

The Queen's Nursing Institute

General Practice Nursing in the 21st Century:

A Time Of Opportunity

Contents

1.Chief Executive's Introduction 3

2.Why this survey? 5

3.Headline findings 5

4.Background 6

5.Findings 6

Workforce Profile 7
Employing organisation 7
Multiple jobs 7
Pay band 7
Increments based on performance 9
Salary 9
Hours of work 10
Working evenings and weekends 10
Annual leave 11
Indemnity cover 11
Job Title 13
Line management 14
Annual appraisals 14
NMC revalidation 15
Qualifications 17
Professional development 19
Entry to and preparation for GP Nursing 22
General Practice Nursing as a career 23
Roles and responsibilities 26
Home visiting 26
Additional areas of responsibility 27
Workload pressures 27
Multidisciplinary working 29
General Practice Nurse skills 30
GPN and District Nurse roles 31

6.Conclusion 33

7. Required actions 34

8. References 35

Edited by Matthew Bradby and Chloe McCallum

Copyright: The Queen's Nursing Institute 2015

‘General Practice Nurses have something important to say and they wish their stories to be heard.’

1.Chief’s Executive’s Introduction

When The Queen’s Nursing Institute embarked on a national survey of General Practice Nurses (GPNs), the aim was to reach at least 1000 nurses working in primary care around the UK.

The survey was required to provide the QNI with robust evidence to support our ongoing campaign for excellence in nursing in the community and primary care - rather than relying on anecdotes from practice - albeit that these stories gave a consistent message about the challenges and opportunities faced by GPNs.

Within a week of the survey opening we had exceeded our target response and by the time the survey closed some ten weeks later, we had responses from 3,405 nurses, representing approximately 15% of the entire GPN workforce in the UK. The large number of comprehensive responses tells a story in itself: General Practice Nurses have something important to say and they wish their voices to be heard.

Furthermore, they trusted the QNI with their stories and to provide a considered analysis of the huge amount of data we were given. My thanks to all those who took the time to complete the survey, to tell us about the joys of working as a nurse in general practice and also the challenges. Above all, theirs is a story of opportunity: the opportunity to work as highly skilled, autonomous practitioners and to serve a local community – but also the unrealised opportunity for a higher profile and a more comprehensive, supported role in meeting the needs of the registered population.

Arguably, there has never been a better time of opportunity for nurses working in general practice, with a current focus on policies to transform primary care and provide an increasing range of services based on the needs of the local community registered with the General Practitioner service (Primary Care Workforce Commission, 2015; NHS England, 2014). General Practice Nurses have the potential to contribute significantly to the transformation agenda and to offer a comprehensive and supportive nursing service to their patients which focuses on health promotion and supported self-care.

Following an exploration of the findings, the report concludes with a call to action to address the issues raised, which require an urgent response. We anticipate that action will be needed locally, regionally and nationally to address the issues we have identified - at the level of employer through to the national statutory bodies, which form part of the structure of our NHS.

The QNI will be responding to the findings too. In 2016, we will publish our online resource: ‘Transition to General Practice Nursing’, to support nurses who are new to the role. Following our launch with QNI Scotland (QNIS) of new voluntary standards for District Nurse Education and Practice (QNI/QNIS, 2015), in 2016 we will develop QNI/QNIS voluntary standards for General Practice Nurse Education and Practice, to enhance the existing NMC standards for specialist GPN practice.

We will also use the findings to support nurses working in primary care and to campaign for excellent nursing care for individuals, families and carers in their local communities.

Dr Crystal Oldman



‘Nurses in General Practice provide significant levels of intervention and support at every point during a person’s life.’

2. Why this survey?

In this study, the QNI has sought to create a snapshot of the role of the General Practice Nurse (GPN) in 2015, based on the perspectives of the nurses themselves. The study was inspired by the 2020 Vision reports that the QNI published in 2009 and 2014, which focused on the work of the District Nurse (DN). Those studies highlighted the particular challenges facing District Nurses, which have led to specific policy responses from the QNI and other healthcare organisations, which are still ongoing. We therefore wished to replicate this work to highlight the unique challenges facing General Practice Nurses, who work in a very different setting to those in the DN service and whose employment structure is completely unlike that of their DN colleagues. As most GPNs work in small teams, employed by small independent organisations, they are subject to an extremely wide variety of terms and conditions, educational and development opportunities and career structures. This survey illustrates and celebrates that variety, but also indicates that standardisation in some areas would be welcome. By gathering and publishing information about the profession, it is hoped that this will enable policy makers, employers, and nurses themselves to be better equipped to deal with current and future challenges and to embrace new opportunities as they arise.

It is clear from the survey that many enter the General Practice Nursing service because of the flexibility that it offers, combined with the challenge, variety, opportunity and inherent value of the nursing work that can be offered in general practice. It is vital to ensure that these elements that make General Practice Nursing work appealing are maintained and developed, in order that nurses continue to be attracted into the service and good staff retained, continuing to develop their skills and knowledge while in the role.

The report is designed to inform the work taking place on the future direction of primary care and the development of new service models. It provides a clear description of the current state of the General Practice Nurse workforce from the perspective of the nurses working in GP practices – and reveals that nurses can be at the centre of future service models in primary care, providing high quality, competent care for their local communities. The headline findings are summarised below.

3. Headline findings

Patients

This survey validates the role of the General Practice Nurse and the significant levels of intervention and support provided by nurses in General Practice at every point in time during a person’s life, from infancy, childhood, adolescence and adulthood, to middle and older age.

Workforce

- 33.4% of General Practice Nurses are due to retire by 2020
- Men are under-represented, comprising only 2.0% of the General Practice Nurse workforce
- 43.1% did not feel their nursing team has the right number of appropriately qualified and trained staff to meet the needs of patients
- At the time of the survey 78.8% had considered preparation for NMC re-validation

Education

- 53.0% reported that their employer always supports their professional development
- 10.6% hold an NMC recordable specialist practice qualification in General Practice Nursing
- 32.6% of General Practice Nurses are independent prescribers
- Just 27.0% of the employers offered placements for pre-registration nursing students, compared to 61.5% offering placements to medical students

Employment

- 22.8% of nurses working in General Practice have two jobs
- 32.6% of General Practice Nurses reported working evening sessions (after 6pm) and 18.5% work weekends
- Over 38.3% indicated that they undertook visits to patients at home
- Only 35% felt that their salary reflected their role within the practice
- Salary and other terms and conditions such as annual leave entitlement vary widely

4. Background

The Queen's Nursing Institute

The QNI was established in 1887 to train District Nurses, but from the 1970s the remit of the charity has broadened to provide a wide range of support to all community nurses, including General Practice Nurses.

