



SYNERGIA

**Evaluation of the New
Graduate Nurse
employment scheme
through the Very Low
Cost Access initiative:
Final evaluation report**

Report for Ministry of Health

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19th May 2015

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ACKNOWLEDGEMENTS

We would like to acknowledge the support of the Very Low Cost Access practices that agreed to take part in this evaluation. We would particularly like to thank all the Very Low Cost Access practices involved in the initiative, and the District Health Board and Primary Health Organisation staff for giving their time and insights into the implementation and achievements of the initiative through the online survey.

We would also like to acknowledge the support of the five practices that took part in the site visits. The views and experiences of the staff at these practices has enabled the evaluation to provide an in-depth insight into the implementation and achievements of this initiative. We would particularly like to thank those who took part in the interviews and provided practice level data.

Finally, we would like to acknowledge the support and insights from key stakeholders at the Ministry of Health.

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1. EXECUTIVE SUMMARY

INTRODUCTION

The New Graduate Nurse (NGN) employment scheme is part of the Very Low Cost Access (VLCA) Practice Sustainability initiative that provided additional funding for qualifying general practices serving high needs populations. The initiative was introduced by the Ministry of Health (MoH) in 2013/2014, partly in response to evidence suggesting that some VLCA practices with high proportions of high needs enrolees were experiencing sustainability issues due to a mix of financial, workforce, clinical and social complexity issues. The NGN employment scheme involved one-off supplemental funding of \$2.4 million to employ and pay salaries for 48 new graduate nurses (NGNs) for 12 months in qualifying practices.

Synergia was commissioned by the MoH to conduct a process and impact evaluation of the NGN employment scheme with the following objectives:

Process Evaluation Objectives:

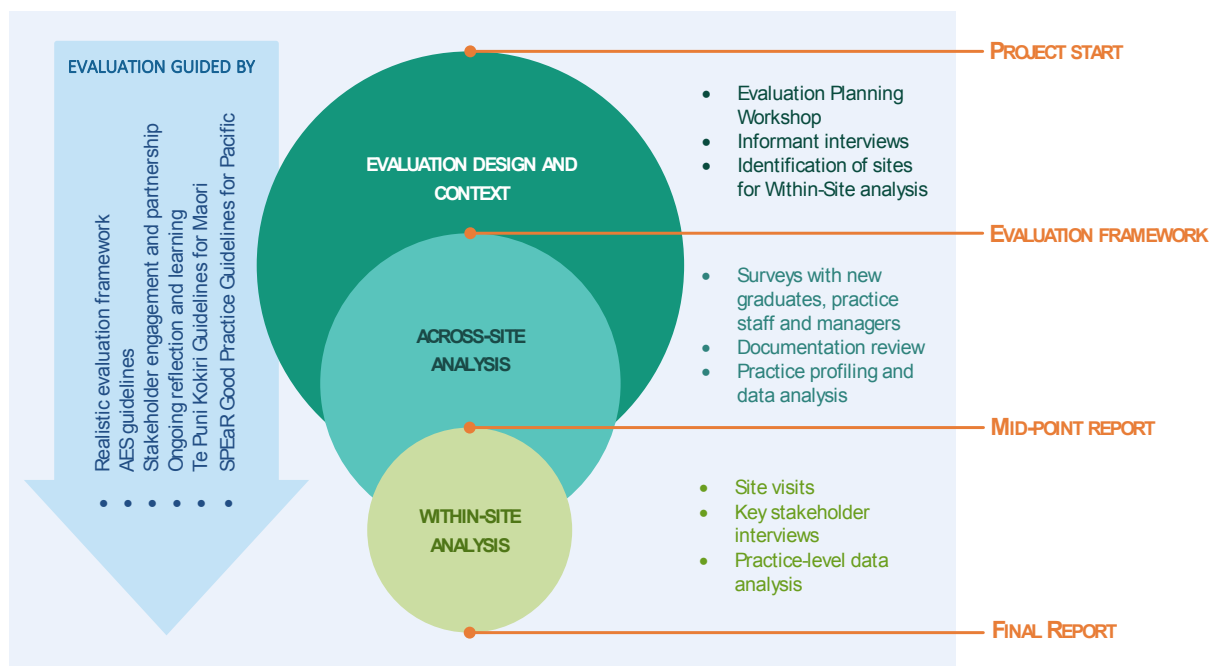
- To evaluate the implementation of the scheme by the VLCA practices, PHOs and DHBs,
- To evaluate the professional development support provided to new graduates nurses,
- Identify key learnings from the VLCA business owners and other stakeholders and
- Identify ideas for modifications and improvements to the scheme and its implementation

Evaluate the impact on:

- The working relationships between the practices, PHOs and DHBs,
- Service delivery and patient care in general practice,
- The sustainability of VLCA practices,
- The workforce of the VLCA practices and
- The new graduate nurses' professional development and career decisions.

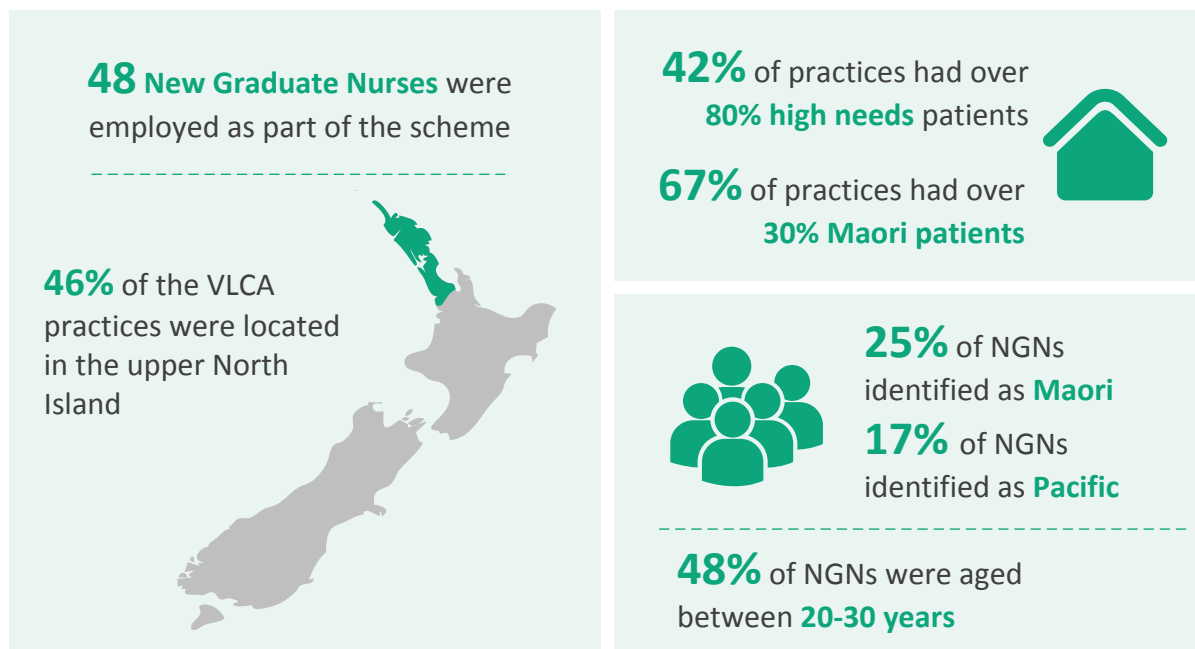
The evaluation utilised the principles of Realistic Evaluation that looks for regularity in outcomes and mechanisms, as well as understanding the role of context and exploring differences. This type of evaluation is best implemented through a mixed methods approach.

EVALUATION APPROACH AND METHODS



This report builds on the mid-point report and integrates findings from the methods in both the across and within-site analysis to address the impact and process evaluation objectives.

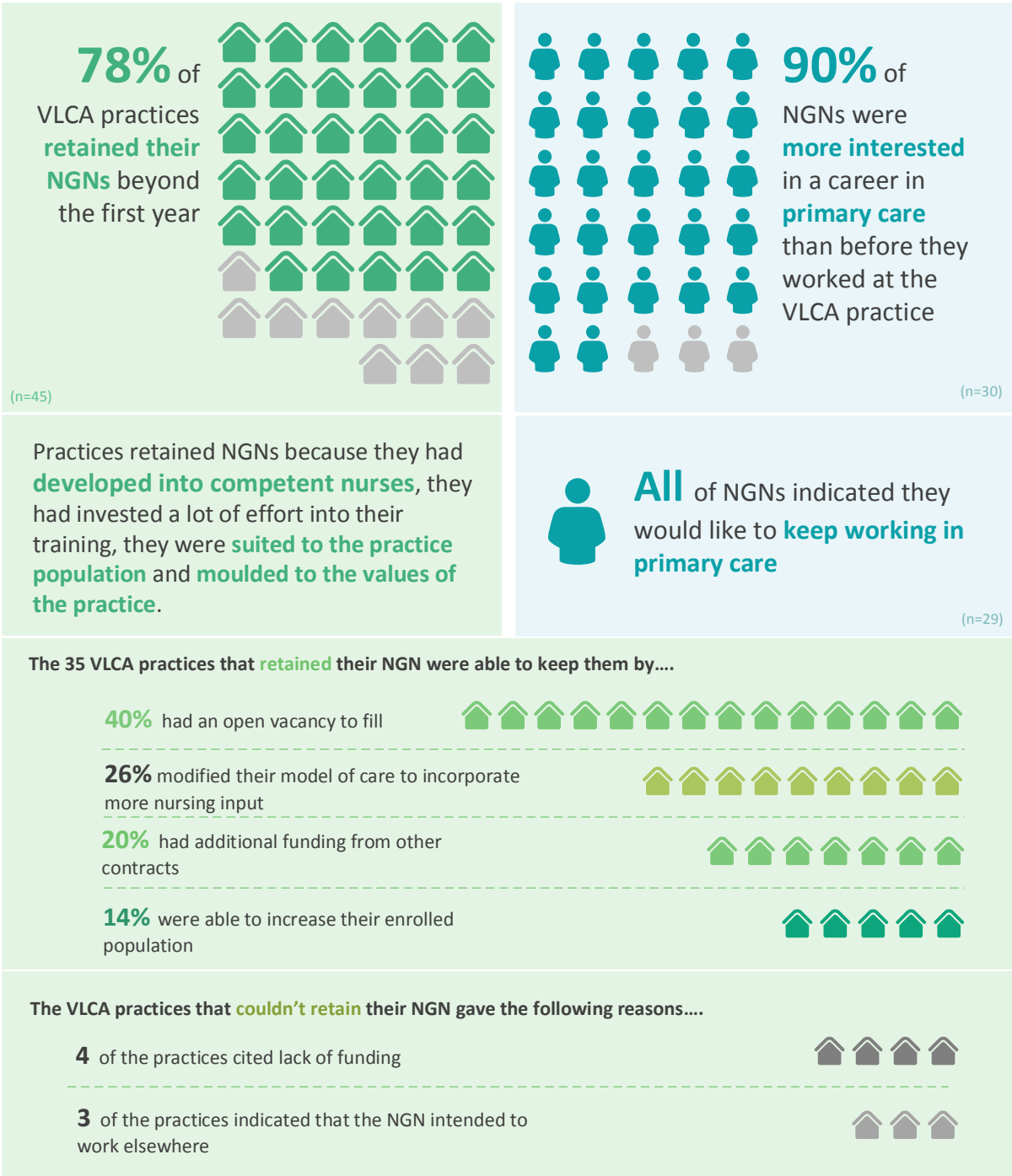
PROFILE OF THE VLCA PRACTICES AND NGNs



Most of the VLCA practices were of reasonable size, with 71% having between 2 and 9 GPs and 73% had an enrolled population between 2,000 and 10,000. Ten of the 48 VLCA practices had previously

employed a NGN before their involvement in the employment scheme (21%), and 11 had previous experience with medical or nursing students (23%).

WORKFORCE SUSTAINABILITY



FINANCIAL SUSTAINABILITY



45% of Practice Managers felt the NGN had increased the **financial sustainability** of the practice

35% felt the NGN had **increased the revenue** of the practice



34% felt the NGN had **reduced the costs** of the practice

(n=33)

Many would not take on another NGN without the additional funding to support the role due to the **financial cost of training them...**

*"If it was sustainable we **would have already been doing it**. We wouldn't have needed the extra to do it"*

-Practice Manager

CLINICAL AND SOCIAL SUSTAINABILITY



60% of survey respondents felt that the NGN had **changed other clinician's practice**

(n=103)

The NGNs were seen as capable of enabling **patients' social issues** to be addressed by the practice...

