ethics approval processes.
- Early design of the evaluation framework, data collection methods and the associated program evaluation tools would streamline the ethics application process for project sites. The RFP should alert project teams to the likely requirement for ethics approval and the potential time required to prepare the application and gain approval.
- Guidelines need to be provided to projects submitting RFPs to assist in the development of their budgets as many projects underestimated project management, training, equipment and evaluation costs. HWA should specify the investment expected in project management, as project teams that invested less have been slower to progress and less responsive to HWA timelines.
- Projects consistently identified that there was not enough time allowed for the set-up phase of the project and for organisations without any experience of expanded scopes of practice, a 6 – 12 month lead time was preferred. This ‘pre-implementation period’ would maximise opportunities within the project.
Project teams require diverse skill sets to effectively manage all aspects of project development, training, implementation and evaluation. Rarely were all skills found within an individual which meant that project officers had to find assistance within or outside their organisation. Smaller organisations have fewer specialist resources.

10.2 Program impact – How did it go?

- Organisations with a receptive context for change have demonstrated greater agility and adaptability during the set-up phase, particularly in their ability to address problems as they arise.
- Recruiting the right people for the Expanded Scope of Practice roles has influenced early perceptions of other members of the health care team, for example, highly competent, experienced and known practitioners who have worked in the organisation and have a positive reputation and track record. In many instances their personal drive and enthusiasm has increased acceptance of the roles. Service models need to be transferable and sustainable at the service level.
- Project teams need a structured approach to change management in workforce innovation projects as ad hoc or reactive responses leaves too much to chance. Whilst project teams are practical at addressing barriers as they arise the approach is usually reactive. Expertise in managing change varies significantly across project teams.
- The experience of project teams to date suggests that workforce innovation requires an incremental approach to change, where organisations build on their previous experience and progress step by step.
- Project teams with established relationships with key stakeholders found consultation and engagement easier; organisations where a senior leader visibly championed the project demonstrated improved acceptance of the role and model of care.
- For most projects the introduction of a new model of care and scope of practice requires approval through the local organisational processes. These timeframes can be outside the control of project teams who are competing for access on busy agendas.
- Clinical advisors need to visit project sites with the HWA project manager early in the set-up phase. This provides a safeguard for HWA and also provides clinical support and expert advice for project teams. The initial site visit could ideally include a member of the national evaluation team to ensure that all parties are starting with a common understanding of project requirements. This ensures consistent messages and reduces the time impost of site visits for project teams. This would also support role clarity between the project manager, clinical advisor and national evaluation team. Subsequent site visits need to be coordinated to avoid duplication and overlapping visits as when data collection is required by the national evaluators, there is a need for independent site visits. As lead sites were also conducting site visits in the first months of the projects, this frequently meant that project teams hosted more than three visits in the set-up phase.
- A series of workshops were planned with the first workshop occurring within three months of projects being funded. These need to be paced across the life of the program with clear aims and alignment with the major project phases. For example, the first workshop appropriately focused on project set-up issues but probably also needed to include more about the models of care and proposed training pathway particularly for projects without lead sites. The second workshop addressed training, capacity development and implementation issues as well as strategies for project sustainability and generalisability. The third workshop could focus on lessons learned, project achievements, evaluation methods and data collection, final report development and dissemination.
- Several projects have been designed in a way that results in the Expanded Scope of Practice clinician implementing the new model of care in their organisation at the same time they are being trained in the role. This means that many clinicians will not be working to full scope for a considerable part of the implementation period. The majority of projects will barely have 12 months of implementation. This short implementation period reduces the likelihood of being
able to generate robust data, demonstrate and measure the contribution of the projects to changes in key performance indicators and embed practice changes.

10.3 **Program sustainability – Can you keep it going?**

- Whilst all project Funding Agreements include the requirement for project teams to commit to continuing the Expanded Scope of Practice role, in reality most projects will need to secure funding for this to happen. Timing for this is crucial as most organisations require business cases submitted at least 18 months prior to expenditure being incurred. However projects will not have any evidence of their impact until implementation is completed and their final report is submitted.

- Helping project teams develop strategies to improve project sustainability needs to occur in the set-up phase, for example, this may be ensuring key decision-makers are included in the membership of steering committees or are provided with regular information on early wins.

