Exploring an Expanded Role for Practice Nurses in Providing Sexual and Reproductive Health Services in General Practice

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Abbreviations

GP  General Practitioner
KI  Key Informant
PN  Practice Nurse
SRH Sexual & Reproductive Health
STI Sexually Transmissible Infection
Executive Summary

Background
Sexual and reproductive health are significant public health concerns in Australia. Several indicators point to poorer sexual and reproductive health outcomes among rural and regional populations than their metropolitan counterparts. This may be in part due to difficulties in accessing appropriate primary care: with the vast majority of Australia’s healthcare delivered in General Practice, a shortage of General Practitioners, particularly in rural and regional areas, may have a significant impact on health outcomes. This report summarises the findings of a project investigating factors that may affect the capacity of nurses to play a role in overcoming barriers to accessing sexual and reproductive health services in general practice in rural and regional areas.

Methods
The project is based on interviews with clinic staff from 6 clinics in rural and regional Victoria, with varying degrees of nurse involvement in sexual and reproductive health services. Observational visits were made to each of the clinics, along with semi-structured interviews with 16 clinic staff and 4 Key Informants.

Key Findings
Participants identified numerous advantages to increased nurse involvement in sexual and reproductive health both to patients and to clinics. These included:

- Increased access to female service providers
- Increased continuity of care and rapport between patients and service providers
- Increased access to and more timely health care
- Attracting larger patient base to particular clinics
- Generating increased number of billable appointments
- Freeing up GP time to attend to other issues

Few disadvantages were identified, and they related primarily to:

- GP attitudes to potentially minimising contact with patients with conditions of interest to themselves
• Nurses finding themselves placed in a more ‘clinical’ role that may not accord with traditional – and potentially more appealing – perspectives of nursing roles.

With respect to the breadth of services undertaken within primary care settings, we found that the following services could be routinely provided by practice nurses:

• Assessing history of sexual and reproductive health issues
• Providing patients with information about safer sex
• Screening for sexually transmissible infections
• Assessing eligibility for emergency contraception
  o Facilitating acquisition of emergency contraception
• Pregnancy support, including discussions regarding termination of pregnancy
• Removal of intrauterine device (one clinic)
• Insertion of the contraceptive implant
• Provision of fertility advice/management
• Pap smears
• Follow-up on results/recall of sexual and reproductive health patients
• Opportunistic sexual and reproductive health services (e.g. discussing safer sex)

This report identified several key factors that were crucial to nurse involvement in sexual and reproductive health within clinics:

• Nurses must be appropriately trained and experienced
• Appropriate facilities must be provided within clinics for nurse consultations (private rooms)
• There must be a clinic-wide approach to sexual and reproductive health services

Of these, perhaps the most fundamental was adequately and appropriately skilled nurses. Given the rural and regional focus of the project, the time and financial pressures involved in attending relevant training courses were perhaps the most fundamental barrier. Financial support from clinics is significant in facilitating access to training, however it may impact on clinic operations.

Barriers to clinic-wide approaches to sexual and reproductive health services included a lack of interest in sexual health on behalf of relevant General Practitioners within the clinic, a perceived lack of need for such services within the population of clinic patients, or a perceived need address issues of sexual and reproductive health within a given clinic.
Encouraging a clinic-wide approach to sexual health, where it does not already exist, may be facilitated by demonstrating need among clinic clientele, or emphasising potential benefits to the clinic: these may include immediate financial benefits, or more long-term benefits such as encouraging patients to develop an association with/return to a particular clinic.

The manner of service delivery by practice nurses largely depended upon the context of the individual clinic: while it may be useful for clinics to receive information containing ideas that may facilitate nurse involvement, providing a range of options is likely to be key, as implementation will require flexibility to a given clinic.

Where the focus on nurse provision of services is to address workforce shortages, current funding and medico-legal arrangements severely restrict the capacity of nurses to do so: the lack of procedures relevant to sexual and reproductive health that can be billed directly by nurses means that practices regularly involve GPs in services whether or not their expertise is required in a particular situation. Similarly, the lack of capacity for nurses to request relevant services such as pathology tests means that, whether clinically required or not, GPs must be involved in consultations.

Conclusions

The results of our investigation suggest that with adequate training and education, nurses may be capable of undertaking the tasks required to conduct a comprehensive sexual and reproductive health examination, and devise appropriate management plans. The manner in which nurses are involved in sexual and reproductive health services must be responsive to individual clinic contexts. Where GP shortages are the primary barrier to accessible services, as in rural and regional areas, current funding and medico-legal arrangements severely hinder the capacity of practice nurses to address workforce shortages as they dictate that GPs must be involved in consultations, even when such involvement may not be clinically necessary.
Background:

Sexual and reproductive health remain issues of significant concern in Australia. Outcomes of concern can include unintended, unwanted and early or adolescent pregnancy and subsequent consequences, or sexually transmissible infections and their sequelae. Access to appropriate health care and information can be an important factor in determining sexual health outcomes. In Australia, General Practice is responsible for providing the vast majority of healthcare – however, increasing shortages of GPs, particularly in rural and regional areas, is a significant barrier to access. Investigating other means of safely delivering services is therefore crucial. Increased use of practice nurses to provide relevant services is one method through which barriers to accessing timely sexual and reproductive health may be addressed. The focus of this report is therefore on examining the role that nurses may play in providing sexual and reproductive health in general practice, and factors that may facilitate or constrain this role.

Sexual and Reproductive Health in Australia

A number of indicators point to widespread poor sexual and reproductive health in Australia, particularly among younger people. Young women in Australia have one of the highest pregnancy and abortion rates in the developed world, 20.8 terminations per 1000 in Australia compared with 7.2 per 1000 in Germany and 7.8 per 1000 in the Netherlands.[1] South Australian data show that the number of terminations among women under 30 is more than double the number for women aged 30 years or above[2] and that 53% of teenage pregnancies are terminated.[2] While pregnancy intention data are not routinely collected, one report found that almost half of respondents had had an unplanned pregnancy, with unplanned pregnancy potentially associated with a number of social, psychological, physical and economic costs[3, 4] Concurrent with poor – or potentially so – pregnancy outcomes, Australia has poor uptake of successful interventions. Long-acting reversible contraceptives (LARCs) – the contraceptive implant and intrauterine devices – are an effective method of reducing unintended pregnancies: women using LARCs are 21 times less likely to become pregnant than those using shorter-acting contraceptives, yet Australia has one of the lowest levels of uptake in the Western World at 3 – 5 % versus, for example, 12% in the United Kingdom.[5-8]

Sexually transmissible infections (STIs) are also of interest. Rates of diagnoses for chlamydia, an easily curable sexually transmissible infection, have increased by over 400% in the last decade in
Australia with over 80,000 cases in 2014.[9] Chlamydia prevalence is approximately 5% among men and women aged 16-29 years attending general practice[10] and analyses of sentinel clinic data show that chlamydia prevalence is increasing by 12% per year.[11] Over 80% of chlamydia is asymptomatic and without screening, most infections will remain undetected and continue to spread. If left untreated, 10% of infections in women will progress to pelvic inflammatory disease (PID)[12] and up to 2/3 of tubal factor infertility may be due to past infection.[13]

These issues may be of particular concern in rural and regional areas in Australia. STI testing rates are lower in rural areas compared with metropolitan areas.[14] Teenage fertility rates are also considerably higher in rural areas[15] and many women in rural areas have poor access to termination services.[16]

Primary Care and Accessibility of Health Services

Access to affordable and acceptable healthcare is vital for maximising sexual and reproductive health in a population. General practice clinics play an important role in primary prevention through risk assessment, education and counselling, the early detection of disease or its precursors and effective management of health conditions. General practice provides over 80% of healthcare in Australia[17] and over 80% of women and men attend a GP each year for their own health.[18]

In Australia, multiple barriers exist to accessing sexual and reproductive health services including long wait times, costs and limited access to female healthcare providers.[19] Many of the barriers are compounded in rural areas. Increasing shortages of GP services across Australia, particularly in rural areas, threaten healthcare availability.[20, 21] Rural populations have less access to GPs and experience poorer health compared with metropolitan populations.[20] Perceived lack of anonymity and confidentiality in smaller rural towns may also act as a barrier to younger people accessing sexual health services.[22]

In light of the shortage of GPs, strategies to improving access to sexual and reproductive health services in a primary care setting could focus on enhancing the role of other health professionals working with GPs[23], such as practice nurses, in delivering these services. Practice Nurses are qualified registered or enrolled nurses who deliver primary healthcare in a general practice setting. Already, over 60% of Australian general practices (87% in rural areas) employ PNs.[24] Additionally, 90% of PNs in Australia are female. [25] In this respect, practice nurses potentially offer an addition to the workforce providing sexual and reproductive health care both in absolute numbers, but also in a manner that may help to redress the gender imbalance among health care providers, with fewer
female primary care practitioners registered in Australia also working fewer hours than their male counterparts.[26]

**Provision of Care by Practice Nurses**

It has been shown that with appropriate training and education, practice nurses may have the capacity to take on new roles or tasks that lead to positive patient health outcomes. PNs engaging in new healthcare roles can increase choices for patients, lead to a more effective and adaptable healthcare team, enhance revenues by enabling clinics to engage in more clinic activities, and improve the professional satisfaction of PNs by enhancing their skillset enabling them to provide more comprehensive care.[27] PN-models of care also have the potential to enhance a clinic’s revenue by reducing wait times and GP clinic load, allowing more patients to be seen in a clinic. PN interventions in Australian general practice have been successful at reducing smoking rates,[28] have significantly improved depression among patients with diabetes or heart disease,[29] have increased chronic disease management in general practice,[30] increased exclusive breastfeeding among mothers attending general practice,[31] improved management of diabetes[32] and increased sexual health access for refugee women.[33] Research has also demonstrated that PN-models of care are acceptable, patients may be more likely to comply with PN instruction and that nurses can offer equivalent levels of care to GPs within their scope of practice, but with longer consultations.[32, 34]

Given the success of previous practice nurse interventions, it is possible that expanding practice nurse roles to routinely provide sexual and reproductive health could also further enhance health outcomes for the general population. Already nearly one quarter of practice nurses are involved in preventative women’s healthcare such as undertaking Pap smears, breast care or consultations regarding fertility or menopause.[24] It is possible that this role could be expanded to provide comprehensive sexual and reproductive health, with practice nurses routinely providing contraceptive and STI counselling, provision of the contraceptive implant, STI screening, providing women with fertility advice and management (including pre-conception planning, referrals for terminations), conducting Pap smear screening and administering the HPV vaccine to males and females.

An expanded role for nurses in sexual and reproductive health is timely, given calls from the Victorian government, the Public Health Association and the Sexual Health and Family Planning Association Australia for PNs to take on new roles to enhance access to care.[35, 36] Furthermore,
since the introduction of the Practice Nurse Incentive Program in 2012 recent changes to funding arrangements for nurses, general practices have been encouraged to expand and enhance the role of practice nurses beyond tasks such as immunisation, cervical smears and treatment of wounds that previously attracted practice nurse payments and restricted their opportunities in the clinic. Anticipated changes to the cervical cancer screening program with the replacement of the Pap smear with a HPV screening test every 5 years[37] means that a skilled workforce may become underutilised. Increased roles for practice nurses in providing sexual and reproductive health of will enable these nurses to utilise their extensive sexual and reproductive health care knowledge and experience.