*"If you really want to make a difference it takes time. You can't just say, 'read this. Next one please.' ...And so the NGN **spends a lot of time with education** and with listening to people on the phone"*

- GP

87% of survey respondents felt that the NGN had increased the **time available to support patients' social needs**



(n=104)

PATIENT CARE AND SAFETY



78% of survey respondents felt that the NGN had increased **number of appointments available to patients**

(n=33)



95% of survey respondents felt that the NGN had lead to **improved patient experience**

(n=101)

NGNs also contributed to the broader efforts to improve patient care and practice targets. Some specific examples included:

A number of NGNs undertook **vaccinator training** and contributed to the practice's **immunisation targets**:

"I do a lot of immunisations. Like I probably do at least one to two every day." - NGN



One NGN led an initiative to **reduce medication reconciliation** time from 4.7 to 3.1 days



Another undertook a project to **screen for pre-diabetic patients** to allow **early intervention**



KEY FACTORS AND SUPPORTS FOR IMPLEMENTATION



90% of practice staff knew the **role of the NGN** and the **activities they were capable of doing**

(n=102 survey respondents)

Practices with **previous NGN experience** were more likely to have accurate expectations of the NGNs ability



84% of NGNs suggested their **preceptors** were providing **mentoring that was meeting their support needs**

(n=31)



81% of NGNs thought the **NETP programme** supported their **professional development** in primary care

(n=31)

Although some NGNs also suggested it had a **hospital focus**

"I think it's aimed towards more hospital. And I think that I could have gotten away with not going to some of the days considering it was a lot about hospital stuff" - NGN



88% of practice staff thought that the practice had a good **induction process**

(n=102 survey respondents)

Practices with **previous NGN experience** were more likely to have good induction processes

"Employing a skilled, local Māori NGN."

"Recruiting a potential Pacific nurse to keep long term."

Practices valued having **local NGNs** who understand local populations

IDEAS GOING FORWARD

- Stakeholders from the mid-point survey and site visits felt changing practice eligibility requirements to **remove the one-off component** and **include non-VLCA practices** would improve the ability of the scheme to develop a primary care nursing workforce.
- Improving the **application process** would help practices respond, allow for greater collaboration, and facilitate access to a wider pool of NGNs
- Some stakeholders thought the scheme could include **opportunities for role-sharing the NGN**. They felt that sharing between smaller practices would allow greater flexibility and sharing with a hospital would give NGNs a broader experience.
- A Practice Manager thought there should be **opportunities to share learnings and knowledge** among practices involved in the scheme.
- A common suggestion in the mid-point survey and at site visits was the idea of **extending the length of the employment scheme**. Many recommend a 2 year scheme.
- Many sector stakeholders suggested **greater promotion of primary care careers** should supplement the scheme.

CONCLUSIONS

The evaluation of the first round of the one-off funding scheme was designed to evaluate its implementation and its impacts on the new graduate nurses and the practices. Drawing on the insights from the mixed methods data integration, the findings suggest that:

1. The scheme has provided a valuable pathway for supporting local NGNs into primary care, resulting in a nursing workforce that better matches the demographics of the VLCA population in most practices.
2. Most practices were able to sustain the NGN role beyond the initial twelve months of funding, identifying the value of the scheme in supporting NGNs into primary care.
3. The integration of NGNs into primary care had positive impacts on service delivery and patient experience. This included increasing time available for appointments, time spent with patients and support for existing clinical staff.
4. The NGNs supported practices performance towards targets, and in many cases were considered to improve performance. The scheme has increased the motivations for NGNs involved to pursue a career in primary care.
5. The scheme has provided a positive learning experience for most NGNs, and has supported their professional development through increasing their clinical skills and experience.
6. The NGNs often increased staff satisfaction, particularly when staff were involved in training the NGNs. For staff with less experience in providing this training and support however, this was not always the case.
7. The NGNs brought new skills and experience to the practice that was valued by the staff and patients, who enjoyed the enthusiasm and energy of the younger nurses.
8. The scheme was supported by and bolstered the existing relationships between some of the PHOs and practices. It did appear to increase connections between some DHBs and PHOs, and in fewer instances DHBs and practices.
9. Impacts of the scheme on financial sustainability were less likely to be experienced by all of the practices, although this influence may change over time in practices that have sustained the role.
10. The scheme did have positive impacts on the sustainability of the workforce, with the consistency of the NGN role valued over the use of more casual staff.
11. Clinical and social impacts were also identified. Clinicians often described the ability to focus on tasks more specifically related to their scope after the arrival of the NGN, and the increased time available for patients was noted for its value in supporting patients' health and social care needs.

12. The impacts of the scheme are affected by its implementation. Key success factors for the implementation of the scheme include:
- a. A good induction process, both for the NGN and for the clinical and non-clinical staff. This is important for managing the expectations of the NGN role and ensuring that their knowledge and skills were appropriately developed and utilised at the practice.
 - b. Previous experience with a NGN maximised the value of the NGN role. For example, knowing the supports that a NGN needs and when to train them in which courses maximised the value of the role for some practices.
 - c. Appropriate level of support for the NGN; nurse preceptor, Nurse Entry to Practice (NETP) programme coordinator and support from other practice staff are crucial. The support of the nurse preceptor was particularly important to the NGNs.
 - d. The recruitment of local NGNs who understood the local patient populations.
 - e. Clarity on the level of work and study load that is required for a NGN. The NGNs were employed at different FTE levels (between 0.8 and 1.0) and this meant some felt the burden of work and study commitments more than others.
 - f. The NETP programme supported connections with other NGNs and professional development. The NGNs suggested that the value of the NETP programme could be enhanced by increasing the relevance to primary care settings.
 - g. Valuable external support from the DHB (NETP Coordinators) and PHO (Nursing Leaders). This was particularly important when the practices had little previous experience of a NGN. Some practices however, suggested that greater coordination between those supporting the NGN would be valuable.

The conclusions from this evaluation highlight the value of the scheme in supporting VLCA practices and in supporting NGNs into primary care. When considering the future implementation of the scheme, the findings suggest that practices with previous experience of NGNs provided better induction and support processes. However, all practices reported some value and benefit from having a NGN and most sustained the role. While it might be tempting to support those practices with previous experience of developing NGNs, these practices were often larger and in more urban locations. Implementing the scheme through these practices would provide a more systematic approach to developing the nursing workforce in primary care. However, this would reduce the value of the scheme for smaller practices and/or those practices experiencing difficulties with recruitment and succession planning, such as those in more rural areas. The value of the scheme in

supporting practices to develop a sustainable local nursing workforce may also be challenged if the availability of the scheme was restricted to specific practices.

What is needed however, is greater consideration of the support that is needed for those practices who are less experienced with NGNs. This is important not only for the development of the NGN, but for the practice to maximise the value of the NGN from the start. For some of the practices with little previous NGN experience, success was enabled by extensive additional support from the DHB and the PHO. When integrating NGNs in this context it is important for the PHO and the DHB to consider the additional supports and challenges that this may bring to their current roles and the level of support that they can provide. The joint application process provides a means of supporting this process.

Drawing on the evidence in this evaluation report, the expertise of nurse preceptors, NETP Coordinators and PHO Nurse Leaders could support the development of a resource that would enable practices to better support a NGN. Specifically, this resource could identify what it means to have a NGN in their practice, the level of support needed, as well as the value and benefits that they can expect to achieve. The development of this resource could also help to clarify the roles and responsibilities of the DHB, PHO and practice in supporting the integration of NGNs into primary care. This should enhance the coordination and integration of the supports available for the NGNs.

2. INTRODUCTION

2.1 BACKGROUND

This report presents the evaluation of the new graduate nurse employment scheme through the Very Low Cost Access initiative. Synergia was commissioned to conduct the evaluation between May 2014 and April 2015. The aim of the evaluation was to conduct a process and impact evaluation of the New Graduate Nurse (NGN) employment scheme in Very Low Cost Access (VLCA) practices. This report integrates findings from the across-site and within-site evaluation phases to identify the key learnings from the first year of implementing the scheme along with key considerations for future implementation.

2.2 THE NEW GRADUATE NURSE EMPLOYMENT SCHEME

The NGN employment scheme is part of the VLCA Practice Sustainability initiative that provided additional funding for qualifying general practices serving 50 percent or more high needs populations (defined as Māori, Pacific, or Quintile 5 populations). The initiative was introduced by the Ministry of Health (MoH) in 2013/2014 partly in response to evidence suggesting that some VLCA practices with high proportions of high needs enrollees were experiencing sustainability issues due to a mix of financial, workforce, clinical and social complexity issues (1).

The VLCA Practice Sustainability Initiative involves two components. The first provides ongoing funding of \$4 million per annum for VLCA practices with 50% or more high needs enrollees. The second component involves one-off supplemental funding of \$2.4 million to employ and pay salaries for 48 new graduate nurses (NGNs) for 12 months in qualifying practices. This one-off funding was intended to support VLCA practices to:

- Address some of their ongoing workforce issues e.g. ageing workforce, recruitment difficulties and poor alignment between patients and nursing workforce demographics.
- Support graduate nurses to transition to primary healthcare practices in a planned programme associated with NETP programme.

In the longer term the scheme was designed support VLCA practices to:

- Implement additional service provision.
- Expand patient care.
- Enhance workforce sustainability.

Eligible practices were required to fill in an application in collaboration with their PHO and DHB which outlined their sustainability issues and capacity to support a NGN. Applications were reviewed by the MoH and 48 practices¹ were approved to receive funding under the new graduate nurse employment scheme. As part of the NGN employment scheme, successful practices were required to: have a trained preceptor, maintain the position as supernumerary for the first six weeks, have an intention to sustain their employment beyond the one year funded through the scheme, and employ a NGN before the commencement of the NETP programme.

The first round of the employment scheme saw 48 new graduate nurses employed for a 12 month period from February 2014, a second round of new graduate nurses have been employed in February 2015. It is useful to note, that the second round of funding was provided to practices that did not receive funding through the first round. This evaluation focuses on the first round of the scheme. Specifically, a process and impact evaluation of the scheme was conducted. This included an across site analysis to evaluate the implementation and impacts of the scheme across all participating VLCA practices, and a within site analysis of a selection of five VLCA practices to provide a deeper insight into the scheme. The findings from the across site analysis were presented in a mid-point evaluation report in October 2014 (2). This report integrates the key findings from the mid-point report with the findings from the within site analysis to provide a comprehensive insight into the implementation and impacts of the scheme.

2.3 PROFILE OF THE VLCA PRACTICES AND NEW GRADUATE NURSES

2.3.1 Very Low Cost Access practices

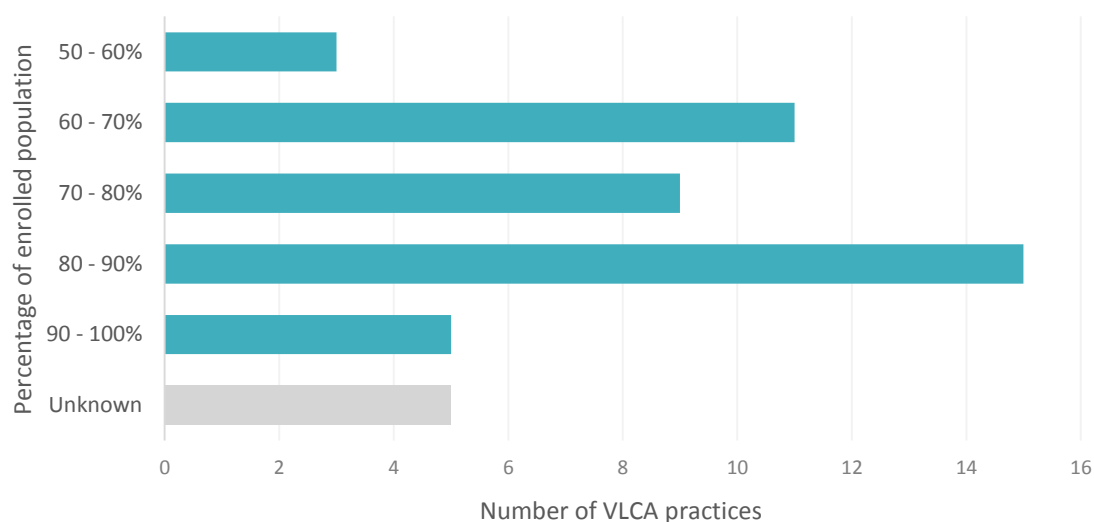
A quarter of the VLCA practices in the NGN employment scheme were located in Counties Manukau DHB (25% or 12 practices), and almost half of the practices were located in an upper North Island DHB (46% across Northland, Auckland, Waitemata, and Counties Manukau DHB).

Most of the VLCA practices had between 2 and 9 GPs, with 38% of practices having 2-4 GPs (18) and 33% having 5-9 GPs. Two-fifths of the VLCA practices had an enrolled population of between 2,000 to 5,000 patients (40% or 19 practices), and a third of practices had between 5,000 and 10,000 enrolled patients (33% or 16).

¹ Note that some of the VLCA practices are multi-site practices (i.e. more than one physical location). However these practices functionally operate as one practice, sharing staff and resources, so for the purposes of this analysis they have been considered one practice

As per the VLCA requirements, at least 50% of all of the practice's enrolled populations were classified as High Needs. Two-fifths of the VLCA practices had a very high proportion of High Needs enrolled population, with over 80% of their patients in this group (42% of practices had 80%+ High Needs patients).

Figure 1: Proportion of enrolled population characterised as High Needs (n=48)



A third of the 48 VLCA practices had less than 30% Māori patients, a third had between 30-60% Māori patients, and a third had more than 60% of their enrolled population identifying as Māori. Almost half of the practices had less than 10% of their population identifying as Pacific (46% or 22 practices), although seven VLCA practices had over 70%.