- Entry requirements for the Expanded Scope of Practice roles must reflect the skills and qualifications required; however this needs to be balanced with increasing access to the pool of potential candidates. Restrictive entry criteria reduce the sustainability of the role and capacity to roll-out the model of care nationally and needs to be balanced with mitigating risk.

- Training models need to be affordable, accessible, demonstrate competency and that clinicians are ‘fit for purpose’. They need to be structured in accordance with adult learning principles, including capacity for recognition of prior learning. Ideally they generate a qualification (or part of a qualification) that is nationally recognised. Training models must be sustainable and appropriately documented.

- These Expanded Scope of Practice roles should be integrated into the broader health care team; when other health professionals can see how the role interfaces with other clinical roles and contributes to the care continuum, professional respect and recognition increases, which in turn supports sustainability.

10.4 **Program capacity – What has been learnt?**

- A basic aim of the HWA-ESOP program is to build capacity in nurse endoscopists, physiotherapists and nurses working in the ED and paramedics. Training has presented particular challenges when sub-projects did not have lead sites and / or inconsistency in the models of care being implemented. The more variation in models of care across implementation sites, the greater the risk for HWA.

- Project teams that are responsible for training must supply a documented training pathway, which includes learning outcomes, course outlines, assessment methods and appropriate learning resources.

- Developing training pathways and supporting resources is time consuming and requires specialist expertise. To implement training on a national basis requires infrastructure; the capacity to transfer this training and mechanisms for assessment and recognition.

- Many project teams responsible for training did not anticipate the work involved in designing the training pathway and resources. For some teams a significant investment has been needed to develop and document the competencies required by the Expanded Scope of Practice role and how these will be assessed.

- Project teams have already identified that circumstances change as implementation progresses, and as the confidence of the Expanded Scope of Practice clinicians and acceptance by the surrounding health care team increases, boundaries can be flexed and the scope of practice extends. This means that vigilance is needed to ensure clinicians are equipped with the right skill set and that clinical governance processes keep pace with these changes.

- For some project teams training has predominantly been finished however new needs may emerge as implementation progresses. There needs to be a review cycle so these emerging needs are identified and additional training can be supplied.
10.5  **Program generalisability – Are your lessons useful for someone else?**

- A range of lessons have been learned about the set-up phase of this program. Sub-projects with common models of care appear likely to be easier to implement on a national basis as there are a broader range of implementation sites and experiences. Staged approaches may offer better opportunity for success.
- Incremental roll-out is potentially more manageable where a fixed number of sites are funded at any one time.
- Some of the models implemented have occurred in such specific contexts that they are unlikely to be suitable for replication unless the next organisation has similar pre-conditions.
- Several sites are yet to show an awareness that their project needs to be packaged in a way that lends itself to national replication. During the set-up phase project teams are focused on ‘doing’ rather than planning for wider generalisability.

10.6  **Program dissemination – Who did you tell?**

- Several project teams were relying on a public launch of their project to generate community interest and potential engagement. This did not occur in a timely way due to delays in Ministerial announcements and this affected stakeholder engagement.
- During the set-up phase most dissemination has occurred internally within the project organisations with a focus on informing internal stakeholders about progress and early achievements.
- Several project teams have developed information resources for consumers, to disseminate information about the Expanded Scope of Practice role and what this means for their care.
- Limited national dissemination has occurred which is appropriate for this phase of the program. However several opportunities will present later in the year (such as the national HWA conference and annual professional conferences) so a coordinated approach will be needed.

10.7  **Next steps**

The next evaluation progress report will focus on baseline data collection for the evaluation and a review of the training processes and materials developed within each sub-project.
Appendix 1  Funding allocation and execution date by project

Grant description: A national program of health workforce innovation and reform will be developed and delivered by HWA. This will encourage the development of health workforce models to support new models of healthcare delivery, facilitate inter-professional practice and equip health professionals and employers to successfully manage current and emerging demands on the health care sector.

