Malatest International

Evaluation Report:

Evaluation of the Nurse Practitioner Programme

January 2024

Acknowledgments

The willingness of nurses, NPs, educators and sector stakeholders to be interviewed and/or complete a survey in the busy pre-Christmas period demonstrated their passion and commitment to the nurse practitioner profession.

Thank you to everyone who contributed. Sharing your perspectives provided us with insights along the different steps of the pathway to becoming and working as a nurse practitioner.

Malatest International

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Executive Summary

Nurse practitioners/Mātanga tapuhi (NP) are highly skilled health professionals registered with the Nursing Council of New Zealand (the Council). NPs assess, diagnose and treat health problems for common and complex health conditions and bring a nursing paradigm to their advanced role.

The nurse practitioner training programme (NPTP) is a one-year funded training programme for nurses wishing to become NPs. It is led by the University of Auckland and includes a consortium of all universities accredited by the Council to offer NP pathways. It is the final year of a complex pathway to becoming a NP.

Health New Zealand | Te Whatu Ora (Health NZ) commissioned Malatest International to evaluate the current NPTP service agreement and the extent to which it supports the development of a NP workforce. The evaluation comprised a document review, in-depth interviews with key stakeholders and NPTP trainees, and a survey completed by 498 nurses and NPs.

The current service agreement has provided a foundation for growth of the NP workforce.

The current NPTP service agreement has supported the establishment and growth of the NP workforce. The number of NPTP trainees has increased each year. A consortium of six universities led by the University of Auckland has been established and has driven growth through early engagement with potential candidates. All university representatives noted the advantage and benefits of the consortium approach to enable the delivery of a nationally consistent NPTP. There has also been increasing support from within the nursing workforce with some Health NZ nursing managers and Directors of Nursing (DONs) actively planning NP career progression pathways for their nurses.

Increasing representation of Māori and Pacific and priority practice groups in the NP workforce requires actions outside the scope of the current service agreement.

Health NZ has identified Māori and Pacific nurses, rural nurses, nurses working with under-served communities and in mental health and addiction services as priorities for NPTP entry.

The largest group of NPTP trainees have primary care backgrounds. The numbers of trainees with areas of practice in mental health and addiction and older people's health have not substantially increased. Increasing the diversity of NP practice areas and increasing the numbers of nurses practicing in mental health and addiction and older person's health requires employer related barriers to be addressed.

Although there are indications that 2024 will see an increase in the number of Māori and Pacific NPTP trainees, the numbers of Māori and Pacific being ready and eligible to enter NPTP has not grown at the pace required to achieve equity in the workforce.

The extent the NPTP service agreement supports the achievement of the service objectives is influenced by wider contexts including the pipeline, nurse readiness for NPTP, the curriculum and minimum requirements, their employment contexts, transition support after NPTP and registration as a NP. Further development of the NP workforce requires consideration of the NP workforce contexts.

Recommendations

Discuss and agree funding of Te Pūkenga NP programmes if all institutions meet the Council minimum requirements for NP training and clinical hours.

Nurses can become a NP by completing NPTP at one of the six universities in the consortium or by completing NP training at three Te Pūkenga organisations. Nurses from both pathways must meet the Council standards for registration. The two programmes differ in the requirements for clinical hours and financial support provided for trainees. The NPTP requirement for 500 clinical hours aligns with international practice. Differences in the benefits of the increased clinical hours for NPTP have not been evaluated in an Aotearoa New Zealand context. The difference in clinical hours requirements is a barrier to a nationally consistent NP workforce.

Service agreement implications:

If minimum standards are met by Te Pūkenga then an equitable approach could require inclusion of Te Pūkenga in NPTP funding.

Develop a national NP advisory group to provide strategic oversight to the development of the NP workforce and removal of pipeline barriers.

The ability to respond effectively to pipeline issues and the employment context for NPTP trainees extends beyond the sphere of influence of a university. Health NZ would be an appropriate organisation to provide leadership and facilitate a national advisory group to align with other national nursing health workforce priorities and activities. This group must be NP-led and work closely with Māori and Pacific partners, the nursing pipeline group, employers and the educators.

Service agreement implications:

The NPTP governance group would be replaced by a group with a focus on continuing to develop NP education and provide oversight to the delivery of NP training. All educators accredited to deliver NP training would be represented. Inclusion of Te Pūkenga alongside universities would contribute to achieving the aim of a nationally consistent programme.

Facilitate employer support for NPs in their workplaces.

While some employers support nurses to become NPs, employment contexts were also identified in the survey as barriers for nurses to becoming NPs. A few employers had well developed pathways through roles they had created and termed NP 'internships' or similar. The pathways include guidance about pre-requisites, nurses working alongside NPs to become ready for NPTP, support during NPTP to develop NP skills, a defined role in the workplace after NP registration and budget to support that role.

Service agreement implications:

Removing the requirement for NPTP trainees to have employment at the end of NPTP may advantage nurses who cannot get employer support. However, employer support in preparing for NPTP, during NPTP and to transition into a team as a NP is essential. Removing the employer requirement may remove access to some of this support for new NPs.

Funding from secondary placements could be progressively shifted to funding for NP 'internships' that meet agreed criteria for support before, during and after NPTP. 'Internships' could target priority groups.

Strengthen the service agreement expectations about priority groups.

NPTP trainees and employers provided feedback about the need for a more modular approach to the programme to meet the different needs of nurses working in community settings and those working in specialist practice.

The NPTP includes a focus on equity and is generally delivered in a Western paradigm. While components of the NPTP must prepare trainees to assess, diagnose and prescribe, there is room for educators to further consider how to also include Kaupapa Māori or Pacific practices within NPTP. Inclusion would benefit all NPTP trainees.

The national advisory group would discuss and monitor potential strategies by working with Māori and Pacific partners and representatives of other priority groups.

Service agreement implications:

Although the NPTP curriculum is out of scope, strengthening expectations in the service agreement about ways to increase the numbers of NPTP trainees from priority groups is a lever to effect change.

In the short-term continue to work with the consortium as the provider of the educational aspects of NP workforce development.

As noted above, discussions are needed to resolve the two different NP training pathways and how Te Pūkenga students can be funded for consistency in training and for nurses wanting to become a NP. In the interim, maintaining the consortium of education providers enables continuation of the collaborative approach and further development of NPTP curriculum and education including strategies to increase the participation of priority groups. All consortium members supported the University of Auckland as the lead educator.

Some or all the governance, management and administrative aspects of NPTP could be separated from the delivery of NPTP education with the potential of achieving the best value for money. The administration of the service agreement could be combined with administration of the national advisory group.

Service agreement implications:

Some changes to the service agreement are dependent on discussions and decisions made as a result of the recommendations in the evaluation. In the short-term and to provide certainty to the sector, continue to work with the consortium to deliver NPTP. Strengthen expectations about priority groups as noted above.

Review the costs of NPTP delivery as they exceed the current funding. Cost increases are primarily driven by increases in salaries for academic NPs and clinical supervisors, as well as for employers to backfill roles.

Build an evidence base to inform decisions about the NP workforce and monitor service agreement outputs.

There are gaps in evidence about the effectiveness of different requirements to become a NP. Evidence reviews and evaluation of patient outcomes and costs within a NP model would inform a national workforce strategy.

1. Background

1.1. Nurse practitioners

Nurse Practitioners as described by the Nursing Council of New Zealand[1].

Mātanga tapuhi/nurse practitioners (NPs) have advanced education, clinical training and the demonstrated competence and legal authority to practice beyond the level of a registered nurse. NPs work autonomously and in collaborative teams with other health professionals to promote health, prevent disease, and improve access and population health outcomes for a specific patient group or community.

NPs manage episodes of care as the lead healthcare provider in partnership with health consumers and their families/whānau. They combine advanced nursing knowledge and skills with diagnostic reasoning and therapeutic knowledge to provide patient-centred healthcare services including the diagnosis and management of health consumers with common and complex health conditions. They provide a wide range of assessment and treatment interventions, ordering and interpreting diagnostic and laboratory tests, prescribing medicines within their area of competence and admitting and discharging from hospital and other healthcare services/settings. As clinical leaders they work across healthcare settings and influence health service delivery and the wider profession.

1.2. Nurse practitioner training

Under the Health Practitioners Competence Assurance Act 2003 (the Act), the Nursing Council of New Zealand (the Council) is the authority responsible for the registration of NPs. Applicants for registration as a NP must complete a master's degree programme accredited by the Council. This comprises a structured programme of taught courses with a clinical focus[2]. Requirements are detailed in Appendix 1.

The Council has accredited six universities and three Te Pūkenga institutes as providing pathways leading to registration as a NP.

[1] https://nursingcouncil.org.nz/Public/NCNZ/nursing-section/Nurse_practitioner.aspx

[2] https://www.nursingcouncil.org.nz/Public/Education/How_to_become_a_nurse/Nurse_practitioner/NCNZ/Education-section/Nurse_practitioner.aspx?

1.3. The Nurse Practitoner Training Programme service agreement

The Nurse Practitioner Training Programme (NPTP) is a Health NZ funded programme for NP trainees in their final year of preparation for NP registration. The current NPTP service agreement is between Health NZ and the University of Auckland. The service agreement includes delivery of the NPTP and supported placements for NPs and enrolled nurses (EN).

The priority areas for developing the NP workforce include primary health care, community and residential care settings, mental health and addiction, Māori health, Pacific health, populations with high health needs, rural and hard to reach areas and communities and areas with high deprivation.

2. The evaluation

In October 2023, Health NZ commissioned Malatest International to evaluate and review the NPTP service agreement to:

- Inform improvements of the NPTP contracting and funding model and support.
- Show the degree to which the contracting and funding model and support have supported the programme to achieve its agreed objectives and outcomes (including how and why).
- Identify areas of improvement to strengthen the contracting and funding model and support for NP trainees and inform a wider programme of work.

2.1. The scope of the evaluation

The focus of the evaluation was the NPTP training programme and the service agreement between Health NZ and the University of Auckland. The service agreement includes two key components, the delivery of NPTP and supported placements. However, aspects of the pipeline, transition support and NPTP curricula are important to inform the evaluation questions.

Out of scope for the evaluation were:

- Assessing the effectiveness of NPTP curricula.
- Assessing the NCNZ registration process.
- The Enrolled Nurse (EN) aspects of the service agreement.
- NP training programmes provided by Te Pūkenga.

2.2. Evaluation approach

The evaluation consisted of a four-phased approach summarised below (Figure 1).

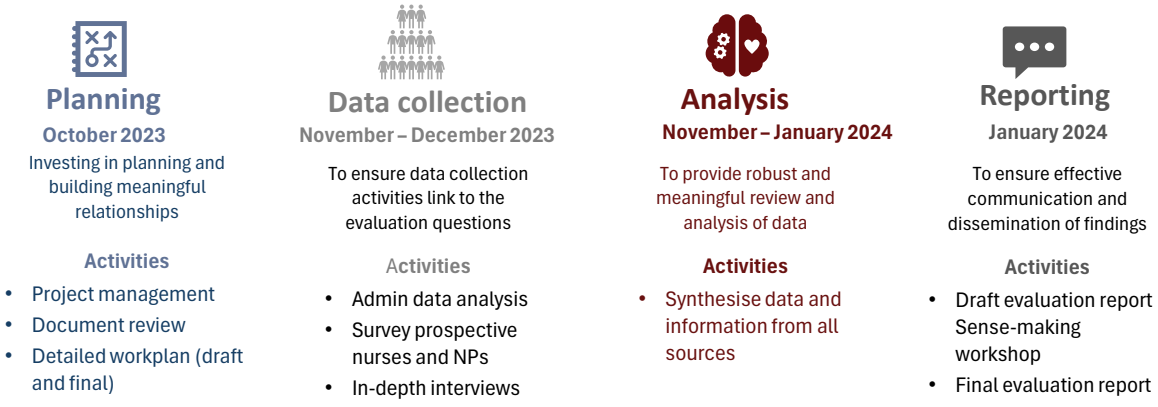


Figure 1: The NPTP evaluation approach

An evaluation framework provided the foundation for the evaluation and the development of interview guides and a survey. The framework comprised indicators and sources of information about:

- Effectiveness: the contract/funding and delivery models are effective in supporting the outcomes.
- Appropriateness: the contract/funding models and NPTP delivery support appropriate programme entry.
- Relevance: the contract/funding models support relevant programme content and delivery of support for training nurses.
- Impact: the contract/funding models support programme completion and sustainability.

2.3. Information sources for the evaluation

A mixed methods approach was used to collect the breadth and depth of information needed for the evaluation. Details are summarised in Figure 2.