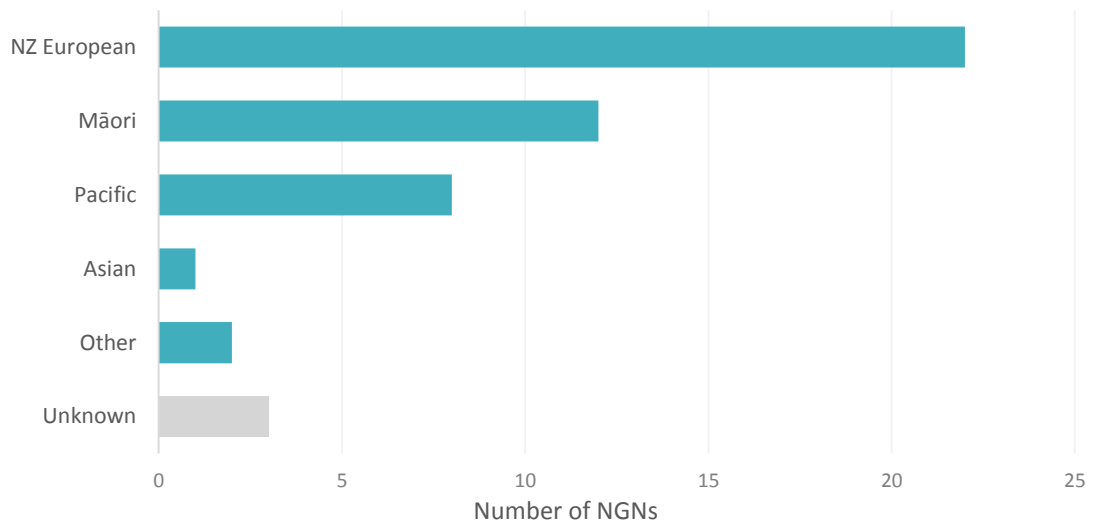
Of the 48 VLCA practices, ten had previously employed a new graduate nurse before the VLCA initiative took place (21%). Eleven practices had previously taught a medical student or a nursing student (23%).

2.3.2 New Graduate Nurse

The VLCA initiative provided funding for 48 New Graduate Nurses.

Almost half of the NGNs involved in the initiative identified as NZ European (46% or 22 NGNs). A quarter identified as Māori (25% or 12) and 17% identified as Pacific (8 NGNs).

Figure 2: Ethnicity of New Graduate Nurses (n=48)



Almost half of the NGNs involved in the initiative were between 20 and 30 years of age (48% or 23 NGNs). A quarter were aged between 30 and 50 years (23% or 11 NGNs), while 6% of the NGNs were over 50 years of age (3 NGNs).

2.4 STRUCTURE OF THIS REPORT

Following this introduction, this report will provide an overview of the evaluation aims and objectives, and approach. The evaluation findings are presented in three key sections that encompass the evaluation aims and objectives; key impacts, implementation of the scheme, and ideas for modifications and improvements. This approach supports the integration of the multiple data sets and allows the evaluation to move beyond the findings of individual data sets to fully address the aims and objectives of the evaluation. Following this, we identify key strengths and limitations, and conclusions.

3. EVALUATION APPROACH AND METHODS

3.1 EVALUATION AIMS AND OBJECTIVES

The evaluation aimed to conduct a process and impact evaluation of the one-off funding of the NGN employment in VLCA general practices. The objectives of the process evaluation are:

- To evaluate the implementation of the scheme by the VLCA practices, PHOs and DHBs,
- To evaluate the professional development support provided to new graduate nurses,
- Identify key learnings from the VLCA business owners and other stakeholders and
- Identify ideas for modifications and improvements to the scheme and its implementation.

The impact evaluation objectives identify the impact of the scheme on:

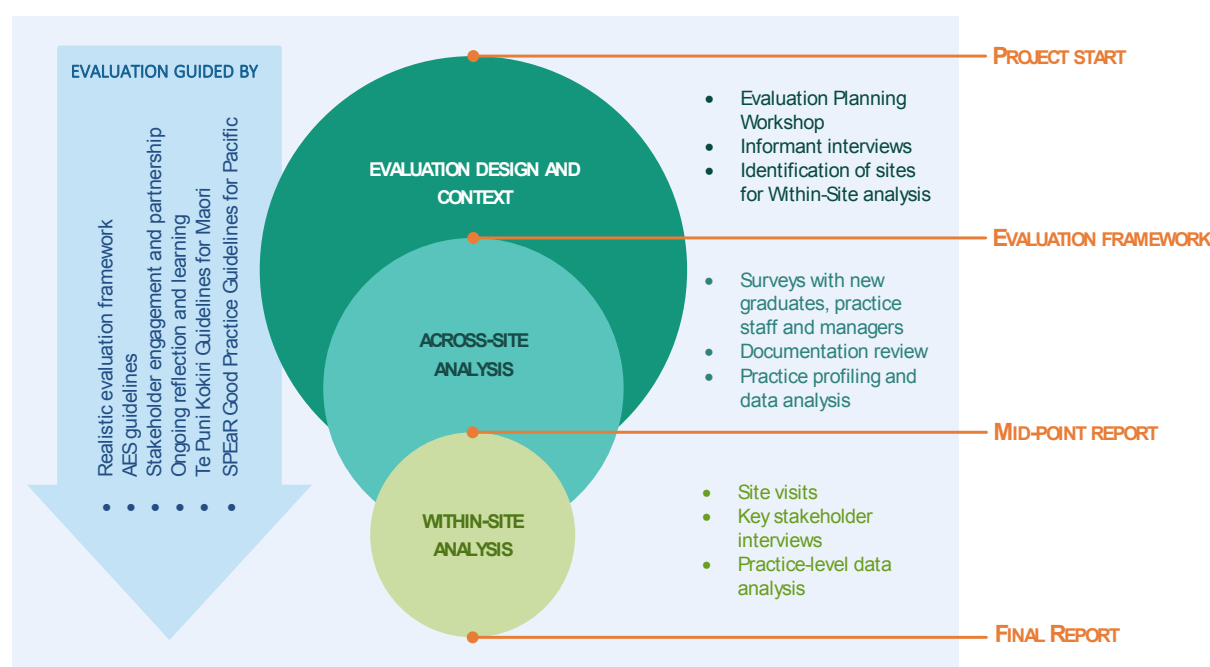
- The working relationships between the practices, PHOs and DHBs,
- Service delivery and patient care in general practice,
- The sustainability of VLCA practices,
- The workforce of the VLCA practices and
- The new graduate nurses' professional development and career decisions.

3.2 EVALUATION APPROACH AND FRAMEWORK

The evaluation draws on the principles of Realistic Evaluation (3).

Realistic evaluation looks for regularity in outcomes and mechanisms, but equally it looks to understand the role of context and explore differences. The approach seeks to understand how mechanisms (e.g. the implementation of the new graduate nurse funding) produce outcomes (both intended and unintended) under specific, contextual circumstances (e.g. variations in the characteristics of practice settings). This type of evaluation is best implemented through a mixed methods approach. The overarching approach, including the principles guiding this evaluation and the methods are identified in Figure 3.

Figure 3: Overall evaluation approach and key methods



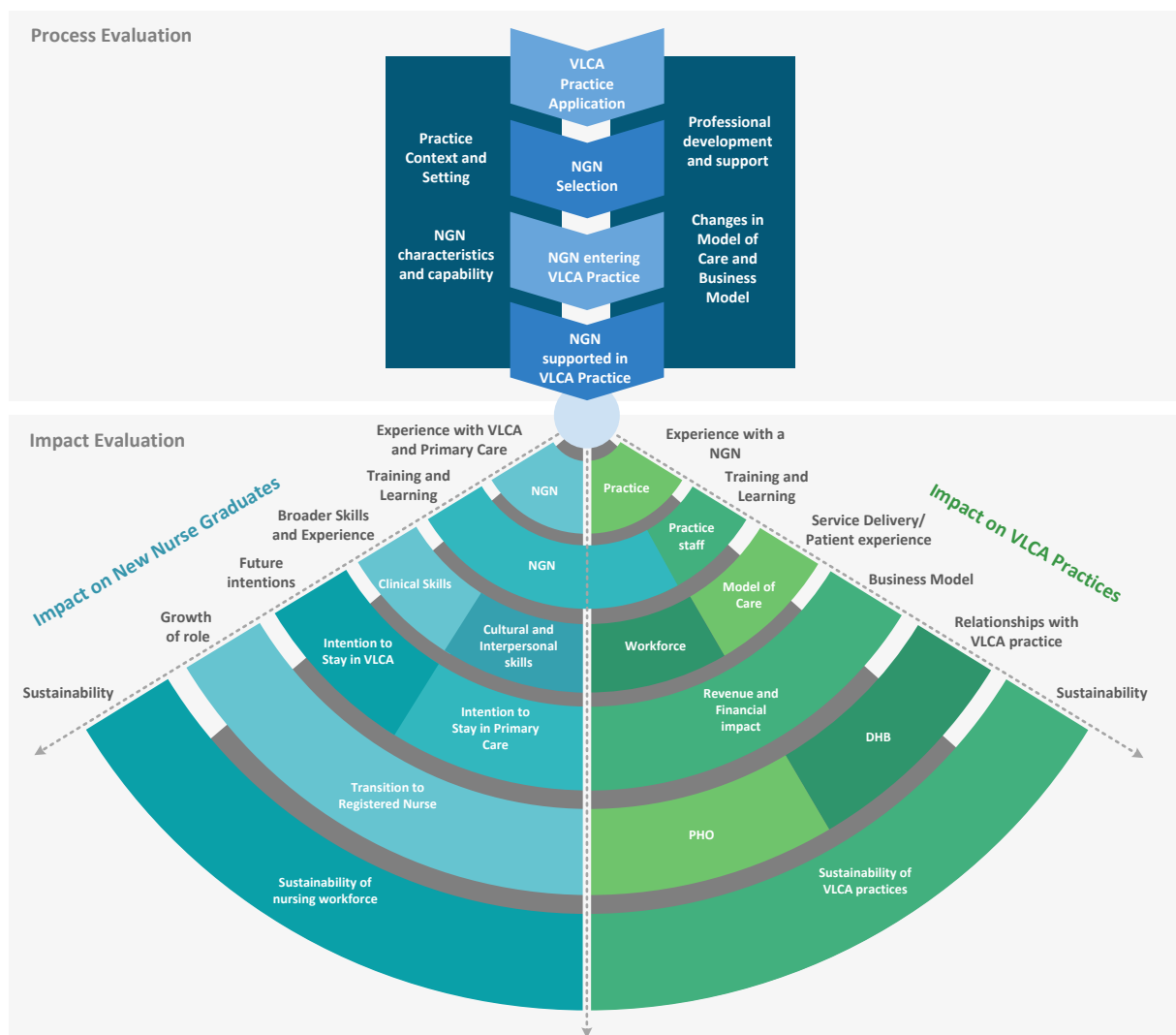
The evaluation design and context phase facilitated stakeholder engagement, refinement of the evaluation plan and the development of an evaluation framework. This was important for ensuring the feasibility, utility, propriety and accuracy of the evaluation.

The across site analysis used practice profiling, document analysis, an online mid-point survey with key stakeholders from the VLCA practices, their partnering Primary Healthcare Organisations and District Health Boards, and a follow up survey with NGNs and practice managers at the end of the scheme. The within site analysis involved site visits to five purposively selected practices. The site visits involved interviews with practice staff, PHO and DHB stakeholders, and an analysis of a small amount of quantitative data that was made available for the evaluation. Full details on the data collection and analysis are provided in Appendix One.

3.2.1 Evaluating implementation and impacts

The evaluation design and context phase identified a set of key process and outcome measures that were explored through the mixed methods approach (Figure 4). The framework recognises the influence of context and implementation on the impact of the scheme. The impact measures are divided among impacts on NGNs and the impacts on VLCA practices, the two key areas of intended benefits from the scheme. They range from immediate impacts such as the immediate primary care experience of the NGN and the practices involved to longer term change, such as the sustainability of the nursing workforce and VLCA practices.

Figure 4: Overview of process and impact measures



As this is the first year of the employment scheme it is not possible to explore the long term benefits. The evaluation was focused on identifying key learnings for future implementation, identifying the short-term benefits and indicators of longer term benefits for the practices, NGNs involved and the nursing workforce. These impacts and indicators are drawn on when addressing the evaluation objectives in the results sections.

4. KEY IMPACTS OF THE SCHEME

4.1 IMPACTS ON THE DEVELOPMENT OF NEW GRADUATE NURSES AND THEIR CAREER DECISIONS

One of the key aims of the scheme was to support graduate nurses to transition to primary healthcare practices in a planned programme associated with the NETP programme. This evaluation provides evidence that identifies the role of the scheme in achieving this and also indicates that many of the NGNs remained in primary care. The factors that supported this included:

- Providing NGNs with an opportunity to develop the skills necessary to practice in primary care.
- The NGNs motivation to continue in a career in primary care.
- The willingness and ability of VLCA practices to continue employing the NGNs beyond the 12 month funding provided through the scheme.