The title of Queen's Nurse (QN) was reintroduced by the charity in 2006 and General Practice Nurses are eligible to apply for the QN title.

As the focus of care delivery moves to primary care, and disease prevention and treatment in the community, it is envisaged that more nurses will move from secondary care to the diversity of community settings. In order for them to make this transition effectively, the QNI is dedicated to providing knowledge resources and other forms of support.

The QNI is currently in the process of publishing a new online resource, 'Transition to General Practice Nursing' which will serve as an introduction to the main themes of working in this setting. The resource is based on already published resources for District Nurses and those entering School Nursing.

Previous GPN surveys

The QNI has not previously carried out a survey of General Practice Nurses. Our findings build on recent surveys from the Royal College of Nursing (RCN, 2010) and the Royal College of General Practitioners (RCGP, 2014), whilst providing a broader, current picture of General Practice Nursing.

Survey method

The QNI used SurveyMonkey to collect responses from 21 April 2015 to 28 June 2015. The survey was promoted principally via nursing media (printed and online) and by the QNI's own networks, including email and social media channels. 3405 nurses responded and respondents had the option to skip questions. This report presents a detailed analysis of both the qualitative and quantitative data that was supplied by respondents.

Percentage values given below refer to the number of nurses as a proportion of respondents to that question, or as a proportion of the total number of respondents where stated.

4. Findings

The QNI operates in England, Wales and Northern Ireland. Our sister charity, QNI Scotland, is based in Edinburgh and operates exclusively in Scotland. It was not practicable to limit the survey to particular parts of the UK; however nurses were asked in what region of the UK they work, which showed a broad geographical spread of all regions.

In terms of country distribution, the respondents are located as follows:

Country	Number of GPNs	Percentage
England	3032	88.5%
Wales	246	7.2%
Northern Ireland	72	2.1%
Scotland	76	2.2%
Total responses	*3426*	

This was the first time that the QNI has carried out a survey of nurses in general practice, so it was not possible to compare results of this survey to a previous QNI sample. However, a review of recent surveys of General Practice Nurses carried out by the Royal College of Nursing and the Royal College of General Practitioners was made when compiling this report, to help establish any common themes or trends that have been reported in recent years.

Respondents were asked for the size of the registered population that their practice covers.

Registered List	Number of GPNs	Percentage
Under 5000	443	15.7%
5000-9999	1077	38.1%
10,000-14,999	862	30.5%
15,000-19,999	302	10.7%
20,000+	144	5.1%
Skipped question	*577*	

‘23.1% of survey respondents have more than one job.’

Workforce profile

Almost 98% of respondents were female. This represents a higher proportion than in other branches of nursing. The survey did not establish reasons for this, but further investigation could be carried out with male nurses to help determine why so few men enter this specialist area of the profession. A large number of respondents indicated that childcare and other family circumstances were a major reason why they entered General Practice, which may help explain the preponderance of women in the workforce.

The majority, some 98.5%, were registered Adult Nurses, 1.0% of respondents were registered Children’s Nurses, 0.3% were registered Mental Health Nurses and 0.2% were registered Learning Disability Nurses.

Employing organisation

The large majority are employed by General Practitioners, but there is a significant number who work for a variety of other organisations, and some are self-employed.

Employing organisation	Number of GPNs
General Practitioner	2971
Local Community Nursing Provider	66
Social Enterprise	23
Community Interest Company	13
Private Company	84
Clinical Commissioning Group	86
University	29
Self-employed	61

Multiple jobs

23.1% of survey respondents have more than one job, which reinforces the flexible nature of this career path and confirms the previous finding by the RCN in 2009 that 22% of General Practice Nurses have an additional job. However, this may also indicate that some nurses are compelled to hold more than one job for reasons outside of their control, for example to achieve a high enough salary or to enable them to manage other commitments.

Respondents were able to comment about the nature of their multiple jobs, which revealed the breadth of their individual experiences. Answers included university lecturer, bank nurse, chiropractor, flight nurse, specialist nurse (e.g. respiratory), midwife, outreach work, nursing home, out of hours nursing, travel clinic, walk in centre, CCG Lead Nurse. Some indicated that they held three different jobs, and one respondent listed five, writing:
‘To balance my family life I work 16 hours a week as a practice nurse. I also work from home for [the] Open University as a practice tutor for pre-reg nursing students 5 hours a week. I have 3 zero hours contracts as a staff nurse, district nurse and smoking cessation advisor and usually work 3-4 shifts a month. Whilst having 5 jobs sounds excessive it is much easier than one district nursing post and much better for my stress levels and my family.’

Pay Band

There is no agreed pay scale for nurses working in general practice. Respondents were asked which pay band reflects their salary.

Pay Band	Number of GPNs	Percentage of total respondents
4	24	0.7%
5	453	13.3%
6	1299	38.1%
7	801	23.5%
8	360	10.6%
Nurse Partner	54	1.6%
Prefer not to say	414	12.2%
Other (please specify)	430	

38.1% responded with Band 6, and 23.5% with Band 7. This smaller number at Band 7 may reflect the number of more senior nurses within practices, who are in a position of managing teams, or may simply reflect local variation, experience or other reasons for seniority.



'My salary compared to that of my peers - who work in secondary care with the same qualification - is much less.'

430 respondents added comments, many of them indicating that they did not know which pay band they were on, or that their practice did not use pay bands, or that they were paid according to the Whitley Scale (the pay scales agreed by the General Whitley Council that preceded Agenda for Change pay scales that were introduced in 2004 www.nhsemployers.org/case-studies-and-resources/2015/03/afc-pay-scales).

Some nurses commented with an hourly rate, on a range between £14.60 and £22 and just 1.6% of respondents answered that they were a Nurse Partner.