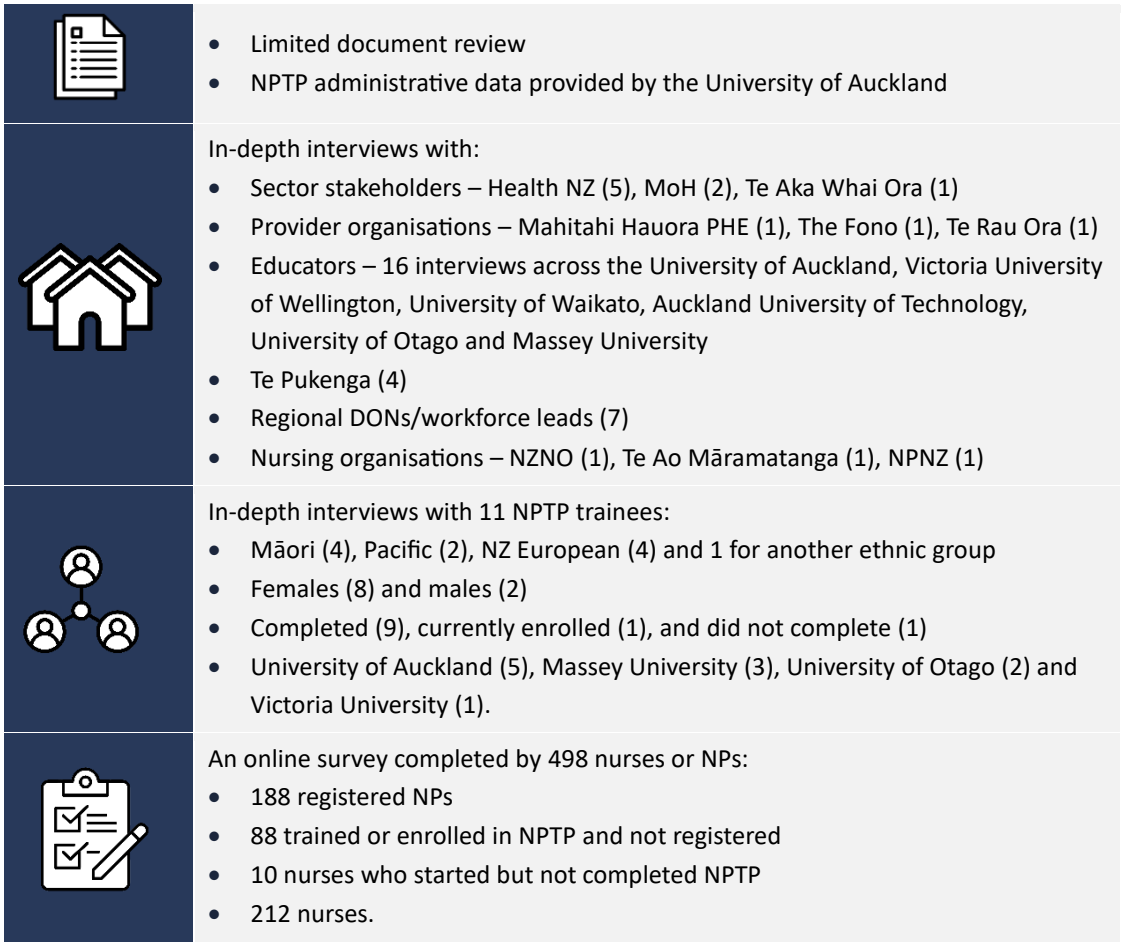


Figure 2. Evaluation information sources.

While the interviews focused on the contracting model in the service agreement, stakeholders also discussed other topics relevant to achieving the NPTP service agreement objectives such as the pipeline, funding support for the pipeline, course completion, transition and achieving equity from the perspectives of different groups.

The survey was disseminated by Nurse Practitioners New Zealand (NPNZ), the New Zealand College of Nurses, Te Ao Māramatanga (NZCMHN) and by the Health NZ Māori and Pacific Workforce managers. A link to the survey was also in the Council December Panui. The survey was completed by NPs and nurses across the country working in a range of practice areas and employment settings: 48% were working in Health NZ or private hospital settings; 35% were working in primary care/community practice; 6% NGO; 11% self-employed or in another category (academics, teachers etc). The survey was completed by 65 Māori NPs/nurses and 11 Pacific nurses.

The profile of survey respondents is detailed in Appendix 2.

2.4. Analysis

We analysed qualitative data from interviews and the survey to identify key themes aligned with the evaluation questions and to describe issues. We developed a coding framework to explore intra- and inter- similarities and differences between and across groups and different contexts.

Quotes are included in the report to highlight themes and points of similarity and difference. Quotes are identified using generic labels to provide some confidentiality to those we interviewed. All interviewed stakeholders were advised that because of the small number of key people in the sector their views might be potentially identifiable, but we would take care to anonymise quotes.

Administrative data about enrolments, completions and student profiles were provided by University of Auckland. The administrative data and the survey data were analysed descriptively.

2.5. Ethics and consent

We completed the Health and Disability Committee (HDEC) application screening overview. Since the evaluation is an ‘audit or related activity’ HDEC approval was not required.

Regardless, we have established ethical principles in place and are committed to adhering to ethical procedures underpinning research and evaluation. Our practices are consistent with the New Zealand Privacy Act and its principles.

2.6. Strengths and limitations of the evaluation

Most evaluation data collection was completed in a short-time frame in the last quarter of 2023. A strength of the evaluation was the willingness of those we surveyed and interviewed to commit time to the evaluation.

The mixed methods approach combined qualitative and quantitative data and provided depth and breadth of perspectives about the NPTP and the NP profession.

The short time frame limited the extent the survey could be disseminated but many of those who responded took the time to provide detailed comments. The survey was completed by 11 Pacific nurses so detailed analysis of their responses was not feasible.

Responses from NPs to the survey also included NPs who may have been trained overseas or through programmes that were not NPTP.

3. The NPTP entry criteria, selection and curriculum

Key messages:

The NPTP service agreement is with the University of Auckland (the provider) who has overall responsibility for the deliverables across the service agreement. The provider developed a collaborative consortium of all six universities accredited by the Council to deliver the NPTP.

All university representatives noted the advantage and benefits of the consortium approach to enable the delivery of a nationally consistent NPTP. However, they also identified challenges because of the association of University of Auckland branding with NPTP. Overall, the universities wanted the collaborative approach to continue.

The NPTP curriculum was developed from the NP pilot. The curriculum quality standards are consistent across the universities delivering NPTP while also allowing bespoke options for NP trainees.

The academic mentor is a critical success factor for NPTP trainees providing site visits, ongoing support and pastoral care. Academic mentors helped trainees feel confident about assessments and provided a link between the university and the workplace.

Secondary placements aim to provide a breadth of workplace experience for NP trainees and further opportunity to work alongside a NP. They are, however, difficult for NP trainees to arrange and trainees may incur additional costs. As NP numbers increase, trainees will have more opportunities to work alongside a NP in their workplace. This and strengthened workplace support will remove the need for secondary placements for some or all NP trainees.

Workplace support to transition into the NP role is not part of the service agreement but was described as essential by all interviewed stakeholders.

Although current NPTP trainees meet the entry criteria, many stakeholders described nurses now entering NPTP as less experienced than earlier cohorts who typically had many more years of clinical experience. Stakeholders described the implications of a less experienced cohort as NP trainees:

- Lacking a full understanding of the NP role and scope of practice.
- Finding the two semester NPTP 'intense' and requiring more support including pastoral support.

NPTP stakeholders note the 500 hours of clinical practice for NPTP ensures a breadth of experience for NP trainees and aligns with international NP training programmes. However, the Council requirement is 300 hours, potentially creating confusion for nurses and resulting in NPs with different clinical practice hours.

3.1. The consortium of universities

NPTP is delivered by a consortium of universities. The lead is the University of Auckland, appointed following a RFP process in 2021. The consortium has grown since the initial agreement and all universities accredited by the Council to offer NP training are now part of the consortium:

- In 2021, the first cohort completed the NPTP at one of three universities: University of Auckland, University of Otago, and Victoria University of Wellington.
- In 2022, Massey University joined the consortium.
- In 2023, University of Waikato and Auckland University of Technology joined.

The consortium delivering NPTP is working to deliver a national training programme of consistent quality. The universities have agreed the number of study days, clinical practice hours, academic mentorship and secondary placements.

Interviewed stakeholders described the advantages of the consortium as:

- A collaborative approach where the universities worked as a group to trouble shoot and resolve issues and to achieve consistent quality standards.

  I think the collaboration is mostly a strength, … there's going to be plenty of robust discussion. And I think that's a good thing. Because at the end of the day, we want to be training nurse practitioners with the same expectations about how they will function with our population. Yes, I think it's all good discussion. It's just not necessarily easy… And uncomfortable at times. (Academic NP)

- Decreasing competition by allowing nurses the choice to remain at the university where they had completed their Master's degree. Many commented they wanted the *'money to remain with the student'*.
- Providing diversity where universities could offer modules on different aspects of NP practice such as community practice, rural practice, mental health and addiction, paediatrics or neonatal care. The ideal was a core national curriculum with bespoke options.

  One programme across many sites is an advantage … consistent standards but not a cookie cutter approach. (Chief Nursing Officer)

- Improving access because the location of universities in different parts of the country reduced travel time for academic mentors and students. Academic mentors could also potentially support NPTP trainees from multiple universities.

At the time of the evaluation interviews, all consortium members considered the advantages of a consortium warranted continuation of the collaborative approach.

> *If you just delegate the funding to the individual universities, you lose the vast benefits which I think outweigh the downsides of having that consortium. That robust standard,*

that talking about issues, about addressing these, about the networking with students, the networking of NPs involved in the programme, that huge sharing of resources. We lose all that. (Academic)

Universities that joined the consortium from 2022 described the challenges that not being part of the consortium had been for them and their students. These universities still supported a continued collaboration to deliver the academic and clinical components of NPTP.

… from my perspective, from being excluded, it has severely disadvantaged the students that have gone to [university], both at undergraduate and postgraduate level and I think, if you looked very broadly, been really, I feel like saying sad but sad is not a strong enough word. (Academic NP)

The main challenge to the consortium approach identified by stakeholders was the University of Auckland branding on the website and application forms. Stakeholders perceived these as suggesting the University of Auckland was the main provider or the only university where nurses could complete the NPTP. They recommended a neutral entry point for information and applications forms.

I do think that the idea of one university holding it is slightly problematic. It's just that all the students then have to go to a University of Auckland website … so it feels like they've got the stronghold - but I mean, they won the contract. (Academic NP)

3.2. Te Pukenga

Three Te Pūkenga education providers are accredited by the Council to provide education pathways leading to NP registration. The three providers are not part of the NPTP consortium.

Current NP trainee numbers at Te Pūkenga are very small. Te Pūkenga stakeholders explained that they often encouraged potential NP trainees to attend the University NPTP because of financial benefits for the trainee.

University stakeholders described the importance of academic standards and the ability for NPs to have sufficient research experience to be able to critically review evidence. Te Pūkenga stakeholders considered they also provided education to the standard required and that this was confirmed by the Council accreditation of them as NP pathway providers. Some Te Pūkenga stakeholders teach or mentor in both the Te Pūkenga NP practicum and the NPTP and were unclear about why they are currently excluded from the consortium.

I've actually done some teaching through [NPTP]. So there's been a bit of cross pollination, just because I know the people that are working there. So I think that what the NPTP programme has allowed, is it's freed people up to be able to concentrate on their studies for that year on being a nurse practitioner intern. (Te Pūkenga Academic).

One of the key differences between Te Pūkenga and NPTP is the minimum clinical hours advertised. Te Pūkenga stakeholders note providing a total of 300 clinical hours because this is the minimum for NCNZ requirements, but said they would be able to amend this and increase clinical hours to 500 to align with NPTP. One noted that in practice, Te Pūkenga NP trainees also meet the minimum 500 clinical hours requirement for NPTP. All Ara NP students for example are currently employed as NP 'interns' which allows them to consolidate their learning in their workplace,

> *So in the NP practicum most of them are doing full time NP internship. So they're doing it every day. That is their job. So wherever they're working, they're getting well over five to 600 [clinical] hours in the year. (Te Pūkenga Academic).*

The implications of NP pathways through Te Pūkenga and NPTP is two cohorts of NPs with different clinical hours in their qualifications. The NPTP cohort have financial advantages over Te Pūkenga NP trainees.

Te Pūkenga stakeholders described:

- Interruptions to the NP pipeline for their nurses and difficulty cross-crediting Te Pūkenga courses at universities.
- Decreasing numbers of NP trainees in their programmes as the financial benefits of NPTP drew nurses to the NPTP courses.
- Filling a gap in localities with no consortium partner. Ara based in Christchurch provides NP pathways to students working in rural practices and settings.
- Potential barriers for their Māori and Pacific students who had completed Te Pūkenga Bachelor of Nursing Māori and Bachelor of Nursing Pacific. They described some of these nurses as older and less able to relocate away from their Te Pūkenga.
- The importance of removing any pipeline barriers for Te Pūkenga graduates who wanted to enter NPTP.

More work is required to provide robust evidence regarding the number of clinical practice hours required by a NP and differences in competencies between NPTP and Te Pūkenga graduates.

3.3. Entry criteria to NPTP

The pre-requisites to entering NPTP are based on NZQA university standards and the Council requirements and comprise:

- A three-year Bachelor of Nursing or Bachelor of Health Science degree from a university or polytechnic.

- Have completed a minimum of three years' equivalent full-time practice (0.8FTE or higher) within the last five years in the area of practice in which they will be registering[3].
- At least one of the three years needs to have been in New Zealand.
- A clinically focused two-year Master's degree approved by the Council.

The pre-requisite pathway, although simplified by NPTP remains complex. The details including names and content of the Master's degrees differ between universities.

In response to the survey, 56% of nurses said they knew how to find out about the requirements to become a NP (Figure 3).

Figure 3. Finding out about the requirements to become a NP (Survey, for nurses who had not enrolled in the programme, n = 212)

In interviews we heard how some nurses complete various postgraduate papers that may be of personal interest and professional benefit but are not core papers for the NPTP. Going back and completing core papers was described as a barrier. Developing a specific NP Master's degree would clarify the expectations for nurses aiming to become NPs.

While the equivalent of a B grade average is ideal, educators described flexibility around the average and a desire to support priority groups to achieve the pre-requisites.

> *When it comes to a student completing a post-grad diploma, they may not have the B grade entry for master's programmes but what we will do is we will say to them, Let's have a look, let's see what your strengths are. We will offer you the opportunity to study some courses as an individual course of study or certificate of proficiency and if you achieve these grades, then that will increase your GPA for Master's. We will build on whatever learning you need. And that enables the student to increase their grade. (Academic NP)*

Ideally, nurses will also have leadership experience and some experience working with or observing a NP, so they understand the scope of the role. Educators described access to a NP as the best way nurses can gain insight into the NP role. Just under one-half of nurses responding to the survey had access to a practicing NP. As the numbers of NPs in the workforce increase, access to practicing NPs will also increase.

[3] https://nurseworkforce.blogs.auckland.ac.nz/nptp/entry-criteria/

But the people who aren't ready are the people who haven't been working in a role with a mentor, much before they start. The people who are successful have worked with the same mentor at least a year before the NPTP. (Academic NP)

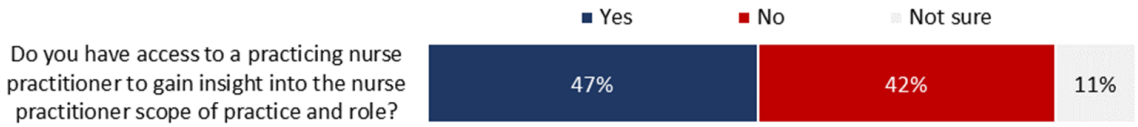


Figure 4. Access to a practicing NP (Survey, for nurses who had not enrolled in the programme, n = 212)

Stakeholders noted that since the introduction of NPTP, the pathway to becoming a NP is easier to navigate resulting in many NP trainees with less clinical and leadership experience than their predecessors who registered as NPs. Their comments alongside discussion about how less experienced NP trainees struggled with the intensity of the course suggest a need to review the entry criteria.