In light of the above, this report discusses the results of a recent investigation exploring whether and how an expanded role for nurses in the provision of sexual and reproductive health may best be implemented. Specific questions included:

- What sexual and reproductive health services may be routinely undertaken by practice nurses in primary care?
- What factors may facilitate nurses undertaking a broader range of sexual and reproductive health services?
- What factors may prevent nurses from undertaking a broader range of sexual and reproductive health services?

Qualitative interviews with key informants, staff working in rural and regional primary care settings and observational visits to clinics were used to address these questions, before considering further the role that practice nurses may therefore play in addressing the availability and accessibility of sexual and reproductive health.
Research Design and Methods

Ethics

This project was given full ethical approval by the Human Research Ethics Council at the University of Melbourne (Project Reference 1646799).

All participants were provided with a plain language summary of the project and its aims (see appendices) and were advised of their right to withdraw from participation at any stage.

Advisory Committee

In addition to gaining ethical clearance, this project was guided by an advisory committee consisting of appropriately qualified and interested professionals working in primary care and/or sexual health. Input from committee members included individual interviews with a member of the research team, as well as a series of meetings at which the advisory committee gave feedback on research design and the development of research instruments. A list of committee members is included in Appendix 1.

Methods

This qualitative study collected data through clinic observation, semi-structured interviews with clinic staff and with selected key informants.

Participant Sampling and Recruitment

Clinics
Clinics were purposively sampled to ensure a range of clinic types including community health, solo practices, group practices and large practices. Clinics were also targeted on the basis of nurse involvement in sexual and reproductive health services, ranging from those clinics in which nurses play a significant role, to those in which the role of nurses was minimal, or to clinics in which the use of nursing staff in sexual and reproductive health services was relatively novel. The sample was chosen to ensure that the research could draw upon and be relevant to a broad range of primary care providers of sexual and reproductive health, and for which the context in which those services
are provided may vary significantly. Clinics were identified using established professional networks through the research team, and also using advertisements distributed to nursing staff through, for example, the local Primary Health Network.

Clinics in which staff members had shown an interest in participating were then formally contacted by a member of the research team, provided with information about the study, their involvement and any potential impact on clinic operations.

Clinic Staff:
From clinics that agreed to participate, individual staff members were invited to take part. Those approached within the clinics included:

- Practice Managers
- Reception Staff
- General Practitioners
- Practice Nurses

Key Informants
Invitations were sent to individuals in key stakeholder organisations identified by the research team and advisory committee. Examples of organisations approached include:

- Royal Australian College of General Practitioners (RACGP)
- Primary Health Networks (PHNs)
- State Government
- Australian Primary Health Care Nurses Association (APNA)
- Australian College of Rural and Remote Medicine (ACCRM)
- Centres Against Sexual Assault (CASA)
- Melbourne Sexual Health Centre
- Australasian Sexual Health Alliance (ASHA)
- Victorian Cytology Service
Data Collection and Analysis

Interviews
Participants were invited to take part in a semi-structured interview. Interview guides (Appendices 2 & 3) were developed by the research team following input and feedback from the advisory committee.

Interviews took place either in person or by telephone according to participant preferences, and were recorded and transcribed. Data was analysed concurrently with collection, allowing the research team to respond to emerging themes and issues. Data saturation was achieved, with several strong, key themes identified and presented below.

Clinic Observation
Observational visits were made to participating clinics in order to provide further context and clarity to interviews with clinic staff. These observational visits were guided by a Practice Assessment Tool (Appendix 4).

Summary of Clinic and Participant Characteristics
Six clinics were recruited for this study, ranging from small, independent clinics, community health clinics, and large super clinics. All were located in the Barwon/Surf Coast region. 16 interviews were conducted with clinic staff, with details provided below. Several participants held dual roles within clinics, and where therefore able to speak to more than one element of clinic practice, and as such the total number of interviews listed below exceeds that of participants.

Table 1: Summary of Participant Type (Clinic Staff)

<table>
<thead>
<tr>
<th>Participant Type/Role</th>
<th>Number</th>
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</thead>
<tbody>
<tr>
<td>General Practitioner</td>
<td>4</td>
</tr>
<tr>
<td>Management/Administrative Roles</td>
<td>2</td>
</tr>
<tr>
<td>Reception</td>
<td>4</td>
</tr>
<tr>
<td>Nurse</td>
<td>5</td>
</tr>
<tr>
<td>Practice Manager</td>
<td>4</td>
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Four key informant interviews were undertaken. Individuals were drawn from organisations with a strong interest in sexual health and referral pathways into primary care (2), primary care and sexual health research (1) and organisations with strong involvement in nurses providing sexual and reproductive health services (1).
Key Findings

The report will proceed with a summary of key findings. Providing context to the perceived role of nurses in sexual and reproductive health, a summary of advantages and disadvantages of increased involvement, as identified by participants will be provided.

The specific patient pathways and the ways in which nurses may become involved in a consultation was highly contextual, depending on a variety of circumstances within each clinic. Despite this, several key themes were identified which were fundamental to the capacity for nurses to be involved in providing sexual and reproductive health services, and as to whether nurses were involved in sexual and reproductive health, and the degree to which they may be involved. These key themes will be discussed below, before returning to consider the ways in which nurses were involved in different clinics. Several significant barriers to nurse involvement will then be addressed.

Throughout this report, the involvement of nurses will be classified broadly as low, medium or high. In clinics where nursing involvement was considered ‘low’, nurses were undertaking very few of the tasks outlined above, and on an infrequent or ad hoc basis. Those with moderate involvement were undertaking a significant number of tasks. In some instances, nurses with moderate involvement may undertake the majority of tasks listed, but may be restricted primarily to undertaking these within particular clinical sessions. For those with the highest level of involvement, nurses were routinely undertaking the majority of tasks listed above, and were able to do so in a manner that was, as far as possible, independent of or with doctor involvement in consultations minimised.

Given the contextual nature of the work being undertaken, these classifications should be considered broadly indicative of nurse involvement, and the potential for involvement to vary within clinics and across individual staff members acknowledged.
Advantages and Disadvantages of Increased Nurse Involvement in Sexual and Reproductive Health

In discussing the role of nurses within clinics, the majority of participants identified a number of perceived advantages and disadvantages to expanding the role of nurses, which may potentially influence decisions made by those responsible for considering the role of nurses within individual clinics. These are summarised below.

Advantages

1) The majority of participants agreed that nurses were capable of taking on a greater role in sexual and reproductive health than may often be the case, and that doing so had – or may have – significant advantages. Numerous benefits to individual patients were identified as outlined below, and with example quotations in Table 2:

2) Gender: participants commonly acknowledged that nurses were likely to be female, and that this may particularly appeal to female patients who may not be comfortable discussing sexual and reproductive health with male GPs, or with having certain examinations and procedures undertaken by male GPs.

3) Patient rapport: several participants also discussed the possibility that patients could more easily establish a rapport with nurses that allowed them to discuss sensitive topics, given that the power differential between patient and nurse was seen to be less than that between patient and doctor. This may be particularly true of young/vulnerable patient populations.

4) Length of consultation: it was recognised that GPs were often time poor, able to invest only a short time with patients, while nurses were able spend significantly longer on interventions such as education around topics such as STI risk behaviours and contraceptive choices.

5) Access: the issue of access was frequently raised. This was perhaps most obvious in clinics with the highest degree of nurse involvement, in which the involvement of GPs was also minimised. In some clinics, there was potential for a range of appointments to be arranged with nurses independently of immediate GP support, allowing necessary interventions to be provided even if no GPs were available. In other cases, it meant increased access to specific services such as routine Pap tests. The idea of continuity of care was also raised, given that
in some clinics making an appointment with a particular nurse may be easier than seeing a particular doctor.

Between increased accessibility of and time for appointments, continuity of care, and patients able to see a provider of their preferred gender, several participants reported that care provided by nurses was as likely to be as good if not better in some respects than that provided by a GP.

There were also benefits at the clinic level as outlined below:

1. Time efficiencies: with GPs able to hand-over a portion of sexual and reproductive health services to nurses, they were able to devote that ‘free’ time to other consultations which may require their particular expertise or skills.

2. Skills efficiencies: there was also a benefit for clinics in which the GPs may not have a particular interest in sexual and reproductive health. Where a nurse was available who had received adequate and continuing education and training, they were able to keep abreast of current best-practice and share that knowledge with colleagues in the clinic.

3. Increased service demand: several participants identified that nurse-led Pap clinics or services often had a follow-on effect of identifying patients who required further appointments within the clinic, with concomitant financial benefits.

   Similarly, the presence of a nurse able to provide services that may otherwise be absent in a clinic was seen as a way of accessing patients who may have chosen to attend a different clinic, or no clinic at all. This was particularly true given the private nature of sexual and reproductive health: with nurses able to take the time to develop that rapport, where a doctor may not, it may increase the likelihood of patients returning to the clinic.

Increased accessibility and timeliness of care was also identified as a benefit to population health: where issues such as sexually transmissible disease require early intervention to prevent further transmission, the capacity for nurses to provide care when a doctor may not was seen as very important.
Disadvantages

The disadvantages identified by participants were few.

1. **Nurses**: for nurses, there was the potential for being inadequately supported in tasks that they were being asked to fulfil, which may be detrimental to both them and the patient. There was also the possibility that their appointments may become too much like those of GPs – focussed on short, clinical interventions.

2. **Clinics**: at the clinic level, the increased involvement of nurses may mean decreased involvement of GPs. For some GPs, this was a matter of preference – those who were interested in sexual and reproductive health may find themselves conducting fewer relevant consultations. In other instances, it was noted that there may be a possibility for nurses to impact on the income of GPs by undertaking services for which the GP may be able to claim a Medicare rebate.
<table>
<thead>
<tr>
<th>Disadvantages</th>
<th>Advantages</th>
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<tbody>
<tr>
<td>Patient</td>
<td>Quality of service</td>
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<td></td>
<td>&quot;To my mind, it’s the same quality of service. Sometimes you know a busy general practice - sometimes the nurses can - you think, wow, they've spent a lot of time with that young person. They've spent a lot of time talking about healthy relationships, respect, trust and all that sort of stuff. But GPs sometimes don't get the chance to do. So I think that young people who go via the nurse often get a better deal than young people who go straight to the GP and they're slotted into a 20-minute appointment.&quot; GP (High Involvement)</td>
</tr>
<tr>
<td>Increased accessibility</td>
<td>&quot;I think that - yeah. Well, I think with young people, if they're not seen on the spot, and they've got something going on and you might not see them again. So it was recognised that they need to be seen then and there. You can't say, look, come back next week, the doctor’s got an appointment next week. Much better to do it on the spot...So using the nurses is just a no - for us, it just made sense” – GP (High Involvement)</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>&quot;The other thing too of course is that often there are only one or two practice nurses, but there might be half a dozen doctors. So, if you can't get to see the doctor of your choice and you had the choice of seeing the nurses that you possibly knew better, I think the relationship you build up with them over time might be better than - could potentially be better than the one that you have with doctors if you just saw the one who was free.&quot; – KI2</td>
</tr>
<tr>
<td>Patient Rapport</td>
<td>“I think the public, you know our patients in particular have a trust in our nursing staff. Most of them are return clients, so they keep coming back. So, for me, if they keep coming back that tells you that they’re comfortable and happy with our service” – Nurse Manager (Moderate</td>
</tr>
<tr>
<td>Nurse</td>
<td>Increased scope of practice without adequate support</td>
</tr>
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</table>