4.1.1 Learning experience

The evaluation highlighted the learning and benefits that the NGNs had gained from being employed in the VLCA practices. Specifically, in the mid-point survey, the NGNs noted the value of gaining experience in a highly supportive workplace, gaining employment, the training and learning opportunities and the value of working in an area that reflected their personal interests and values.

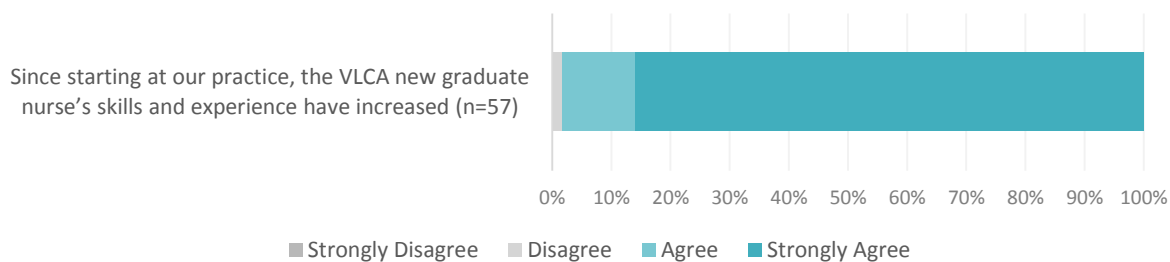
The stakeholder interviews during the within site phase supported this notion, with the NGNs suggesting that being in primary care meant that they learnt different skills to their peers in the hospital. One NGN even suggested that they had learnt more than their peers due to the variety of the work and patients that were able to experience or care for.

This level of learning and experience gained throughout the year, was even acknowledged and valued by one NGN who did not feel well supported by their practice and felt they would have been better supported in a hospital setting.

4.1.2 Professional development

Both the across site and within site phases of the evaluation found that NGNs had developed their clinical skills and increased their competency.

Practice staff in the mid-point survey thought the NGNs skills and experience had increased (98% agreed or strongly agreed).



The NGNs also identified improvements in the mid-point survey. They felt their confidence in undertaking clinical procedures had improved (93%; n=30), their clinical skills and experience had increased (90%; n=30), they were more able to identify client's needs (83%), and they were more aware of the policies and procedures required for safe clinical practice (83%).

All of the NGNs at the site visits also indicated that their confidence and skills had improved throughout the year. However, one NGN thought there was less ability to practice clinical skills in their practice as they suggested that 60% of their work was paperwork and documentation. While they still gained some skills especially patient interaction and immunisation and cervical smear training, they felt less confident to perform immunisations alone due to the fewer opportunities to practice. This highlights the importance of ensuring that NGNs have the opportunity to practice and refine their clinical technical skills.

The site visits also found that some NGNs were thinking about their longer term professional development. One NGN was continuing to complete her Post-graduate diploma, while another had long-term ambitions of becoming a Nurse Practitioner with support from a Nurse Practitioner at their practice.

4.1.3 NGN career intentions

Overall, involvement in the VLCA NGN employment scheme increased the attractiveness of a career in primary care for the NGNs employed by the practices.

The mid-point survey found that before taking part in the scheme 53% of the NGNs were very interested in working in primary care and 34% were fairly interested (n=32); and a similar number were interested in working in VLCA or high needs practices (47% very interested and 28% fairly interested; n=32) before the scheme. After having worked in a VLCA practice as part of the employment scheme 90% of the NGNs **were now more interested** in a career as a Primary Care Nurse than before (n=30). Specifically, the mid-point survey found almost all of the NGNs would like to keep working at their VLCA practice (93%; n=29), and all of them would like to continue in primary

care (n=29). This finding was further reinforced in the site visits and the follow-up survey at the end of the evaluation, where all NGNs indicated that they wanted to remain in primary care beyond the end of the scheme (n=8 for the survey and 5 NGN interviews for the site visits). Key reasons for this included their enjoyment of the work, the rewarding nature of working in a high needs area and continuing to gain experience.

4.1.4 Retention of the NGNs

There has been a high rate of NGN retention by the VLCA practices involved the scheme, though not all of the NGNs were employed by the practices beyond the end of the funded year.

When contacted at the end of the evaluation, thirty-five of the forty-five practices (78%) who responded were continuing to employ their NGN beyond the year funded by the scheme. Ten practices did not sustain the NGN role and three of the practices were unable to respond in time for the writing of this report.

An analysis of retention rates by DHB, high needs populations, practice size, previous experience and rurality identified no specific patterns or themes in the retention of the NGN role (Appendix Two).

The follow up survey provides an insight into the retention of the NGN role. Practice managers' and owners' reasons for continuing to employ the NGN included the competency of the nurse and the value they added to the practice:

"She is very competent and confident, and is working to a high level of her scope of practice."
– Practice Manager (follow up survey answer)

The practice managers and business owners also felt that they had invested considerable effort into training the nurse to be part of their team and wanted to continue to see the benefits of this at their practice. Two practices suggested that they were keeping the NGN as it was a requirement of engaging in the scheme. This suggests a difference in the interpretation of the scheme from different practices, with some perceiving the scheme to include specific requirements and others viewing them as guidelines.

The document analysis of the initial application forms to the scheme identified eight practices that were uncertain about how they would sustain their NGN's employment. At the completion of the scheme, this evaluation found that only one of these eight practices did not continue to employ their NGN beyond the funded year. This suggests that even when practices were unsure of the sustainability of the role at the beginning of the scheme, by the end of the year most saw sufficient value in the NGN to continue supporting the role.

For the ten practices that were not retaining the NGN, the most common reason was a lack of funding (40% or 4), followed by intention of the NGN to work elsewhere (30% or 3), mismatch in the fit between the NGN and the practice, and one practice indicated they did not have the capacity to continue supporting the NGN.

While not all NGNs remained at their VLCA practice beyond the first year, the involvement of the DHB and the PHO in the scheme provided other opportunities. For example, the site visits found that although two of the VLCA practices could not sustain the role, in one case the NGN was offered employment by another practice owned by the same PHO, and in another case the NGN accepted employment with a PHO itself. This highlights the value of the partnership approach to sustaining the NGN in primary care.

4.2 IMPACTS ON SERVICE DELIVERY AND PATIENT EXPERIENCE

Overall, the NGN was seen to contribute to improving, sustaining or supporting patient care and safety at the VLCA practices. While the evaluation did not explore this impact from the patients' perspective, the comments from practice staff in the surveys and the site visits suggests that the NGNs had a positive influence on patient care and safety, and in some instances target performance.

4.2.1 Influence on patient care and safety

The mid-point survey indicated that practice staff thought NGNs resulted in:

- increased number of staff available for appointments (89% agree or strongly agree; n=117),
- increased number of appointments available to patients (78%; n=110),
- increased number of patients seen at the practice (80%; n=103),
- increased the time available to support patients' social needs (87%; n=104),
- and improved patient experience (95%; n=101).

The site visits found that in addition to these benefits, there have been some more specific impacts on patient care. At one practice, the NGN initiated and conducted a project on pre-diabetes screening. They presented the project to staff at clinics across the PHO and took a leadership role in the policy and implementation. The project involves providing intervention early to encourage prevention rather than waiting until patients become diabetic to treat them. All staff at the practice had positive comments about the project and suggested that it would improve the health of the population in their area.

At another practice, the NGN has been leading a number of projects relating to patient care and safety. The largest of these involved looking at discharge summaries to reduce unplanned hospitalisations and to ensure medication reconciliations were being conducted. From February to August 2014, the NGN had reviewed a total of 364 discharge summaries; 192 had been self-referrals to hospital and 81 were identified as avoidable hospitalisations. This analysis was still underway at the time of the interviews. In terms of the impacts on time to a medication reconciliation decision however, this had decreased from an average of 4.7 days in June 2014 to 3.1 days in September 2014. This NGN was also leading the influenza vaccinations and the rheumatic fever project in the clinic.

One practice manager also noted the benefit of having a younger nurse for their patients. They suggested that this improved the experience for patients accustomed to older nurses, as they added some more energy and enthusiasm to the environment. Other staff also complimented the NGNs personality and way of communicating with patients which would contribute to positive patient feedback. Most practices felt their NGN related well to patients:

“The feedback from the patients around having someone young and enthusiastic and that sort of thing. So we certainly have had lots of positive feedback around the young nurse that you’ve got. So you’ll know the workforce is an ageing workforce. So it’s definitely nice to have some young enthusiasm in the clinic.” – Practice Manager

Only one practice identified a situation where the NGN had practised outside their level of experience on one occasion and needed to be reminded of their boundaries. This situation was mentioned by the practice manager and nurse preceptor. In this instance the patient was followed up by the doctor and no adverse effect on patient safety had been brought to their attention. However, it should be noted that in this setting the NGN was lacking the support from other nurses at the practice. This again highlights the importance of good levels of support for NGNs.

4.2.2 Target performance

Improving performance on health targets was often cited as a key benefit of employing a NGN through the scheme. At the time of the mid-point survey almost all (90%; n=30) NGNs had completed their vaccinators training and many had also undertaken cervical smear training (67%; n=30) and ABC for cessation training (60%; n=30). Many NGNs had also completed other training that enabled them to assist with the achievement of primary care targets, such as cardiovascular risk assessment and management training. The NGN interviews suggested that they were improving the target performance of the practice at which they were working.

“I definitely think for health targets because no one was vaccinating. Before when [nurse] were here, no one was vaccinating or anything so all the kids that needed vaccinating had to go to town to be immunised... I do a lot of immunisations. Like I probably do at least one to two every day.” - NGN

At the site visits, the practice managers were mixed on whether the introduction of the NGN was having an impact on their target performance. This tended to relate to the context of the practice and the role of the NGN. When the NGN was an additional role, their contribution to targets, and specifically an increase in target performance, was more likely. When the NGN was filling an existing nursing role, the NGN contributed to target performance but did not necessarily increase target performance itself.

4.3 IMPACTS ON THE WORKFORCE OF VLCA PRACTICES

The evaluation identified the impact of the NGNs on the current workforce at the VLCA practices. These impacts included providing support to the existing workforce, enhancing job satisfaction for some staff through their role in mentoring the NGNs and the continuity provided by the NGN role, and the introduction new skills and ideas to the practices by the NGNs.

4.3.1 NGN role in practices

Initially, NGNs required a good deal of support but as they have progressed and developed in their roles, they have become more independent. Their role differed slightly between practices with some undertaking valuable project based work and others performing more patient consultations and supporting GPs. Data from one site indicates their NGN recorded an encounter with a total of 6700² patients within the 10 months starting from February.

The mid-point survey and the site visits also found that the NGNs helped to share the staff workload. The addition of the NGN was described as relieving the burden on other clinical staff who noticed the difference in their workload when the NGN is away. It has also allowed for some staff to take leave and attend professional development opportunities that they otherwise would not have been able to take due to lack of staff cover.

² This does not necessarily equate to a full consultation but rather reflects the encounters that the NGN recorded in MedTech.

4.3.2 Staff satisfaction

The mid-point survey and the site visits identified the level of satisfaction that many practice staff experienced when supporting the NGN. For example, one of the doctors noted that they used to teach quite often and enjoyed the opportunity to teach a NGN:

“I like teaching, so I enjoy that aspect of my job... That’s actually something that I haven’t done as much here as I did in the States, so it’s actually nice for me to do it more.” – GP

The nursing staff also valued this role:

“Having the opportunity to Precept the New Grad although it was not my role. I saw her on occasion needing support so took the opportunity to awhi her as Practice Nurses should. It helped me increase my Leadership skills.” – Practice Nurse

When identifying the individual benefits of the scheme in the mid-point survey, the practice staff also frequently noted the value of bringing local NGNs into primary care:

- *“Employing a skilled, local Māori NGN.”*
- *“Increase Māori nurses in GP practice.”*
- *“Recruiting a potential Pacific nurse to keep long term.”*
- *“Bringing new 'blood' into primary care before they get snaffled up by the DHB who pay more.”*

For other staff at practices that experienced difficulties in recruitment, the satisfaction of working with a more consistent team was a key benefit:

“It was actually better to have somebody that maybe didn’t have the experience but who was going to be here that we could train versus someone who was just coming in periodically, that by the time you’ve kind of got them used to the system, they were gone anyway... Now we have two regular nurses and two regular doctors and a nurse practitioner and it’s just a much nicer environment to be working.” - GP

However, this was not the case at all practices. One practice nurse at one of the site visits did not have the role of the NGN or their arrival date clearly communicated to them. This led to resistance towards the introduction of the NGN from some of the staff who were needed to support the NGN, especially in the early stages of the scheme.

4.3.3 New learning

Hoare et al (4) found that training NGNs in general practice lead to ‘reciprocal role modelling.’ They found that NGNs were often experts at sourcing information. Specifically, they would assist

experienced nurses develop these skills and assist in the dissemination of best practice. This idea of learning from the NGN was also found in the mid-point survey with 80% of practice respondents indicating that NGNs had introduced new skills or processes (n=112).