Limited clinical experience can hinder participant success in the NPTP as nurses that have worked in multiple areas, such as hospitals and community care have a broader skill set that is beneficial for the NPTP final year. (Academic mentor)

But my personal opinion would be anyone less than 10 years [should be excluded]. I don't think you have that grounding in that bank of knowledge that you need to draw on from time to time. (NPTP trainee)

The students that transition from Designated RN Prescribing do better in the Nurse Practitioner Prescribing. I think some of that is knowledge but some of it is confidence. (Academic NP)

3.4. Nurse selection for NPTP

Nurses apply for NPTP to the university where they want to study. Nurses must have employer support to apply for NPTP. However, interviewed stakeholders were not sure the scope of the NP role was well understood amongst the wider sector including some nurse leaders. Lack of employer understanding of the NP role could lead to employer support for nurses for NPTP who were not ready for NPTP or conversely, not supporting a nurse who is ready for NPTP.

Some employers were described by stakeholders as regarding a NP as a progression without understanding the different scope of practice.

… the nurse practitioners especially want to meet the equity needs of clients and this often involves working in a slightly different way to the medical model. I struggle with my doctor colleagues to understand how nurse practitioners can do what they do but I struggle with my nurse colleagues, for them to understand that as a nurse practitioner, when you have responsibility for diagnosing and treating and referring, I have to come to the table with all of the knowledge of my medical colleagues … (Academic NP)

Lack of employer support was one of the main barriers to entering NPTP for nurses. The other main barrier was workplace demands in their current roles (Appendix 3).

All NPTP applicants are assessed using a ranking system that has been developed over time (Table 1).

Table 1: The NPTP application and acceptance process

The application process	Implications
Applications are centralised on the University of Auckland website.	Creates potential bias towards University of Auckland.
Applicants select their university	Applicants can choose the university they are familiar with. Te Pūkenga graduates need to select a university option.
Administrator checks applications and eligibility is assessed	An objective process to ensure all pre-requisites have been achieved.
Universities interview their own candidate pools using standardised guidelines and prioritised scoring is used to rank candidates nationally. Educators come together as a group to discuss the bottom 20%.	The aim is to provide consistency across applicants. While the ideal would be to have interviews completed with at least one educator from another university, this is not feasible within the capacity of the current workforce. The alternative is to discuss the bottom 20% as a group. Māori and Pacific team members provide input about Māori and Pacific applicants. Stakeholders discussed other priority groups that are not included in the scoring e.g. hardship scores and unclear definitions of rural.
Places are considered as a total across the collaboration	If applicants have a 'champion' in the assessment process their contexts can be described more accurately. Some applicants may meet the criteria, but their scope of practice may not be considered a priority area to receive NPTP funding. These applicants may choose to reapply or seek alternative funding options.
Those below the threshold receive advice about what they need – qualifications and experience	Individualised advice prepares nurses to reapply. There was some discussion about the need for an appeals process for candidates.
Employer support	Nurses must have employer support and a clinical supervisor to accept a place. If there are difficulties, the NPTP team will try and resolve these.

3.5. The curriculum

The NPTP curriculum is 60 credits. The NPTP curriculum was developed from the NP pilot. Course coordinators/convenors from each university work together as a group to align their programmes.

As part of the NPTP, NP trainees receive:

- 12 study days per year.
- Academic support from a NP academic mentor (at least bi-monthly) including visits to their practice at least three times per year to assess the NP trainee and support through to successful panel assessment with the Council.
- 500 hours of clinically supervised practice by an authorised prescriber (either NP or medical).
- Secondary placement of 80 hours in total (and with a NP supervisor if they were not supervised by a NP in the main placement).
- OSCE (Objective Structured Clinical Examination) and viva examination at the end of each semester.
- Preparation of a portfolio in readiness for submission and registration by the Council.

3.5.1. Clinically supervised practice

NP trainees with limited clinical experience have implications for NPTP experiences and an increased the need for pastoral support and mentorship. Stakeholders and NPs consistently described the NPTP as an intense and difficult year.

> *… the students would say it's an extremely tough year, and that they feel completely overwhelmed. (Academic NP)*

> *It was such a stressful year. And it was nice to know that everybody felt the same way. Like you weren't the only person that was struggling in terms of your physical and mental health. It just made you feel better as a person because you're all crying in the room together. (NPTP trainee)*

> *You literally have to give up home life. (NPTP trainee)*

The NPTP includes 500 hours of clinical learning. NPTP educators considered the 500 hours was important for NPTP trainees and aligned with international standards. However, the Council website specifies a minimum of 300 hours of clinical learning. Therefore, nurses are becoming NPs with different clinical hour requirements. Objective evidence about the correlation between clinical hours and NP competencies is needed to inform discussions with the Council and resolve differences.

3.5.2. Academic mentoring

NP academic mentoring was described by stakeholders as an important success factor for the NPTP. Each NPTP trainee has an academic mentor who is a NP.

> *I had a really good academic mentor... I found her invaluable... she was like, 'no you don't need all of that, this is what you need'… (NPTP trainee)*

In response to the survey, 64% of NPs or those training to be a NP had access to an academic mentor. Those who did not may have trained overseas, enrolled in earlier programmes or other NP training courses (Figure 5). Most of those with an academic mentor described the support they received as very good (46%) or good (26%). There is potential to improve academic mentoring experiences as 28% described it as only fair or poor.

Ideally Māori NPs and Pacific NPs would be mentored by either a Māori or Pacific mentor, but the number of Māori and Pacific NPs is not yet sufficient to allow this.

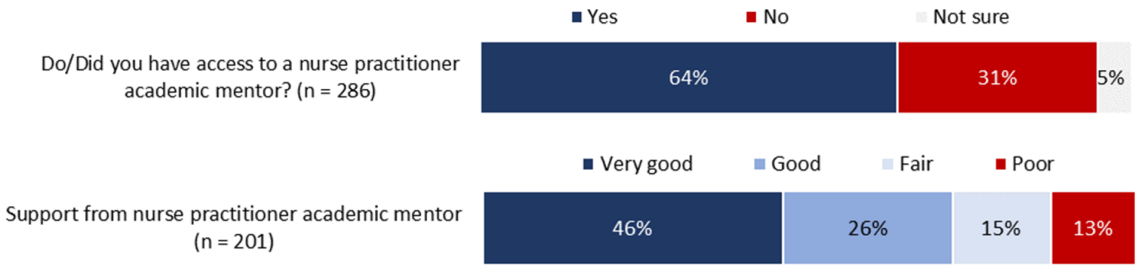


Figure 5. The role of academic mentors (Survey responses from NPs and NP trainees)

3.5.3. Secondary placements

It is ideal for every NPTP trainee to have a NP clinical mentor but as this is not feasible some NPs receive clinical mentorship from another prescribing professional such as a GP. Clinical mentors who are not NPs require additional support due to lack of experience or knowledge in preparing NPs for independent practice.

When NPTP trainees lack access to a NP in their current workplace and seek a more comprehensive clinical experience than what their workplace provides, secondary placements serve to enhance their breadth of clinical knowledge. Most importantly, secondary placements afford all trainees the opportunity to work with an experienced NP allowing them valuable hands-on experience.

Some NPTP trainees said it was difficult enough to find appropriate clinical supervisors for their first placement. NPTP trainees discussed the possibility of the university or consortium taking a more active role in brokering the second placement to help alleviate the *'added stress'* of finding a secondary placement.

> *The biggest issue with the secondary placement was the university didn't help you find them. So you had to find them yourself … but it's actually really hard to find those*

placements… But I know there was a few that found that whole secondary placement, extremely stressful, lots of tears for a lot of them. They left it till the last minute because it was a struggle to find somebody. (NPTP trainee)

With time as the NP workforce grows, more NP trainees could be supervised by NPs in clinical settings. NP trainees and graduates with a breadth of clinical experience and workplace experience supervised by a NP may not require secondary placements.

But I found it really useful, though really invaluable, because that was my opportunity to work with a NP. Because in my place of work, there's no NP, so I was working with the doctor… I know the NP that I went to for my secondary placement, he ended up doing more than one of us over the year. (NPTP trainee)

Kaupapa Māori and Pacific services may not have appropriately qualified mentors. There are opportunities to explore other ways to support NPTP trainees in Māori and Pacific organisations.

I think exploring those other models of funding. It can be a lot of costs for one provider. But if a group of providers contributed to the cost of a NP, that means that NP is employed. They can support multiple providers and it's less of a financial burden to providers, … we want NPs to get into [the Māori and Pacific health] sector. (Stakeholder).

3.5.4. Pastoral care and support

Pastoral care and support were provided by mentors and for some NPTP trainees by NP colleagues in their workplace. NPTP trainees have also created their own peer mentoring groups within and across institutions to provide academic and moral support.

… luckily I also had another colleague [at my university], and luckily with my employer at the same time. So it's been really nice to have someone to like kind of lean on and like help me through and things like that. I think potentially if I was in an environment where I was by myself, it wouldn't be really good… because I do think you need each other to get through. (NPTP trainee)

Me and [another NPTP trainee] run a NP intern group. So it's been passed down. It was started by my NP lead about three years ago. So we basically just put it out to all the universities and all the interns across all the country can join it. And then once a month, usually the first Monday of every month, we all zoom together. ... (NPTP trainee)

3.5.5. Programme length

Most academics wanted the NPTP to remain as a one-year course. However, due to the widespread acknowledgement that the NPTP is an intense 10-month programme some interviewees suggested options to complete the NPTP over 18 or 24 months or to broaden the scope and provide a NP Master's programme.

I think a two-year programme, it would just need to be re-designed and this is where university regulations become an issue but yes, the first year should be that evidence-based practice research project alongside them working, doing that clinical practicum work in their clinical space. (Academic NP)

We do disadvantage those who have got very busy lives, who would benefit from studying maybe over 18 months … they might benefit from studying from February one year to June the next year, rather than February to October. (Academic NP)

… flexibility in terms of the programme will be nice, rather than saying you had to complete in 10 months … (NPTP trainee)

3.6. Nursing Council of New Zealand registration

The Council approves assessment against the NP competencies to register as a NP. The Council assessment aims to moderate any differences between NP education programmes.

NPs were less positive about the Council panel process than other aspects of NPTP. Only 25% described the panel process as very good and 38% as fair or poor. The NPTP curriculum includes support for trainees to prepare for the panel process. Some queried the need for the Council review for NPTP trainees.

If a TEP [tertiary education provider] runs a validated course, why then do they have to prove themselves again. Candidates also produce a portfolio including a competence assessment. There seems to be some variation between panelists and I have heard of many instances of unfair or unprofessional conduct during panels. (Survey)

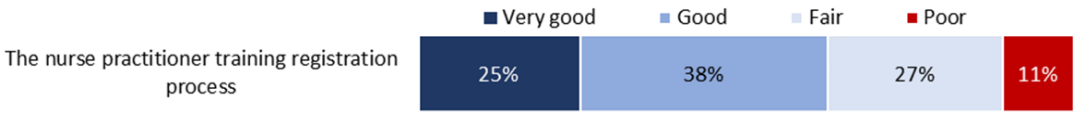


Figure 6. NP experiences of the registration process (Source: Survey responses from NPs and NP trainees, n = 237)

3.7. Transition support

New NPs need support to step into roles with confidence and avoid feeling overwhelmed. Survey responses suggested that while most NPs can transition to a NP scope of practice following NPTP, some have struggled (Figure 7). Educators and other stakeholders saw transition support as essential to support newly qualified NPs to transition successfully into their new roles.

Figure 7. The extent NPs have been able to transition to NP practice in their current roles (Survey responses from NPs and those who completed the programme but are not registered, n = 224)

A programme to provide transition support into NP roles was funded from COVID underspend. Transition support for NPs fills the gap when employer support is lacking. The importance of post-transition support may increase with the removal of the requirement for NPTP trainees to have NP employment after NPTP.

4. The NPTP service agreement

Key messages:

The University of Auckland manages and administers the NPTP. From the consortium, an operational group of NPTP leads focuses on the NPTP development and delivery. Three partner organisations are included as part of the service agreement to support key deliverables of the service agreement.

A governance group formed by the provider sits over both the EN and NP service deliverables. Views about the efficacy of governance varied. Academics were more positive than other governance group members who described the governance focus on the delivery of the NPTP curriculum as limiting without strategic discussion about issues sitting outside the NPTP delivery. Some considered the group would be strengthened by stronger representation of NPs and Māori and Pacific partner organisations. Some members asked for more communication about finance and other NPTP details.

Broader national oversight of NP workforce development is needed. Achieving the diverse NP workforce that is needed requires strategies and actions that sit outside the sphere of influence of universities. A national advisory group with a wider focus on strategic development of the NP workforce could provide national governance and guidance on future priorities. The national advisory group must be NP-led and include representatives from Māori and Pacific organisations, employers and educators. A representative should sit on the NPTP governance group to maintain communication.

The costs of delivering NPTP in its current form have not kept up with increases in salaries for academic NPs, clinical supervisors and backfill funding for employers.

4.1. The NPTP service agreement

The service agreement is with one provider, University of Auckland, who hold responsibility for the deliverables and service components. The service agreement is not limited to NPTP as it also includes provider and partner responsibilities for EN objectives.

The service objectives are to:

- Ensure equitable access nationally to NPTP.
- Support expansion of Māori and non-Māori NP training with a focus on mental health and addictions in primary health care settings.

- Prioritise Māori participation and partnership in promoting NP service delivery models for Māori and identify potential Māori NP trainees.
- Increase Pacific participation by promoting NP service delivery models and identifying potential Pacific NP trainees.
- Support NP and EN workforce placement into primary mental health care settings.
- Share learnings and ideas to increase the success of programmes through the Providers networks across both North and South islands.