<table>
<thead>
<tr>
<th>Recipient</th>
<th>Victorian Department of Health Funding Allocation</th>
<th>Execution Date</th>
<th>Total Funding (GST Incl.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expanded Scope of Practice: Advance Practice in Endoscopy Nursing</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Austin Health (Consortium) – Lead Organisation*</td>
<td>$155,000</td>
<td>26/06/2012</td>
<td>$385,000</td>
</tr>
<tr>
<td>Austin Health (Consortium) - Implementation Site</td>
<td>$65,000</td>
<td>26/06/2012</td>
<td>$440,000</td>
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<tr>
<td>Austin Health (Consortium) - Alfred Health - Implementation Site</td>
<td>$65,000</td>
<td>26/06/2012</td>
<td>$440,000</td>
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<tr>
<td>Austin Health (Consortium) – Southern Health - Implementation Site</td>
<td>$65,000</td>
<td>26/06/2012</td>
<td>$439,670</td>
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<tr>
<td>Austin Health (Consortium) – Western Health - Implementation Site</td>
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<td>26/06/2012</td>
<td>$437,140</td>
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<tr>
<td>Department of Health and Human Services TAS (Mersey Hospital) - Implementation Site</td>
<td>N/A</td>
<td>25/03/2012</td>
<td>$390,000</td>
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<tr>
<td>Queensland Health (Logan and Beaudesert Hospitals) - Lead Organisation</td>
<td>N/A</td>
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</tr>
<tr>
<td>Queensland Health (Logan and Beaudesert Hospitals) - Implementation Site</td>
<td>N/A</td>
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<td><strong>Expanded Scope of Practice: Physiotherapists in Emergency Departments</strong></td>
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<tr>
<td>ACT Health - Canberra Hospital - Lead Organisation</td>
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<td>Alfred Health - Lead Organisation</td>
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<tr>
<td>Northern Territory of Australia, C/- the Department of Health (Alice Springs Hospital) - Implementation Site</td>
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<td>Recipient</td>
<td>Victorian Department of Health Funding Allocation</td>
<td>Execution Date</td>
<td>Total Funding (GST Incl.)</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>--------------------------------------------------</td>
<td>----------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Queensland Health (Cairns Base Hospital) - Implementation Site</td>
<td>N/A</td>
<td>26/06/2012</td>
<td>$313,042</td>
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<tr>
<td>Southern Adelaide Local Hospital Network (Flinders Medical Centre) - Implementation Site</td>
<td>N/A</td>
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<tr>
<td>Southern Health - Implementation Site</td>
<td>Yes</td>
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<td>$356,725</td>
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<tr>
<td>St Vincent’s Hospital (Melbourne) Limited &amp; Ballarat Partnership - Implementation Site</td>
<td></td>
<td>26/06/2012</td>
<td>$345,000</td>
</tr>
<tr>
<td>The State of Queensland through Queensland Health (Gold Coast Health Service District) - Implementation Site</td>
<td>N/A</td>
<td>21/06/2012</td>
<td>$316,553</td>
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</table>

**Expanded Scope of Practice: Nurses in Emergency Departments**

<table>
<thead>
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<th>Victorian Department of Health Funding Allocation</th>
<th>Execution Date</th>
<th>Total Funding (GST Incl.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern Health - Implementation Site</td>
<td>No</td>
<td>25/05/2012</td>
<td>$310,362</td>
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<tr>
<td>Illawarra Shoalhaven Local Health District (Wollongong Hospital) - Implementation Site</td>
<td>N/A</td>
<td>12/06/2012</td>
<td>$265,681</td>
</tr>
<tr>
<td>Kilmore and District Hospital - Implementation Site</td>
<td>No</td>
<td>12/06/2012</td>
<td>$101,645</td>
</tr>
<tr>
<td>Murrumbidgee Local Health District - Implementation Site</td>
<td>N/A</td>
<td>23/05/2012</td>
<td>$255,380</td>
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<tr>
<td>South Eastern Sydney Local Health District (Prince of Wales Hospital) - Implementation Site</td>
<td>N/A</td>
<td>23/05/2012</td>
<td>$325,000</td>
</tr>
<tr>
<td>Sydney Local Health District, The Royal Prince Alfred Hospital - Implementation Site</td>
<td>N/A</td>
<td>12/06/2012</td>
<td>$343,455</td>
</tr>
<tr>
<td>The Royal Children’s Hospital - Implementation Site</td>
<td>No</td>
<td>6/06/2012</td>
<td>$119,000</td>
</tr>
<tr>
<td>Western Health (Sunshine Hospital) - Implementation Site</td>
<td>No</td>
<td>23/05/2012</td>
<td>$350,000</td>
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</table>
## Expanded Scope of Practice: Extending the Role of Paramedics