The finding was further supported through the site visits. At one practice, colleagues of the NGN suggested that they learnt new skills, such as finding best practice information and up-to-date brochures on the computer. At this practice, the NGN had also taken leadership in setting up a computer folder where staff could save any resources they found to be particularly useful. Some of the practice staff also indicated that mentoring the NGNs supported them to refine and reflect on their own practice.

Some of the practice staff also felt the introduction of the NGN brought more than just sharing of new skills and information but influenced the culture in the practice:

“One of the good things I like about bringing new blood into any workplace is it puts some pressure on your already existing people who can actually be a little bit stale and whatever... I think puts a little bit of pressure in the environment for the people that have been around for a little while to lift up their socks.” – Practice owner

At one practice, this shared learning was not experienced, and was considered to be due to the young age of the NGN. One of the DHB staff indicated that from their experience, some NGNs do not feel confident to challenge the status quo as it might indicate a lack of respect for senior staff. In particular, this stakeholder thought that Māori and Pasifika NGNs might be less likely to challenge existing staff due to a cultural focus on respecting elders. The experiences of the other practices and NGNs identified in the interviews and survey however, suggests that this was not generally the case.

4.4 IMPACTS ON THE RELATIONSHIPS BETWEEN THE PRACTICES, PHOs AND DHBs

Overall, the scheme had increased connections between the practices, PHOs and DHBs. These increased connections were most likely to be experienced between the PHOs and the practices. The role of the NETP coordinator in the implementation of the scheme however, facilitated connections between some practices and the DHBs.

The mid-point survey found that most respondents felt the scheme had increased the connections between the practice and the PHO (62%; n=87) and increased the connections between the DHB and the practice (53%; n=88). PHO and DHB respondents were more likely to agree that the scheme had increased connections than respondents from the VLCA practices. These increased connections

were also noted as individual benefits of the VLCA scheme by DHB and PHO staff in the mid-point survey:

“An opportunity to engage with an Iwi provider.” – PHO staff

“It has increased my positive working relationship with the PHO by supporting these practices.” NETP Coordinator

“Getting to know the practice and practice staff better.” – PHO Staff

The mid-point survey suggests that the scheme has helped to secure relationships between practices and PHOs but there were fewer direct links between practices and DHBs, as these relationships tended to be facilitated through the PHO. Some of the practices selected in the site visits were owned by their PHO which made the impact of the scheme on these relationships harder to explore. The other practices involved in the site visits also often had existing relationships with their PHO.

The site visit interviews did provide an insight into the impact of the scheme on the relationship between practices and DHBs. For example, one practice suggested that they now had a more positive relationship with the DHB. They suggested that their relationships with the DHB had moved from one of just monitoring practice activities to the practice feeling that they had more traction with the DHB. The increased connections with the DHB had also increased their awareness of the training the DHB offered to primary care staff.

The stakeholder interviews suggested that scheme increased the connections between the DHB and PHOs. For example, some of the DHB staff were aware that they did not have the resources or time available to visit all the NGNs in their practices to provide support. This resulted in some increasing their engagement with the PHO nurse leaders to ensure that appropriate support was provided to the NGNs.

4.5 IMPACTS ON THE SUSTAINABILITY OF VLCA PRACTICES

When reviewing the impact of the scheme on the sustainability of the VLCA practices, it is important to be mindful that this reports provides an insight into the implementation and impacts of the scheme just after the initial 12 months of funding. Following up with the VLCA practices in another six to 12 months would be important for providing further insight into the impact of the scheme on

the sustainability of the VLCA practices. This follow-up could identify the impact on financial, workforce, clinical and social sustainability after the 12 months of funding.

This evaluation however, does provide an insight into the impacts of the scheme on the sustainability of the VLCA practices. While practices were less likely to suggest that the NGN had impacted on the financial sustainability of the practice, the contribution of the scheme to workforce, clinical and social sustainability was often noted by the practice staff.

4.5.1 Financial sustainability

The mid-point survey suggests that the NGNs only influenced the financial sustainability of half of the practices who took part in the survey. Specifically, just under half felt that the NGN increased the fiscal sustainability of the VLCA practice (45%; n=33), 35% indicated the NGN had increased revenue at the practice (n=34) and 34% indicated they reduced costs (n=32).

This sentiment was echoed in the site visits. One practice mentioned that the funding does not entirely cover their costs of the NGN for the year and their contribution was an illustration of their commitment to the employment scheme. Some of the practices without previous experience of NGNs also suggested that they would not take on another NGN without the additional funding to support the role due to the financial cost of training them. Site visit interviews similarly suggested that the NGN role had limited impact on financial sustainability. However, the scheme did provide additional resource for practices to have a new graduate nurse, which for some would not have been possible without the scheme.

4.5.2 Workforce sustainability

Practice managers and owners suggested that the scheme contributed to the sustainability of the workforce. Most of the practices we visited had a recent resignation or were short-staffed and the NGN filled the gap in their workforce. This was most relevant to practices outside the large metropolitan areas which faced recruiting difficulties. For one practice, just being able to employ a nurse full-time was the most beneficial aspect of the scheme. This shows the value of the scheme in supporting practices to bring on new nurses into the workforce:

“There are a lot of nurses leaving the cities and coming back to rural areas. You know, kind of the semi-retirement option. This practice particularly is not a semi-retirement option. It’s a very, very busy practice. And so we were looking to groom somebody to be here who was energetic and vibrant and trainable and had a good attitude.” – Practice Manager

Practice managers also identified the value of having a staff member who was easily molded into their practice culture:

“Key benefit is that we were able to mold a person to the style of practice that we have and to adhere to the protocols. Sometimes when you have a more experience person they are quite set in their ways. It’s difficult to move them from how they think nursing should be to our practice, this is how we want you to provide nursing services. So that is very beneficial. You know, you haven’t got any old habits to get rid of.” – Practice Manager

The mid-point survey also suggested that the introduction of the NGN role had some immediate benefits for the management of the workforce at the individual practices:

- *“Managing staff resources was a little easier due to additional nurse.” – Practice Manager*
- *“Increased nurse cover - increased availability to patients.” – Practice Nurse*

Some practice staff also indicated that the presence of the NGN had increased their satisfaction at work. This related to having a consistent nurse rather than temporary staff, the addition of a teaching dimension to their role, and the personalities of the NGNs themselves.

Staff at the PHO and DHB that were interviewed for the site visits also thought the scheme was beneficial in raising practice awareness about their role in building workforce capacity and sustainability. The DHB and PHO stakeholders suggested that even if the NGNs are not retained by the practice, the practice has increased the NGNs level of competency and therefore contributed to a more sustainable nursing workforce in their area.

4.5.3 Clinical and social sustainability

There is evidence from the mid-point survey and site visits that the scheme has improved the clinical sustainability of the practice by enabling clinicians to focus on activities that better reflected their scope. At one practice for example, the NGN was described as reducing the number of nursing tasks that needed to be completed by the Doctor. The mid-point survey supported this finding, as three-fifths (60%; n=103) of respondents suggested that the NGN had changed other clinician’s practice. One of the site visits also described the impact of the NGN on the amount of time that Doctors needed to spend with each patient. They suggested that this resulted in an increase in the number of GP consults, as the NGN was able to support the Doctor in meeting the needs of the patient. In this instance, the GPs were also able to reduce their hours at the practice.

The site visits also reinforced the view that the scheme was enabling patients’ social issues to be addressed found in the midpoint survey. Specifically, 87% of practice staff felt that the NGNs increased the time available to support patients’ social needs (n=104). This notion was also supported by comments from some of the NGNs in the mid-point survey:

- *“Increasing the amount of time we have for each client; particularly those with high social needs.” – NGN*

The interviews suggested that the NGNs were able to do this due to having more time available for patients. This also enabled the NGNs to support patient literacy and education:

“She does a lot of education. Like the smoking cessation or cardiovascular risk. If you really want to make a difference it takes time. You can’t just say, ‘read this. Next one please.’ You need to actually go through and answer their questions and give them an invitation to ring back and discuss it further. And so she does spend a lot of time with the education and with listening to people on the phone.” – GP

5. IMPLEMENTATION OF THE SCHEME BY THE VLCA PRACTICES, PHOs AND DHBs

5.1 APPLICATION PROCESS AND NURSE SELECTION

The practices, PHOs and DHBs tended to suggest that they did not experience many difficulties when applying for the funding, selecting or recruiting the NGN and putting together their contract. Some of the stakeholders however, identified the following considerations:

- Extending the time available to complete the application form.
- Ensuring that the timing of the application and the scheme enables practices to access the first round of Advanced Choice of Employment (ACE).
- Providing practices with clearer guidance on the contracting requirements for the NGN.

5.1.1 Application Process

Overall, practices had no issues with time and capacity to complete the application. The mid-point survey found that of those involved in the process the majority thought there was sufficient time available to complete the application (63% agree and strongly agree; n=76) and they had sufficient capacity to complete the application (88% agree or strongly agree; n=75). DHB staff were most likely to think there was not sufficient time.

For others the application process was more challenging. The site visits suggest that the time available to complete the application was a challenge for some. The timing of the process was also identified as an issue for some who suggested that there was a reduced pool of NGNs available to them after the first round of ACE positions had been appointed.

The collaborative approach encouraged through the application however, supported some of the practices. For example, some of the PHO stakeholders described working alongside their practices to support them in accessing opportunities, such as the one-off funding:

“They’re really busy practices and quite often if there’s applications or expressions of interest they just say we haven’t got time although we’d love to be part of it. So we tend to work, we roll up our sleeves and work really closely with our practices to get them the best opportunities that they can have.” – PHO stakeholder

The mid-point survey suggested the PHO often acted as a connector between practices and DHBs in the application process. The site visit interviews also found evidence of this role where the PHO worked with the practice and went to the DHB with their recommendations.

“So we had good conversations about this and then we also collated that really carefully and then went to the DHB with our recommendations for the practice.” – PHO

5.1.2 Nurse selection and recruiting

Overall, practices were able to find a suitable NGN and were happy with the NGN that was employed through the scheme. This was reflected in the mid-point survey, where 78% of those involved in the selection of the NGN were positive about the ease of finding a suitable candidate (n=73).

Three of the five practices involved in the site visits worked with the DHB to produce a list of candidates using the ACE scheme³ which matches employers with new graduates. Practices found this scheme useful as it minimized the work required to identify nurses interested in working in primary care in their area.

Practices also received support from their PHO when recruiting from the list of candidates, although the level of involvement was varied. Some PHOs provided a shortlist of candidates for the practice and supported the interview process, whereas others had more of an advisory role, such as reviewing the short list.

Most practice staff involved in the interviews suggested that the size of the application pool was sufficient. However, comments from the mid-point survey and site visits suggested some practices found they had a limited range of NGNs available. These comments sometimes related to the timing of the application process:

“I get the talent call from ACE in October. I go through it, we pick out the cream of the crop that we want, and because we don’t know which PHO sectors, or what money’s been allocated, automatically those areas are not going to get first choice.” – NETP Coordinator

While the mid-point evaluation survey identified the cultural competency within the NGN pool and the value of being able to support local NGNs, one practice that serves a large Māori population commented on the ethnic diversity available in their pool of NGNs:

“I would have been looking for probably a bit more cultural diversity. We are a Māori health provider. That’s not to say I was necessarily going to pick a Māori staff member but to have had a mix.” – Practice Manager

³ The ACE system generates an electronic talent pool of applications from new graduates looking for employment that employers can easily access to select suitable candidates to interview.

This however, was likely to reflect those nurses that were available within the specific area of this practice, rather than the pools that were available across the country.

The site visits suggested that selection process was facilitated for those already engaging with NGNs. For example, one of the practices described how they identify potential NGNs while nurses are doing their placements as part of their degree. This enabled them to recruit a NGN that they had some prior experience working with, and subsequently had an understanding of their capabilities and fit with their practice:

“So what we usually do here, we get some student nurses and we pick from there depending on their ten weeks of placement at our clinic.” - Preceptor

5.1.3 Clarity of the NGN contract

One practice brought up the issue of setting up the employment contract which had not been explored in the mid-point survey. They suggested that this process was challenging, as they were putting together the contract when they had not yet received confirmation of the funding. This made them nervous about committing to a full time salary. They were also unclear of the specifics of the NGN contract and the typical level of employment that this involved:

“That was part of the rush to get them on board. I didn’t realise everybody else had gone point-eight. And we’d gone a full FTE. And had I known that I probably would have brought her on less. Because that would have given us a break as well in terms of the nurses who were trying to support [them].” – Practice Manager

5.2 PRACTICE READINESS AND INTEGRATION OF THE NEW GRADUATE NURSE

Orientation and induction were key success factors to the integration of the NGNs, with practices who had previous experience with NGNs or students being better equipped for this process. Expectations of the NGN abilities was also important, with over and under estimates of the NGNs impacting on their integration. Overall however, the evaluation found that the NGNs were well integrated and accepted at their practices.

5.2.1 Orientation and induction

The mid-point survey indicates that the practices were generally well prepared for the arrival of the NGN, and good support structures were in place to support their integration and development. Specifically, the survey found that most practice staff thought the practice was prepared for the arrival of the NGN (86% agree or strongly agree; n=100) and had a good induction process (88%;

n=102). Most NGNs felt supported by their practice; 88% felt that they were supported during their transition into practice and 94% indicated that they knew who to go to for help and support (n=32). In terms of development, over three-quarters of NGNs had a professional development plan (78%) and the majority of respondents indicated that the plan was supported by the practice (91%; n=32).