4.2. Partners

In addition to the consortium of universities the University of Auckland works in partnership with three health organisations:

- Mahitahi Hauora PHE – Northland's largest primary health organisation.
- The Fono – An Auckland based Pacific health and social services provider.
- Te Rau Ora – a Māori led national Māori workforce centre predominantly focused on mental health and addictions based in Wellington.

Mahitahi Hauora and The Fono noted that they had more engagement with the EN aspects of the service agreement than with the NP aspects. Te Rau Ora had originally bid for the initial NPTP RFP together with Massey University and were invited to become a partner once University of Auckland was awarded the service agreement.

4.3. Governance and management

A governance function is essential to provide NPTP overview and strategic direction to achieve the service objectives. The governance group provides oversight to both the EN and NP aspects of the service agreement. Consortium members are usually represented by the heads of the schools of nursing. The governance group on paper also includes a range of other stakeholders including Māori and Pacific representation, NPs, key organisations and NP employers.

The terms of reference (TOR) describe the governance group as a collaboration of partners, stakeholders and leaders from across the health and academic sector who will come together to consult, discuss and advance the programme regionally and nationally. The role of the members aligns with the NPTP service agreement objectives and emphasises a strengths-based approach embedded in Te Tiriti ō Waitangi principles.

Academic governance group members generally considered the consortium to be well managed by University of Auckland or did not raise specific issues.

I think that the consortium has grown from strength to strength. I think … it's managed well, you know, I I wouldn't challenge that and I think our relationships have improved significantly. (NPTP lead)

Academic governance group members were generally more positive about the function of the group than other members who identified a need for a broader strategic lens and an increased focus on addressing issues for Māori and Pacific nurses.

Queries were raised by stakeholders about:

- Whether there was sufficient representation of NPs on the governance group.
- Whether the governance group would be more effective if governance functions were separated for EN and NP.

Some stakeholders noted the need for:

- Better data and information from the programme to help provide strategic advice particularly for NP trainees from rural, Māori and Pacific communities.
- Utilise expertise across the governance group on how service agreement deliverables for Māori, Pacific, mental health and addictions and rural NPs could be strengthened.
- More oversight into the budgets and finances to inform decisions about the reallocating underspends to support the priorities of mental health and addictions, rural communities, Māori health and Pacific health.
- Additional feedback mechanisms to allow governance members to provide input into changes on delivery of the service agreement.

An operational group of NPTP course coordinators meets twice weekly. Feedback from operational leads suggested the need for improved communication flow between the governance group and the operational leads.

Some interviewed NPTP course leads were not aware of the details of the budget allocation and asked for more transparency about how it was used to inform their operational roles. While University of Auckland described presenting financial reporting at each governance group meeting, we heard that the intended separation of EN and NP aspects would provide more transparency over the funding. There is a need for more access to financial information by the operational leads.

…I don't actually understand what is happening. [Auckland] do need to be clearer about how the funding is being spent. Because it's public good money. … we need to be accountable. (Academic NP)

4.4. Administration

The University of Auckland administrator works 0.2FTE on the NPTP managing the budget and service agreement coordination. Responsibilities comprise:

- Setting up provider contracts.
- Financial reporting alongside the accountant.
- Compiling applications and checking details.
- Calculating travel based on where nurses live – payments are largest for those living further away from their university. University of Auckland provide travel funding to each partner university. Some universities reimburse for travel whereas others provide a fixed sum.
- Employer payments and responding to employer issues e.g. if a nurse is not receiving her usual salary from her employer.

Consortium members recognised the need for a management and administrative lead and there was positive feedback from consortium members about the administrator.

Centralised administration enabled some flexibility in managing the travel budget and allocating more travel money to nurses for whom travel was very difficult or more expensive. However, management and administration could be separated from the academic and clinical deliverables if there was good communication between the administration provider and the university teams.

> *… there's a body that has that overall responsibility for organising the meetings, for collating all of the dates, for application, putting those into the different universities, interview processes, even notifying the students, looking after the fund, communicating with Te Whatu Ora. All of that sort of thing I think needs to happen, from someone, and it doesn't happen so much in the consortium. So I do think you need to have someone that's a fund-holder and I don't know what that looks like. (Academic)*

4.5. The costs of delivering NPTP

The costs of delivering NPTP include fixed and variable (per student costs). The University of Auckland preliminary internal evaluation outlines the costs of the service agreement per trainee (Table 2). All universities get paid the same amount for their course director, per student amounts for academic mentors and student travel. Additional funds may be paid to Māori and Pacific NPTP trainees e.g. $1,500 to support the Council application. In Semester 1 an additional $1,000 was available from the Māori Health Directorate for Māori in the South Island.

The academic mentor funding was initially $4,500 per student and increased to $5,000 at the end of 2022. The University of Auckland team stated overheads had not been applied to the NPTP service agreement but that this would need to change.

Table 2. An overview of 2023 funding (GST exclusive) to support the practicum year (Source University of Auckland internal evaluation)

Funding type	Amount per trainee	Paid to
500 hours of clinical release time	$15,000	Employer/agency
Clinical supervision allowance	$5,600	Employer/agency
Study day release time - minimum of 12 days	$3,000	Employer/agency
Course fees for 60 credits	Vary per university (fully paid)	University
Travel allowance for study days	$200-$1,700 per year depending on student's distance from university	
Secondary placement	$1,000 per 40 hour block	Secondary placement provider
Secondary placement travel allowance	Student can apply for funding if it is more than 150k from place of residence	Student

Funding is also required for:

- Programme administration @ 0.2FTE for University of Auckland
- Course directors @ 0.3FTE
- National oversight and development
- Māori and Pacific national co-ordinator.

Stakeholders identified funding gaps associated with:

- NP salary costs. Each student has an academic mentor. The University has to pay employers 'buy-back' rates at the NP salary rates.
- Payment of clinical and study day release time for NPTP trainees. Release time was described as crucial but the amount available as not reflecting the costs of clinical release for employers.

  The amount paid for supernumeracy time isn't sufficient, and that creates its own problems and barriers. And let's be fair, that's usually a private business and they have a business model where they have to meet costs. (Academic NP)

- Administrative time. Consortium members noted that the administrative time including meeting with other course coordinators was valuable but more than they expected and exceeded their NPTP funded hours. We heard that additional financial support for NPTP was provided by their respective Departments of Nursing but that this could not continue.

Within the university, we spend a lot of additional time supporting the students, we go above and beyond. And so the funding that we get for the mentorship of those students is already not adequate. And then when we're putting a lot more wraparound services and time and effort, because we really want to see them succeed. (Academic NP)

Clinical supervision was described as another funding challenge. Supervision requires time from the supervisor on top of their usual responsibilities. For example, the number of patients seen in a day, or the consultation time may increase and may require the supervisor to work additional hours. The clinical supervision allowance may not be received by the clinical supervisor who incurs the extra workload. Hospitals and other employers were described as retaining the supervision funding but not providing supervisors with other forms of compensation such as time off in lieu.

Stakeholders suggested aligning NP payments and release time payment with MECA salary scales. Based on stakeholders' estimates of time spent on NPTP programme delivery, costs per NPTP trainee are summarised in Table 3. Course sizes have financial implications as some costs of running the programme remain constant regardless of the number of NPTP trainees. There was agreement that there is a minimum feasible size of between five and ten NPTP trainees.

Table 3. An overview of updated funding requirements

Funding type	Estimates of funding requirements
500 hours of clinical release time	Update costs to MECA scales for senior nurse of RN prescriber
Clinical supervision allowance	$9,812.50 based on $125 per hour. Average of 1 hour per 8 hours student time - varying over the programme. Est 78.5 hours.
Study day release time - minimum of 12 days	Update costs to MECA scales for senior nurse of RN prescriber
Course fees for 60 credits	Continue to fully pay registration and course fees
Travel allowance for study days	$200-$1,700 per year depending on student's distance from university
Secondary placement	Review
Secondary placement travel allowance	Student can apply for funding if it is more than 150k from place of residence
NP academic payment per student	$9,480 per student estimated. 0.2FTE of an academic mentor to support 4 NPTP trainees

Funding increases are also needed for a Pacific national co-ordinator to also help with increasing the number of NPTP trainees and to reflect course director time.

> *…and there needs to be ring-fenced funding for a Pacific lead to address our specific needs. (Pacific Stakeholder)*

Funding gaps associated with support for NPTP trainees were identified as the need for hardship funding that could be used for NPTP trainees for whom costs were a barrier. Financial support based on need would be beneficial for any NPTP participant experiencing financial hardship, particularly for solo parent households.

> *I have students who are non-Māori and non-Pacific who are solo mums, who are working really, really hard. And it's quite difficult for me … not to be able to support them in the same way … So that's a concern for me. (NP Academic)*

Academic leads highlighted the importance of funding certainty as early as possible in the year to enable preparation. The earlier NPTP trainees could be advised of their selection the more time they had to prepare. Longer service agreement duration would also enable stability and certainty.

5. The extent the NPTP service objectives have been achieved

Key messages:

The NPTP service agreement has supported an increase in the numbers of NPTP trainees that has flowed through to an increased number of NPs. The increased numbers are a solid foundation for development of the NP professional workforce and strategic planning to identify where NPs are needed, their demographic profiles and areas of practice.

Across all years the largest group of NP trainees have a primary care background. The numbers of trainees with areas of practice in mental health and addiction and older people's health have not substantially increased.

Increasing the diversity of NP practice areas and increasing the numbers of nurses practicing in mental health and addiction, and older person's health requires employer related barriers to be addressed. Some employers are supporting nurses to become NPs through a role they describe as a NP 'internship' which offers support prior to NPTP, during NPTP and transition to practicing as a NP in their workplace. Funded NP 'internships' have the potential to target gaps in the NP workforce and reduce the need for secondary placements.

The development of specialist modules within core NPTP course requirements is likely to facilitate increases in the numbers of NP trainees with specialist areas of practice. A modular approach with core requirements and flexibility may better meet the needs for NP education for both generalists and specialists.

Although there are indications that 2024 will see an increase in the number of Māori and Pacific NPTP trainees, the numbers of Māori and Pacific being ready and eligible to enter NPTP has not grown at the pace required to achieve equity in the workforce. Many of the barriers to increasing the numbers of Māori NPTP trainees and Pacific NPTP trainees are beyond the scope of influence of the University of Auckland and the consortium. Such barriers include the small size of the pool of Māori and Pacific nurses and their personal and employment contexts.

However, there are opportunities for NPTP to increase equity by responding to:

- The lack of recognition of non-university qualifications and Māori health and Pacific health postgraduate papers from other tertiary institutions held by Māori and Pacific nurses. Responses may require NZQA and/or the Council changes to requirements.
- Expansion of NPTP curriculum to include modules and clinical practice embedded in Māori and Pacific health paradigms.
- Recruitment of a national Pacific coordinator (aligned with the existing Māori national coordinator role).

Further progress to increase the numbers of Māori NPs and Pacific NPs requires partnerships with more Māori and Pacific organisations and strengthened support for any Māori and Pacific NPTP trainees, including from employers.

5.1. Increasing the number of registered NPs

The NPTP service agreement has underpinned an increase in the number of registered NPs after completing NPTP (Figure 8).

> *I think this contract gives them much more support. They have more study days, and there is additional support, monetary wise to get to the schools, and plus getting the fees paid, and the ability for the employer to get the money to backfill their position, although that doesn't always happen. (Academic NP)*

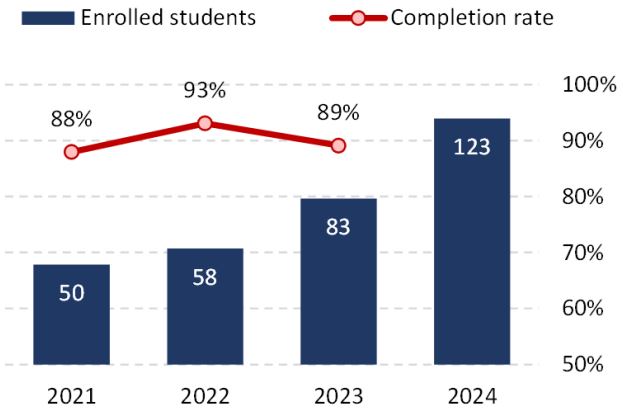


Figure 8. The numbers and completion rates of NPTP (University of Auckland data)[4]

Most NPTP trainees (89% in 2023) who entered NPTP completed the programme. The educators described being flexible and offering additional support to NPTP trainees who were struggling as important factors for completion.

The survey findings identified reasons for non-completion as personal issues, lack of relevant experience, their employment environment and mentor issues. Academics also identified lack of previous clinical experiences and understanding of the NP role as reasons for lack of completion.

Some academics considered, that at times, to meet service agreement targets, they felt under pressure to accept nurses from priority groups that they deemed were not ready for NPTP. The impact on students who were not ready was loss of confidence and potential loss from the NP workforce.

[4] Note: University of Auckland data record 50 trainees in 2021 and Health NZ data record 52.

... There has been pressure for us to accept those students [who we feel would benefit from another year of practice] and my worry is that, while some will go on and succeed and we'll have been wrong but some will be put under such pressure, that they'll have personal and professional trauma related to their lack of preparation. And they're going to fail and they might never come back because it's been too traumatic experience for them. And it puts a great deal of pressure on us to have to fail people. (Academic NP)

In response to the survey, most NPTP trainees were generally positive about their NPTP achievements with some exceptions (Figure 9).

Figure 9. NP assessment of NPTP learning experiences (Source: Survey responses from NPs and NP trainees, n = 251-252)

5.2. Expansion of training and placements of NPs into mental health and addictions and primary care settings

One stakeholder noted NPs are often highlighted as key to improving healthcare systems, with NPs being particularly effective in primary care and public health. This view may have contributed to the early dominance of NPTP trainees working in primary healthcare (Figure 10). Just over one-half (51%) of the 2024 NPTP trainees have a range of other practice areas including secondary care which will contribute to meeting the needs of secondary and tertiary services.