| Preferred Provider Gender | "The nurse, I think that has helped. Yes. There can be some women in particular who, you know they don't want to see a male doctor, so we're able then to put [the nurse] in that space. She sees them first and then we allocate a female doctor. We're always quite mindful of that." – Nurse Manager (Moderate Involvement) |

| Involvement) | "Because I remember there was some research ages ago that talked about the fact that nurses made patients feel more comfortable and part of the reason they make them feel more comfortable is because they think that they're not as busy as the doctor, there's not such a power differential between them and the doctor, and so patients are often happier to take up more of the nurse's time because they don't see it as being as precious as doctors' time, even though we might argue and nurses probably would argue that it was, because they're doing different jobs." – KI2 |
| Impact on nature of nursing role | "If I was a nurse, I'd be worried about becoming too much like a doctor and then being limited to a 10 or 15 minute consultation, because it's brutal." – KI4 |
| Clinic/GP | Handing over work of interest/possible loss of funding | "Yeah, I miss it, I probably don't do as much as I did before having the nurses able to do it..." – GP (High Involvement) |
| Clinic/GP | "One of the female GPs who is great and she runs the Women's Health Clinic and she voiced concerns last week about taking work from her. She runs a Women's Clinic and she was worried that this service that the nurses provided will take people from her, but I said to her look I think that's something we deal with down the track as it comes." Practice Nurse (Low Involvement) |
| Clinic/GP | Retaining patients/offering additional services within clinic | "But I think if there was an alternative - most GPs are not very happy about having to refer to people out of the practice. They might know that down the road there's a female GP and some of them are actually big enough to say I don't like doing that here but Mrs - Doctor So-and-so will do that down the road. But I think if there was a nurse, a practice nurse who even might only just be there on certain days, I think GPs would be quite happy to take that on board, particularly those who've already embraced the nurse pap smear providers, because they're the ones who probably see that they're going to get financial benefit from it. " – KI3 |
| Clinic/GP | Perceived potential for loss of funds | "It is also interesting too. My job is to help everyone obviously, but women's health I wouldn't say is my greatest strength and I'd probably have to sit down and do a lot more reading on it which I just don't have the time to do at the moment." – GP (High Involvement) |
| Clinic/GP | Generating billable appointments | "It's unbelievable. When I did my placement with all the other nurses in Geelong I swear that 50 to 75 per cent of pap smears done by the nurse required follow up consults because of something that was taken from a proper health assessment; something else that was going on in their life. So then you think well there you go that's just paid for having me here." – Practice Nurse (Low Involvement) |
“Look, I suppose if you - I think there's a lot of advantages for a practice. If you’re trying to encourage more people to come in and you know that these kinds of - you’ve never really thought about these consultations as being really critical, you could actually really encourage people to come in with that additional query and just see the nurse to bring in more money to your practice if you could get the right kind of Medicare rebate.” – KI2

| Increased time for GPs to undertake other services | “Frees up doctor time - doctor consultation. As I said, it’s stuff that we can't do that the doctors can do.” – Practice Nurse (High Involvement) |
| Population Health | Preventing transmission of disease | "The whole idea of getting the results in a timely way is to prevent transmission of disease, by getting a timely result and treating a patient, and then hopefully preventing transmission to that patient’s contact and onwards. So, there is actually a public health agenda to actually doing this efficiently, in a timely way.” – KI4 |
Key Facilitators

Nurse Training/Qualifications

"I think capacity training and qualifications need to be there at baseline. I think that’s very, very important." – Key Informant 4

While the breadth of activities undertaken by nurses within the clinics with higher degrees of nurse involvement, as noted above, illustrates that nurses are certainly capable of undertaking a variety of sexual and reproductive health activities within General Practice, perhaps the most fundamental prerequisite for this was that they were adequately trained in the specific requirements of sexual and reproductive health. Whether ‘training’ related to formal qualifications or to experience differed across respondents. In either case, however, a number of barriers and facilitators to the acquisition of appropriate skills and knowledge – which were seen to be beyond those acquired as a routine part of nursing qualifications – were identified.

At the individual level, it was acknowledged that taking on sexual and reproductive health services was dependent on the interest of the nurse involved. This was not only because of the perception that it required the acquisition of particular clinical knowledge and skills, which depended upon the motivation on the part of the individual nurse, but also due to the potentially sensitive or uncomfortable nature of the subject matter, with which not all people may be equally comfortable.

Where such interest and motivation was present, it was noted that formal/professionally delivered courses were one way through which the necessary knowledge and skills could be acquired. The cost of such courses was commonly seen by participants as being a significant barrier to attendance. This was compounded by the rural/regional location of the clinics, which meant that in addition to the cost of enrolment, attendance at courses required additional leave from their usual role (potentially at the cost of annual leave or leave without pay), as well as paying for travel and accommodation.

In some instances, this significant barrier was overcome through assistance from the clinic: clinics assisted nurses either with funds, funded time away from their usual position, or both. In optimal circumstances, with respect to nurse training, support from clinics covered these costs in their entirety, however this was not always the case, leaving the nurse with significant barriers to overcome. It was noted, too, that even where clinics were supportive, it was not without difficulty
for the organisation themselves: aside from cost, there were operational issues such as replacing staff, which may be difficult for small/isolated clinics.

Acknowledging the significant impact that distance/remoteness had on the accessibility of training, several participants stated that having locally accessible training was – or could be – a significant facilitator in acquiring and retaining the necessary skills. In some instances, this referred directly to having a suitably qualified mentor/instructor, such as a Pap test preceptor, within a clinic. In others, it was suggested that training could be provided outside major metropolitan areas by established organisations.

In addition to formal qualifications, it was acknowledged that maintaining the appropriate skills and knowledge required frequent – if not continuous – practice, education and experience. As with formal qualifications, ongoing training was greatly facilitated by the presence within a clinic of a suitably qualified person who could provide guidance and supervision to those with less experience. This requires not only a qualified mentor/instructor, but also one who is both willing to share that knowledge and experience, and a clinic context in which knowledge sharing is facilitated.

Knowledge sharing was also a significant facilitator in nurses keeping abreast of developments within sexual and reproductive health, with some participants stating that information relayed to them by doctors returning from conferences or meetings was an important source of information. In other respects, ensuring that knowledge was up-to-date often came down to self-motivation among participants: the lack of a consolidated source of up-to-date information meant that nurses actively had to seek out the most relevant resources from a variety of sources, and that knowing whether those resources were complete and comprehensive could be difficult.

A significant barrier to retaining skills was a lack of demand for some services – either from nurses or within clinics as a whole – which meant that nurses were not able to meet quotas required for credentialing (Pap tests, for example), or simply did not retain confidence in particular skills.

A related, and potentially influential consideration, is that while adequate training was a necessary precondition for nurse involvement, it was important also that nurses were perceived to be adequately trained – if not by all staff within a clinic, then at least by those who were responsible for determining the ways in which patient appointments were to be managed, be it a management group/partners or individual GPs. Several participants mentioned that ‘trust’ in their colleagues was an important facilitator affecting their confidence in sharing particular tasks: an extended working relationship was a key foundation for this trust.
As noted, different individuals may place more importance on either formal qualification or informal training/experience, though there was a recognition that formal qualifications are likely to become more influential in future, particularly if doctors were aware of the educational standards required.

It is possible that attitudes towards nursing qualifications – and subsequently, the capacity of nurses to undertake particular tasks or roles within clinics – are shaped by perceived institutional attitudes towards nursing and its place in the medical workforce.

These barriers and facilitators are summarised in Table 1 (below), and illustrated in Figure 1 (below).
### Table 3: Barriers and facilitators to gaining appropriate skills and qualifications

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<tr>
<th></th>
<th>Barriers</th>
<th>Example Quotes</th>
<th>Facilitators</th>
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<tbody>
<tr>
<td><strong>Individual</strong></td>
<td>Lack of interest in or comfort with SRH</td>
<td>“The nurses need to have an interest for a start. If they’re not interested or comfortable, it’s just not going to work because it’s such a - what’s the right word for it - such a touchy sort of area.” – Practice Nurse (Moderate Involvement)</td>
<td>Clear interest in SRH</td>
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<td>Requirement to ‘specialise’</td>
<td>“Well in my situation, maybe if I upskilled, but the thing is I can’t take on anymore because I have to be across everything. If I only did sexual and reproductive health, then I might do more, you know get more upskilled in it and be a nurse practitioner in sexual and reproductive health. I actually like doing the breadth, so maybe that’s why I’m keeping it to a certain level.” - Practice Nurse (High involvement)</td>
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<td>Motivated by self-directed learning</td>
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<td>Time and cost of training</td>
<td>“I can’t see anybody doing it off their own bat anymore, because it’s too expensive, well I think it’s too expensive, especially if they’re older and they’ve got families and they’re rural and it means travelling to - well it used to be the Family Planning clinic. You’d have to go there for a week and do hours, I don’t know, get so many hours.” – Practice Nurse (High Involvement)</td>
<td></td>
<td>“Well I suppose it’s - I think pretty much it is self-motivated - but certainly ongoing training and updating is essential. But I think most professions are required to do continuing professional development. Certainly because it is so relevant to my role then I take the opportunities to do regular updates in relation to sexual health.” – Practice Nurse (High Involvement)</td>
</tr>
<tr>
<td><strong>Clinic</strong></td>
<td>Time and cost of training</td>
<td>“As in time and finances. They’re probably two of the biggest barriers for nurses to ongoing education. To get the time away from the current position to upskill and then the cost. As you know courses aren’t cheap.” – Nurse Manager</td>
<td>Support for external training opportunities</td>
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**Example Quotes**: “I know for me that public health, women's health and women’s rights were my main interests professionally, so I always believe I moved into general practice that hopefully - pap screen and sexual health particularly older teens has always been an interest of mine. So I just started looking into it.” – Practice Nurse (Low involvement)