Increments based on performance

Respondents were asked if they had increments applied to their salary based on their performance. The large majority, representing 81.5%, responded negatively. 9.7% responded yes, and the remainder gave qualified answers or in some cases were unsure. Comments included:

'As far as I understand it, as I become more skilled - and bring in more money for the practice, I will hopefully have some reflection of this in my pay. If this does not happen then I may move on, as at the moment Practice Nurses are difficult to recruit where I live so the nurse is in a position of strength (for once).'

'No - within general practice the majority of staff have to fight and negotiate for ANY form of salary increase/enhancements/increments. GPS are classed as private employers and so staff do not benefit from NHS recruitment / salary initiatives i.e. "Agenda for Change "!'

'No, I had a pay rise due to handing in my notice and 2 weeks prior to leaving the partners apologised and offered me a pay rise in order to stay which I accepted. I have worked at the surgery for 4 years and this was my only pay rise.'

'No, Practice Nurses are mostly employed by GPs who can pay us what they like. Whilst trying to negotiate my own pay rise last year (the first for 6 years,) I rang round several other local surgeries to find that Practice Nurses, who are all doing the same job get very different salaries and remuneration.'

'No. Whenever I have completed some training that means I gain a new skill I have had to negotiate an increase in my salary to reflect the new role I am performing. Other colleagues who are uncomfortable doing this have had no increase in salary.'

'We do not have an incremented pay scheme at work and do not know a GP surgery that does. I feel this would be a worthwhile structure as you can see where you are and where you are likely to get to if you continue to broaden your practice base skills/specialist areas…The surgeries I have worked in have all compared the current practice nurse salary to the agenda for change pay spine but have never taken on the incremental pay.'

Do you think your salary reflects your role?

Respondents were able to respond to this question with free text. Approximately 35% answered 'yes' or equivalent. The remainder (65%) either answered 'no' or gave an equivalent negative response, in some cases emphatically so. Some answers entered into more detail about their reasoning for their answer. That two thirds of General Practice Nurses believe they are not properly remunerated should be a cause of concern to their employers and to commissioners responsible for staff retention and workforce planning.

A selection of typical comments is given below:

'We have quite a bit [of] responsibility, within lone working, chronic disease management and being encouraged to undergo nurse prescribing, which I feel a pay band 5-6 does not reflect.'

'My role as clinical nurse manager, I am responsible for all clinical areas including infection control, health and safety, policies with the practice, purchasing, education, invoicing and claims for enhanced services. Managing all if this gives me a remuneration if £15.98 p/h.'

'No. I am the clinical lead nurse. I mentor junior nurses and advise on all aspects of the role to colleagues. I am paid the equivalent of £15 / hr gross, which I do not feel reflects the degree of responsibility, stress, organisational and department management and organisational skills that my role entails. I earned

more in the private sector in a nursing home without my degree and masters level qualifications.'

'No. I think we are taking on more and more responsibility. INR clinics, 24 hour blood pressure monitoring, post-natal checks, increased number of childhood/teenage immunisation, medication reviews, annual chronic disease checks, over 75 health checks, NHS health checks, smears, injections, phlebotomy etc. to name but a few.'

'Not at all. I am a supplementary and independent prescriber and my salary compared to that of my peers who work in secondary care with the same qualification is much less. I work very much in isolation and am often the only clinician on the premises which carries a great deal of autonomy and responsibility.'

Hours of work

The number of hours worked shows a very broad spread, with the large majority of nurses working between 16 and 40 hours per week. This data supports the comments made by respondents (see below – why nurses entered general practice) around the importance of flexibility and work-life balance.

Number of hours worked	Number of GPNs		
	Job 1	Job 2	Total
up to 5	15	194	207
6 to 10	57	268	318
11 to 15	138	118	238
16 to 20	465	76	517
21 to 25	681	18	696
26 to 30	661	9	670
31 to 35	556	6	561
36 to 40	770	9	777

Respondents were able to add additional comments. Some respondents commented that they worked up to 50 hours per week, and many commented that their hours varied from one week to another.

Hours of unpaid overtime worked per week

Working some unpaid overtime is not unusual for many GPNs. The table suggests that many nurses are working thirty minutes to an hour more than their contracted hours each day. Less than one third of those who responded report doing no overtime at all.

Number of unpaid hours worked	Number of GPNs	Percentage
None	1027	31.3%
1	573	17.5%
2	685	20.9%
3	359	10.9%
4	208	6.3%
5	147	4.5%
More than 5	280	8.5%
Skipped question	*126*	

Working evenings and weekends

Unsocial hours worked	Number of GPNs	Percentage of total respondents
Weekends	630	18.5%
Evening sessions (after 6pm)	1109	32.6%

32.6% work some evening sessions, and 18.5% work weekend sessions. It should be noted that the question specified 'evening working' as after 6pm, so GPNs working up to 6.30pm for example, would be classified as working in the evening.

1829 respondents gave additional commentary around how often they do additional hours and whether this is remunerated at an additional rate. It is difficult to produce exact numbers around how many enjoy an enhanced rate, as not all nurses commented on this specific issue. The majority of those who did comment on this point indicated that they received normal rates of remuneration, in some cases pointing out that this was determined as a policy by the CCG, within certain hours. For example, enhanced rates only applied after 8pm. Only a very small number indicated that they received additional payments, and these were typically 1.5 times their normal salary rate.

‘The number who report having less than 20 days annual leave is a cause for concern.’

Reasons given for undertaking out of hours work included flu clinics, family planning clinics, to reduce pressure on Accident and Emergency, as part of 7 day access pilots, or for regular extended hours sessions held one evening per week or a Saturday morning.

Many of the survey respondents indicated elsewhere that they chose General Practice Nursing because it provides flexible working hours and so some evening and weekend working may reflect this choice and opportunity for flexible hours.

The comments below reflect the views of nurses in relation to hours worked in the evening and weekends and the concern regarding the current government drive to have routine NHS services accessible for patients 7 days a week (NHS Commissioning Board 2012 - www.england.nhs.uk/everyonecounts)

‘GP nurses are often very good nurses that have opted for this work because of the hours. If they are forced to work unsociable hours we may well lose some of them from the NHS.’