<table>
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<tr>
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<th>Victorian Department of Health Funding Allocation</th>
<th>Execution Date</th>
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<tbody>
<tr>
<td>SA Ambulance Service Inc (Limestone Coast) - Implementation Site</td>
<td>N/A</td>
<td>26/06/2012</td>
<td>$680,446</td>
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<tr>
<td>SA Ambulance Service Inc (Port Lincoln) - Implementation Site</td>
<td>N/A</td>
<td>26/06/2012</td>
<td>$690,727</td>
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<tr>
<td>St John Ambulance Australia Northern Territory Inc - Implementation Site</td>
<td>N/A</td>
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<td>$712,903</td>
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<tr>
<td>State of Tasmania through the Department of Health and Human Services, trading as Tasmanian Ambulance - Implementation Site</td>
<td>N/A</td>
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<td>$879,600</td>
</tr>
<tr>
<td>The Australian Capital Territory through the ACT Emergency Services Department, trading as ACT Ambulance - Implementation Site</td>
<td>N/A</td>
<td>29/06/2012</td>
<td>$962,000</td>
</tr>
</tbody>
</table>

* The Austin Consortium holds funding for all Victorian implementation sites; HWA has not entered into individual contracts with each Victorian implementation site.
### Appendix 2  Example of site visit agenda

<table>
<thead>
<tr>
<th>Date and time</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Attendees</td>
<td></td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
<tr>
<td>Contact numbers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Topic</th>
<th>Issues</th>
</tr>
</thead>
</table>
| 1. Introductions, orientation to site and meeting venue | Overview of the day  
Amendments to agenda |
| 2. Overview – project progress | Recap of the service model  
Progress with implementation – barriers and enablers to date  
Project management – issues arising; lessons learnt to date |
| 3. Evaluation issues | Local evaluation plan  
Ethics approval  
Requirements from the national evaluation team  
Revisions to Key Performance Indicators and data collection requirements, methods and tool  
Sustainability issues |
| 4. Data specifications | Current administrative data sets:  
- capacity to identify patients seen by ESOP clinicians  
- location specific information systems e.g. patient safety data, incident information management systems  
- financial data |
| 5. Reviewing the training evaluation tools | Review of training evaluation tools with the national evaluation team |
| 6. Emerging risks | General discussion  
- Clinical governance processes  
- Project risks |
| 7. Other business | Any other issues / questions |
| 8. Close and next steps |  
- Actions arising from the site visit  
- Ongoing contact and support |

The national evaluation team is available to attend Project Steering Committee meetings, meet with ESOP clinicians or other key stakeholders as required. If possible, a brief tour of the ED or workplace where the ESOP clinicians are based should be undertaken.
Appendix 3  Summary of responses from project teams about elements of project progress

Figure 2  Expanded Scope of Practice: Advanced Practice in Endoscopy Nursing Summary of Responses

<table>
<thead>
<tr>
<th>Assessment of the APEN sub-project</th>
<th>Austin Hospital</th>
<th>Logan Hospital</th>
<th>Southern Health</th>
<th>The Alfred</th>
<th>Western Health</th>
<th>APEN Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 = Not true for this project and 7 = Completely true for this project</td>
<td>PR 1</td>
<td>PR 2</td>
<td>PR 1</td>
<td>PR 2</td>
<td>PR 1</td>
<td>PR 2</td>
</tr>
<tr>
<td>Staff taking on new expanded roles are comfortable with the changes.</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Staff taking on new expanded roles have the knowledge required.</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Staff taking on new expanded roles have the skills required.</td>
<td>-</td>
<td>-</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>The project team has confidence that the model will be successfully implemented.</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Staff taking on new expanded roles have the support they need.</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>More training needs to be undertaken to build staff capacity for their new role.</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>The health care team understand the need for these project changes.</td>
<td>4</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>The health care team support these project changes.</td>
<td>5</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>The project is supported by management.</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>More needs to be done to engage stakeholders and build support for change.</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>The project is resulting in positive changes to attitudes about the value of expanded practice roles in the workplace.</td>
<td>5</td>
<td>6</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Changes to systems created by the project will remain after the project ends.</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>Changes to practices undertaken by the project will remain after the project ends.</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>-</td>
</tr>
<tr>
<td>The project could be replicated and run in another location.</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>The data required for the evaluation are being routinely collected.</td>
<td>4</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>The data required for the evaluation are of high quality.</td>
<td>5</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
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</table>