**Example Quotes**: “Well I suppose it’s - I think pretty much it is self-motivated - but certainly ongoing training and updating is essential. But I think most professions are required to do continuing professional development. Certainly because it is so relevant to my role then I take the opportunities to do regular updates in relation to sexual health.” – Practice Nurse (High Involvement)
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<tr>
<th>Barriers</th>
<th>Example Quotes</th>
<th>Facilitators</th>
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<tr>
<td>Limited support for nurse training</td>
<td>&quot;Obviously me doing this Pap course is costly. We went halves in the cost so it's cost me $750 and 11 days of annual leave and really for no - only for my own professional development, my own career.&quot; – Practice Nurse (Limited Involvement)</td>
<td>Accessible, on-site supervision</td>
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<td>Lack of opportunity to utilise and sustain knowledge/training</td>
<td>&quot;I suppose - I mean I wouldn't take it on - I mean a lot of the nurses I used to work with we'd fit the [IUDs]. I don't think we fit enough here for me to feel confident to be doing that. I mean it'd be something I'd [be] wanting to do two or three or more a week, but we just don't get the throughput for that.&quot; – Practice Nurse (Moderate Involvement)</td>
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<td>&quot;Yes. We have a certain budget that we allow the nurses to spend individually each year as well as we pay - if it was to fall on a day that they would normally be working, they would claim that as just normal hours or if that wasn’t we’d pay them overtime to attend training.&quot; – Practice Manager (Moderate Involvement)</td>
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<td>&quot;That's probably the only way I've learnt over time, is to have someone else who is more experienced or more confident with their examination skills I guess and clinical knowledge, to be able to say oh yes that's such and such. Then you see okay this is what they do. That's what they do with that situation - that's what they do in that situation. So the next time it occurs you already know kind of what's likely to happen.&quot; – Practice Nurse (High Involvement)</td>
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<td>&quot;[Our nurse] joined us in 2012 and she came from a women’s health background...so she’s been a real benefit to not only just our practice but the other nurses that we have here working. She’s also a preceptor so she’s a very good one at training.&quot; – Practice Manager (High Involvement)</td>
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<td>Barriers</td>
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<td>“I feel like the reproductive health and the pap screening - I’m going to be using that soon, but a lot of the information that I learnt about STIs and those stats that are really helpful when you’re educating people I feel like oh that’s sitting there in my brain but if I don’t get to use it soon it’s going to disappear and I’ll feel like I wish I could just quickly go and do the course again. So it’s a - it’d be good to do the course knowing you could get straight into something.” – Practice Nurse (Low Involvement)</td>
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<td>‘Time’ required to develop trust in/develop nurse skills</td>
<td>“Well, I think you get the confidence when you see that they’re able to do the job as well as you are. So it’s a mixture, I think, yeah. That’s building that relationship and having confidence, I think, to hand over some of these jobs to the nurses, to the nursing staff.” – GP (High Involvement)</td>
<td>Acceptance of formal qualifications as evidence of capacity</td>
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<td>“I think getting to know the nurses and getting - having confidence in the nurses is more important [than formal qualifications] but, yeah, maybe. It’s a relationship over a long time, I think. It makes an enormous difference.” – GP (High Involvement)</td>
<td>“Yes, they just - they seem to be a bit more trusting when they know you’ve got specialised training in the area.” – Practice Nurse (Moderate Involvement)</td>
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<td>“[Her qualifications are] why we wanted her to come to our clinic.” – GP (High Involvement)</td>
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<td>Context</td>
<td>Rural/regional location increases time and cost required to attend training</td>
<td>“I guess she’d probably need additional training, getting the funding that for, her time away from the clinic, having to replace her while she’s away. Being so isolated it’s not like it’s half an hour and you can go somewhere and do some training.” – Practice</td>
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<td>“The support for sexual and reproductive health that is, the VCS is just the best thing, the best support......They give you education. They give you updates. They invite you to do, be involved in trials. They’re always on the phone if you’ve got a question. Just really really helpful.”</td>
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<tr>
<td>Barriers</td>
<td>Example Quotes</td>
<td>Facilitators</td>
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<td>Manager (High Involvement)</td>
<td><strong>Specialised versus general care</strong>&lt;br&gt;“For each clinic, you’d have someone specialising and seeing as many people as you can but it is a specialty area. It’s not like I’m doing wound dressings and everyone’s just doing it because it’s a normal part of it.” – Practice Nurse (Moderate Involvement)</td>
<td>You get, you know they're just fantastic. They'll come and do an in-service. They go through everything...When they change things they explain it. Their recommendations, you know their guidelines, just everything about them. Very professional and very - because cervical screening that's their gig...” – Practice Nurse (High Involvement)</td>
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<tr>
<td>Specialised attitudes towards nurse capacity</td>
<td>“But also give them the authority they need. I've heard some ridiculous competitive statements from doctors about nurses and the nursing role. So I think a lot needs to be done with the AMA and its state wide representatives to make sure that nurses are a valued allied health member and not treated as a second rate or whatever - I'm not describing them that way. But I think they need permission, from the system not a particular clinic, to administer their roles. So their role in community nursing needs to be strongly endorsed by whatever governance structure we have in place.” – KI2</td>
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Figure 1: Flow chart of factors affecting nurse qualification, training and experience (major barriers highlighted in red)
Infrastructure

Along with adequately trained staff, appropriate infrastructure was another fundamental requirement for nurses to be involved in sexual and reproductive health. In short, this relates to the availability of an appropriately appointed, private space in which nurses can consult with patients.

"That's really important, too. Where is your nurse going to be? You need to have an appropriate space that a nurse can also personalise. I've told you about those nurses who had the models in their rooms. I mean, they were given permission to set their room up in a way that works for them. I think that is very, very important, and that they have equipment that they use and feel comfortable with." – KI4

"At the moment we're not doing as much in that sense so in the treatment room setting in terms of - when we're doing travel vaccinations we try to take that opportunity to do some education on safe sex when we can, but it's not the ideal setting because you're in the treatment room with lots of other people." – Practice Nurse (Low Involvement)

Finally, in those clinics with the highest level of nurse involvement, nurses had their own consulting rooms – often very similar to those utilised by GPs – and were therefore able to respond more flexibly to the specific consultation in question. The capacity for nurses to conduct their appointments with patients in private treatment rooms also increased opportunity for sexual and reproductive health services, even when that may not have been the original reason for the patient’s visit. One nurse reported:

“'I guess because you're doing fairly private - fairly - private examinations and talking about personal things, a lot of women will open up about very personal issues they're having mentally, physically, socially. That often comes up, even when it's a non-sexual and reproductive health consultation, even if they've come in for something completely different, but probably more so if it's for, even just their regular cervical screening....Definitely, a lot of opportunistic, I'm big on that..." – Practice Nurse (High Involvement)

If nurses did not have their own consulting rooms, but rather nursing rooms set aside at specific times for specific purposes, this was adequate and appropriate for delivering a ‘nurse-led clinic’ style of sexual and reproductive health service.
Conversely, the lack of private treatment rooms was seen as an important barrier to opportunistic services or those given ‘on demand’ according to patient or GP requirements: where nurses lacked their own consulting room, the procedural difficulties involved in both finding an available nurse and consulting room, and then of booking the two together, were seen to be significant.
Clinic-Level Approach to Sexual Health

The drive to increase nursing involvement in sexual and reproductive health is predicated on a need – both real and perceived – for these services to be provided within a given clinic as an area of specific care, and how urgently they must be provided.

The degree to which this need was overtly acknowledged varied within participating clinics. The breadth of services provided within General Practice gives rise to a context in which a clinic may successfully operate and provide an excellent service to a client base without having a particular focus at the clinic-level on sexual and reproductive health. Clinicians/clinic administrators and decision-makers may focus attention on other conditions through their own interests or the perceived needs of their clientele (for example, the patient demographic may fall outside those perceived to be most in need of a broad range of sexual and reproductive health services), or patients themselves simply may not actively request sexual and reproductive health services at a given clinic on a consistent basis.

Where the need to provide sexual and reproductive health services was not recognised at a clinic level, participants reported that increasing nurse involvement may be difficult: it may be that the sexual health services on offer in such clinics were provided by individual doctors with a distinct interest in sexual and reproductive health, who would consequently be reluctant to divest themselves of relevant consultations to nurses. Alternatively, there may be a perceived need to ‘justify’ increasing involvement of nurses in any official capacity: where the focus on sexual and reproductive health did not already exist, a formal role for nurses in providing these services may be undermined by a lack of recognition of need, or of the perceived costs of providing nurse-led services versus perceived benefits.

Patient demand for sexual and reproductive health may represent an intersection of client needs and clinic focus, in that it could be both patient driven or clinic driven. In some instances, clinics with a focus on sexual and reproductive health acknowledged that they were responding directly to the needs of a client base for whom these were acknowledged to be important issues – clinics directly targeting or located near populations considered to be at risk for sexual and reproductive health issues, such as young people, for example. In others, it was simply a philosophical stance, in that addressing the needs of a potential client base required offering specific sexual and reproductive health services. In others still, it was a position taken by default: a paucity of alternative services meant that a clinic would need to address sexual and reproductive health issues to some degree.
Whether responding to patient demand or trying to increase it, however, clinics that focussed on sexual and reproductive health tended specifically to advertise these services. As observed using the Practice Assessment Tool (PAT), these clinics often had sections on their website explicitly addressing and publicising their sexual and reproductive health services, and had similar information visible within waiting rooms. These advertisements may include leaflets or posters specifying particular services (e.g. Pap tests) or simply raising the issue of sex and sexuality – for example, posters signifying that the clinic was a safe place for members of LGBTI populations. Adequately publicising services was seen as a facilitator in driving need for both sexual and reproductive health services, and those provided specifically by nurses, and may include informing key personnel within referring organisations of services offered. Once a clinic was known for providing particular services, it was considered that reputation was an important facilitator in maintaining demand.
| Table 4: Factors affecting demand for and approach to sexual and reproductive health within clinics |
|---|---|---|---|
| **Barrier** | **Example quotation** | **Facilitator** | **Example quotation** |
| **Clinic Level** | **Patient Demographic** | “It’s a strange demographic here... It’s probably middle to upper - I mean we definitely have those lower socioeconomic clients but I think probably in general middle to upper-class white people and I just find it’s a bit - it’s all a bit cultural to get a little bit awkward with the questioning including the nurses.” – Practice Nurse (Low Involvement) | **Patient Demographic** | “So, well, one of our big things is that we don’t separate out sexual health and I think that’s really important with adolescent health.” – GP (High Involvement) |
| **Insufficient publicising of services** | “I don’t think we publicised it well enough at the time. There weren’t posters up. It wasn’t on our - we didn’t have a Facebook page, so whether we come back to that and revisit, we can see.” – Practice Nurse (Moderate Involvement) | **Publicising nurse-led SRH services** | “Well we actually have a community development worker. So they promote the services, what’s offered at [this clinic]. That’s an ongoing program where they do lots of activities within the community and also with local schools... But that was certainly a way [this clinic] was promoted as a place you could go for sexual health as well, or any health reason yeah.” – Practice Nurse (High Involvement) |
| **GP/Practice Owner Interests** | “There are some people who go into general practice because they’re really keen and there are other people who do it a little bit more by default. I mean, it’s still a specialty but they might have a really strong special interest in some other aspect” | **GP/Nurse Reputation** | “Our main GP has a very good name within [this area]. He has been part of the sexual health and reproductive chain - for want of a better word - for quite a long time so he’s got quite a good name in [this area], and we’re always available.” – Practice Manager (High Involvement) |
that's nothing to do with sexual health. They might have a strong interest in sports medicine or something like that. Well, those GPs are wanting to do the best by the patient, but they're probably not going to have the slightest interest in sexual health.” – KI2

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<thead>
<tr>
<th>Lack of clinic-wide approach to/focus on SRH</th>
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<td>&quot;But I find that at every step having to justify everything and I get that from a business point of view. I really do but I suppose it's always coming from us. It's never a request. It's not the business or the doctors saying to us 'gee we wish the nurses could do that'.&quot; – Practice Nurse (Low Involvement)</td>
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<td>&quot;We get a lot of - we do an IUD clinic...but I don't - it feels - I think we all feel a little bit - the nurses we feel sometimes like we're flying a little bit blind because a lot of us who are really keen to do nurse-led clinics are new to practice nursing as well. So it's all a bit intimidating. We don't really know where to go or how to start.&quot; – Practice Nurse (Low Involvement)</td>
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Nurse Involvement in Sexual and Reproductive Health

The degree to which nurses were involved in providing sexual and reproductive health services varied significantly between clinics. In the most limited instance, very few relevant services were routinely offered by nurses: rather, specific tasks may be undertaken at the request of a doctor as required.