The other thing that I think is the Auckland focus on primary health care… which are important but the message that has gone out now to the sector is that NPs are all about primary health care right? They are in part, but we need nurse practitioners in secondary and tertiary services desperately. (NP academic)

So we need to grow our nurse practitioner workforce in our secondary care environment as well. So we can support our primary health care colleagues, but that's often not, not seen, not valued. (NP mentor)

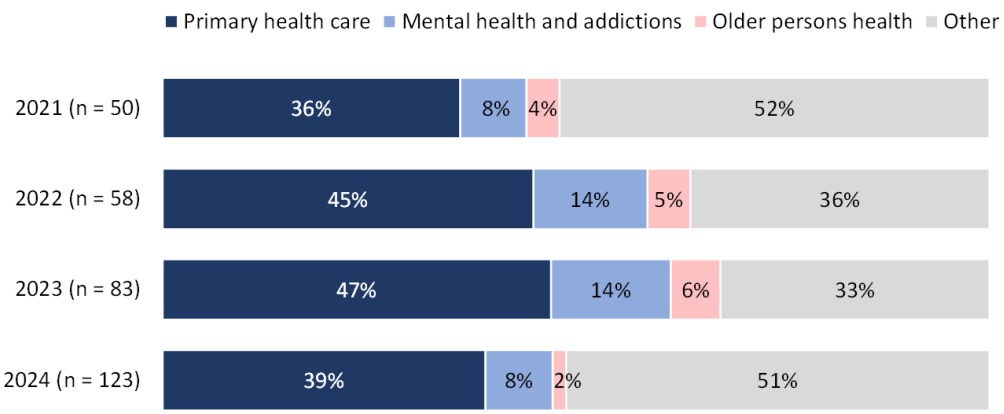


Figure 10. The practice areas of NP trainees (Source University of Auckland data[5] – the 'other' category in 2024 likely reflects data still to be collected from 2024 NPTP trainees)[6]

However, increasing the numbers of NPTP trainees with practice areas in mental health and addictions and older persons health are important for Health NZ to address workforce needs.

> *The support and establishment of NPs is essential within mental health and addictions, to really enable and create those advanced practice roles, which enhance the MDT [multidisciplinary team] and enhance the clinical function of services, alongside psychiatrists and alongside other members of the multidisciplinary team. (Sector nurse leader)*

Challenges for NPs specialising in mental health and addictions were described as lack of a good pathway to NPTP and a shortage of clinical mentors. Some stakeholders also described resistance to the NP role amongst some medically qualified mental health and addiction staff.

We heard from stakeholders that while increasing the numbers of NPs with mental health and addiction backgrounds has been a focus of NPTP, efforts such as a short course in mental health, have not been as successful as hoped. NPTP trainees specialising in mental health and addictions highlighted the need for more specific NPTP content on mental health and addictions.

> *So really that whole programme is focused a lot on physical health, rather than mental health. So the assessment processes are more so around GP practices in primary care, rather than working at the hospital or secondary settings. (NPTP trainee)*

[5] The 2021 – 2023 data includes trainees who completed the programme only. The 2024 data includes all trainees who enrolled in the programme.

[6] Note: University of Auckland data record 50 trainees in 2021 and Health NZ data record 52.

This quote highlights the tension between delivering a balanced NPTP that meets the needs of NPs working in communities and NPs working in specialty areas. Many stakeholders, NPs and NP trainees shared similar concerns.

> *… I don't want my NPs working in our specialist hospital to be prescribing for a patient what would normally be prescribed by the GP, because they're not providing general practice primary care for this patient. They're providing a NP service model, which is about the area of secondary, or tertiary service delivery. (Chief Nursing Officer)*

> *[A NP working in a specialised secondary care area commented] I spent a lot of time learning about conditions I would never be looking after. (NP)*

NPTP trainees from non-primary care areas may also feel isolated as there are often only one or two from their speciality at each university.

The increased size of the consortium and the increased number of NPTP trainees provides a foundation for offering NPTP as a modular approach with core standard papers and specialist areas. The opportunity for diversity was highlighted as a strength of the consortium which can be leveraged to support a modular approach for specialities and may provide an additional incentive for employers to support nurses to become NPs.

5.3. Equity of access nationally to NPTP

The NPTP entry criteria and assessment processes were designed to facilitate equitable access for nurses who apply for NPTP. However, this only applies to university graduates and NP trainees. Nurses who have graduated with nursing degrees from Te Pūkenga must change to a university to receive the benefits of NPTP. Financial support available for NPTP trainees is not available to Te Pūkenga NPs unless their local employer funds their participation.

5.4. Increasing the numbers of Māori NPTP trainees and Pacific NPTP trainees

Increasing the number of Māori NPTP trainees is a key service agreement deliverable. The number of Māori NPTP trainees has increased each year from 4 in 2021, 10 in 2022, 13 in 2023 and 17 enrolled for 2024. Although the numbers of Māori NPTP trainees have increased the proportion has not consistently increased and has not met annual targets for enrolment (Figure 11).

> *[Māori and Pacific nurses] are not being advantaged to reduce the inequality. … that means they're not getting into the programme and being successful in the programme. … the predominant people that are currently engaged in our NPTP are non-Māori and non-Pacific. So we have got significant inequity. (Chief Nursing Officer)*

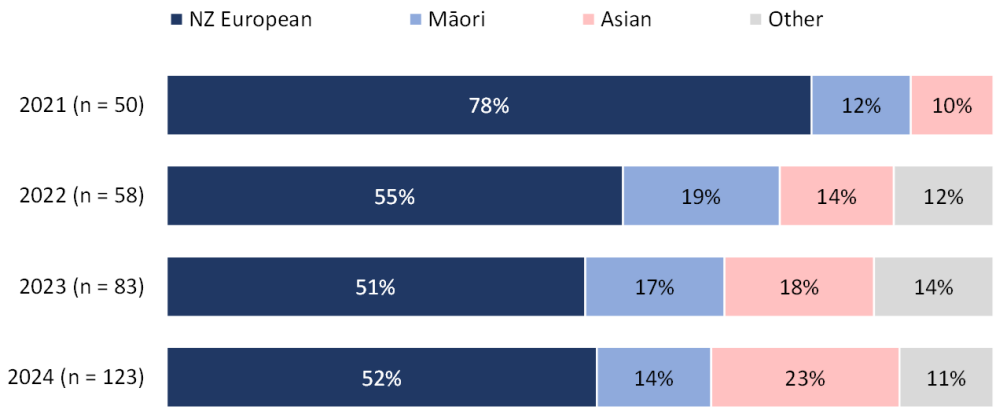


Figure 11. The ethnicity of NPTP trainees (Source: University of Auckland data[7])

Pacific enrolments are not reported as a separate category in Figure 11 but 2024 administrative data shows five Pacific students were accepted. The NPTP academic leads have made efforts to develop the flow of Māori and Pacific nurses into NPTP by offering pipeline support to potential NPTP trainees.

> *I think the NPTP programme has been really good in in that way of developing the pipeline to get there. (Workforce planner)*

There was very little difference in the ratings Māori nurses and NPs provided in the survey about motivation to becoming a NP. A slightly higher percentage noted the importance of equity of access and healthcare opportunities for communities. Higher pay was slightly more important. A slightly higher percentage of Māori nurses identified the education pathway, confidence, need to travel, workloads and other education demands as barriers.

Many of the barriers to increasing the numbers of Māori NPTP trainees and Pacific NPTP trainees are beyond the scope of influence of the University of Auckland and the consortium.

> *… we clearly have increased the number of Māori nurses going to the programme but the feedback that I want to give is, we don't have enough ability to work back downstream because it isn't the final year that's the barrier. Our programme is successful. If we have people ready to go into the programme, they are mostly successful. (Academic)*

However, barriers such as the lack of recognition of non-university qualifications held by Māori and Pacific nurses and the inclusion in the NPTP of Māori and Pacific health paradigms along with Western paradigms can be addressed by the consortium.

[7] The 2021 – 2023 data includes trainees who completed the programme only. The 2024 data includes all trainees who were enrolled in the programme in late 2023.

NP is a very Western model and I am not sure it is right. (Academic NP)

Although Māori and Pacific nurses are a priority because of the value placed on their cultural knowledge and skills, cultural learning is not commonly recognised by universities as meeting the pre-requisite requirements for NPTP. Māori nurses may have completed culturally-specific training at a wānanga or similar that enhances their practice as a Māori nurse or NP. Academics and NPTP trainees described '*little wriggle room'* for entry points into the programme as they are required to comply with the regulations of their university.

… if we're going to reduce the inequities, we have to value, we have to put a higher weighting on that, on that knowledge and experience that they bring. That's the only way that will reduce the inequity - if we actually do weight that higher. (Chief Nursing Officer)

… rather than making requiring our Māori nurses to go through a pathway, which is traditionally a colonized pathway, … actually having much more flexibility in that and recognizing the contribution that they're bringing, as Māori. (Chief Nursing Officer)

For Māori nurses there is alignment with the Ngā Manukura o Āpōpō: Clinical leadership training programme for Māori Nurses and Midwives but there is currently no alignment with the Aniva Pacific leadership programme based at Te Pūkenga Whitieria-Weltec in Wellington, popular with New Zealand's Pacific nursing workforce. The Aniva programme has the highest Pacific nursing completion rates in Aotearoa New Zealand and can provide shared learnings on supporting Pacific nurses.

From a Pacific perspective we have a new leadership programme, Aniva which has the highest graduation rate, so you could develop that programme more to encompass the NPTP and partner with potentially Massey University. (Pacific Stakeholder)

Aniva and Massey University do have a relationship where courses from the Aniva programme can be cross-credited at Massey University. This demonstrates the potential to expand this relationship into the NPTP consortium to provide the Pacific cultural content needed for all NPTP trainees.

Awareness of NP as a profession was described by Pacific stakeholders as increasing with almost *'every second Pacific nurse'* enquiring about NP as a pathway as they have a *'glorified vision that the NP is like a doctor.'* Despite these aspirations there is a lack of understanding about the pathway and the academic requirements necessary to enter a NP training programme.

The problems for Pacific nurses start way before NPTP so it takes a lot of work that needs to happens for nurses to be aware about the pathway… the groundwork needs to start as soon as they start their nursing degree… but the majority of nurses or student nurses aren't aware and not informed. (NPTP trainee)

To be inclusive of Māori and Pacific contexts, programme content should move beyond discussions of health statistics and equity to include how te ao Māori worldviews and

different Pacific models of health into NP practice. Inclusion of Māori and Pacific healthcare models and approaches requires co-design with Māori and Pacific experts.

> *Nothing on Māori health or kaupapa Māori [in NPTP]... Kaupapa Māori means, like that kind of holistic case management of a patient, and including the whānau... So just grappling with that too, and trying to articulate in a way that makes sense to everybody. But we have heard that, you know, one of the key fundamental things, too, is making sure that there are Māori nurse practitioner instructors, and the programme courses, that it's co-designed all these good things that we know about, but for some reason, just haven't been implemented yet. (Māori NPTP trainee)*

> *What we're seeing more and more of is Māori nurses really wanting to work within Māori models of care. We've got a Māori kaupapa service in [locality], where Māori nurses are going to work in this service because they get to work in this indigenous model, which gives a great deal of job satisfaction and reward and all of those things. (Clinical Nurse Director)*

> *… it's that conflict between medical model versus cultural model … experienced and senior nurses who are going into nurse practitioner, you'll see them walk that line quite beautifully between having a really good understanding of the cultural models and frameworks and how they adapt their medical model to work within it … (Clinical Nurse Director)*

Another programme consideration is ensuring adequate support for Māori and Pacific learners including understanding any additional family and cultural obligations and different learning styles.

A national Māori coordination role has focused on supporting Māori nurses. Pacific nurse practitioners have lacked champions in NPTP and a national Pacific coordinator has the potential to enhance success and support Pacific nurses with issues that may arise in their workplaces[8]. For example, we heard that Māori and Pacific trainees found it harder to manage workload during their training year and say no to covering shifts when colleagues are sick or away when they are meant to be on study leave.

> *Key details for academic support and readiness need to be locked in for Pacific nurses in the contract to ensure accountability. (Pacific stakeholder)*

[8] There is a Pacific coordinator on a short term contract.

Support for Māori and Pacific NPTP trainees could include:

- More Māori and Pacific NPs sharing their experiences and perspectives from the programme.

  Nobody wants to unsafe practitioners, … people have to understand the science, they have to be able to prescribe safely, they have to be able to diagnose, they have to meet standards around that. … their point where they start from can be very, very different. And the support you wrap around people will be very, very different based on different things.. (Chief Nursing Officer)

- Peer support for Māori nurses and Pacific nurses and NPTP trainees. This is important work for the Pacific pipeline but is unsustainable and unfair for the recent graduates who have taken on these roles.

  I think the point is that we've got these beautiful gems of amazingness who need to be supported to do what they're doing and it's very hard. [Pacific NP] is committed to supporting and supervising to grow other Pacific nurse practitioners. She's got a Māori NP in the making and two Pacific NPs who are coming through their Master's at the moment, who she's supervising and she's committed to their journey to get their registration. But goodness me, it's hard and she's doing a lot of hours in her own time. (Clinical Nurse Director)

To support the need for intensive Pacific peer mentoring, graduates and Pacific stakeholder have questioned whether they could partner with the Pasifika Medical Association (PMA) given their success at providing peer mentorship across nursing and the medical profession.

The commitment to increase the numbers of Māori NPs and Pacific NPs is there but systemic change is needed to shift the dialogue from 'unique learning needs' and discussion of family commitments to how the health sector and academic environment needs to be adapted to enable Māori and Pacific nurses to apply and succeed. Māori and Pacific stakeholders and trainees also emphasised the importance of separating Māori and Pacific health initiatives to address specific needs and avoid '*lumping them together'*.

Some strategies suggested through interviews apply to both Māori and Pacific nurses and include:

- More active engagement with rural, Māori and Pacific communities, health providers and education providers to identify nurses early and support them through the NP pipeline.

  … I think recruiting from rural is important, because if they're working in rural and they're being recruited to do the pathway, then actually they're more likely to practice in their community and bringing people from out of the area to practice in our rural communities would be challenging. (Partner)

- Pipeline support - Increased support for career planning by all organisations employing Māori nurses and Pacific nurses.
- Better quality data on the NP workforce and strategic priority areas across the whole sector.

Considering NPTP pre-requisites:

- Formally recognising the cultural knowledge and skills Māori and Pacific nurses offer.
- Formally recognising post-graduate leadership programmes and training for Māori nurses and Pacific nurses.
- Reviewing the extent of flexibility around the grade point averages to see whether additional support is required for Māori and Pacific nurses.