‘7 day working within general practice as hoped by the government will need extensive financial investment - there is no point is expecting current staff to cover this. One of the main problems with practice nursing is the GPS are “private employers” and so anything goes with regards to practice nurse / team terms & conditions / salary - there is no “ clout “ from the CCG / Government to ensure we are adequately reimbursed in salary / holidays / training needs - to the extent the rest of nurses are in the NHS. CCG etc. sympathise but do not have the power to ensure GPs are adequate employers and for practice nursing to proceed and expand to a new area this needs to be resolved.’

Annual Leave

Nurses were asked how many days annual leave they are entitled to (pro rata).

Number of days of annual leave	Number of GPNs	Percentage
19 or less	222	7.5%
20	267	9.0%
25	1271	43.0%
30	818	27.6%
35	381	12.9%
Other (please specify)	608	
Skipped question	*446*	

This range appears to broadly reflect what one would expect to find in the workforce. However the number who report having less than 20 days annual leave is a cause for concern.

The 608 other comments included some who stated their numerical annual leave in other forms, and some who made comments regarding the reality of negotiating with GP partners for annual leave terms, for example retaining enhanced annual leave for long service built up with a previous employer.

This situation stands in stark contrast to nursing colleagues employed by large provider organisations, whose terms and conditions are determined at a more collective and remote level, and whose remuneration is aligned with the ‘Agenda for Change’ pay scale (www.nhsemployers.org/case-studies-and-resources/2015/03/afc-pay-scales).

Indemnity Cover

It is an NMC requirment to have indemnity for professional registration (www.nmc.org.uk/standards/code/). Nurses were asked who provided their indemnity cover. Whilst 66.4% of respondents said their employer provided their indemnity cover, others had their own cover, and 0.5% of respondents stated that they did not have any indemnity cover.

There were comments made about the increasing cost of indemnity and how some employers were refusing to pay for it. It is also of note that whilst the Royal College of Nursing (RCN) does not provide


Contour

‘Often patients think a Practice Nurse is someone practising to be a nurse.’

cover for employed nurses, a significant number of respondents commented that they are RCN members in response to this question. This suggests that some nurses have assumed that the RCN provide their indemnity.

The following examples illustrate the comments received on this subject:
‘BIG ISSUE - MDU have just increased my annual indemnity which the GPs pay from £695 per year to £6700 per year from Oct 2015 onward. My role may be made redundant as I am now ‘too expensive to insure’. I also know of nurse prescribers facing a significant increase and who have been stopped from prescribing as they are now ‘too expensive to insure’. This is crazy... shortage of nurses, shortage of GPs… Held to ransom by greedy insurers and seemingly none of our professional bodies with the clout or authority to tackle this at national level.’

‘As a group of practice nurses we asked our practice manager to clarify this for us. That was about 6mths ago...still not heard!! Think about this periodically and it is concerning but then you are so busy in work and so stressed by the time you come home that it goes out of your mind again.’

‘My employer previously. However, I was being asked to change my contract to self-employed and get my own cover, I’m not doing this, another reason why I’m retiring.’

‘This has been a nightmare to sort, it is still being reassessed. GP contractors can be covered under a group scheme, which will include the practice nurses and employed staff; but because we are nurses we are not allowed to be involved in this scheme and must pay individually for our staff should we choose to. For 3 nurse partners alone the cost this year is £27000, with additional payments for our salaried doctors.’

‘This is an area that needs significant national consideration as it is blocking patient services and delivery of a scheme the government is trying to drive. I am particularly anxious as I have discussed this with some colleagues considering passing this cost directly to nurses - that is probably anything between £450-£1000 depending on the extent of their role! Please help!’

Job Title

Respondents were asked whether the job title ‘General Practice Nurse’ was used in their place of employment.

General Practice Nurse title	Number of GPNs	Percentage
Yes	1227	37.0%
No	2086	63.0%
Skipped question	*92*	

The survey asked what alternative job titles were used in the practice. The most common alternative title used is ‘Practice Nurse’ (77%). Respondents also noted that other job titles Nurse Practitioner, ANP (Advanced Nurse Practitioner) or Sister were being used. From the data it is clear that either Practice Nurse or General Practice Nurse are the most common job titles in use in this setting.

Many commented that the title of ‘Nurse Practitioner’ needs to be regulated. Some liked the generic title of General Practice Nurse/Practice Nurse, whilst others found it too vague. Some typical comments included:

‘A very contentious issue! Often patients think a Practice Nurse is someone practising to be a nurse. Also titles vary in different locations so no real consistency or patient understanding of the complex and challenging job we now do.’

‘It does not reflect the experience and skills that I have, there is no differentiation between a newly qualified nurse, or someone new to general practice, and a senior nurse with years of experience and skills.’

‘I’m concerned that there is a variation in the use of title especially around Nurse Practitioner or Advanced Nurse in Primary Care often without formal academic qualification/experience/activity to validate its use - confusing for patients and other clinicians alike.’

‘It is a pity that the nursing establishment never

sorted out an accredited recognised course for Practice Nursing and for nurse practitioners. Some nurses seem to just choose one of these titles with little understanding of what the title really entails- patients don't recognise all these different titles anyway - to them you are always a nurse - they are always very happy to see you when you can sort them out to their own satisfaction.'

'I prefer the term General Practice Nurse. Firstly because some patients think Practice means you are training, not that you work in a [GP] Practice, secondly because I think GP and GP Nurse are a bit clearer to the public that you both work in General Practice.'

'I think it's great ...a bit old fashioned but people understand it and I think it reflects my level of training and status. I am concerned over HCAs using the title 'nurse' which is happening.'

'I think we should be referred to as primary care nurse, in order to shift mind-sets towards integrated care and whole primary care nursing teams.'

These comments do indicate a degree of dissatisfaction with the most commonly used title of Practice Nurse. Arguably, what is most important, however, is the patient's understanding of the role and the scope of competence of the nurse working in a GP practice – and this may be best conveyed by a title awarded against a set of education and practice standards which are regulated by the professional body (NMC).

Line Management

The survey asked the respondents for the position of their line manager. The responses show no overwhelming rule – General Practice Nurses either report to practice managers, or to GPs or, in the case of junior nurses, to their senior nursing colleagues. However the Practice Manager appears to be a default option in many practices that employ just one nurse.