For clinics in which nursing involvement in sexual and reproductive health was high, tasks that were routinely undertaken by nurses included:

- Assessing history of sexual and reproductive health issues
- Providing patients with information about safer sex
- Screening for sexually transmissible infections
- Assessing eligibility for emergency contraception
  - Facilitating acquisition of emergency contraception
- Pregnancy support, including discussions regarding termination of pregnancy
- Removal of intrauterine device (one clinic)
- Insertion of the contraceptive implant
- Provision of fertility advice/management
- Pap smears
- Follow-up on results/recall of sexual and reproductive health patients
- Opportunistic sexual and reproductive health services (e.g. discussing safer sex)

Where nurses were routinely involved in sexual and reproductive health, a variety of service delivery models and patient pathways were utilised.

Figure 1 (below) provides an overview of potential pathways discussed by nurses regarding their involvement in sexual and reproductive health services.
Figure 2: Overview of pathways for nurse involvement in Sexual and Reproductive Health services (red box denotes issue of uncertainty/contention)
The breadth of tasks undertaken by nurses was not necessarily determined by the patient pathway during the consultation, and clinics did not always adhere to the same pathway for sexual health consultations, often varying according to patient needs and preferences and availability of relevant staff at a given moment. Key points in the various pathways, and factors that affect the likelihood or otherwise of these, are discussed in more detail below.

**Nurse-led versus Doctor-led appointments**

In clinics where nurses were significantly involved, a common approach was to allow patients to book directly with nurses. This could be done ‘on demand’, at the request of patients/colleagues, or could be limited to a ‘nurse-led clinic’ model, in which session times were set aside at the practice for a nurse-led clinic specifically directed at sexual and reproductive health.

The need for appropriate infrastructure and booking mechanisms has been addressed above, however several other key elements influencing the success or otherwise of the process were identified. While no patients were interviewed for this evaluation, several participants identified that their attitudes towards privacy can potentially be an issue to determining pathways, or impact on the way that the clinic responded to patient appointments, as well as clinic level factors:

These were:

- Patient concerns about privacy
- Reception staff capacity/comfort with assessing reasons for patient visits and appropriate pathways
- Patient comfort with nurse consultations

Rather than being exclusively considered as barriers or facilitators, participants were merely sensitive to these factors being part of the broader considerations to nurse involvement, often on a case-by-case basis. Some patients, for example, may be more comfortable than others in revealing the reason for their visit. Familiarity with nurse-led clinics or services may increase patient comfort with nurse involvement, encouraging them seek such services in future. Some examples of participant responses are given below (Table 4).
Table 5: Factors affecting initial choice of service provider

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<th>Determinant</th>
<th>Participant Examples</th>
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<td>Patient privacy concerns</td>
<td>“So if they’ve been open about what they’re coming for then the receptionist will be able to refer them straight to me, but the receptionist doesn’t always ask them because of, just from privacy and politeness; only if the patient offers it.” – Practice Nurse (High Involvement)</td>
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<td>Reception staff capacity/comfort for assessing appropriate pathways</td>
<td>“If they’re going to be examined or if they want a pap smear or they want to know something about STIs or something, I might refer them to the nurse to do their actual examination for a female patient or the female GP because [our GP] doesn’t do examinations on female patients. If they just wanted a script for the pill, then I just put them in to a doctor. If they tell you but if you don’t know you...” – Practice Manager (High Involvement)</td>
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<tr>
<td>Patient comfort with nurse consultations</td>
<td>“Well a lot of the time the doctors would say, oh if they come in for - or your Pap smear’s due, the nurses are able to do those now, so book in with the nurse. The girls at reception, again, if someone phones up for a Pap smear and they’d say can I book a Pap smear with the doctor. Oh, are you aware that all the nurses can offer that service now. So slowly the word’s spread now. They just phone up and say can I book a Pap smear with the nurse. So that was good.” – Practice Nurse (High Involvement)</td>
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<td>“I think the public, you know our patients in particular have a trust in our nursing staff. Most of them are return clients, so they keep coming back. So, for me, if they keep coming back that tells you that they’re comfortable and happy with our service” – Practice Manager (Moderate Involvement)</td>
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Where appointments could be directly booked with nurses, the primary difference in involvement lay in whether their services were offered on an ‘on demand’ basis, per requirements of the clinic or patients, or whether they provided a ‘nurse led clinic’. In the former model, patients could be booked directly with nurses at any time (provided nurses were available). In the latter model, session times were set aside at the practice for a nurse-led clinic specifically directed at sexual and reproductive health, with the bulk of nurse-provided services occurring during these times. Participants reported that decisions regarding the approach taken within a clinic depended upon consultation between staff and decision-makers, however the formality with which these consultations were undertaken varied significantly according to the context. For those clinics in which a specific session time was set aside for nurse-led consultations, key considerations appeared to be ensuring that appropriate facilities (e.g. consulting rooms) were available, and that staff could
be appropriately rostered so that the nurse clinic was adequately supported by GPs with experience in sexual and reproductive health.

Within the context of consultations themselves, protocols were often seen as useful tools in assisting staff in ensuring that nurses were following appropriate clinical pathways. In clinics with a specific focus on sexual and reproductive health, these protocols may have been internally developed over time to suit the particular approach of the clinic:

"Look I think there are guidelines that have been developed over the years...There are certainly procedural guidelines in relation to emergency contraception for example where there's a checklist of things that we need to do. We do get that signed off by a doctor. We can do that for the pill as well, for quick start if required... That's a checklist as well. There are clinical guidelines that - sexual health - that have been developed by [a GP] that includes sexual health assessments as well." – Practice Nurse (High Involvement)

Similarly, in clinics in which nurse involvement in sexual and reproductive health had recently increased – following the appointment of a qualified nurse, for example – checklists may be developed to help standardised procedures:

“There weren't any - it's not paperwork, that's the wrong word. There were no sort of structured documents in place. So what I've done is I've done like a checklist for implant pre-imposed for the IUDs. I've done a pill check one which we're hoping to introduce because of the changes with the Pap smears next year.” – Practice Nurse (Moderate Involvement)

Again, in clinics where nurse involvement was low, or a new initiative, and in which practice nurse experience in sexual and reproductive health may be limited, checklists and protocols were seen as a potential means of overcoming practice nurse/patient embarrassment about the sensitive nature of some questions:

“Yeah, definitely because I think that if you can say to someone at the start look I've got some questions here about sexual health, how about we just go through these, then it makes the nurse feel more comfortable in terms of the patient doesn't feel like they're prying. It's just look this is what we're doing; we're going to do a sexual health assessment; let's just put it out there and then just think through those questions. So then make it clinical - in that sense I think would help if it could just - for the nurse and the patient if they could just go through those list of questions and just follow a path with the questions. If it's a yes to that then move onto here and ask this and move through there.” – Practice Nurse (Low Involvement)
Within all clinics, participants reported a process by which appointments were followed up in some way by a GP. For the vast majority of participants, this meant that at some point in or directly after the consultation with a nurse, the GP was involved to a greater or lesser degree. Again, a key point of difference was between stand-alone nurse-led sexual and reproductive health clinics, versus opportunistic services provided ‘on demand’. Where the nurse-led clinic was in operation, the ‘consultation’ may be divided into two parts: the first conducted with the nurse, and the second conducted with the GP.

In other instances, the process was less formally described. The point at which patients may be directed towards a GP may differ according to nurse capabilities and confidence. Furthermore, the degree to which GPs may need to be involved may differ according to nurse capability, the relationship between the GP and the nurse – particularly trust in the other’s knowledge and qualification – and the reason for the patient presentation. The involvement of GPs may be as simple as signing a form/management plan devised by the nurse following consultation:

“So they might just come in and see me and then I’ll examine them and tell [the GP] what they need and then he’ll write the script. So they see me.” – Practice Nurse (High Involvement)

In other instances, it may require further discussion between the nurse, patient and GP:

"If I see something abnormal or that requires a script or a path request or that's beyond my scope of my provider number or if they need an ultrasound or if they need a referral to a gynaecologist or something like that.... Yeah, if I see something abnormal. Usually I describe it to him and that's enough. He feels he doesn’t have to re-examine the patient, for their sake as well." – Practice Nurse (High Involvement)

In some clinics, nurses had been empowered to conduct consultations without the immediate intervention of a GP. As will be discussed in greater detail below, frequently the primary motivation for involving GPs in the consultation was not an issue of patient safety. Instead, where the knowledge and capabilities of nurses were acknowledged and trusted by other clinic staff, GP involvement was seen as a ‘hurdle’ requirement in receiving payments from Medicare, or to overcome the fact that nurses were unable to write requests for services such as pathology, and therefore needed to involve a GP to meet both of these requirements. In clinics where nurse positions were fully funded by government agencies – or other bodies supported by government – the demand for Medicare rebates was reduced, meaning that GP involvement on this basis was no
longer a requirement. In the context of factors discussed above – practice commitment to sexual health, demand for sexual health services, etc – where accessibility to services such as screening or emergency contraception for patients was seen as an absolute priority, the requirement for GPs to authorise particular services was circumvented through the use of pre-signed forms provided to nurses (see the red box in Figure 1). While various checks may be put into place – phone calls to GPs, seeking consent before adding non-standard or additional tests to pathology requests, follow-up appointments booked with GPs, and the inclusion of GPs in all test results etc – the pre-authorisation of pathology requests could be an important facilitator of providing a timely consultation where this was deemed a priority. As with the issues of funding models, this barrier to the scope of nursing practice, and its impact on the role of nurses in sexual and reproductive health services, will be addressed in the report as a barrier to nurse involvement.

**Doctor-Led Consultations**

While those clinics with the highest level of nurse involvement in sexual and reproductive health tended to facilitate nurse-led consultations, doctor-led consultations were not inherently limiting to nurse involvement: in several clinics, patients initially booked with doctors may be referred almost immediately with their consent to the nurse for the remainder of the consultation, undertaking a wide variety of tasks, as listed above. This may purely reflect the fact that a patient had been booked with a GP for a service that was generally conducted by a nurse, potentially because they had not revealed the reason for their visit at the time of booking.

The potential for GPs to refer to nurses may depend on several factors. Primarily, these may relate to the GP’s perception of the nurse’s capability/role of nursing versus that of GPs: where GPs perceived that certain tasks required the training of a GP, they were reluctant to release these tasks to nurses. Patient gender was also a factor under consideration: if the patient were male, there was less imperative to involve a nurse, as they were often seen to be addressing the concerns of a female patient base. GP interest and training in sexual and reproductive health was also a significant factor in whether, or when, relevant consultations may be assigned to nurses:

"Probably as soon as they, it's anything to do with sexual or reproductive health.... Yeah or anything that involves an examination - an examination, pubic or breast examination, put it that way... He'd say, he'll just come straight, he'll either ring me or he'll ask me and then he'll - he'll ask the patient first are they comfortable with that and then he'll just come and grab me and say would you, could you come in? He'll introduce me and say this is ... our practice
nurse. Sometimes he'll say can you see them now or can you make another time? Usually I can see them straight away or within 15 minutes." – Practice Nurse (High Involvement)

"It is also interesting too. My job is to help everyone obviously, but women's health I wouldn't say is my greatest strength and I'd probably have to sit down and do a lot more reading on it which I just don't have the time to do at the moment." – GP (High Involvement)

GP interest in sexual health may also present a barrier to nurse involvement, irrespective of nurse capabilities or the way in which nurse involvement was organised within a clinic, as it may result in an inherent desire to retain relevant appointments for themselves:

“One of the female GPs who - is great and she runs the Women's Health Clinic and she voiced concerns last week about taking work from her. She runs a Women's Clinic .... and she was worried that this service that the nurses provided will take people from her, but I said to her look I think that that's something we deal with down the track as it comes. " – Practice Nurse (Low Involvement)

In this instance, an interest in sexual and reproductive health was cited by the GP as an area of significant appeal for her, both as it related to clinical issues of interest, but also as it allowed her to develop long-term relationships with patients during important life events such as pregnancy and child-rearing.