Considering NPTP delivery:

- Maintaining quality but recognising there may be different ways to achieve safe NPs. For example, moving away from a Western paradigm and embedding kaupapa Māori approaches into assessment.
- Consider additional face-to-face tutorials and mentoring, such as local wānanga or tutoring groups.
- Broadening the scope of the service agreement. One of the limitations of the service agreement is the narrow focus on the final year of the NPTP. Given the challenges and shortage of nurses for rural, Māori and Pacific communities, all partners recommended future service agreements include academic preparedness for Master's, the NPTP and transition support once NPs complete the registration process.

  Yeah, so I think maybe the contract could widen its scope so that it's not just in the final year with support, but for support in the beginning, and I guess helping nurses to be ready for an intense programme, and then sort of post or a transition period where they've got a little bit more support, rather than congratulations 'Here's your piece of paper'. (Partner)

The extent the non-inclusion of Te Pūkenga in NPTP affects the pipeline for Māori and Pacific nurses is not clear and should be explored. While there is some movement in developing support groups for Māori NPTP trainees, access and engagement with all Māori NPTP trainees remains a challenge. Exposure and socialisation to Māori NP and Pacific NP groups earlier is beneficial to fill the gap in terms of additional academic and mentoring support while completing the NPTP.

> *I recently went to a Māori NP hui so I got to meet like 20 other Māori NPs. We didn't even know about these other Māori nurse practitioners. There's no kind of group forum. There's no kind of support in that way. So, when we met them we were kind of thinking well where were you guys during my training! (Māori NPTP trainee)*

5.5. The employers

Employer support is very important both in the lead up to a NPTP application, in supporting a nurse through NPTP and in building the nurse's role as a NP after registration.

Employer support could be a major facilitator to nurses becoming NPs. Mentorship and support in the one to two years prior to NPTP was highlighted as important to build readiness for NPTP. Employers who had well developed workforce planning supported nurses with career planning, linked that with post-graduate funding, and helped nurses to gain the pre-requisite qualifications and experience they needed to enter NPTP.

> *… some places really have done the work, they understand, there are many NPs who are working in the organisation, it's been very successful. But we still have significant areas where there isn't that understanding and there isn't a process to replicate that understanding so that people have access to that. (Academic NP)*

Barriers for employers to support nurses to become NPs were identified in the survey and interviews as:

- An onerous application process – requiring multiple people completing separate components of the application form for students. A more streamlined process for employers and clinical supervisors to submit their components would make it easier.
- Gate keeping within health organisations and within academic institutions who may not be supportive of a potential candidate.
- Difficulty in finding nurses to backfill roles of NPTP trainees. Backfilling roles was challenged by both availability of staff with the necessary skills and funding. The employer allowances for backfilling roles were described by stakeholders as not matching the salaries of the NPTP trainees.

  > *I think our biggest challenge locally and I suspect anecdotally nationally from mental health, is just finding the staff to fill that backfill. (Clinical Nurse Director)*

  > *I've got students who've said, we've got this great opportunity, we've got the NPTP, this is the entitlement for money, you can have your fees paid, you can get release time, and students will say, 'My workplace don't want to release me. I've got a very specialised role, you can't pay for backfill, so there's not much point in me having that and I'd need to do more hours, and my fees are paid by my workplace. (Academic)*

- People declining to be clinical supervisors because of their workloads.

Stakeholders and survey responses described variation in support between employer types and within organisations (Figure 12). Employer support for clinical release time was very good or good for 43% of NPs and poor for 22%.

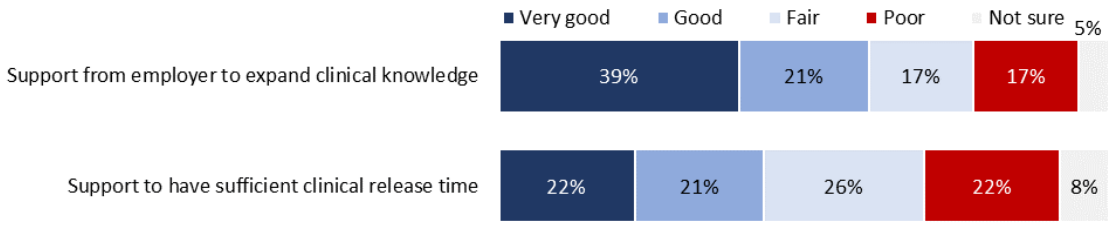


Figure 12. Employer support to develop NP roles (Survey responses from NPs and NP trainees, n = 285-286)

Hospitals were generally described by stakeholders as better placed to provide support for NPTP trainees compared to primary healthcare settings because they had the size and systems to provide support and cover trainees during their training. However, survey responses from nurses employed by Health NZ indicated slightly more barriers than for nurses in primary care.

In primary care organisations that value NP roles, planning and budgeting for a NP may be easier than within a large organisation. However, changes in primary care organisation management can remove commitment to a NP role. Examples were given of responses to the amount available to backfill the roles by reducing the NPTP trainee's salary on clinical release days. There may be additional barriers for small organisations such as NGOs and stand-alone general practices.

> *A GP employer had recently bought the practice. … because the funding for the two days equates to approximately minimum wage for nurse practitioner, he wanted to put her on minimum wage for the two days she was supernumerary… (Academic NP)*

Variation amongst Health NZ organisations seemed to be driven by nursing leadership and the workforce development teams. Some organisations offered planned development pathways and NP internships. There were also hospital management issues relating to:

- Differences in understandings of and access to post-graduate funding.

  We no longer we no longer get [PD funding] as a revenue stream from Health Workforce New Zealand. And some districts, to my knowledge, have been able to secure the funding internally through their management accounting processes. And some haven't. And I'm aware that there are districts who don't have any funding for postgraduate nursing and 2024. (Workforce planner)

  We ring-fence continuing professional education funding for our nurses, they have individual entitlements. We're one of the only districts that does that. (Clinical Nurse Director)

- Different support for career conversations with nurses.

  I do with the rest of the team have career conversations with everybody that applies for post-graduate funding. And that has been the mechanism of making sure that people are choosing the right papers, especially if they're wanting to do the nurse practitioner

pathway, or the RN prescribing pathway, or any advanced practice roles. But those conversations have been really, really important. (Workforce planner)

- The extent budget had been allocated for NPs.

  Some areas do have budgeted FTE that they've planned for. Many don't and are pushing for it but it's not a priority or there isn't any additional funding and we've been in a freeze for a little while and yet our numbers of nurse practitioners going into the training programme's now growing. (Clinical Nurse Director)

  My DON … and certainly the Chief Medical Officer, have been very supportive to say, 'Let's just do what we need to do to get more nurse practitioners trained.' … So I'm able to create the pathways using underspend and vacancy and different creative ways to make that happen without too many barriers… one of the biggest barriers across the country that's a massive issue is there is no budgeted FTE for nurse practitioners within the district. (Clinical Nurse Director)

- NP salaries

  So the collective agreements that exist right now have restrictions and what our nurse practitioners tell us is that we're asking our nurse practitioners to consider coming into our after-hours rosters because we're so short of doctors. Will they pick up registrar shifts? Why would they because the on-call rates are $8 an hour and their medical colleagues may be potentially paid quite a bit more for the same job. (Clinical Nurse Director)

- Resistance amongst medical staff to NP roles.

  … the business case is not just for the development of the nurse practitioner, but also the service and the colleagues within that service as well. (TWO Workforce planner)

  What we have found is often you know, the socialisation of the role in the service, if it's a new role it is really, really important to get right … working alongside other medical professionals. So that investment knowing that there's a role there, that everybody's on board really helps rather than just a manager saying, Yeah, I'll support you to do this training. (TWO Workforce Development)

Many stakeholders identified the need for more direction from Health NZ.

Te Whatu Ora should be telling each hospital to have a pathway and focus in areas of need. (Academic NP).

… there have been many different strategies in the previous DHBs across the country, there was no consistent strategy and the support from both the nursing and medical staff has been highly varied. I would so advocate for there to be a review of what best practices are, around the country, and for Te Whatu Ora to then implement those best practices. (Academic NP)

5.6. NP training roles - NP 'interns'

Some employers and stakeholders described developing a new role which they called a NP 'intern'. The role is not a defined MECA role but the term was used by employers and some NPTP trainees with some employers are advertising for NP interns. The College of Nurses website[9] includes the following:

> The NP 'intern' is a relatively new term in New Zealand and in this case, it is being used to describe those who have entered into a formal service agreement (HWNZ, NP training Pilot programme commenced 2016) with their employer and the academic facility at which they are completing their prescribing practicum.

Interviewed stakeholders described NP 'internships' or similar roles as a more extensive programme that included the year before and after NPTP. The aim of the role was to support nurses who wanted to become NPs to develop a career pathway, to work with a NP in the year preceding NPTP, to receive protected time and support during NPTP and support to transition to a NP in their workplace. This extended programme had the benefit of socialising and establishing the NP role in the workplace. Nurses who had been part of a NP 'internship' described it as making it easier to complete NPTP.

Hospital and primary health organisation employers described the optimal FTE for NP 'intern' programmes.

> *… we work quite hard to provide placements beyond what the NPTP require, because we look at a candidate see or internship for up to two years… two days a week isn't enough to grow someone to be working at the level to be a nurse practitioner within a specialty service, an aged care service or primary health care. And so in reality, you know, the minimum for a NP 'intern' would be point four, and optimally, point five. So you need the funding for a full time role to be secured (TWO workforce development)*

A common theme from NPTP trainees was the paradigm shift and transition from a nursing biopsychosocial model to the NP biomedical diagnostic model. There is a certain point during the NPTP year where NP trainees begin to default to diagnostic thinking in both their studies and practice. NPTP trainees working as NP 'interns' do not have to work in their previous role as a nurse but can develop their NP practice over the NPTP year.

> *At some point during that year, you stop being a registered nurse, and you start being a nurse practitioner, who's critically thinking at the next level, or the next few levels above what your nursing colleagues are doing. So for instance, if I'm in triage, triaging a patient as a registered nurse, but I'm on the internship programme, I was thinking about differential diagnosis and treatment plans and what other tests we needed. So all of a sudden, my three minute triage was 25 minute consult. (NPTP trainee)*

[9] https://www.nurse.org.nz/supervisors-for-np-interns-resource-toolkit.html

Targeted support for funded NP 'internships' by employers or as part of a NPTP service agreement has the potential to increase participation from nurses working in mental health and addictions and older person's health. Nurses working as NP 'interns' could be exempt from secondary placements if their workplace support meets criteria that could be defined by the educators.

NGOs wanting NPs may not be set up to supervise a NPTP trainee alone but could potentially do so across multiple organisations. An example was given of a PHO that provided a NP 'internship' and the NP worked across multiple organisations.

5.7. Sharing learnings through Aotearoa provider networks

The development of three regional hubs (Northland, Auckland with Waikato, and Bay of Plenty) was included in the service agreement. The aim of the hubs was to enable the development of strong networks including providers (Health New Zealand Districts, PHOs/PHEs, and others); clinical settings; NPs (as clinical supervisors and advisors to NPTP); tertiary education providers; community leaders; other stakeholders. Each hub was intended to have governance and a steering group to oversee the implementation.

Early progress was described by the service agreement holder as limited in the early set-up of NPTP and diversion of potential NPTP trainees to COVID responses. Further development of the hubs has not happened.

The current partnerships in the service agreement are set up well to service the EN placement components of the service agreement compared to NPTP. Reflections from the partners and trainees indicate that there are many other Māori, Pacific and rural organisations across the country that can also help with growing the NP pipeline. They suggested finding ways in which the service agreement can foster more relationships for shared learning, particularly for the priority groups.

> *Maybe we should look at PMA (Pasifika Medical Association) because they are doing well with their mentoring and workforce scholarships and they can take ownership of workforce development for nurses. (Pacific NPTP trainee)*

From interviews with a range of key stakeholders there were assumptions that universities would also leverage their own networks to assist with the NPTP deliverables as part of the consortium particularly with Māori and Pacific partners. Based on interviews with trainees this has not yet eventuated and provides an opportunity for a redesign to share learnings and ideas with their respective networks and partners.

An example of a NP 'Internship'

JESSE

BACKGROUND

Jesse graduated with a nursing degree in 2016 and worked in different hospitals across the country. While working at Auckland Hospital they worked with a group of NPs which inspired them to pursue NP as a pathway. After completing their Masters they enrolled in the NPTP the following year in 2022.

While applying for the NPTP Jesse had to find new employment to meet the NPTP employer requirement for the application. Jesse was fortunate to join a PHO who were offering a NP internship for the academic year at 0.8FTE. This meant that effectively for their entire NPTP year Jesse was able to study and work as an NP compared to most of their colleagues who still had to maintain their substantive RN role as well as the 500 NP clinical hours.

THE IMPACT OF NP INTERNSHIP

Transitioning from nurse to NP

One of the key challenges that Jesse found during the NPTP year was transitioning from their previous role as a clinical nurse specialist to thinking diagnostically as a nurse practitioner.

I think we all experienced the same transition of going from nursing to then diagnostic thinking. It doesn't matter if you've had 30 years nursing experience, or seven years like me, we all struggle with that transition. And that successful transition, from my experience and talking to medical colleagues seems to come from practice and being in that environment where you're encouraged to diagnostically think.

Younger clinicians are more open to NPs and their role but there needs to be more education and engagement to change societal perceptions.

If investment could be there to train NPs fulltime that will be beneficial for the health system because those NPs come out that little bit further ahead. I've come through feeling really supported and ready to go versus some of my colleagues.

Broader societal challenges

Jesse notes that there is still room to educate clinicians and patients about the role of NPs. Although Jesse works for an organisation that has trained and employs several NPs for some time now they have been called doctor from patients who are unclear about the difference between a GP and a NP.

Bridging the theoretical gap

An NP internship has multiple benefits for supporting NP trainees during the NPTP year as well as post-registration. Jesse's experience as a NP intern while completing the NPTP has made them confident to step into the NP role post-registration compared to colleagues who had less experience. They were able to transition into the NP role a lot easier because of the continuous NP experience and the support they receive from their organisation.

There's still that theoretical gap... an element of that as a nurse practitioner, but the intern training program in that year is a lot better because you're on the floor constantly getting that experience. I was lucky. I was a full time nurse practitioner intern at [Employer] so they fully invest in your training.