Position of GPN's line manager	Number of GPNs		
	Job 1	Job 2	Total
Senior Nurse	800	213	958
Practice Manager	1668	136	1715
Nurse Partner	48	15	63
General Practitioner	929	85	969
Other	150	223	359

Responses to 'Other' included self-employed, agency, Clinical Commissioning Group, Chief Executive of a private company, Director of Nursing, Nurse Practitioner and Team Leader. Some respondents specified that they are the Nurse Partner or Lead Nurse in their practice, with no line manager.

Annual Appraisals

Respondents were asked if they have annual appraisals.

The number of respondents who receive an annual appraisal was encouraging, with more than 80% engaging in a review of their performance each year. This is particularly relevant given the introduction of revalidation by the Nursing and Midwifery Council in April 2016. For comparison, the RCN also found that 80% of respondents had an annual appraisal in 2009, whilst the RCGP reported that a higher proportion (93.9%) had an annual appraisal in their 2014 survey.

In receipt of an annual appraisal	Number of GPNs	Percentage
Yes	2675	80.1%
No	115	3.4%
Sometimes	549	16.4%
Skipped question	*66*	

However, for almost 20% of the respondents, there was a lack of engagement with an annual appraisal process. It must be remembered, too, that engagement with the process does not always reflect a high quality experience, which was highlighted in the comments.

Some typical comments included:
'All staff are supposed to have annual appraisals but the nursing team are often not prioritised and this

‘Over 28 years I’ve had about 5 appraisals in all. The problem is that GPs are not trained to be managers.’

can lead to an 18 month-2 year review.’

‘Although these are performed by the lead nurse and feels like a paper exercise that needs to be completed for QOF. There is no guidance as to performance, service gaps or requirements.’

‘Contractually I’m supposed to have one annually but in experience I find I have one when it’s a QOF indicator for which the practice will be remunerated for doing! … Although with the recent NMC revalidation the surgery will now take this seriously and I am just preparing for the first one.’

‘In my current job!! But over 28 years I’ve had about 5 appraisals in all! The problem in GP land is that GPs are not trained to be managers and usually need to be chivvied by efficient practice managers to get nurse appraisals done. Experience has shown me that those practices that have got this right, have clerical or clinical managers who understand their role and ensure that all the GP administrative requirements are fulfilled.’

Who carries out the annual appraisal?

Responsibility for the annual appraisal	Number of GPNs	Percentage
GP	1681	53.3%
Practice Manager	700	22.2%
Nurse Manager	770	24.4%
Skipped question	*254*	

The majority of the 843 respondents who commented further on this question indicated that it was a combination of staff who carried out their annual appraisal: usually the GP in conjunction with the Practice Manager. It is interesting that there is a substantial difference between the named line manager of the nurse (mostly a practice manager) and the person with whom they have their annual appraisal (mostly a GP or a senior nurse). This may reflect the need for a greater understanding of their clinical expertise when conducting an appraisal rather than general aspects of their performance within the review.

NMC Revalidation

Asked whether they had considered how they would meet the requirements of NMC revalidation, 80.7% of respondents said yes and 19.3% said no (80 people skipped this question). These figures are encouraging, given that at the time of the survey the date for implementation had yet to be agreed by the NMC.

Respondents commented positively regarding actions they plan to undertake in order to meet the requirements of re-validation, which included attending study days, courses and practice updates; compiling their records into a portfolio, possibly using an online tool; collecting staff and patient feedback; further reading and online studying; appraisals and clinical supervisions; attending meetings to discuss revalidation; and writing reflective pieces about their experiences of CPD.

Those with concerns around the process of re-validation were worried about the time required to complete it alongside their demanding workload, access to training, fees for online portfolio tools, insufficient information or support and not having a senior nurse to act as their confirmer.

Some of these anxieties are shown in the comments below:

‘It will take a great deal of work, and as understaffed and admin time minimal at work there will be no provision to undertake this during work time. Job satisfaction and motivation very low, with no immediate remedy, salary appalling with no pay rise/ increment for years. Thinking seriously about leaving Nursing, at a time when every incentive should be made to support and encourage Nurses to stay in the profession.’

‘I have been planning this, although I am struggling a bit as I don’t get any protected time.’

‘Keeping clear documentation of work and training as well as reflection are going to be important. Time is going to be the problem.’

‘I am very lucky to have a supportive GP and


COMMUNITY SPE
PRACTITION

'32.6% of all respondents indicated that they are an independent prescribers.'

practice manager who encourage all members of staff to update, we are very forward thinking and motivational and enjoy keeping up to date to enhance our knowledge and skills, this will not be a problem to me, just finding time to reflect.'

'I have been looking at RCN website and NMC guidelines but need to know more about what's expected and work out how I am going to manage my time & commitments to meet the requirements necessary to re-validate - have also been looking at early retirement or reducing my hours.'

'Concerns me as keep written portfolio, but not sure re doing it online. All sites seen seem to be going to charge! Already pay RCN/NMC etc., feel another charge, feel reluctant.'

'I am concerned as I am the only nurse in the Practice. Am hoping in my 2nd job where there is a senior nurse I may be able to be signed off. Also networking and discussions are hard as a lone practitioner.'

'With some difficulty as I am the only Registered Nurse working for a single-handed GP. However, our local Practice Nurse forum is working towards us supporting each other and using the forum as a way to "sign each other off" and give each other help and support.'

Respondents were asked whether they have access to a clinical supervision. The number with no access to clinical supervision is of particular concern and is reflective of the nature of many nurses working in general practice, which can be professionally isolating and lack easy access to both formal and informal contact with peers and senior colleagues.

Clinical supervision	Number of GPNs	Percentage
Yes	1259	37.9%
No	1369	41.2%
Sometimes	695	20.9%
Skipped question	*82*	

Informal arrangements for clinical supervision were commonly described in the comments, and respondents revealed a variety of positive and negative experiences, for example:

'I feel that the clinical supervision available locally is largely inadequate and does not properly meet my needs. I have therefore sought out my own clinical supervision with a colleague outside of the area at my own cost and in my own time.'

'I have a pastoral supervisor and a clinical supervisor who I meet with monthly, to look at my prescribing and clinical work, we have a daily meeting when we discuss cases and areas of concern.'

How nurses accessed clinical supervision revealed an extremely broad range of answers. Those who do have a regular clinical supervision were asked whether they could access this during working hours, to which 60.7% of respondents answered yes and 39.3% answered no.