There is also the possibility, raised by one participant, that handing over sexual and reproductive health elements would result in fewer billable consultations for GPs.
Barriers to an Increased Role for Nurses in Improving Access to Sexual and Reproductive Health Services

While the discussion above has provided an overview of barriers and facilitators to nurses having a role in sexual and reproductive health in primary care, the breadth of tasks they may be able to undertake and given pathways, it is notable that in the vast majority of cases, sexual and reproductive health services provided by nurses, in whatever form, were viewed as an adjunct to a consultation with a GP. This was not necessarily a reflection the capacity of nurses to provide a sexual and reproductive health consultation, as participants frequently noted that nurses were capable of providing a service equivalent to – if not better than – that of GPs under many circumstances. That nurses were not able to provide these services independently came down to two primary barriers: sources of funding for nurses and how this was perceived within a given clinic, and the inability for nurses to request necessary services to complete sexual and reproductive health consultations, including the prescription of necessary medications/contraceptives.

Funding for Nurse Roles and the Role of Nurses Within the Clinic

“Then what are the costs involved and can you make this, can you resolve this into your business and still provide a service that is accessible to women from a financial point of view, that it’s not a barrier? So, that is one. Can we have an item number please?” – KI4

Though not necessarily specific to sexual and reproductive health, the way in which nurses were funded in clinics had a direct role in shaping the way in which they were integrated into service provision. In the simplest terms, those clinics in the community health sector, in which nurses were funded directly by government or by government funded organisations, tended not to discuss the issue of funding in relation to the provision of sexual and reproductive health. In some clinics, increasing nurse involvement in care provision was itself seen to be advantageous, for reasons similar to those discussed above regarding sexual and reproductive health. In one instance, the benefits of nurse-led clinics and services were such that in addition to funding from the Practice Nurse Incentive Program (PNIP), nurses were further funded through a portion of Medicare rebates paid to GPs. For participants in these clinics, too, funding was not a topic of concern.

Most commonly, the practice nurses were largely funded through the PNIP. However, many participants reported – either explicitly or implicitly – that reliance on a generic funding stream for
nurses was a barrier to increased participation in specific sexual and reproductive health services, and to the long-term sustainability of those services. The degree to which nurses were able independently to provide the appropriate services to patients was significantly hindered by the lack of itemised funding for which nurses could bill Medicare: as noted above, in the majority of cases it was standard practice for clinics to involve a doctor in consultations. Participants were often conflicted about this, however: particularly – though not necessarily exclusively – in cases where patients were asymptomatic, the involvement of doctors was seen to be largely for the purposes of being able to bill a Medicare item, rather than for the benefit of patients.

Even in cases where a practitioner acknowledged the potentially superior knowledge/expertise of their practice nurse in sexual health matters, and believed them capable of undertaking a greater range of tasks, the imperative to recover costs meant that there was often some element of ‘doubling up’ of service provision. If a doctor was not necessarily involved – in the case of, for example, simple advice or follow-up, or a Pap test – a charge was sometimes levied to the patient to cover the nurse’s time.

In other cases, participants indicated that nurses may simply be strictly limited in their involvement in sexual and reproductive health services. Where there was no direct correlation between a nurse’s activity and funds coming into a clinic, nursing involvement was limited and/or overshadowed by a perceived need to ‘justify’ the work being conducted. Despite support through the PNIP, given the lack of directly billable items for practice nurses working in sexual and reproductive health, there was a perceived need to cover the ‘cost’ of nurses’ time and skills that made decision-makers in some clinics reluctant to divest GPs of tasks that may be charged to Medicare.
Table 6: The role of nurse funding in shaping participation nurse provision of sexual and reproductive health services

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<th>Example quotations</th>
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<tr>
<td><strong>Tension between service provision and need to recover costs</strong></td>
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<td>“We do have a fee that we sometimes charge patients that come and just see a nurse. It’s $10 for a concession card holder or pensioner and $20 for a private patient. Then there’s no fee but they don’t see a doctor at all. We sometimes charge that but we try to get them to see a doctor that way it goes through - we can either bulk bill them that way if they need to be bulk billed.” – Practice Manager (High Involvement)</td>
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<td>&quot;Then probably cost is probably one of my main concerns here - is - the same with the pap clinic - that if - we’re a private billing and bulk billing’s at the discretion of the doctor, and for young people that’s - $75 for a consult with a doctor is not really accessible, and then determining how does it work if it was a nurse-led clinic or a - I find those billing discussions - yeah, I find that tricky because it’s that balance between providing a health service and running a business.” – Practice Nurse (Low involvement)</td>
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<td><strong>Perception that SRH does not fit within PNIP</strong></td>
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<td>&quot;We can’t bill and we need to pay for her…..There’s the PNIP, which is…We get that incentive from Medicare. There are a couple of item numbers but not obviously for these items.” – Practice Manager (High Involvement)</td>
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<td>“Yeah, so it’d just be nice if nurses could be - I don’t know, make the most of us because we’re really keen. Also maybe rewarded for all the services. So I know that by bringing in the Practice Nurse Incentive payments that that was the idea that they didn’t have to individually bill for items just to make it simpler, but part of me feels though that [the directors] forget that a lot.” – Practice Nurse (Low Involvement)</td>
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<td>“What I do too is I make sure that I make lots of money on all the other things that the practice can make money on, and that’s the care plan, the enhanced primary care and all the other items where Medicare, that attracts a Medicare item. All the other consults that attract a Medicare item, I make sure I try and do as many of those as I can and use that to the fullest extent, so that I hope that any time that I’m spending with people that is like free time, that that’s, I’m more than countering, compensating by my other work.” - Practice Nurse (High Involvement)</td>
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<td>&quot;So I get - so sometimes I think oh but then I know that if I go and do all these women who are four years overdue their pap smear and they get the incentive payment for the timeframe being so overdue, that payment’s going to go to that GP who I did that pap smear for. So that forty dollar bonus for getting the Pap smear done when it was so overdue that’s paid to the GP who didn’t see the patient. So I’m justifying the time that I’m taking to provide what I think are really good health services.” – Practice Nurses (Low involvement)</td>
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<td>“Doubling-up” on Service Provision</td>
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| Concerns about long-term viability | “It's always funding isn't it?....If they do procedures they should be paid for the procedures, so they should be able to access - they should be able to do investigations and in ordering investigations, but yeah, just the funding. They should be paid. " – GP (High Involvement) |
Scope of Practice:

While the inclusion of GPs in consultations was often seen to be necessary for the purposes of funding nurse activities in sexual and reproductive health, a similar principle was in operation when it came to the capacity of nurses to complete consultations, with nurses unable to order requisite tests and pathology, or prescribe treatment. Again, it was noted several times that this was not necessarily a reflection of the nurses’ capacity to understand the issues and devise an appropriate management plan, merely the requirement for such tests to be ordered by a GP.

As with the issue of funding and the lack of specific Medicare items for procedures undertaken by nurses, this requirement meant that clinics generally included the GP in the consultation at some point. With respect to the need for GPs to sign particular requests, several participants made a distinction between the provision of asymptomatic care and symptomatic care, emphasising the straight-forward nature of consultations with the former, and that the inability for nurses to order tests even in the case of asymptomatic presentations was particularly frustrating. While several participants acknowledged that becoming a nurse practitioner would allow them to undertake more elements of the consultation, it seemed that the study requirements involved were a significant deterrent.

As noted, in some clinics, the issue of ‘doubling up’ on services – having a patient seen both by a GP and a nurse – had been overcome by an arrangement in which nurses were provided with protocols for the conduct of consultations, and also with pre-signed pathology requests by the GPs with whom they worked. This was seen as an important way in which accessible services were provided to patients, in a timely manner, who could be seen even when a GP was not immediately available. Within clinics where this practice was undertaken, it was noted that nurses were very experienced, protocols were in place, and there were excellent relationships between staff members such that GPs were able to have input into any decisions made should it be required. However, the imperative to provide accessible, timely services meant that such an arrangement was a valuable tool within the clinic in achieving optimal health outcomes. It was acknowledged that this practice appeared to be widespread, and could be considered an important way of increasing accessibility of services, particularly in rural and regional areas where GP shortages were most acute. The practice was difficult, however, as the medico-legal implications were unclear: there was uncertainty as to exactly what the legal requirements were for GP involvement at all stages of the process, and/or what degree of involvement was required. This lack of clarity could be particularly frustrating given that the practice was perceived to be common – and potentially necessary for optimal patient outcomes.
Table 7: Limitations to Nurse scope of practice and impact on the provision of services

<table>
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<th>Example quotations</th>
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| Nurse capability versus authority | "She could probably do path requests and things. I think she does it now she just doesn't do the end bit, but she certainly I think has the skills and the ability and probably would be happy to take on more." – Practice Manager (High Involvement)  
"I'm sure you're aware, but the GP needs to generate the path forms et cetera but [the nurse] does the swabbing, she takes the blood, she does the whole shebang, but she needs the GP there to generate." – Practice Manager (Moderate Involvement) |
| Symptomatic versus asymptomatic patients | "What about the asymptomatic STI screen? That's a very important part of sexual health. It's actually a fairly straightforward set of tests that haven't changed too much, actually, over time. Really, in the heterosexual population, it's pretty non-invasive. It's really, in most cases, a urine test... So, again, is a sexual health and reproductive nurse able to take a competent history which will then guide recommendations around appropriate STI screening? Then is she able to initiate appropriate STI screening by requesting the tests or not? – KI4  
"So it would be great, with having these special qualifications that we have some privileges that, if they're asymptotic, we're doing asymptomatic screening, that we can just send the patient on their way, rather than having to wait around and see the doctor. That's huge. I don't know what can be done about that but that would be good. That's the thing, the only way I can get around that is if I become a nursing practitioner, which is a lot of schooling just to be able to do that." – Practice Nurse (Moderate Involvement) |
| Reluctance to progress to Nurse Practitioner Qualifications | "I guess, I mean [the practice managers is] always talking to me about becoming a nurse practitioner so that I could write scripts and do requests, but I guess I’m a bit daunted by the study it would take." – Practice Nurse (High Involvement) |
| Impact of restricted scope of practice on patient outcomes | "So, they've examined a patient, they've collected a swab, they've collected a urine, they're not able to sign off on the request form. That's a barrier for them and it's a barrier for the patient getting a result in a timely way." – KI4 |
| Pre-signed pathology forms | "Yeah, so for opportunistic screening, clearly they've got to have a signed form. They can't do it themselves ... They all - I sign off on a whole lot of forms. All the results come through to me, just for chlamydia and gonorrhoea, urine PCR - all the results come through to me. If the nurses have someone that they feel needs a more comprehensive screening, their..."
blood-borne virus risk, et cetera, et cetera, then they would usually ask about and say, can I add this to it? Those results would also come through to me. So the results come through to me but they also come through to the nurse who ordered it. There's a two-way check that that's being dealt with” – GP (High Involvement)

“No, I'm just saying that while we have no directive from the government to allow nurses to do it, in the interim if we could please just get on with providing a timely critical service, that would be great. If it means then - my understanding is that that is something that also the representative peak bodies that represent nurses need to be representing at that level. While all that politics and decision making and bureaucracy and admin is going on, how are we going to get on with the job that we know is happening anyway? ...It's happening anyway. So, how are we going to do it in a way that will allow the nurse to actually see the patient in a timely way, get a result back and initiate management? I don't know.... We've got some nurses who have a bunch of - stack of forms that are signed. Others who have to then take it to be co-signed." – KJ4
Discussion

In assessing the potential for greater nurse involvement in sexual and reproductive health services, and by extension, the potential for nurses to address rural and regional workforce shortages in primary care in relation to sexual and reproductive health, this project has identified a number of key elements. Fundamental to increasing nurse involvement are appropriately skilled nurses, adequate facilities, and a clinic-wide recognition of the need to provide sexual and reproductive health services to the patient community. Where these requirements are met, nurses are capable of routinely undertaking a broad range of sexual and reproductive health tasks. The processes by which nurses undertake tasks related to sexual and reproductive health within a clinic is highly contextual, relating to service demand, attitudes of clinic staff and staff relationships. While it was acknowledged that nursing staff may often be capable of providing appropriate sexual and reproductive health care to patients, their ability to do so independently of GPs was significantly hindered by funding structures underpinning nurse activities and their perceived purpose within practices, and by legislative requirements for GPs or other suitably authorised professionals to approve necessary services.