Approximately a third of practice nurses (33%, n=9) and NGNs (29%, n=31) surveyed thought the practice was not well prepared for the NGN's arrival. A minority of Practice Nurses, NGNs, and other practice staff suggested that the induction process was not good (20%; n=51). It is useful to note that, the staff who felt that their practice did not have a good induction process were more than twice as likely to come from a practice that had no previous experience with NGNs or student nurses.

The value of previous experience in providing a good induction process was also reflected in the site visits. Practices with previous/current experience with NGNs tended to be more aware of the support needs of NGNs and already had existing processes in place for their arrival. For example, a practice manager from a practice with lots of experience with NGNs was able to identify the core components of a good induction and integration process for NGNs (Figure 5).

Figure 5: A practice manager's perspective on the key components of a good induction and integration process for a NGN

MedTech or patient management system training	Scripts or guides for recalls: <i>“If you’re recalling a patient for immunisations, have a written script. ‘Hello, this is, Doctor Smith has asked me to phone you because Joey is due for his 15-month immunisations.’ We can’t just pull people off the street and out of university and ask them to do that.”</i>	Time out with NGN
Orientation as part of the NETP programme		Have targets – explain to NGN why they are there and how the practice can work together to meet them
A nurse leader is available to debrief the NGN after any patient incident		Do the vaccinators course within 4 weeks of starting

The importance of MedTech or patient management system training was reinforced by the other practices. As these systems also record their performance against health targets, they needed to be sure that NGNs were recording the work being done to contribute to these targets.

In terms of cultural support during induction, the mid-point survey found that all except one NGN (97%; n=32) felt that they were supported to practice in a culturally competent manner. This was explored in the site visits to determine what type of cultural support had been provided. There was a limited amount of specific cultural support provided to NGNs. Most of the NGNs were local nurses who already knew the populations they were working with. The normal orientation they received along with support from the preceptor, practice staff and education from the NETP programme was identified as being sufficient to support them. The NGNs also suggested they knew who to ask if they had any questions or needed support. The employment of local nurses is important to note here, as the scheme sought to enhance the alignment between patient population and nursing workforce demography. The value of employing local nurses was also reflected in the mid-point survey.

Understanding the role of context in orientation and induction

One of the practices that we visited did not have past experience with NGNs and also had a change of practice manager during the employment scheme. This practice suggested that they struggled to properly orientate the NGN. Specifically, the interviews suggested that they were not clear on the capability of a NGN or the support required to train them. The change in the practice manager also meant that the arrival of the NGN was not well communicated to other practice staff. The lack of communication led to problems where the practice staff were not clear on the NGNs role, scope of practice, and development plan. Clinical staff in the practice either did not want to make the effort to support the NGN or did not know what would be most useful. This resulted in the NGN feeling unsupported in the clinic.

To add to these challenges, the preceptor at this site was working in the community nursing team rather than in the clinic where the NGN was based meaning that initially support was largely the responsibility of the practice nurse and other staff. While the location of the preceptor was not ideal for NGN development, the practice responded by having the preceptor on site at the practice for approximately six weeks. Following this, the NGN would then spend a day each week working in the community alongside their preceptor.

The impact of changes in staff on the induction and integration of the NGNs was also identified by two other sites. Specifically, two practices had nurse resignations that impacted on the way the NGN was utilized in the practice. In these cases this meant there was more pressure to have the NGN independent as soon as possible:

“Just before she started, we’d had a couple of nurses resign and we were in a bit of a crisis in terms of staffing. So she was a bit of a godsend coming on in that we were having an extra

staff member, but it was also going to take its toll on me being a bit slowed down to train her, and that she was going to get pushed a little bit harder.” – Preceptor

The NGNs at these practices still suggested that they were well supported and often noted the high level of support they received from other practice staff including nurses and GPs. This suggests that having support for NGNs from across the practice is important for reducing the impact of staff turnover on support for the NGN.

5.2.2 Expectations of the NGN ability and support needs

Overall, there was a good level of understanding about what the NGN was capable of with 90% of practice respondents agreeing they knew the NGNs role and the activities they were able to undertake (n=102). The interim survey and the site visits suggested that the level of understanding a practice has about the ability and support needs of their NGN is influenced by their past experience with NGNs and nursing students. Previous and/or current experience with NGNs and/or student nurses helped practices to better understand and meet the needs of the NGN. Still, the site visits suggested that some of the practices who had experience with student nurses but not a NGN underestimated the study needs and amount of time off required by a NGN on the NETP programme.

A NETP Coordinator supporting a number of NGNs involved in the scheme suggested that practices without previous experience with NGNs or nursing students were more likely to have inaccurate expectations of the ability of a NGN. They suggested that some practices overestimated the ability of a NGN and expected them to be capable of working as an experienced practice nurse. Other practices underestimated their ability and limited their activities in a way that restricted the NGN's opportunity to learn and develop their skills and expertise. In these situations, the NETP coordinator suggested that support from the DHB or PHO was important to help the practice learn what was needed to support the development of the NGN.

Communicating expectations of the NGN role across the practice

Within practices, non-clinical staff were even less likely to know what they could expect from a NGN. This could involve non-clinical reception, administration staff or practice management staff. One practice mentioned that in the early stages of the scheme reception staff were unsure on which appointments should be booked with the NGN and the value of booking in appointments with the Doctor to support training and development. This led to the NGN having many gaps in their schedule. When the other nurses noticed the lack of bookings for the NGN, they helped to communicate the role and the types of appointments that should be booked with the NGN:

“But it wasn’t until a little while later we noticed things still weren’t being booked with her. And I said... ‘This could have been booked with [NGN]’. And ‘Oh, we’re not booking anything with her that needs a doctor’. Well, actually, those are the best things to book with her... But they were looking at it from a clogging up the schedules timing sort of thing rather than assisting her to train” - Preceptor

This highlights the importance of ensuring that clinical and non-clinical staff are fully informed of the NGN role and the steps needed to support their integration into the practice. In this instance the leadership and experience of clinical staff will be valuable for enabling non-clinical staff to understand the role.

5.2.3 Integration of the New Graduate Nurse

Overall, NGNs were well integrated into their practices. The mid-point survey found NGNs were being accepted as part of the team (98% agreeing or strongly agreeing; n=89), supported by other nurses (99%; n=89), supported by other practice staff (99%; n=87), and had arrangements in place to provide professional development or support (94%; n=89). This finding was supported by the site visits. At one practice, integration of the NGN also involved participating in social events outside work.

The support from other clinical staff facilitated the integration of the NGN, even when the preceptor was not regularly available. For example, one NGN moved to a rural clinic after a 3 month orientation due to a shortage of nursing staff at that clinic. While this resulted in the NGN being based some distance from the preceptor, the NGN described receiving considerable support from the other staff at the clinic. The NGN also commented that at the rural clinic she felt like a more valuable part of the team as the environment was smaller and more intimate than the larger urban practice.

Expectations of the NGN role could also affect their integration into a practice. While most NGNs suggested that they were undertaking clinical processes appropriate to their skill set in the mid-point survey (97%; n=30), that survey also suggested that some practices needed to be reminded of the role of the NGN. In one practice for example, the survey comments suggested that the practice began to use the NGN to cover the receptionists’ sick leave:

“[The] organisation [was] wanting to use new graduate RN as receptionist role when receptionist had extended sick leave. This was reversed after NETP coordinator met with the Practice Manager.” – NETP coordinator (from mid-point survey)

These findings highlight the role and value of support from the DHB and the PHO, particularly when practices have limited experience with NGNs.

5.3 DHB AND PHO INVOLVEMENT

The evaluation identifies the key role of the DHB and the PHO in supporting the implementation of the initiative. DHB involvement was through the provision of the NETP programme and PHOs often supported practices through their nursing leaders. While the DHBs and PHOs drew on existing systems and structures to support the NGNs, the NETP Coordinators often noted an extension or change in the level of support that they were used to providing for nurses in secondary care. This was particularly apparent when practices had little or no previous experience with NGNs.

5.3.1 DHB Involvement

The mid-point survey and site visits found that DHB involvement included the provision of the NETP programme including study days, coordinating the assessment component, practice visits and providing preceptor support. The newness of the scheme and the limited experience of some of the practices with NGNs did have some implications on the level of support needed from staff at the DHB, and most frequently the NETP Coordinator:

“So the [practices] don’t have a strong understanding of our Regulatory Requirements basically. So there are lots of different levels of support which I don’t have to do here in the DHB because the Clinical Nurse Managers know the structure and system” - NETP coordinator

This level of support was exacerbated in the practice where the NGN did not feel well supported. At this practice, the NETP Coordinator provided an orientation checklist, a specialist nurse educator, and a DHB nurse leader giving supervision. In this context, the level of support provided was perceived to be beyond their typical role and responsibilities:

“The biggest challenge for me was that I had to provide an excessive amount of support to that Practice than any other of the 40 Graduates I had...It was time consuming and it was about me being aware that there was no support for the Graduate so I took on an additional role, which is not my role. I’m a facilitator.” – NETP coordinator

In line with this notion, one NETP coordinator noted that they found it difficult to support all the NGNs in their DHB within their current resources. To address this challenge, the NETP Coordinator worked in collaboration with the PHOs to ensure that all NGNs were being visited by a PHO nurse leader. As practices become more aware and experienced in supporting NGNs, this higher level of support need is likely to reduce over time.

5.3.2 PHO Involvement

The site visit interviews identified the level of PHO involvement after recruitment. This often included making regular contact with the NGN, assisting in the orientation, and providing ongoing education and peer support. The PHOs were available to support both the practice and the NGNs if required. This type of support was not unique to the NGN one-off funding scheme, rather one PHO CEO mentioned that the scheme was able to draw on existing support systems and structures. They went on to suggest that this type of support can be particularly useful when a NGN is feeling unsatisfied in their role, as they can engage with the preceptor and the practice.

The PHOs were also identified as having a role in supporting the unique training needs of some of the NGNs:

“We had a new grad at a GP practice who was running asthma clinics and we thought wow, that’s a huge responsibility. So once we realised what her actual role was and how specific it was, the ADON from that PHO got her on a lot of the asthma courses, respiratory courses and really brought her up to speed in terms of putting her on the courses for the skills and knowledge that she needed for that particular practice.” – NETP coordinator

The site visits indicated that the level of support from PHOs to practices tended to be bolstered when the PHO owns the practice. The interviews suggested that this high level of integration facilitates easy access to different types of support and efficiencies in terms of resources and time.

5.4 NEW GRADUATE NURSE DEVELOPMENT AND SUPPORT

The NGNs were provided with a range of professional development opportunities and supports. This included the NETP programme, preceptor support and specific clinical skills training. All of these supports were highly valued by the NGNs and were considered to improve their clinical knowledge and skills. The NGNs suggested that the support from the preceptor was the most valuable. The NGNs felt that the value of the NETP programme could be enhanced through increasing the relevance to primary care.

5.4.1 Preceptor support

The midpoint survey found that NGNs were happy with the support from their preceptors. The survey found that preceptors were a key support for the NGNs. Nearly all (97%; n=31) agreed that their preceptor had the skills and experience required to support their role and 84% felt that their preceptor was providing mentoring that met their support needs (n=31). The site visits also found that the NGNs considered their preceptor to be their most valuable source of support, and they

were identified as the key point of contact for help and support. The preceptor role was also particularly important for consistency, organisational policy and procedure questions, and maintaining their development portfolio.

The mid-point survey indicated that NGNs in the employment scheme had high quality preceptors. All had completed preceptor training, 69% held a post-graduate qualification, and only 12% did not have past experience as a preceptor (n=16). The site visits supported this finding.

While preceptor support was highly valued, the amount of time preceptors had available was sometimes limited. NGNs considered their preceptors to be accessible but busy. Preceptors suggested that they did not have as much protected time as they would have liked to provide regular, structured support to the NGNs. One stakeholder at the DHB also suggested there was the potential for preceptor burnout when practices do not have multiple preceptors available. When the preceptor was busy however, the NGNs often suggested that other practice staff would help them. Indeed, many NGNs noted the multiple levels of support from a broad range of staff at the practices. The site visits suggested that this extended support was particularly important at the two practices who did not have a preceptor on-site.

5.4.2 NETP

The NETP programme was valued by NGNs. The mid-point survey found that most NGNs thought the NETP programme supported their professional development in primary care (81% agree or strongly agree; n=31), met their theoretical and academic training needs (80%; n=30), and met their practical and clinical training needs (77%; n=30). When making comments on the NETP Programme in the survey however, the NGNs tended to report that the programme was overly focused on the hospital setting, and that the preceptor support in practices was often more relevant to developing skills and expertise as a nurse in primary care. This notion was reflected during some of the NGN interviews:

“I think it’s aimed towards more hospital. And I think that I could have gotten away with not going to some of the days considering it was a lot about hospital stuff” - NGN

The evaluation found that some aspects of the NETP programme can be highly relevant to primary care or could be applied at the practice. At one DHB, for example, the NETP programme included a quality improvement project. The result of this project was a pre-diabetes screening project, which was seen as a key benefit for the NGN, the practice and their patients. This example highlights the benefits that can be achieved when the NETP programme has the potential to be adapted or applied to primary care.