For those who could not access clinical supervision during working hours, this places additional pressure on the nurses to manage their professional supervision within their own time, rather than it being considered as part of the requirement to maintain their professional competence.

Qualifications

Respondents were asked if they had a specific qualification in General Practice Nursing.

Qualifications	Number of GPNs	Percentage of total respondents
SPQ General Practice Nursing (NMC recordable qualification)	362	10.6%
GPN Foundation Programme	112	3.3%
Advanced Nurse Practitioner (Primary Care)	277	8.1%
Nurse Practitioner (Primary Care)	300	8.8%

In addition, 32.6% of all respondents indicated that they are an independent prescriber and 25.8% said that they are an NMC qualified mentor.
The survey also asked when respondents last updated their mentorship training.

Most recent mentorship training update	Number of GPNs	Percentage
Within the last year	400	30.0%
2 years ago	165	12.4%
3 years ago	90	6.8%
More than 3 years	678	50.9%
Total responses	*1333*	

The NMC Mentorship qualification needs to be updated annually by the university that provides the students for the placements. For those who have not updated their qualification for 3 years or more, they are likely to have challenges in supporting students on a curriculum that may have changed during that time: the risk of being out of date with the teaching and learning needs of students is estimated to apply to more than 50% of all GPNs who hold the mentorship qualification.

Respondents were asked whether their practice provided placements for medical students and pre-registration nursing students.

Provision of placements for students	Number of GPNs		Percentage Yes
	No	Yes	
Medical students	887	2095	70.5%
Pre-registration nursing students	1761	918	29.7%
Skipped question	*311*		

Our findings are similar to the RCGP 2014 survey, which found that 25% of respondents provide pre-registration placements for student nurses. It is disappointing and concerning that such a limited number of practices offer the opportunity for placement learning to nursing students. If students are to be introduced to the diversity and challenge of work in a GP practice, and the rewards that it brings, it is important that they are able to undertake a placement during their pre-registration training. This becomes even more important when considering the concerns around staff retention and replacement. These views are echoed by nurses who gave further comments, shown below.

'General practice is only going to continue to grow, and with the difficulties of recruiting GP's there is a massive opportunity for nurses to develop their skills and become real specialists in this area. I think more time needs to be put into pre-reg nursing education around general practice and that a placement in the area should become mandatory. With the emphasis on caring for people in the community and avoiding hospital admission it surely makes sense for student nurses to spend more time in this area.'

'I would like to see more GP practices supporting pre-registration nurses in placements and actively recruiting newly qualified nurses, as practice nurses are hugely under-represented in both these areas. There is a misconception that to apply for a practice nurse position you need to have many years post qualification experience, when in fact all you need is an open-minded employer willing to invest the same time and money into training newly qualified staff as someone who has pre-registration experience. Preceptorship is not complex, time consuming or difficult to arrange and is the only specific requirement of a newly qualified nurse in comparison to those with experience.'

'Practice nursing is extremely rewarding for those who wish to run with the role and develop themselves. It is, I think, in many quarters still looked at as a nice, quiet job before retirement which it most certainly isn't. Nurses need to be very experienced and well trained before being left to face to face consultations with patients. We are responsible for the bulk of the work remunerated through QOF and as such it is up to us to make sure we are seen to be professional and knowledgeable, as this job will continue to take on the care of growing numbers of patients with chronic conditions, in the face of depleted numbers of GPs in the next 10 years.'

'Practice Nursing is, I think, in many quarters still looked at as a nice, quiet job before retirement which it most certainly isn't.'

Professional Development

Respondents were asked what extent their employer supports/encourages their professional development and who pays for their Continuing Professional Development (CPD):

Support for professional development from employer	Number of GPNs	Percentage
Always	1804	57.4%
Sometimes	1138	36.2%
Rarely	164	5.2%
Never	39	1.2%
Skipped question	*260*	

Responsible for payment to support CPD	Number of GPNs	Percentage
My employer	1655	53.6%
Self-funding	134	4.3%
A combination of sources	1298	42.0%
Skipped question	*318*	

These figures are encouraging and indicate a broad level of support by employers for nurses' professional development. However they also indicate that there are a minority for whom professional development is not supported.

460 respondents gave additional comments, which provide more information about the reasons why people found access to professional development difficult. Chief among these were time and cost. Where nurses wished to undertake training days, cover would need to be organised for their work.

A typical comment was:

'The Nurse Team Manager is very supportive, particularly with courses that are a few hours to a day or two. The GPs/Practice Manager, less so. I did a MSc research project at the surgery - I paid and did it fully in my own time, with very little support or interest from the surgery. I also took a week's annual leave to do a contraception course I wanted to do.'

The question was asked if there were a specific number of days allocated for professional development. 25.3% said yes, 74.7% said no (298 people skipped this question). This supports the comments given around this subject, which tend to suggest that training is mostly organised on an ad-hoc basis, and negotiated on a personal level between nurses and their managers. Almost half of respondents (48%) indicated that they had to take annual leave or unpaid leave all or some of the time in order to access professional development (277 people skipped this question).

Respondents were asked what educational or development opportunities were available to them, and the answers included NHS training days, statutory and mandatory training, university-based modules/courses, sponsored training days, online modules and informal learning from colleagues.

Professional development undertaken in the last year by respondents included postgraduate or degree level modules at university, study days held by their employing organisation or a CCG, commercially sponsored study days, conferences, online training modules and distance learning. Only 0.6% of respondents had not undertaken any professional development in the last year (396 people skipped this question). This is particularly encouraging, but the lack of a systematic way in which CPD is planned, supported and accessed remains a concern.

Respondents were asked about whether they felt there were gaps in their nursing knowledge, and the areas of their knowledge and skills which they considered required further development. Only a quarter of respondents did not feel they had any gaps and many nurses commented on the need for continuous improvement and learning to keep their knowledge and skills up to date.

'There are always new guidelines and updates for all the above and therefore as a PN I am constantly developing my skills and knowledge to try and keep up to date and ensure evidence based practice.'


Systolic BP.
SNIP SNIP SNIP

‘I am sure there are a lot of very well qualified hospital nurses who are keen to move into primary care, but the pathway isn’t clear.’