The need for nurses to be adequately trained before undertaking sexual and reproductive health tasks is clear, however as noted by participants, this can be a particularly onerous undertaking for nurses in rural and regional areas. Courses that may be relevant to practice nurses that are conducted by key training organisations are often located in metropolitan centres – for example, Family Planning Victoria courses centred in Box Hill [38] or cervical screening courses located in the Melbourne central business district [39] – are difficult to attend given the time and cost involved. While support from clinics was an important facilitator in overcoming these barriers, such support was not without cost to the clinics themselves, both financial and in terms of human resources.

Given the fundamental role that nurse training plays in ensuring the provision of quality services, increasing its accessibility to rural and regional nurses may be a particularly effective means of increasing capacity in this area. Potential means of achieving this may be through financial assistance provided through federal or state government, peak bodies, or training providers for nurses from rural and regional areas to attend accredited courses, or by encouraging training providers themselves to expand the number of locations in which courses are provided. While it is impractical to expect providers to conduct courses in an unlimited number of locations, it is possible that time and costs for consumers may be decreased should providers be able to facilitate courses in
regional centres that are more accessible to nurses outside major cities. While on-line modules may offer an apparently attractive option, the lack of reliable internet services in some regional and rural make this unlikely to be a viable solution. [40] As noted by one clinic, the availability of a preceptor within their staff had been seen as a significant facilitator to greater nurse involvement in sexual and reproductive health: expanding the preceptor program through greater advocacy and funding may have similar beneficial effects elsewhere.

In addition to initial qualifications, ongoing education for nurses, or keeping up-to-date with current best practice, was also an issue for nurses given their distance and potential isolation from other practitioners. Given a reliance on self-directed learning, a central or consolidated database outlining current best-practice may be of particular use to those who are unable to keep abreast of developments that are reported through, for example, academic conferences. This would be particularly useful if it could bypass the need for expensive subscriptions to academic journals, and could possibility be facilitated through existing networks such as the Primary Health Networks.

Another primary facilitator in increasing nurse involvement was a focus on delivering sexual and reproductive health services at a clinic level. This focus may depend on a number of factors, primarily a recognition among decision-makers (for example, principle partners or funding bodies) that there was a benefit to addressing sexual and reproductive health, whether this benefit be primarily either for the patients themselves, for the clinic, or a combination of the two. Given varying professional interests and priorities among service providers, where sexual health falls outside the perceived priorities of those managing clinic services, such benefits may not be immediately obvious. In these situations, the capacity to demonstrate ‘need’ for sexual and reproductive health services, through the provision of relevant statistics regarding sexual health outcomes for particular regions, for example, may be a useful tool for those seeking to advocate for greater involvement of practice nurses in sexual health. Again, this may be a role that could be undertaken by local Primary Health Networks. Our participants also reported a number of benefits of involving nurses in clinics: providing a consolidated resource for those considering or attempting to initiate nurse-led services in general practice, outlining evidence-based benefits to both patients and clinics, may be an effective means of encouraging a clinic-level response where this does not already exist.

One significant ‘benefit’ that must be acknowledged is that of financial recompense to clinics for services being provided by nurses. The lack of billable Medicare items for nurses for sexual health services has made this benefit less immediately obvious, with nurses in some practices reporting
that it was unclear which sexual and reproductive health services that they provide were covered by the Practice Nurse Incentive Payments. Our findings in this regard mirror those of an earlier study, in which practice nurses reported that the removal of Medicare Benefit Schedule item numbers from practice nurses would impact the way in which GPs understood the role of practice nurses in sexual health.[41] Educating clinic managers on the intended uses of PNIP funding may be one way of overcoming this with respect to more general service provision. Conversely, if finances are the primary incentive at administrative levels within clinics, and it is possible for a clinic to be operated at an adequate profit margin using the PNIP with only a limited number of sexual and reproductive health services provided by practice nurses, then there may be limited incentive for clinics to expand the role of nurses within the clinic without specific payments related to nurse activities. Increasing nurse involvement may therefore rely on a reintroduction of procedures that can be billed by practice nurses through Medicare.

Attitudes towards nurses – at both the individual and institutional level – and their qualifications was an important factor in determining how services may be offered within a clinic. Participants identified that a shared understanding of nurse qualifications may be a facilitator in contributing to a team-based rather than doctor centred approach to sexual and reproductive health care. While professional training courses already exist, our findings suggest that these may be considered necessary but insufficient by the GPs with whom practice nurses work, with GPs not necessarily certain of how formal qualifications may translate to practical nursing skills. As indicated by one participant, one potential avenue for addressing this may be to raise the general profile of practice nurses and their qualifications within primary care – a need which has been recognised in other facets or primary care nursing.[42] Though it was acknowledged that attitudes towards formal versus informal qualifications may be shifting in favour of the former, making the requirements for relevant nursing qualifications and educational standards explicit at the level of relevant peak bodies, with relevant peak bodies mutually endorsing such endeavours, may also assist in increasing understanding of and respect for nurse qualifications.

While the precise pathways in which nurses may be involved in sexual and reproductive health were highly contextual, it was noted by several participants that the availability of checklists and procedural guidelines were useful for establishing nurse-led clinics or consults. Again, a centralised, consolidated resource for practice nurses which provides examples of such checklists may be particularly useful in clinics where there is no established role for practice nurses in providing sexual and reproductive health services. However, given the variety of contexts in which general practitioners and practice nurses are employed, prescriptive recommendations are unlikely to be helpful: rather, the aim could be to provide models of successful nurse involvement in various
contexts that may be useful in generating conversations within clinics attempting to initiate similar services.

Given that a primary impetus for investigating the potential role of practice nurses in sexual and reproductive health was to assess increased access for patients, one crucial factor identified in the conduct of this project was the philosophical difference between expanding the number of tasks related to sexual and reproductive health that nurses may undertake and increased accessibility. While a nurse’s capacity to undertake particular tasks was pre-requisite for increased accessibility through nurses, some systematic elements restricted the degree to which ‘increased accessibility’ could be achieved, regardless of nurse skills. These were, fundamentally, the need for patients to be seen by a GP in order to receive a financial rebate for clinic time through Medicare, and the restrictions of nurses’ capacity to order necessary tests or referrals for patients, even when such decisions were within the bounds of their capabilities.

Effectively, these two elements meant that while an experienced sexual and reproductive health nurse within a clinic may be able to increase the overall number of patients seen within a clinic by reducing the workload or time requirements of GPs, they are not necessarily able to improve the accessibility of sexual and reproductive health service to those who need them. Even if a nurse is available and capable of providing a given service, if legislative or financial requirements mean that a GP must be involved in the sexual and reproductive health consultation, the capacity for nurses to address the shortage of GPs – particularly in rural and regional areas – remains limited to the accessibility of GPs. With respect to the financial aspect, as mentioned above, educating GPs and decision-makers as to the intended purpose of the PNIP may be sufficient to convince them of the financial benefits of involving nurses in consultations such that financial concerns regarding nurse involvement are allayed. However, the requirement for GPs to sign for pathology services remains a significant structural barrier. Given the acknowledged, widespread methods used by GPs to circumvent this requirement in order to meet patient or population health needs, there is a strong argument to be made for investigating models of care capable of providing relevant services to patients that do not compromise the medico-legal position of either nurses or general practitioners, while still ensuring patient safety and beneficial outcomes. While the option for qualifying as a Nurse Practitioner exists, several participants indicated that the requirements for qualifications – time and financial – were disproportionate when their focus was primarily on sexual and reproductive health. Furthermore, the relative costs to clinics of hiring a Nurse Practitioner versus a Practice Nurse may make this option less viable.
One possible avenue for overcoming these issues may be to separate consults into those dealing with asymptomatic versus symptomatic patients: while participants varied in their opinions regarding the capacity of or appropriateness for nurses to address symptomatic cases, frustrations with barriers to dealing with asymptomatic patients were more clear, with participants largely agreeing that these consults could safely be managed by nurses with no risk to patients. If barriers to managing the latter could be removed – such as the capacity for nurses to request further tests – it may be that the needs of these patients could be safely and appropriately met within a nurse-led sexual and reproductive health clinic. Evidence suggests that a significant proportion of people attending General Practice for sexual health reasons do so in the absence of symptoms.[43] While delimiting nurse-led sexual and reproductive clinics in this way may therefore have some impact on the extent to which they can affect accessibility of services, it may be marginal, and could indeed be offset by the degree to which GPs are themselves made more available to deal with symptomatic cases, though further research in this area is required.
Conclusions:

With recent policy documents having made nurse-led care a priority action area for delivering sexual and reproductive health in rural and regional areas, our results suggest that there are few inherent barriers to this being a viable option.[44] Many nurses are already displaying both willingness and capability across a number of necessary tasks, with varying modes of service delivery. When examining specifically rural and regional locations, perhaps the greatest barrier to nurse involvement are the time and cost required to gain adequate training and qualifications. This issue may be compounded when ongoing training and education are considered. Given current requirements regarding authorisation for standard elements of sexual and reproductive health consultations and/or follow-up, limitations to the capacity for nurses to fully employ additional skills gained may also be a significant deterrent. It is possible that, were nurses able to utilise any training and skills more fully, the relative cost to themselves and to clinics may be less significant.

Feedback from both nurses and clinic staff indicated that costs to clinics may also be a significant barrier to initiating nurse-led clinics, as well as a lack of resources available to assist in the development of appropriate processes. In light of this, a useful avenue of future research may include a pilot program involving the design, implementation and evaluation of nurse-led sexual and reproductive health clinics in a limited number of general practice clinics of varying types. This would provide an opportunity to purposefully collect both relevant financial data such that an economic evaluation of nurse-led clinics could be conducted, and to document procedures in order to develop useful resources that might be distributed to practices initiating such clinics or services of their own.
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Canberra: AIHW, , AIHW: Canberra.