Overall, responses to statements indicate a generally positive situation for APEN projects. The extent of reported change between the first two reporting periods was relatively small. Support by management of projects is strong for all projects. It is apparent that more training needs to be undertaken by the majority of projects (which may be expected considering the training pathway for this sub-project), and that more work needs to be done to ensure compliance of some projects with evaluation data collection expectations.
### Figure 3

**Expanded Scope of Practice: Physiotherapists in Emergency Departments Summary of Responses**

<table>
<thead>
<tr>
<th>Statement</th>
<th>ACT Health</th>
<th>Alkira Springs Hospital</th>
<th>Ballina Health Services Base Campus</th>
<th>Calais Base Hospital</th>
<th>Filders Medical Centre</th>
<th>Gold Coast Hospital</th>
<th>Inverell Hospital</th>
<th>Richmond Hospital</th>
<th>Rockhampton Hospital</th>
<th>Townsville Hospital</th>
<th>Toowoomba Hospital</th>
<th>UQ Herbert Park</th>
<th>UQ Gatton</th>
<th>UQ Palmerston</th>
<th>HWA Expanded Scopes of Practice Program: Evaluation Progress Report 1</th>
<th>HWA Expanded Scopes of Practice Program: Evaluation Progress Report 2</th>
<th>PED Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff taking on new/expanded roles are comfortable with the changes.</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
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<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>4</td>
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<tr>
<td>2. Staff taking on new/expanded roles have the knowledge required.</td>
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<td>2</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>-</td>
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<td>7</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>3. Staff taking on new/expanded roles have the skills required.</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>5</td>
<td>-</td>
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<td>6</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>4. The project team has confidence that the model will be successfully implemented.</td>
<td>4</td>
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</tr>
<tr>
<td>5. Staff taking on new/expanded roles have the support they need.</td>
<td>3</td>
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<td>-</td>
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<tr>
<td>6. If other needs to be undertaken to build staff capacity for their new role.</td>
<td>7</td>
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<tr>
<td>7. There is less stress on the health care team in need for these project changes.</td>
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<tr>
<td>8. Other members of the health care team support these project changes.</td>
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<td>9. The project is supported by management.</td>
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<tr>
<td>10. It will be needed to engage stakeholders and build support for change.</td>
<td>4</td>
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<tr>
<td>11. The project is actually generating support for this change to be sustained.</td>
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<tr>
<td>12. The project is realising positive impacts in attitudes about the value of expanded practice roles in this workplace.</td>
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<tr>
<td>13. Changes to system created by the project are in place after the project ends.</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>3</td>
<td>-</td>
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<td>5</td>
<td>2</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>14. Changes to practices undertaken by the project are in place after the project ends.</td>
<td>3</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>4</td>
<td>-</td>
<td>3</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>15. The project could be duplicated and run in another location.</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>6</td>
<td>-</td>
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<td>4</td>
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<tr>
<td>16. The data required for the evaluation are being routinely collected.</td>
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<td>17. The data required for the evaluation are of high quality.</td>
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</tr>
</tbody>
</table>

Overall, responses to statements indicate a generally positive situation for PED projects. A clear positive trend was evident in the average scores of the second progress reports, with improvements indicated by responses to the majority of statements. Support by management is strong for all projects. It is apparent that more training needs to be undertaken by the majority of projects; however this may be expected considering projects were still in the set-up phase at the time of these reports.
### Figure 4 Expanded Scope of Practice: Nurses in Emergency Departments Summary of Responses