‘There will always be gaps, it is impossible to know everything; however, it is important to recognise your limitations and lack of knowledge. This enables you to continue developing and seeking help when you cannot manage a problem. Keeping up to date with ongoing changes is difficult.’

Further comments about education and training focused on the need for:

- Student placements and mentorship training;
- A general foundation programme for those beginning as a GPN;
- A clear career pathway throughout and
- The standardisation of training to reduce variation across practices.

‘A common foundation programme that everyone has access to is important. We need to recruit younger nurses and give a transparent career pathway. It is a fantastic environment to gain huge amount of knowledge and skills and to really help people. Ongoing updates - similar to GP hot topics scheme is essential for those involved in same day acute care/minor illness as well as chronic disease management.’

‘Need national drive to standardise and ensure opportunities for those wishing to come into General Practice Nursing as well as a strong career framework. Whilst this is in development nationally it still remains long overdue. Also need to ensure nurses released to update.’

‘I try to keep updated on General Practice Nursing skills in CDM etc. but we also need help in keeping updated in all the changes in local service provision-referral pathways, new services, closed services, changing roles of other health professionals.’

‘Every area should have a Practice Nurse Facilitator to oversee education and standards of GPNs - to offer advice on accessing training, to pick up those not keeping up to date etc.’

‘I think we need to consider some general foundation training for new practice nurses and we need to encourage practices to engage with student nurse placements. It is only by focussing on these things that we can ensure we have a future workforce fit for purpose. ‘

‘I feel a placement in general practice should be a mandatory part of a student nurses training. It would be inconceivable that a student nurse wouldn’t go on a medical ward prior to qualifying, so why is it OK that they don’t do a placement in general practice? It is the first point of healthcare access for the public and such a large volume of people are seen and treated within general practice. There needs to be an understanding by nurses of the importance of general practice, how it works, what the patient experiences, and to encourage more student nurses to seek a career in this area.’

‘We need widespread mentorship training to become mandatory to train the ongoing workforce. Unless it becomes mandatory we will not be released to do it. We need pre-reg students regularly spending time in general practice to consider practice nursing as a career option. We need a career structure whereby qualified nurses can then specialise and come out equipped with the necessary experience and qualifications in cervical screening/asthma/diabetes/hypertension/immunisation etc.’

‘Until there is a financial incentive to take students (which I really enjoy doing) very few practices will take students. The training we are able to offer is very time consuming and a great deal of time and effort is put in.’

‘I am sure (like myself) there are a lot of very well qualified hospital nurses who are keen to move into primary care, but the pathway isn’t clear, and not possible without clinical support. There should be a clearer pathway into primary care - possibly part time transition courses - that are advertised in the hospital setting, allowing for a flow of experienced staff.’

‘This needs to be more explicitly required, monitored and documented. Too many nurses are not trained and rely on QOF boxes and templates to dictate the care they give without understanding the rationale for and implications of what they do. There should be a national accredited network of clinical supervision, delivered locally but administered centrally to bridge

this gap and ensure access to good quality education for all nurses resulting in better care for patients.'

'It's very inconsistent and variable depending on the GP practice where nurse is employed. Extremely difficult to standardise and impose training and support as the GP independent contractor status can be a barrier. As GPs employ nurse directly they have influence over access and time given for nurse to do training/development. We should be aiming for a minimum standard for training for new nurses, standard induction and an ongoing training/development programme.'

'*My experience is that access to training and development varies between practices, and can be at the whim of the employers. CCGs provide training opportunities, funding and access to support yet often General Practices feel this is not enough and will not allow their nursing staff to access training. I believe there should be more mandatory requirements for GPs as employers to provide learning and development opportunities to their nursing staff. For too long, General Practice has not been monitored regarding their obligation as employers to provide access to this for nurses. Nurse education is often seen as if secondary importance to medical education. The culture of General Practice must change and adapt so that they can become learning organisations for all staff.'*

Entry to and preparation for General Practice Nursing

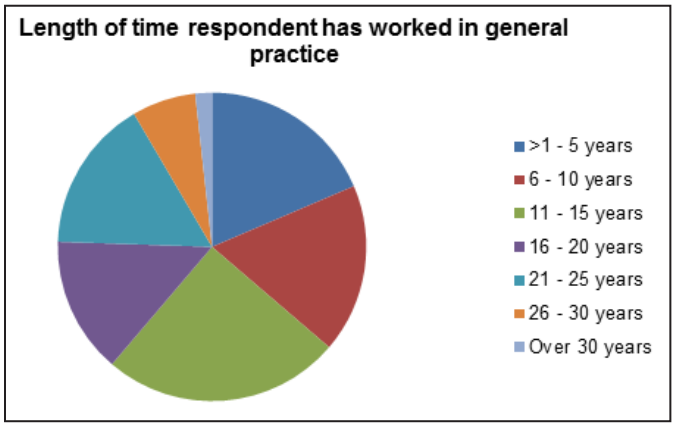
The survey asked where respondents worked prior to general practice and allowed free responses on this question. Answers reflected that nurses came to general practice from every field of nursing and from both hospital and community environments.

Common answers included:

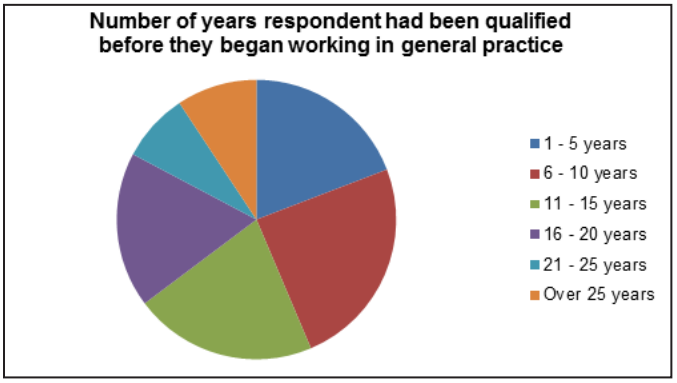
- District Nursing
- Midwifery
- Health Visiting
- School Nursing
- Community Nursing
- Hospice
- General Hospital
- Acute care
- Surgical ward
- Accident and Emergency

Others indicated that they had previously worked overseas, as a bank nurse, or in a private hospital.