Appendices

Appendix 1: Advisory Committee Members

Chris Bayly, Royal Women’s Hospital
Emily Lee-Ack, Women’s Health and Wellbeing Barwon South West
Louise Holland, Bendigo Community Health Services,
Jane Opie, Western Victoria Primary Health Network
Jayne Lucke, Australian Research Centre in Sex, Health and Society
Lauren Coelli, Gateway Health Wangaratta
Meredith Temple Smith, Department of General Practice, The University of Melbourne
Patricia Moore, Family Planning Victoria
Susanne Prosser, Geelong Adolescent Sexuality Project (GASP)
Tim Denton, Kardinia Health Geelong
Deborah Bateson, Family Planning NSW
Appendix 2: Clinic Staff Interview Schedule

Clinic Staff Interview Schedule

Introductory statement:

*This interview forms part of a project exploring what factors – at individual, clinical and structural/contextual levels – may influence the implementation of an expanded role for nurses in providing sexual and reproductive health services, particularly in rural and regional areas. If you have any questions or concerns regarding the project, please feel free to discuss them with me before we begin.*

- Confirm receipt/comprehension of PLS/Consent form
- Permission to record interview

PART 1: BACKGROUND INFORMATION

- Gender
- Clinic Type
- Job title/responsibilities

PART 2:

- Can you tell me what involvement you have in providing sexual and reproductive health services at the clinic? Can you describe the processes that you’re involved in?
  
  *Prompts:*
  - Administrative
  - Clinical
  - Other

- What support or interactions with other staff might you have when providing SRH services?
  
  *Prompts:*
  - Clinical supervision/support
  - Referrals to other staff/services
  - Administrative
• Why do you think patients might choose to come to this clinic for SRH consultations in this clinic?
  *Prompts:*
  o Patient driven?
  o Referrals?
  o Reputation?

• Can appointments be made directly with nurses? How well do you feel this service has been received? Why?

• How might a redistribution of tasks affect the day-to-day operations of the clinic?
  o On you?
  o On other staff?
  o On the clinic?

• Can you tell me a little about the different roles of staff members within the clinic? Do you feel that tasks associated with different roles are well aligned?
  *Prompts:*
  o Professionalism
  o Capability
  o Recognition of qualifications
  o Role allocation according to qualifications
  o Knowledge of training and accreditation processes /content
  o Knowledge/attitudes re: medico-legal and ethical considerations

• How is change managed within the organisation, and who is involved in those processes?
  *Prompts:*
  o Who is involved in decision making
  o How are decisions communicated
  o What sort of documentation is produced
  o What sort of monitoring/evaluation is undertaken

• How are nurse appointments managed within the clinic? Are you involved in the process in any way or do you have the capacity to be involved?

• Can you identify any key problems with or drawbacks to having an expanded role for nurses in SRH services in the clinic?
  *Prompts:*
  o Governance
  o Patient outcomes
  o Workload
  o Job creep
  o Communication systems
What might be some key barriers to such an expanded role for nurses in your clinic and more broadly?

*Prompts:*
- Funding
- Governance
- Risk management
- Patient perceptions
- Legislative framework
- Structural factors related to clinic set up
- Operating times
- Room availability

How might these be overcome?

What support might be needed to ensure such a role was viable long term?

*Prompts:*
- For individual roles?
- For clinics?

That covers my questions – is there anything else you’d like to add about the things we’ve talked about today?

Many thanks for your help. Please don’t hesitate to contact me if you’ve any more questions.
Appendix 3: Key Informant Interview Schedules

Key Informant Interview Schedule

Introductory statement:

This interview forms part of a project exploring what factors – at individual, clinical and structural/contextual levels – may influence the implementation of an expanded role for nurses in providing sexual and reproductive health services, particularly in rural and regional areas. If you have any questions or concerns regarding the project, please feel free to discuss them with me before we begin.

- Confirm receipt/comprehension of PLS/Consent form
- Permission to record interview

PART 1: BACKGROUND INFORMATION

- Organisation

- Job title/responsibilities – relevance to context (training, support for GPs/PNs, accreditation, networks etc)

PART 2:

- From the perspective of x organisation, what might be some key benefits of an expanded role for practice nurses in SRH? How would an expanded role for nurses achieve this?
  Prompts:
  - For patients?
  - For clinics?
  - For population?
  - For workforce?

- What might be some key drawbacks or problems of an expanded role for nurses in providing sexual health services?
  Prompts:
  - Governance
  - Patient outcomes
  - Medico-legal considerations
  - Workforce considerations
Training/qualification provision & accreditation

- What might be some of the key barriers to an expanded role for nurses?
  
  *Prompts:*
  - Funding
  - Governance
  - Risk management
  - Patient perceptions
  - Legislative framework

- How might these be overcome?

- What support might be needed to ensure such a role was viable long term?

That covers my questions – is there anything else you’d like to add about the things we’ve talked about today?

Many thanks for your help. Please don’t hesitate to contact me if you’ve any more questions.
## Appendix 4: Practice Assessment Tool

<table>
<thead>
<tr>
<th>Practice Assessment Tool</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completed By:</td>
<td></td>
</tr>
</tbody>
</table>

### Practice Details

<table>
<thead>
<tr>
<th>Name:</th>
<th>Postcode:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Website:</td>
<td></td>
</tr>
</tbody>
</table>

| Is the practice accredited? | Yes: ☐ | No: ☐ | Accreditation Date: |

### Opening Hours

<table>
<thead>
<tr>
<th>Monday:</th>
<th>Tuesday:</th>
<th>Wednesday:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thursday:</td>
<td>Friday:</td>
<td>Saturday:</td>
</tr>
<tr>
<td>Sunday:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Practice Personnel
Describe the workforce in the clinic, with respect to type of staff, age range, gender and full time equivalent (FTE):

**Practice Characteristics**

<table>
<thead>
<tr>
<th>Clinic Type</th>
<th>Solo:</th>
<th>Group:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community:</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Corporate:</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Is the clinic within walking distance to:

<table>
<thead>
<tr>
<th></th>
<th>Schools:</th>
<th>Pharmacy:</th>
<th>Public Transport:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist SRH services?</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospitals:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

The location of the clinic within the town is:

<table>
<thead>
<tr>
<th></th>
<th>Central:</th>
<th>Peripheral:</th>
</tr>
</thead>
</table>

Are there any leaflets/posters advertising the role of nurses in the:

<table>
<thead>
<tr>
<th></th>
<th>Waiting room?</th>
<th>Website?</th>
</tr>
</thead>
</table>

Describe briefly:

Are there leaflets/posters advertising SRH services in the:
<table>
<thead>
<tr>
<th>Waiting room?</th>
<th>Website?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Describe briefly:

Is there a pathology service:

<table>
<thead>
<tr>
<th>On site?</th>
<th>Walking distance</th>
<th>Neither:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Can samples such as urine be collected privately on site:  
Yes  | No  |
|-------|-----|

If not, describe any issues identified (layout, location of toilets, etc):

Do nurses have consulting rooms:  
Yes  | No  |
|-----|-----|

If yes, describe the rooms (private/shared, layout, privacy, equipment present etc):

If no, describe the rooms in which nurses consult patients:

**Patient Profile:**  
Briefly describe in general terms the predominant demographic and type of clinical presentations seen at the clinic (e.g. chronic care management, vaccination etc):

**Clinic Administration/Governance**  
Which practice management software does the clinic use?

Are bulk-billing services offered to:  
Young people:  | HCC Holders:  | Students:  | Everyone:  |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Other (please specify):
Describe any other billing procedures (e.g. different weekend rates, rates for young people), and how these are publicised:

| Does the clinic have written policies and procedures regarding risk management/incident reporting? | Yes: ☐ No: ☐ |
| Does the clinic have an established process for managing change in procedures and protocols? | Yes: ☐ No: ☐ |

Please indicate to which role responsibility for the following primarily falls:

| Record Keeping: | Care co-ordination: |
| Recall/reminder systems: | Providing test results: |
| Addressing ‘failure to attends’: |

Please briefly describe how communication with patients regarding the above (test results, FTA, recall/reminders) is conducted (e.g. by whom, through what means)

---

### Nursing workforce and support structures

How are nurses in the clinic funded?

| PNIP: | Chronic Disease Care Plans: |
| Other (please describe): |

Are nurses provided with ongoing training and/or support in attending relevant training courses?

| Yes: ☐ No: ☐ |

Is training provided:

| On-site: | Off-site: | NA: |
| Internal providers: | External providers: |

Is support for training provided in the form of:

| Paid leave: | Unpaid leave: | Course fees: |

Other (please describe: | ☐ | ☐ | ☐ |
| Question                                                                 | Yes | No | |---|
| Does the clinic have insurance for services provided by nurses?         | ☐   | ☐  | |---|
| Please describe any formal processes for feedback/support between Doctors and Nurses: |     |    | |---|
| Are nurses involved in strategic decisions at the clinic level, for example in change management processes? | ☐   | ☐  | |---|
| Please describe their involvement:                                       |     |    | |---|
| Are clinic nurses involved in support networks through organisation such as primary health networks? | ☐   | ☐  | |---|
| Please describe:                                                         |     |    | |---|
| Describe the process used for booking appointments with the nurse:       |     |    | |---|

**Appointment procedures and the management of SRH services**

| Question                                                                 | Yes | No | |---|
| Does the clinic specialise in/focus on SRH?                              | ☐   | ☐  | |---|
| Are patients able to make appointments directly with nurses:             | ☐   | ☐  | |---|
| Are external organisations able to refer patients directly to nurses:    | ☐   | ☐  | |---|
| If applicable, please indicate the main sources of direct referrals to nursing staff: |     |    | |---|
If not the patient/referring service, who triages patients to either a doctor or nurse for initial consultations?

<table>
<thead>
<tr>
<th>Reception:</th>
<th>Nurse:</th>
<th>Doctor:</th>
</tr>
</thead>
</table>

Give a brief description of how this process occurs:

Please indicate which of the following are routinely undertaken by nurses:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess history of sexual and reproductive health issues:</td>
<td>☐</td>
</tr>
<tr>
<td>Counsel/provide information to patients about safe sex:</td>
<td>☐</td>
</tr>
<tr>
<td>Conduct STI screening:</td>
<td>☐</td>
</tr>
<tr>
<td>Assess eligibility for emergency contraception:</td>
<td>☐</td>
</tr>
<tr>
<td>Insertion of contraceptive implant:</td>
<td>☐</td>
</tr>
<tr>
<td>HPV testing:</td>
<td>☐</td>
</tr>
<tr>
<td>Pregnancy counselling/support, including termination of pregnancy:</td>
<td>☐</td>
</tr>
<tr>
<td>Cryotherapy for genital warts:</td>
<td>☐</td>
</tr>
<tr>
<td>Insertion of intrauterine devices:</td>
<td>☐</td>
</tr>
<tr>
<td>Provision of fertility advice and management:</td>
<td>☐</td>
</tr>
<tr>
<td>Pap smears:</td>
<td>☐</td>
</tr>
</tbody>
</table>

Please provide any details about the above, or describe other services provided by nurses:
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are any SRH activities expressly excluded from the nurse role? Please describe (e.g. menstrual disorders, sexual function/dysfunction):</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does the clinic have written protocol for managing SRH services, including outlining staff roles and responsibilities?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Does the clinic have policies for supporting nurses providing SRH services in the clinic (e.g. presence of GP for all insertions of IUDs, etc)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>