During the site visits, one practice manager also commented that they valued the NETP programme as it reduced some of the training and development burden for the practice.

Practices that had not had a NGN before would however, have liked more information on the NETP curriculum. They felt that this would enable them to reinforce what the NGN was learning on their study days. They suggested that the communication they received was related to compliance with the programme rather than assisting a consistent approach to developing the NGN:

“They didn’t really talk to us a lot. They sent us forms to say fill in your feedback. But there wasn’t any, for example, this is what we’re covering in the NETP programme in the three days coming up. There was no two-way conversation. It just seemed like we were doing our thing. They were doing their thing.” – Practice Manager

In addition to the training, NGNs valued the presence of the NETP staff as a neutral support party. They felt that they could contact the NETP coordinators if they had any issues. Even when they did not access the NETP coordinator for help, the NGNs valued having the option of support outside of their practice.

Balancing work and study commitments

Balancing working life with NETP study was challenging for some of the NGNs. In the site visits, the NGNs who were working full-time were more likely to note these challenges than those who were working fewer hours at their practice. Previous experience with a NGN was also important here, as one practice encouraged the NGN to take on fewer hours despite their initial interest in working full time:

“Before I started working here, like last year I wanted to do 40 hours a week, but they said they don’t recommend it in your first year. And now that I’ve worked this year I understand.”
- NGN

While the response rate was low for the follow-up survey (17% for NGNs), it did identify the variation in the work commitments of the NGNs. Specifically, the follow up survey received eight responses from NGNs and found that four of the NGN respondents were working full time, two were working 4.5 days (0.9 FTE) and two were working 4 days (0.8FTE). These variations highlight the potential value of providing practices with guidelines on the ideal level of work and study time for a NGN.

5.4.3 Skill training

Both surveys found that NGNs have undertaken many formal training requirements during the year. The most common have been vaccinator training, ABC for cessation training, and cervical smear taker training. Whilst these courses are useful for developing the skills of NGNs, the site visit interviews suggested that the stage and pace of NGN professional development activities may warrant more consideration when providing training opportunities. For example, one practice with extensive experience with NGNs noted that they would not usually expect a NGN to complete smear taker training in their first year:

“They said that all their VLCA nurses need to have done the cervical smear takers certificate in the first year. And I’ve been working for a long time and I never get them to do that because seriously, they’re figuring out how the heart beats.... at that stage.” – PHO nurse leader

While the site visits suggested that most of the NGNs were conducting cervical smear tests, this was an area that they were still developing their confidence with.

Formal training was further bolstered by the support provided from the practice staff that enabled the NGNs to develop their clinical practice skills:

“I have received an amazing amount of extra training and support as opposed to some of my colleagues in the DHB NETP programme.” – NGN

“Getting some experience in a practice that has been so supportive.” – NGN

6. IDEAS FOR MODIFICATIONS AND IMPROVEMENTS

This section identifies the sectors ideas for modifications and improvements as identified through the mid-point evaluation survey, site visit interviews and follow-up survey.

6.1 PRACTICE ELIGIBILITY

Stakeholders from the site visits and mid-point survey suggested that the eligibility criteria for inclusion in the scheme could be reviewed. These comments tended to relate to the exclusion of non-VLCA practices. For example, when discussing eligibility some of the stakeholders identified the value of other practices in supporting the sector to develop a sustainable primary care nursing workforce. Specifically, they suggested that non-VLCA practices, and particularly rural practices experiencing difficulties with recruitment might benefit from the scheme.

In terms of ongoing eligibility, the practices also queried the value of not being able to apply for the second round of funding due to their involvement in round one. One practice with extensive experience in training NGNs felt they were penalised for developing high quality NGNs, as they could not have the opportunity again. This relates to clarity on the purpose of the employment scheme – if the aim is to give opportunities to NGNs then the one-off component could pose a barrier to having NGNs developed by quality teaching practices, as well as the opportunities for other practices to build on their initial experiences of having a new graduate nurse. One PHO representative stated that the one-off component also reduced the pool of practices eligible to participate in the second round and made it more difficult to secure opportunities for NGNs in their region. The ability for practices to apply for a second round of funding however, would need to be balanced against the potential for the funding to be seen as an ongoing funding source that might discourage some practices from sustaining their current NGN.

6.2 IMPROVED APPLICATION PROCESS

The application process was an area that stakeholders thought required improvement. This involves lengthening the application timeframe to give practices, PHOs and DHBs more time to respond and collaborate in the application. The stakeholders also felt that this process could be improved by changing the timing of the application process. Specifically, it was suggested that it would be more appropriate earlier in the year when the first round of ACE applications occur.

6.3 ROLE SHARING

In the mid-point survey and interviews, some of the stakeholders identified the potential opportunities for role sharing. They suggested that this could be particularly valuable for smaller practices who might not be able to support a full time NGN. The interviews suggested that this could involve sharing the NGN across practices that could support a part-time nurse or sharing the NGN between a practice and the DHB.

The interviews suggested that this could bring the benefits of the NGN to a broader range of practices. They also suggested that this would give practices the flexibility to utilise the NGN where there is the most patient demand or the greatest learning opportunities at the time. It useful to note that two of the VLCA practices had multiple physical sites that the NGN could work at. When discussing the retention of the NGN with these practices, one of the practice managers suggested that they were able to sustain the NGN because they were spread across more than one practice site.

Another potential for role-sharing is between practices and the DHB. The interviewees suggested that this would provide the NGNs with a broader experience in their first year. Some of the interviewees also suggested that this would support the NGNs to develop different skills, which would develop a more flexible nursing workforce that is capable of transitioning easily between primary and secondary care.

The evaluation evidence however, indicates that consideration would need to be given to the induction, support and professional development process when sharing an NGN across sites. Further, the need to introduce the nurse to different clinical settings and contexts may pose an additional challenge to the NGNs.

6.4 SHARING LEARNING

The practices involved in the scheme had different levels of experience in supporting the development of NGNs. For some of the practices, this lack of experience posed challenges to the integration of the role. Some of the staff at these practices noted that it would be useful to have a means of sharing learnings across practices. They suggested that this could be driven at a national level or be more focused on context specific learnings relevant to their area or region. This would allow those who have had NGNs before to support practices new to training NGNs. It was anticipated, that this would lead to a less variation in the support provided to NGNs in primary care.

6.5 EXTENDING THE SCHEME

A common theme, in both the mid-point survey and site visits, was the idea of extending the employment scheme beyond the current twelve months of funding. Most practice staff, DHB and PHO stakeholders felt that two years funding would be more valuable. The interviewees indicated that practices would be more able to sustain the position after two years, as they would have more time to make changes to either their model of care or business model. The interviews also noted that the NGN is more likely to be generating sufficient income to sustain their position after an extra year.

The interviews also suggested that the NGNs would benefit from extending the scheme. This tended to relate to the level of training and professional development that is required over the twelve months. It was considered that spreading this learning across two years could help address the high workload for NGNs. One preceptor who has also trained NGNs in Australia over a two year period, mentioned that the training and support was far easier to manage. From the perspective of the NGNs, two years of work experience would also make them more employable as many job advertisements asked for at least two years' experience.

There were different ideas on how an extended scheme could be implemented and funded. Ideas included keeping the first year the same and providing a reduced amount of funding for the practice to sustain the NGN for a second year. Other ideas included keeping the overall amount the same but allocating the funding support at different levels in line with the support needs of the NGN. This would involve initial front-loading to cover induction and reduced productivity of other staff resulting from the introduction of the NGN and reducing the amount of funding from the scheme as the NGN becomes more independent and requires less training and support.

6.6 PROMOTING PRIMARY CARE

Many stakeholders felt that the employment scheme was a good initiative that had provided a role and an opportunity for nurses wanting to work in primary care. However, they thought more needed to be done to encourage nursing students to consider a career in primary care. The interviewees portrayed that primary care needs to be promoted while nurses are still studying to create the motivation for a career in primary care. One practice with connections to the university was already contributing to this themselves:

“What we do is we get [NGN] and [young nurse] they go and talk to the third year students. So that’s a way of getting the students then to want to choose primary healthcare for their

*10 week placement which then sets them up to become new grads in primary healthcare.” –
Nurse Practitioner*

Other stakeholders also mentioned promoting rural and VLCA practices to new graduates with initiatives similar to the rural bonding scheme for doctors. This would encourage NGNs to work in practices that struggle with recruitment and cannot compete with the salaries that DHBs can offer to nurses.

7. STRENGTHS AND LIMITATIONS

When reviewing the findings from this evaluation it is important to consider the strengths and limitations of the design. The evaluation presented here presents a comprehensive evaluation design that draws on multiple data sources to identify the implementation and impacts of the Round One funding for the new graduate nurse employment scheme. This mixed methods approach supports the evaluation in moving beyond the findings from one data source to address the aims and objectives of the evaluation.

These data sources were implemented and analysed in line with methods and analyses traditionally associated with each data source. For example, the surveys were analysed using descriptive statistics and interviews were analysed using a general inductive approach. There are however, some limitations that warrant consideration when interpreting the findings. Firstly, the evaluation describes the impact on patient care and safety without engaging patients directly in the evaluation. Instead, the views and experiences of practice staff are used as indicators of patient experience.

Secondly, the follow-up survey did not have a high response rate in comparison to the mid-point survey. This limited the quantitative insights into the impacts at the end of the scheme from some of the practices, and particularly from the NGNs. To address this limitation we telephoned the Practice Managers to complete the questions on the retention of the NGN. This was important for supporting the evaluation in understanding the sustainability of the NGN role at the practices at the end of the scheme. Future evaluation may wish to consider further follow-up with the NGNs involved in the scheme.

Thirdly, the evaluation was unable to secure the level of quantitative data that we anticipated. Future evaluation would benefit from conducting a more in-depth analysis of practice level data, including consultation rates and financial data. When considering this however, it is important to

note that this data is difficult for many practices to provide and may require onsite support to extract data from their patient management system and financial records.

Overall however, the evaluation has provided a valuable insight into the implementation and initial impacts of the scheme. Furthermore, these insights are supported across multiple data sources and practice sites.

8. CONCLUSIONS

This evaluation was designed to evaluate the implementation of the scheme and its impacts on the new graduate nurses and the practices. While the evaluation has provided a comprehensive insight into the implementation and impacts of the scheme, it is important to be mindful that this evaluation only reflects the initial twelve months of the NGNs experience. In addition a second round of the initiative and funding for 25 NGNs has commenced in early 2015.

Drawing on the insights from the mixed methods data integration, the findings suggest that:

1. The scheme has provided a valuable pathway for supporting local NGNs into primary care, resulting in a nursing workforce that better matches the demographics of the VLCA population in most practices.
2. Most practices were able to sustain the NGN role beyond the initial twelve months of funding, identifying the value of the scheme in supporting NGNs into primary care.
3. The integration of NGNs into primary care had positive impacts on service delivery and patient experience. This included increasing time available for appointments, time spent with patients and support for existing clinical staff.
4. The NGNs supported practices performance towards targets, and in many cases were considered to improve performance. The scheme has increased the motivations for NGNs involved to pursue a career in primary care.
5. The scheme has provided a positive learning experience for most NGNs, and has supported their professional development through increasing their clinical skills and experience.
6. The NGNs often increased staff satisfaction, particularly when staff were involved in training the NGNs. For staff with less experience in providing this training and support however, this was not always the case.
7. The NGNs brought new skills and experience to the practice that was valued by the staff and patients, who enjoyed the enthusiasm and energy of the younger nurses.

8. The scheme was supported by and bolstered the existing relationships between some of the PHOs and practices. It did appear to increase connections between some DHBs and PHOs, and in fewer instances DHBs and practices.
9. Impacts of the scheme on financial sustainability were less likely to be experienced by all of the practices, although this influence may change over time in practices that have sustained the role.
10. The scheme did have positive impacts on the sustainability of the workforce, with the consistency of the NGN role valued over the use of more casual staff.
11. Clinical and social impacts were also identified. Clinicians often described the ability to focus on tasks more specifically related to their scope after the arrival of the NGN, and the increased time available for patients was noted for its value in supporting patients' health and social care needs.
12. The impacts of the scheme are affected by its implementation. Key success factors for the implementation of the scheme include:
 - a. A good induction process, both for the NGN and for the clinical and non-clinical staff. This is important for managing the expectations of the NGN role and ensuring that their knowledge and skills were appropriately developed and utilised at the practice.
 - b. Previous experience with a NGN maximised the value of the NGN role. For example, knowing the supports that a NGN needs and when to train them in which courses maximised the value of the role for some practices.
 - c. Appropriate level of support for the NGN; nurse preceptor, NETP coordinator and support from other practice staff are crucial. The support of the nurse preceptor was particularly important to the NGNs.
 - d. The recruitment of local NGNs who understood the local patient populations.
 - e. Clarity on the level of work and study load that is required for a NGN. The NGNs were employed at different FTE levels (between 0.8 and 1.0) and this meant some felt the burden of work and study commitments more than others.
 - f. The NETP programme supported connections with other NGNs and professional development. The NGNs suggested that the value of the NETP programme could be enhanced by increasing the relevance to primary care settings.
 - g. Valuable external support from the DHB (NETP Coordinators) and PHO (Nursing Leaders). This was particularly important when the practices had little previous experience of a NGN. Some practices however, suggested that greater coordination between those supporting the NGN would be valuable.