<table>
<thead>
<tr>
<th>Statement</th>
<th>Eastern Health</th>
<th>Northern District</th>
<th>Prince of Wales Hospital</th>
<th>Royal Children's Hospital Melbourne</th>
<th>Royal Prince Alfred Hospital Sydney</th>
<th>Sunshine Hospital</th>
<th>The Kimberley &amp; District Hospital</th>
<th>Wollogong Hospital</th>
<th>NED Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff taking on new or expanded roles are comfortable with the changes</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Staff taking on new or expanded roles have the knowledge required</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>4</td>
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<td>6</td>
</tr>
<tr>
<td>Staff taking on new or expanded roles have the skills required</td>
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<td>6</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Staff taking on new or expanded roles have the confidence required</td>
<td>5</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td>7</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>The project team has confidence that the new roles will be successfully implemented in their area</td>
<td>7</td>
<td>7</td>
<td>4</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>6</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Staff taking on new or expanded roles have the support they need</td>
<td>7</td>
<td>7</td>
<td>1</td>
<td>6</td>
<td>7</td>
<td>7</td>
<td>5</td>
<td>6</td>
<td>7</td>
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<tr>
<td>Staff taking on new or expanded roles need the support to continue to implement their roles</td>
<td>5</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>3</td>
<td>2</td>
<td>5</td>
<td>6</td>
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</tr>
<tr>
<td>There is a clear discussion by the health care team about the need for these project changes</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>6</td>
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</tr>
<tr>
<td>There is a clear discussion by the health care team about these project changes</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>5</td>
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<tr>
<td>The project is supported by the regional health department</td>
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<tr>
<td>The project is generating support for the change that needs to be implemented</td>
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<td>1</td>
<td>7</td>
<td>2</td>
<td>3</td>
<td>2</td>
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<tr>
<td>The project is generating support for the change to be implemented</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>The project is generating support for the change to be implemented about the value of expanded practice roles in their workplace</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>6</td>
<td>6</td>
<td>6</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Changes in system are caused by the project in new all after the project ends</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>7</td>
<td>6</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Changes to practices undertaken by the project in new all after the project ends</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td>7</td>
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<td>6</td>
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</tr>
<tr>
<td>The project could be duplicated and run in another location</td>
<td>6</td>
<td>6</td>
<td>4</td>
<td>7</td>
<td>6</td>
<td>4</td>
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<tr>
<td>The data required for the evaluation are being systematically collected</td>
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<tr>
<td>The data required for the evaluation are of high quality</td>
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</tbody>
</table>

Overall, responses to statements indicate a generally positive situation for NED projects. A positive trend was evident in the average scores of the second progress reports, with improvements indicated by responses to the majority of statements. Support by management of projects is strong for all projects. The confidence of most project teams in successfully implementing the model is high, and ESOP staff from most projects have the support they need. It is apparent that more training needs to be undertaken by the majority of projects; however this may be expected as projects were still in the set-up phase at the time of these reports.
Figure 5  Expanded Scope of Practice: Extending the Role of Paramedics Summary of Responses

<table>
<thead>
<tr>
<th>Assessments of the ERP sub-project</th>
<th>ACT Ambulance Service</th>
<th>Tasmanian Ambulance</th>
<th>SA Ambulance Limestone Coast</th>
<th>SA Ambulance Port Lincoln</th>
<th>NT Ambulance (N) Darwin</th>
<th>ERP Average</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PR 1</td>
<td>PR 1</td>
<td>PR 1</td>
<td>PR 1</td>
<td>PR 1</td>
<td>PR 1</td>
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<tr>
<td>Staff taking on new/expanded roles are comfortable with the changes</td>
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<td>3</td>
<td>4</td>
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<tr>
<td>Staff taking on new/expanded roles have the knowledge required,</td>
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<td>4</td>
<td>5</td>
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<td>4</td>
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<td>3</td>
<td>7</td>
<td>4.6</td>
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<tr>
<td>Project team has confidence that the model will be successfully implemented</td>
<td>3</td>
<td>3</td>
<td>6</td>
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<td>4.6</td>
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<tr>
<td>More training needs to be undertaken to build staff capacity for their new role,</td>
<td>4</td>
<td>4</td>
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<tr>
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<tr>
<td>More needs to be done to engage stakeholders and build support for change,</td>
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<td>6</td>
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<td>3</td>
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<td>5.2</td>
</tr>
<tr>
<td>The project is in part generating support for this change to be sustained,</td>
<td>4</td>
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<td>5</td>
<td>3</td>
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</tr>
<tr>
<td>The project is resulting in positive changes to attitudes about the value of expanded practice roles in this workplace,</td>
<td>4</td>
<td>4</td>
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</tr>
<tr>
<td>Changes to systems created by the project will remain after the project ends</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>5</td>
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<tr>
<td>Changes to practices undertaken by the project will remain after the project ends</td>
<td>4</td>
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<td>5</td>
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<td>4.4</td>
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<tr>
<td>The project could be duplicated and run in another location</td>
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<td>The data required for the evaluation are being routinely collected</td>
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</tbody>
</table>