6. Summary and recommendations

The NPTP service agreement is the evaluation focus. However, the extent the NPTP service agreement supports the achievement of the service objectives is influenced by the pipeline, nurse readiness for NPTP, the curriculum and minimum requirements, their employment contexts, transition support after NPTP and registration as a NP.

Review of the service agreement provides an opportunity to consider what has worked well and changes required to support the development of a NP workforce.

6.1. The effectiveness of the NPTP service agreement

The current NPTP service agreement has supported the establishment and growth of the NP workforce.

The number of NPTP trainees has increased each year. University of Auckland and other consortium members have driven growth through early engagement with potential candidates. There has also been increasing support from within the nursing workforce with some Health NZ nursing managers and Directors of Nursing (DONs) actively planning NP career progression pathways for their nurses.

Numbers of NPTP trainees in priority groups have not increased to the extent needed to meet workforce needs.

Health NZ has identified Māori and Pacific nurses, rural nurses, nurses working with under-served communities, mental health and addiction services, and older person's health as priority groups for NPTP entry.

Targets for the numbers of Māori NPTP trainees are included in the service agreement. Although there are indications that 2024 will see an increase in the number of Māori and Pacific NPTP trainees, the numbers of Māori and Pacific being ready and eligible to enter NPTP has not grown at the pace required to achieve equity in the workforce.

Māori and Pacific nurses often bring different skillsets such as cultural leadership, competence and cultural safety to better address the high health needs of their communities. Specific mātauranga Māori and Pacific qualifications, leadership qualifications and training are not generally recognised as pre-requisites for NPTP and may not meet university criteria for academic points. Consultation and development of ways to acknowledge cultural knowledge such as by including kaupapa Māori and Pacific health papers as optional papers, is likely to help break down some barriers to entering NPTP for Māori and Pacific nurses.

The largest group of NPTP trainees have primary care backgrounds. The numbers of trainees with areas of practice in mental health and addiction and older people's health have not substantially increased. Increasing the diversity of NP practice areas

and increasing the numbers of nurses practicing in mental health and addiction and older person's health requires employer related barriers to be addressed.

Increasing the diversity of NP practice areas and increasing the numbers of nurses practicing in mental health and addiction and older person's health requires employer related barriers to be addressed.

6.2. Impact of the service agreement on programme completion and sustainability

Programme completion rates are high. All education providers described how they supported NPTP trainees to extend their NP training or return in a subsequent year rather than ending their participation. NPTP trainees who struggled the most were those who were less prepared clinically to enter the programme.

Our survey highlighted the workload demands of nurses' current roles as a major barrier to training as a NP. Although funding is available through the NPTP for employers to backfill training and placement time, the funding does not match pay rates for experienced senior nurses or nurse prescribers and/or employers may not be able to find a nurse to backfill the position. Some NPTP trainees feel they need to try and fill the gaps while also completing NPTP.

Employer support was an important factor for nurses considering NPTP. A supportive employer can facilitate a nurse entering the programme whereas lack of employer support was a commonly identified barrier. Interviewed stakeholders also identified challenges in finding money within their budgets to meet the increased salary entitlements once nurses became NPs.

These findings highlight the need for career planning and pathways for NP development. A few organisations had roles they described as NP 'internships' that enabled nurses to gain the experience they needed before entering NPTP, have support in their workplace during training and enter planned roles on registration as NPs. Working with employers to offer targeted funding for NP internships to priority groups has the potential to increase NPTP trainees in these groups.

6.3. Sector leadership and strategic development

Many stakeholders talked about the need for a national advisory group with a wider focus on strategic development of the NP workforce. The group would guide future priorities, have a wider sphere of influence than the NPTP governance group and could provide oversight of the NPTP educators. The scope of the group would include the pipeline, employment contexts, identifying the priority profiles of NPTP trainees and working with partners to develop strategies to break down barriers to becoming NPs for the priority groups.

Stakeholders emphasised the need for the group to be NP-led and include representation from health agencies, employers including NGOs and Māori and Pacific organisations. Regional input was also described by stakeholders as important, but this may be more relevant for implementation of a workforce strategy rather than part of the development of the workforce plan.

6.4. The pipeline

There is still lack of understanding of the NP role. Leadership from health agencies is required to promote the role, build awareness and break down barriers to NP employment. As the NP workforce increases, familiarity with NPs and experiences of NP practice will increase understanding of their scope of practice.

Trainees who are well prepared for NPTP find it less stressful, are more likely to complete and register to practice. Some employers offer career pathway planning and roles during NPTP for trainees that make room for them to focus on their training. This approach also helps their colleagues understand the NP scope of practice and make the most of their skills once they complete their training.

Formalising this model into new funded NP 'internships' has the potential to increase the consistency of employer support for NPTP trainees. Employers who can appoint a new staff member into a NP trainee's role and not have to find a part-time person to backfill are more likely to support their nurses to participate in NPTP. Increasing employer support for NPTP will likely make targeting the priority groups easier. Administering the NP internships could sit with the NPTP administrator under the guidance of the national strategic NP group.

The development of NP pathways also has the potential to remove some of the variation in papers required to complete the pre-requisite Master's courses.

6.5. The NPTP service agreement

The NPTP service agreement has provided a mechanism to enable educators to work together on delivering the NPTP curriculum. Maintaining the consortium to deliver the curriculum and education aspects is important to continue NPTP development as it places the educators on an equal footing, removes the potential for competition and contributes to the ongoing development of a nationally consistent NPTP.

Consortium members supported the continuation of the University of Auckland as the service agreement holder because of the issues highlighted above and resisted the notion of a RFP process. Some or all the governance, management and administrative functions of NPTP could be separated from the delivery of NPTP with the potential of achieving the best value for money.

Regardless of the provider, there is the need to include expectations in the service agreement to innovatively address:

- How to recognise Māori and Pacific leadership, cultural knowledge and skills as part of pre-requisites for NPTP entry.
- How to incorporate Māori and Pacific healthcare models and delivery into NPTP.
- How to meet the needs of both generalist NPs and those working in specialised fields.
- Options for extending the length of NPTP and/or making the pre-requisite pathway clearer.

Developing changes will require working closely with the national strategic group. The consortium governance group and the operational group are necessary to continue to develop NPTP. Representation from the national strategic group should be included in the consortium governance group to provide strategic leadership and ensure communication between the educational aspects and other parts of the NP workforce pathway.

The NPTP service agreement funding needs to be revised to better align with current salaries. Additional funding is required:

- For educators to participate in the governance and strategic functions.
- To cover changes in salaries of NPs and other academics. Stakeholders suggested alignment of NP salaries with MECA.
- To adequately fund employer release time.

6.6. Recommendations

The recommendations below outline what is needed to meet the overall aim of the NPTP service agreement. Some actions sit outside the scope of the current service agreement and require actions on the part of other health agencies.

Discuss and agree funding of Te Pūkenga if all accredited institutions meet the Council minimum requirements for NP training and clinical hours.

Nurses can become NPs by completing NPTP at one of the universities in the consortium or by completing NP training at Te Pūkenga. Nurses from both pathways must meet the Council standards for registration.

Six NPTP consortium partners and three Te Pūkenga providers are accredited by the Council to provide education pathways to NP registration. The two programmes differ in the requirements for clinical hours. Te Pūkenga meets the Council minimum

requirement of 300 hours whereas NPTP requires 500 hours. An evidence review may be required to support a discussion of the minimum requirements.

NPTP provides financial support including fee payment for NPTP trainees. Te Pūkenga NP trainees may receive financial support if their employer funds their training as part of a professional development pathway.

Evaluation of Te Pūkenga NP training was out of scope, but some insights are relevant to the NPTP as they may influence equity of access to NP training. Te Pūkenga described their nursing graduates as including higher numbers of Māori and Pacific nurses, older nurses and those in rural locations. Equitable access requires removal of pipeline barriers for Te Pūkenga nurses while maintaining a NP training programme of nationally consistent quality.

The NP entry requirements are also set by the Council. Trainees who are well prepared for NPTP find it less stressful, are more likely to complete and register.

Service agreement implications:

If minimum standards are met by Te Pūkenga then an equitable approach could require inclusion of Te Pūkenga in NPTP funding.

Develop a national NP advisory group to provide strategic oversight to the development of the NP workforce and removal of pipeline barriers.

The ability to respond effectively to pipeline issues and the employment context for NPTP trainees extends beyond the sphere of influence of a university. Health NZ would be an appropriate organisation to provide leadership and facilitate a national advisory group to align with other national nursing health workforce priorities and activities. This group must be NP-led and work closely with Māori and Pacific partners, the nursing pipeline group, employers and the educators.

Task the national advisory group with:

- Raising awareness of the NP scope of practice
- Working with the Nursing Pipeline group to identify the NP workforce needed and the characteristics of the workforce. Communicate this information to the NPTP consortium so they can integrate priorities into the assessment and selection process.
- Working with employers, NGOs including Māori and Pacific organisations to identify and respond to pipeline barriers.

Service agreement implications:

The NPTP governance group would be replaced by a group with a focus on continuing to develop NP education and provide oversight to the delivery of NP training. All educators accredited to deliver NP training would be represented. Inclusion of Te Pūkenga alongside universities would contribute to achieving the aim of a nationally consistent programme.

Facilitate employer support for NPs in their workplaces.

Employers can support nurses to become NPs but employment contexts were also identified in the survey as barriers for nurses to becoming NPs. Barriers included workloads in current roles, inability to gain adequate release time to take part in NPTP and lack of support to become a NP after registration.

Variation in employer understanding of NP roles, workforce planning and preparation of the workplace was evident in interviews. A few employers had well developed pathways that included guidance about pre-requisites, nurses working alongside NPs to become ready for NPTP, support during NPTP to develop NP skills, a defined role in the workplace after NP registration and budget to support that role.

There is a role for health agencies including Health NZ to set expectations amongst its organisations to have plans for their NP workforce and a budget to support them.

Service agreement implications:

Removing the requirement for NPTP trainees to have employment at the end of NPTP may advantage nurses who cannot get employer support. However, employer support in preparing for NPTP, during NPTP and to transition into a team as a NP is essential and removing the employer requirement may remove access to some of this support for new NPs.

Funding from secondary placements could be progressively shifted to funding for NP 'internships' that meet developed criteria for support before, during and after NPTP. 'Internships' could target priority groups.

Strengthen the service agreement expectations about priority groups

There was feedback from NPTP trainees and employers on the need for a more modular approach to the programme to meet the different needs of nurses working in community settings and those working in specialist practice. An advantage of the consortium is that different universities could offer different specialty modules. For example, remote and rural NP practice could be offered from University of Otago or University of Waikato while University of Auckland could offer specialist courses in NP practice for children.

We heard that Māori and Pacific nurses may prefer to work within Kaupapa Māori and Pacific contexts and this may be a barrier to their participation in NPTP. The NPTP includes a focus on equity but is generally delivered in a Western paradigm. While components of the NPTP must prepare trainees to assess, diagnose and prescribe, there is room for educators to further consider how to also include Kaupapa Māori or Pacific practices within NPTP which would benefit all NPTP trainees.

The national advisory group would discuss and monitor potential strategies by working with Māori and Pacific partners and representatives of other priority groups.

Service agreement implications:

Although the NPTP curriculum is out of scope, strengthening expectations in the service agreement about ways to increase the numbers of NPTP trainees from priority groups is a lever to effect change.

In the short-term continue to work with the consortium as the provider of the educational and curriculum aspects of NP workforce development

As noted above, discussions between the Council and the educators are needed to resolve the two different NP training pathways and the role of Te Pūkenga organisations. In the interim, maintaining the consortium of education providers enables continuation of the collaborative approach and further development of NPTP education including strategies to increase the participation of priority groups. All consortium members supported the University of Auckland as the lead educator.

Some or all the governance, management and administrative aspects of NPTP could be separated from the educational aspects with the potential of achieving the best value for money. The administrative aspects of the service agreement could be combined with administration of the national advisory group.

Service agreement implications:

Some changes to the service agreement are dependent on discussions and decisions made as a result of the recommendations in the evaluation. In the short-term and to provide certainty to the sector, continue to work with the consortium to deliver NPTP. Strengthen expectations about priority groups as noted above.

Review the costs of NPTP delivery as they exceed the current funding. Cost increases are primarily driven by increases in salaries for academic NPs and clinical supervisors, as well as for employers ot backfill roles.

Build an evidence base to inform decisions about the NP workforce and monitor service agreement outputs.

There are gaps in evidence about the effectiveness of different requirements to become a NP. An evidence review and evaluation of patient outcomes and costs within a NP model would inform a national workforce strategy.

Appendix 1: Nurse Practitioner Programme Structure and Curriculum

Excerpt from the NCNZ Education programme standards Matanga Tapuhi/Nurse Practitioner scope of practice March 2017.pdf

5.1 The master's programme is equivalent to 2,400 hours of study including 240 credits. The master's degree must comprise a minimum of 40 credits at level 9 with the remainder at level 87.

5.2 The duration of the programme is expected to be aligned with the requirements for postgraduate-level qualifications and must include sufficient face-to-face contact time to enable students to learn alongside other students and to share and consolidate their learning. Other ways of learning, such as distance learning and open learning formats, may be used provided they complement face-to-face contact time and attendance requirements.

5.3 The structure of the programme must incorporate a nursing conceptual framework, encourage development of critical thinking, clinical reasoning, self-directed learning skills and reflective practice, and the application of research and theory to advanced practice. It must prepare graduates for the autonomy, clinical judgement, collaborative relationships and level of accountability in the nurse practitioner scope of practice. A map of the content against the Competencies for the nurse practitioner scope of practice and the Competencies for nurse prescribers that shows the links between learning outcomes, assessments and graduate competencies is required.

5.4 The tertiary education provider must collaborate with practice partners to develop the curriculum and practice experiences, prepare mentors and orientate students. It must ensure effective links are maintained with the nursing profession and other relevant stakeholders in curriculum development, delivery, ongoing consultation and dialogue regarding all aspects of the programme. The programme must have an advisory committee demonstrating partnership with consumers, professional organisations, primary and secondary health providers, and representatives of the communities where nurse practitioners may be employed, e.g. rural, Māori, high needs.