The conclusions from this evaluation highlight the value of the scheme in supporting NGNs into primary care and in supporting VLCA practices. When considering the future implementation of the scheme, the findings suggest that practices with previous experience of NGNs provided better induction and support processes. However, all practices reported some value and benefit from having a NGN and most sustained the role. While it might be tempting to support those practices with previous experience of developing NGNs, these practices were often larger and in more urban locations. Implementing the scheme through these practices would provide a more systematic approach to developing the nursing workforce in primary care. However, this would reduce the value of the scheme for smaller practices and/or those practices experiencing difficulties with recruitment and succession planning, such as those in more rural areas. The value of the scheme in supporting practices to develop a sustainable local nursing workforce may also be challenged if the availability of the scheme was restricted to specific practices.

What is needed however, is greater consideration of the support that is needed for those practices who are less experienced in supporting NGNs. This is important not only for the development of the NGN, but for supporting the practice to maximise the value of the NGN from the start. For some of the practices with little previous NGN experience, success was enabled by extensive additional support from the DHB and the PHO. When integrating NGNs in this context it is important for the PHO and the DHB to consider the additional supports and challenges that this may bring to their current roles and the level of support that they can provide. The joint application process provides a means of supporting this process.

Drawing on the evidence in this evaluation report, the expertise of nurse preceptors, NETP Coordinators and PHO Nurse Leaders could support the development of a resource that would enable practices to better support a NGN. Specifically, this resource could identify what it means to have a NGN in their practice, the level of support needed, as well as the value and benefits that they can expect to achieve. The development of this resource could also help to clarify the roles and responsibilities of the DHB, PHO and practice in supporting the integration of NGNs into primary care. This should enhance the coordination and integration of the supports available for the NGNs.

9. REFERENCES

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10. APPENDIX ONE: DATA COLLECTION AND ANALYSIS

10.1 PRACTICE PROFILING

There were 51 practices involved in the 48 successful applications for the one-off funding for a NGN. Practice profiling was important for identifying the key characteristics of the practices that were participating in the scheme. This profiling provided important contextual information that also supported the selection of five practices for the within site analysis.

Data to support this analysis was provided by the MoH in the form of: a PHO enrolment breakdown for 2013, New Graduate Nurse placements, and application forms of the successful VLCA practices participating in the employment scheme. A google search was utilised to find the number of GPs that worked within each practice. Information from these sources was integrated into one practice profile spreadsheet to summarise the context within which the employment scheme was being implemented. Specifically, practice level data was included for:

- Size of practice enrolments.
- Proportion of high needs enrolees.
- Proportion of Māori and Pacific enrolees.
- Age structure of enrolees.
- Deprivation index of enrolees.
- Size of the practice workforce.
- Whether a practice was a Māori or Pacific provider.
- Ethnicity, age and gender of the NGN.
- Previous training experience of the practice.

A descriptive analysis of the practice profiling data was used to describe the key characteristics of the practices involved in the employment scheme.

10.2 DOCUMENT ANALYSIS

An analysis of the 48 successful application forms for the VLCA Sustainability Initiative and NGN employment scheme was also undertaken. This provided an insight into the types of practices involved in the scheme and the intended implementation of the employment scheme at each practice. The open ended questions were analysed using open coding to identify key themes and patterns in the data. Specifically, the documents were analysed to provide an insight into the ways in which the practices intended to use the one-off funding to:

- Address sustainability.
- Improve practice efficiency.
- Address the needs of high needs patients.
- Sustain the employment of the NGN.
- Provide support for the NGN at the practice.

10.3 ONLINE MID-POINT PRACTICE, PHO AND DHB STAKEHOLDER SURVEY

The mid-point online survey was designed to evaluate the process and implementation of the NGN role across the breadth of the VLCA practices, and to begin to explore the impact of the one-off funding scheme. Proving these insights during the implementation of the scheme was also designed to support learning for MoH and the practices, PHOs and DHBs implementing the scheme. This learning was facilitated by timely feedback on the evaluation findings to the sector through sharing the executive summary and full evaluation report via email and on the MoH website.

The mid-point survey was designed to engage stakeholders from the practices, DHBs and PHOs involved in the employment scheme. The mid-point survey was designed to ask stakeholders to share their perspectives on:

- The application process and selection of the NGN
- Readiness of the practice for the arrival of the NGN
- Role of the DHB and PHO in implementation
- Support for the NGN
- Changes in the NGNs' skills and experience
- Impact of the NGN role at the practice
- Future intentions
- Sustainability of the role
- Key benefits, challenges and ideas for improvements

While the mid-point survey had some core questions that were answered by all stakeholders, there were specific sets of questions for different stakeholders. The NGNs, practice staff and NETP coordinator for example, was asked questions on the level of support for the NGN, which were not asked of the other DHB and PHO staff. Business owners and practice managers were also asked about the impacts of the NGN on the business model and financials at the practice. This was designed to engage a broad range of stakeholder perspectives in the evaluation and also ensure that the questions were relevant to the different stakeholder groups.

10.4 SURVEY DISTRIBUTION

The mid-point survey was disseminated online using contact details provided through the application forms and provided to us directly from the MoH. The initial email invite was sent out on the 22nd of August 2014. This initial email was followed by a series of reminders designed to encourage participation. The mid-point survey remained in the field for six weeks.

When sending out the initial email invite, we had responses from the sector asking if they could send the survey on to others involved in the scheme. We were very grateful for this offer and then encouraged other stakeholders to do this same. This does make it difficult to calculate a response rate.

Survey analysis

The mid-point survey was analysed using descriptive statistics to provide an insight into the views and experiences of the key stakeholders involved in the scheme. When we found differences in the perspectives of different groups of stakeholders and providers these were identified in the mid-point report. It is important to note however, that these are emergent patterns in the data. The sample sizes for some of the different stakeholder groups were sometimes too small to support a statistical analysis. The key purpose of the mid-point survey however, was to understand the experience of the sector and provide formative feedback rather than identifying differences between specific groups.

10.5 SITE VISITS

Site visits were conducted with five of the 48 practices involved in the employment scheme. These sites were purposefully selected in consultation with the MoH using information from the practice profiling and the mid-point survey. Practices were selected to ensure a variety in:

- Māori practices and PHOs
- Geographic location
- Urban or rural locations
- Previous experience with NGNs
- Level of success in initial implementation

Practices were contacted directly by the evaluation team to invite them to participate in the site visits. This was initially done via email and then followed up with a phone call. Table 1 identifies the key characteristics of the five sites.

Table 1: Practices selected or site visits

Practice	Māori provider or PHO	Location	Previous experience with a NGN	Perceived level of NGN support	Perceived impact on sustainability
Practice A	Māori provider and Māori PHO.	A small urban practice in the eastern North Island.	Yes.	Medium	Medium
Practice B	Non-Māori provider and PHO.	A large urban practice in the Auckland region.	Yes – highly experienced	High	Medium
Practice C	Māori provider with non-Māori PHO.	A small rural clinic in the upper North Island.	No - Nursing students only	High	Low
Practice D	Non-Māori provider and PHO.	A small urban practice in the Auckland region.	Yes – highly experienced	High	High
Practice E	Māori provider with non-Māori PHO.	A small urban practice in the eastern North Island.	No	Low	Unknown

Site Visit Data Collection

During site visits semi-structured interviews were conducted with the practice manager, NGN, preceptor, GP or other nurses, and involved stakeholders from the PHO and DHB including the DHB NETP coordinators, DHB senior nurse leader and PHO management. Where face-to-face interviews with stakeholders from the PHO or DHB could not be arranged at the time of the site visit, these were conducted by telephone. Some interviewees also preferred to be interviewed in pairs e.g. two nurses were interviewed together. In total, 29 interviews were conducted with 34 people. These interviews were designed to explore:

- Rationale for involvement in the scheme
- Current implementation
 - Practice readiness and support
 - NETP support

- The role of the PHO and DHB
- Impacts of the scheme
 - For the practice
 - For the NGN
- Future intentions of practices and NGNs
- Key learnings

Following the site visits, practices were asked if they could provide practice level data for 2013 and 2014 on:

- Nurse consultation rates
- Total number of patient appointments
- Performance against health targets

Within the timeframe for the data collection, only two practices were able to partly respond to this. Due to the limited amount of data available, this data has been used to provide examples of points that were brought up in the interviews rather than standalone evidence of impacts from the scheme.

10.6 FOLLOW UP ONLINE SURVEY

The follow up survey was designed to further explore the impacts of the scheme and future intentions of the practices and NGNs with respect to employment at that practice and/or remaining in primary care and/or a VLCA practice. This focus on impacts and the sustainability of the NGN at the practices resulted in two surveys; one for the NGN and one for the practice manager or owner. The follow up survey was disseminated online on the 23rd January 2015 and remained in the field for three weeks. We received a low response rate of 17% among NGNs and 31% among practice managers and owners.

To address this response rate, we made phone calls to the Practice Managers and/or business owners that had not answered the follow up survey to answer key questions on the sustainability of the NGN role. This included asking if the practice continued to employ the NGN beyond the funding from the scheme, why they did or didn't continue their employment, and how they were able to sustain the position. This achieved a much greater response with data collected from 45 practices (94%).

The follow up survey was analysed using descriptive statistics to provide an insight into the sustainability of the role and the reasons influencing sustainability of the position.

10.7 MIXED METHODS DATA ANALYSIS AND INTEGRATION

Evaluations involving quantitative and qualitative data sources can be integrated to provide greater insight and understanding of an initiative (5). Integration focuses on a specific variable of interest or evaluation question to comprehensively assess both quantitative and qualitative data.

In this evaluation the findings from all data sources in both the across-site and within-site phases were integrated around the evaluation objectives. Special attention has been given to the indicators identified in the evaluation framework, as well as identifying findings that are unique to specific contexts.

11. APPENDIX TWO: RETENTION OF NGNs

Information on the retention of the NGN beyond the one year funded by the scheme was collected for 45 of the 48 applicants involved in the scheme. Overall, 78% of the NGNs were retained at their practice. The breakdown by practice characteristics is provided below, although it is important to note there are no significant differences between the different types of practices.

11.1 RETENTION BY OF NGNs AT PRACTICES BY DHB REGION

There are many DHBs with high NGN retention rates, including Northland which kept all four of their NGNs. The small numbers of NGNs in many DHBs has meant the retention rate by DHB is greatly affected by lack of retention in any one practice. No DHB had more than one practice that did not sustain their NGN.

DHB	Retention rate	Number of practices
Auckland DHB	50%	2
Bay of Plenty DHB	67%	3
Canterbury DHB	100%	2
Capital Coast DHB	75%	4
Counties Manukau DHB	92%	12
Hawkes Bay DHB	0%	1
Hutt DHB	100%	1
Lakes DHB	67%	3
Mid Central DHB	0%	1
Nelson Marlborough DHB	100%	1
Northland DHB	100%	4
Tairāwhiti DHB	50%	2
Taranaki DHB	100%	1
Waikato DHB	67%	3
Waitemata DHB	75%	4
Whanganui DHB	100%	1
Total	78%	45

11.2 RETENTION BY HIGH NEEDS POPULATIONS

Retention rates were slightly greater for those practices with a lower proportion of high needs enrollees, although these differences are not significant.

High needs proportion	Retention rate	Number of practices
50 - 60%	100%	4
60 - 70%	85%	13
70 - 80%	60%	5
80 - 90%	79%	14
90 - 100%	67%	9
Total	78%	45

11.1 RETENTION BY PRACTICE SIZE

Retention rates were higher for larger practices based on both enrolled population and number of GPs. This reflects some comments that larger practices, or a group of practices, were able to absorb the NGN salary across the business.

Enrolled population	Retention rate	Number of practices
<2,000 enrollees	71%	7
2,000-5,000 enrollees	69%	16
5,000-10,000 enrollees	81%	16
10,000+ enrollees	100%	6
Total	78%	45

Number of GPs	Retention rate	Number of practices
1 GP	67%	3
2-4 GPs	68%	19
5-9 GPs	83%	12
10+ GPs	100%	3
Unknown	88%	8
Total	78%	45

11.2 RETENTION BY PREVIOUS EXPERIENCE TRAINING NGNs

Retention rates were similar for practices that had past experience training NGNs compared to those who were new to the role.

Previous NGN	Retention rate	Number of practices
Yes	75%	8
No	78%	37
Total	78%	45

11.3 RETENTION BY RURALITY

Urban practices were more likely to retain their NGNs than rural practices. This may be related to the smaller sizes of rural practices.

Location	Retention rate	Number of practices
Rural	70%	10
Urban	80%	35
Total	78%	45