Overall, responses to statements indicate a generally satisfactory situation for ERP projects. Support by management of projects is strong for all projects. Responses indicate that more needs to be done by each project to engage stakeholders and build support for change. It should be noted that ERP projects had only submitted one progress report at the time of writing this first evaluation progress report, thus comparison between time points was not possible.
## Appendix 4 Ethics approval status

<table>
<thead>
<tr>
<th>Project implementation site</th>
<th>Progress</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Expanded Scope of Practice: Advance Practice in Endoscopy Nursing</strong></td>
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<tr>
<td>Austin Hospital</td>
<td>In progress</td>
</tr>
<tr>
<td>Heidelberg Hospital</td>
<td>In progress</td>
</tr>
<tr>
<td>Southern Health (Monash Medical Centre)</td>
<td>In progress</td>
</tr>
<tr>
<td>Alfred Health (The Alfred Hospital)</td>
<td>In progress</td>
</tr>
<tr>
<td>Western Health (Western Hospital)</td>
<td>In progress</td>
</tr>
<tr>
<td>Logan Hospital</td>
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</tr>
<tr>
<td><strong>Expanded Scope of Practice: Physiotherapists in the Emergency Department</strong></td>
<td></td>
</tr>
<tr>
<td>The Alfred Hospital, Sandringham Hospital</td>
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</tr>
<tr>
<td>Alice Springs Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Southern Health, Casey Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Southern Health, Dandenong Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>St Vincent's Melbourne</td>
<td>Approved</td>
</tr>
<tr>
<td>Ballarat Hospital (Ballarat Health Service)</td>
<td>Approved</td>
</tr>
<tr>
<td>ACT Health (The Canberra Hospital)</td>
<td>In progress</td>
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<tr>
<td>Calinda Base Hospital</td>
<td>In progress</td>
</tr>
<tr>
<td>Flinders Medical Centre</td>
<td>In progress</td>
</tr>
<tr>
<td>Gold Coast Health District (Robina Hospital)</td>
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</tr>
<tr>
<td><strong>Expanded Scope of Practice: Nurses in the Emergency Department</strong></td>
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</tr>
<tr>
<td>Kilmore and District Hospital</td>
<td>Application not lodged</td>
</tr>
<tr>
<td>Eastern Health (Box Hill and Maroondah Hospitals)</td>
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</tr>
<tr>
<td>Sunshine Hospital</td>
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</tr>
<tr>
<td>Royal Children's Hospital, Melbourne</td>
<td>Approved</td>
</tr>
<tr>
<td>Wellington Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Murrumbidgee Local Health District</td>
<td>In progress</td>
</tr>
<tr>
<td>Prince of Wales Hospital</td>
<td>Approved</td>
</tr>
<tr>
<td>Royal Prince Alfred Hospital</td>
<td>Approved</td>
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<tr>
<td><strong>Expanded Scope of Practice: Extending the Role of Paramedics</strong></td>
<td></td>
</tr>
<tr>
<td>South Australian Ambulance Service - Limestone Coast</td>
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</tr>
<tr>
<td>South Australian Ambulance Service - Eyre Peninsula</td>
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<tr>
<td>Ambulance Tasmania</td>
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<tr>
<td>ACT Ambulance Service</td>
<td>Application not lodged</td>
</tr>
<tr>
<td>St John's Ambulance Service</td>
<td>Application not lodged</td>
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