5.5 The tertiary education provider has policies and practices which ensure the programme is underpinned by current research and scholarship in nursing, pharmacology, prescribing, education and health. The curriculum is based on national health priorities and contemporary healthcare and practice trends.

5.6 The curriculum addresses competencies related to interprofessional practice and provides educational and practice experience opportunities to achieve

interprofessional/team-based competencies, including teaching, scholarship and practice. Partnerships are established within and across programmes and practice experience locations to support interprofessional education.

5.7 The programme incorporates a wide range of innovative and emerging methods of teaching and learning, including technologies, standardised patients and low to high fidelity simulation.

The nurse practitioner practicum

7.1 The nurse practitioner practicum must be the final component of the master's programme for the nurse practitioner scope of practice. Students who do not have prescribing authority must also meet the requirements of the prescribing practicum for registered nurses preparing to prescribe in primary health and specialty teams.

7.2 The nurse practitioner practicum must consist of a minimum of 300 hours9 of practice experience within a collaborative health team environment, i.e. the student must be able to focus on achieving their learning goals and the Competencies for the nurse practitioner scope of practice.

7.3 The education provider must negotiate the practicum and clinical mentors for each student, and have a process by which these are assessed as satisfactory to enable student learning before the commencement and for the duration of the practicum.

7.4 The student will have a clinical mentor for each practice experience to support the student to develop the skills to practise as a nurse practitioner and an authorised prescriber. This may be a nurse practitioner and/or an experienced registered medical practitioner. In one area of practice experience the clinical mentor must be a nurse practitioner.

7.5 The nurse practitioner practicum will include opportunities to further integrate academic theory with diagnostic and clinical decision-making skills for more complex health consumers and to develop advanced leadership, collaborative and innovative clinical practice skills, working with population groups across more than one setting.

7.6 The student, clinical mentor and academic mentor complete a formative assessment at the beginning of the practice experience and the student then establishes learning goals.

7.7 The nurse practitioner practicum includes: a. completion of 300 hours of protected clinical learning verified by the clinical mentor (and prescribing mentor if the student is applying for prescribing rights for the first time) b. completion of a diary of clinical practice experience c. two in-depth, comprehensive case studies d. a summative assessment against the Competencies for the nurse practitioner scope of practice completed by the clinical mentor in collaboration with the academic mentor.

Appendix 2: Profiles of survey respondents

Demographics	Total	Current NPs	Nurses not NP
Total	**498**	**188**	**212**
Status			
Registered as a nurse practitioner	38%		
Completed training but not registered	7%		
Currently enrolled in training or will be in 2024	10%		
Enrolled but did not complete the training	2%		
No – not active	43%		
Gender			
Male	10%	11%	9%
Female	90%	89%	90%
Gender diverse	<1%	0%	0%
Ethnicity (total count)			
European	82%	90%	75%
Māori	13%	14%	10%
Pacific Peoples	2%	1%	3%
Asian	6%	3%	8%
MELAA	2%	2%	2%
Other Ethnicity	1%	1%	0%
District they work in			
Auckland	16%	13%	19%
Bay of Plenty	6%	11%	2%
Canterbury	20%	9%	32%
Capital and Coast	7%	8%	5%
Counties Manukau	4%	4%	2%
Hawkes Bay	3%	4%	2%
Hutt and Wairarapa	3%	4%	3%
Lakes	3%	2%	2%
Midcentral	3%	4%	1%

Demographics	Total	Current NPs	Nurses not NP
Nelson and Marlborough	3%	4%	3%
Northland	3%	5%	3%
South Canterbury	1%	1%	0%
Southern	7%	11%	4%
Tairawhiti	1%	1%	1%
Taranaki	3%	2%	1%
Waikato	8%	9%	9%
Waitemata	4%	4%	3%
Whanganui	1%	2%	0%
Another location	3%	13%	19%
Employer (multi select)			
Health NZ/Private hospital	48%	40%	60%
General practice/Primary health/Community organisation	35%	43%	23%
NGO	6%	6%	6%
Self-employed/Other	11%	11%	12%
Organisations they work for (multi select)			
An iwi or kaupapa Māori organisation	7%	11%	3%
A Pacific provider	2%	2%	2%
A disability service	2%	1%	2%
A mental health service	14%	6%	22%
None of the above	79%	83%	76%
Working status			
Full-time	61%	36%	34%
Part-time	35%	62%	60%
Not currently working	2%	2%	3%
Other	2%	1%	3%
Main area of nursing practice			
Primary care or community practice	48%	52%	37%
General hospital nursing	10%	5%	17%
Aged care	5%	5%	5%

Demographics	Total	Current NPs	Nurses not NP
Mental health and addiction	12%	5%	18%
Specialist practice	22%	34%	17%
Health management, research or education	2%	0%	5%
Length of time they worked in their area of practice (for at least 0.6FTE)			
12 months or less	6%	4%	9%
1-2 years	11%	10%	14%
3-5 years	20%	22%	18%
6-10 years	20%	21%	18%
More than 10 years	42%	43%	39%
Not applicable	1%	1%	1%
Length of time they have been registered as a nurse			
12 months or less	2%	0%	5%
1-2 years	2%	0%	4%
3-5 years	5%	9%	7%
6-10 years	14%	18%	18%
More than 10 years	77%	72%	67%
Length of time they have been registered as a nurse practitioner (nurse practitioner only)			
12 months or less	13%	13%	
1-2 years	18%	18%	
3-5 years	34%	34%	
6-10 years	23%	23%	
More than 10 years	12%	12%	

Appendix 3: Barriers and facilitators to becoming a nurse practitioner

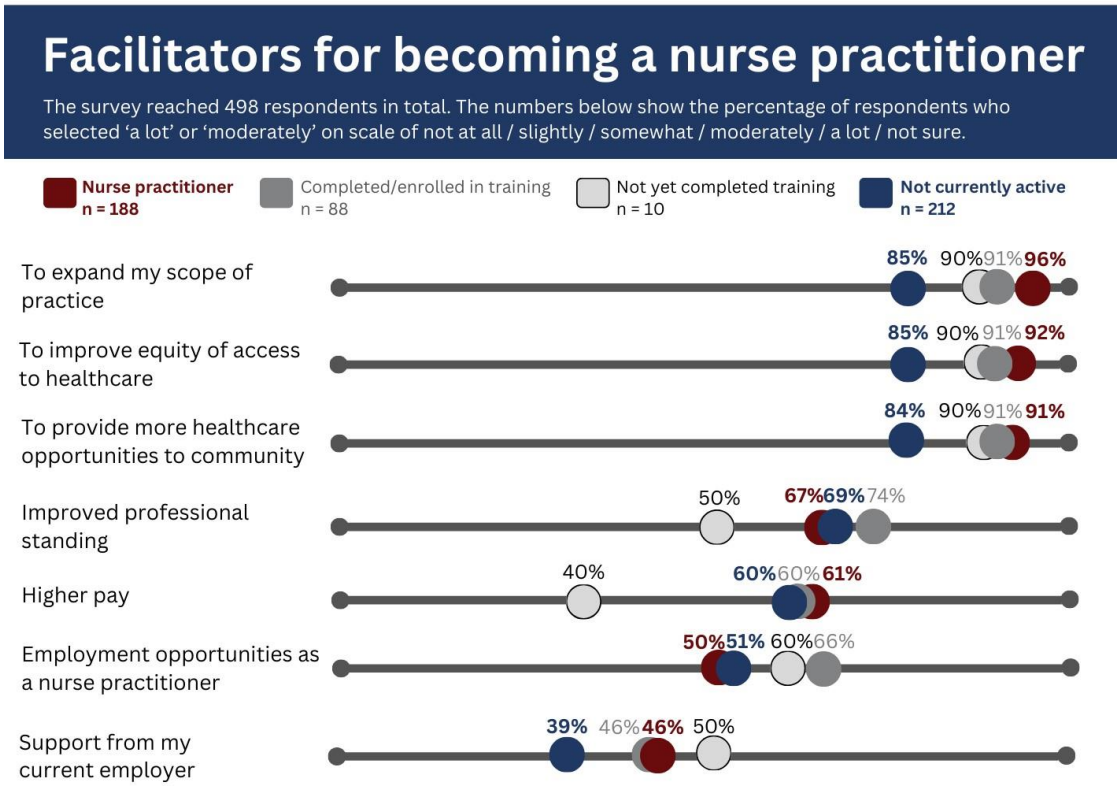
In response to the survey, 79% of nurses had thought about enrolling in a NP training programme, suggesting awareness of the NP professional group is not a barrier to NPTP entry.

Figure 13. The proportion of nurses who had thought about NP training (Survey, for nurses who had not enrolled in the programme, n = 212)

In the survey, 54% of nurses who had not entered NP training rated their understanding of the NP role as 71% or higher on a 0-100% scale (Figure 14).

Figure 14. Nurse awareness of what a NP does (Survey – 0-100% scale completed by nurses who had not enrolled in the programme, n = 202)

Survey respondents were asked to rate factors that may have motivated them to become a NP. Across all groups, the main facilitators were expanding scope of practice, improving equity of access, providing communities with more healthcare opportunities. Those working in MH&A provided lower ratings for employer support (32%) and employment opportunities (39%).



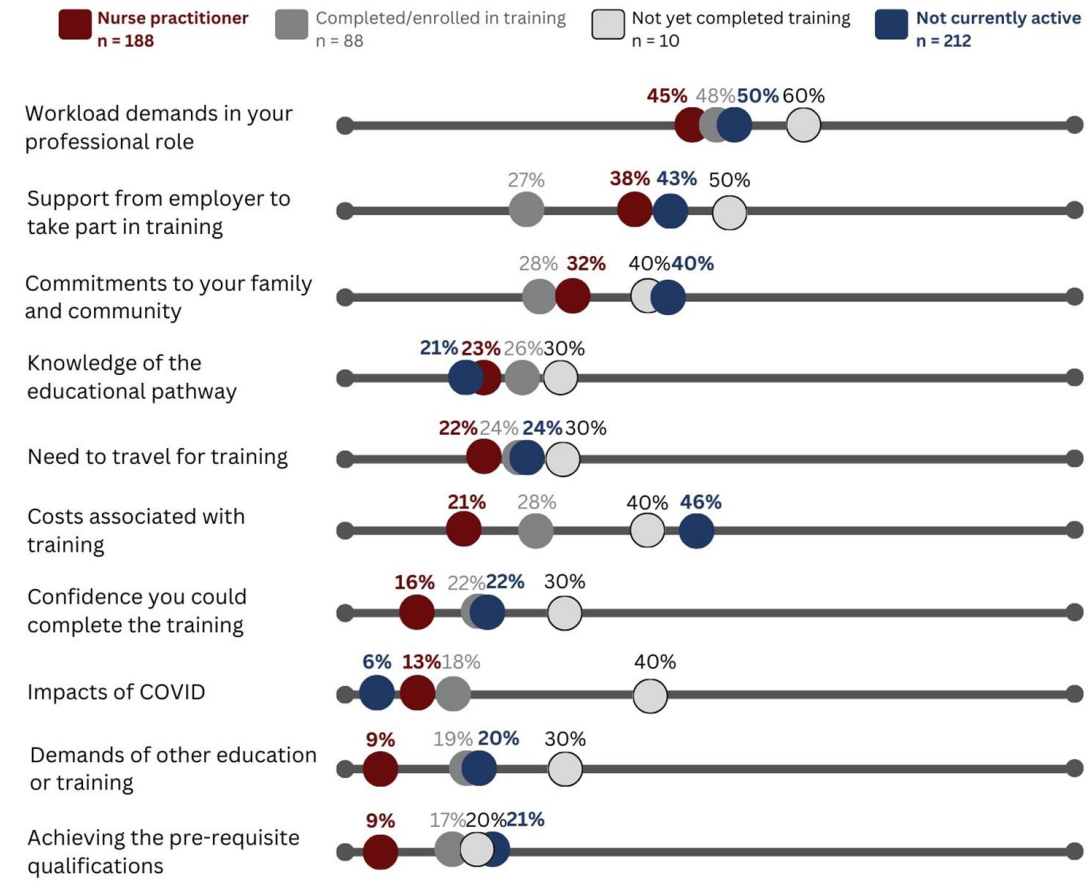
Survey respondents were also asked to rate a range of factors that may make it difficult for them to become a NP. The main barriers were the workload demands in their current roles, the costs associated with NP training, lack of employer support and family commitments. Although NPTP is funded, the costs of a Master's and pre-requisite papers may be difficult for nurses. While hospitals have a budget for clinical release time it may not be accessible, or it may be less than what the nurse would usually be paid per hour.

A higher percentage of survey respondents employed by Health NZ identified workload (56%) and lack of employer support (43%) as a barrier to NP training. Fewer (22%) identified the need to travel as a barrier.

Nurses who had started but not completed NP training generally identified more barriers but only small numbers responded to the survey.

Barriers to becoming a nurse practitioner

The numbers below show the percentage of respondents who selected 'a substantial barrier' or 'a moderate barrier' on scale of not a barrier / a slight barrier / somewhat a barrier / a moderate barrier / a substantial barrier / not sure.



Appendix 4: University of Auckland internal evaluation key findings

The key outcomes to date are:

94 NPs have completed NPTP in 2021 and 2022. In 2021, 22 NPTP interns worked in the broader primary healthcare (PHC) sector, 5 in mental health and addiction services (MH&A); and in 2022, 27 in PHC and 7 in MH&A.

A consortium of four universities is delivering NPTP in 2023 with 80 trainees, of whom 12 are Māori.

Service establishment placements (SEPs):

9 ENs, of whom 5 are Māori and 2 are Pacific
12 NPs, of whom 4 are Māori, and 1 is Indian.
25 kaimahi active in earn as you learn (EAYL), of whom 21 are Māori and 4 are Pacific.
35 newly registered NPs commenced the NP Transition Programme in February 2023 with working in areas broadly defined as PHC, community, aged care, MH&A, or integrated roles between secondary and PHC services.

26 Māori and Pacific RNs are being supported by the programme team to progress along the NP educational pathway; 3 of these students are now active in NPTP 2023, 3-5 will be academically ready for NPTP 2024 with the majority starting to be eligible for NPTP from 2025 onwards.