Nurses were asked how long they had worked in General Practice. They were given specific year options from 1 year up to 30+ years. The answers tend to suggest that some respondents rounded their answers to the nearest five years, as the number answering 5, 10, 15, 20 or 25 years was higher than for other numbers.



We then asked how many years respondents had been qualified before they entered General Practice Nursing, with options from 1 year up to 25+ years. As with the above question, some respondents gave an approximate answer to the nearest five years. The pie charts therefore show the responses grouped in five year time bands.



Respondents were also asked when they planned to retire.

'The hours and the pay are good, but the patient satisfaction is fabulous.'

Planned retirement date	Number of GPNs	Percentage
Within the next year	154	4.6%
Within the next 2 years	188	5.6%
Within the next 3 years	199	5.9%
Within the next 4 years	123	3.7%
Within the next 5 years	472	14.0%
Within the next 10 years	929	27.6%
More than 10 years	1300	38.6%
Skipped question	*40*	

33.4% of all respondents plan to retire within the next 5 years. This headline figure is a national average and does not show the numbers at a local level, where significantly more or less nurses may be due to retire in the next few years in different locations. This finding confirms the trend identified in an earlier survey (RCGP, 2014), that a large proportion of experienced nurses in general practice are nearing retirement.

Selecting General Practice Nursing as a career

Respondents were asked why they chose to enter general practice. The answers to this question tended to fall into two categories: those who entered general practice for a range of positive reasons, and those for whom their primary reason was because the working environment was preferable to other areas of nursing where they had worked previously.

The following comments reflect these two perspectives:

'I have been a matron for many years in the community and now work as an Advanced Nurse Practitioner in a surgery - I love admission avoidance and enjoy caring for people in their own environment - I have been able to give more effective rewarding care.'

'The hours and the pay are good, but the patient satisfaction is fabulous. One-to-one care and the ability to follow people up. Very satisfying. Also, I've been able to progress amazingly. In London I was a commissioner for 2.5 years after becoming a Nurse Practitioner. I've specialised in COPD and Asthma, Diabetes and CHD and love it. The variety of each day is very stimulating.'

'After 22 years as a specialist nurse, I decided to move into a more generalist role. This gave me the opportunity for learning about a range of acute and long term conditions and I could use my enhanced consultation skills, prescribing and experience of primary care based nursing to move into the role of GPN (as a nurse practitioner).'

'Less bureaucracy - less stress/professional pressure and the opportunities to actually take care of patients from a holistic perspective.'

'Because I quite liked the idea of building longer lasting relationships with patients. Because working in A&E was becoming intolerable and I did not feel we were offering a good service so there was no job satisfaction for me.'

'A change in personal circumstances meant I could no longer commit to working on call or all night duties which made it impossible for me to remain in that role. General Practice allowed me to remain in nursing.'

'After years of working nights and weekends I wished to work more normal hours that meant I could spend quality time with my family at the weekends.'

'Looked at different roles away from ward work due to increase in pressures, low morale, reduced time to give high standard of care and a lack of funding towards training. Managed to get a practice nurse role with training included. Variety of role biggest reason for change.'

'To have more autonomy. To be able to promote health and prevent patients needing to attend hospital. At the time A&E was in yet another crisis with patients on trolleys overnight and left in corridors. I wanted to provide good quality care and felt I could no longer do so in a hospital setting.'

'To make a difference to peoples' lives in promoting better health and to manage patient's in the community and at home to prevent hospital admissions and to prevent ill health and or worsening



‘After the drug companies stopped doing training, there has been very little training as GPs had to pay for it.’

of long term conditions. To work with patients of all ages and to have better continuity of care. To be in a stable and secure environment and part of a smaller team where you are not just a number, where you may be more valued, and I saw it as a promotion and a role that I could develop and make my own until retirement.’

‘Whilst working in Intensive Care I realised that I was often just trying to pick up the pieces after many years of health neglect. Most patients died and it was quite depressing. I decided that I wanted to help people to care for their health and prevent the diseases that ended up in Intensive Care.’

A key question that the QNI wished to answer through this survey was the preparedness of nurses entering general practice, and to identify areas in which they felt under-prepared.

The respondents were asked whether there were any areas of GP nursing for which they believed they were unprepared. Approximately 10% of respondents did not feel they were unprepared, whereas 15% said they were unprepared for all areas. The responses regarding the need for more preparation focused on the following areas:

- Extensive training, study and practice in unfamiliar areas, such as cervical screening, baby immunisations, travel health, sexual health, ear care, and chronic disease management, including diabetes, COPD and spirometry. Having specialist knowledge of all these areas, meeting high patient expectations and keeping up with constantly evolving guidelines were seen as challenges

- Coping with isolation and making autonomous clinical decisions after being used to working as a team

- Time management, in order to see many patients in a day, with a short time-frame in which to assess, plan and implement care for each patient

- Adapting to the change in employment e.g. working with colleagues who are also your employers, being employed by independent contractors who may have a poor understanding of the scope of nursing roles, learning to negotiate terms and conditions and not being subject to the same pay conditions as nurses on Agenda for Change salaries

- Computer skills, often working with a completely new computer system.

Nurses were asked how their employer supported them to undertake the GPN role in their first job in general practice. Respondents were able to select one or more of the options below.

Support for new role as a GPN	**Number of GPNs**	**Percentage**
Training	2573	82.2%
Induction	1944	62.1%
Observation of GPN	1669	53.3%
Preceptorship	680	21.7%
Skipped question	*276*	

More than 1000 nurses added comments to this question. The comments revealed that nurses experienced a wide variety in the level of support for the new role from employers.

‘Training/induction/supervision has been a huge problem for me. I was expected to work alone after 1 week despite not having practiced baby imms or smear-taking before.’

‘A lot of the required tasks were taught in house: watch one, be watched, then do one.’

‘Most of it was learning by experience. After the drug companies stopped doing training, there has been very little training available as the GPs had to pay for it.’

‘I had a one week induction with the opportunity to observe another GPN and other members of the team. My employers supported me to access several study days and courses over my first few months and years.’

'I underwent a Practice Nurse Induction course, so was able to visit and observe in a wide range of clinics. I then had teaching sessions with my mentor. I also worked alongside Practice Nurses at the surgery for the first 1-2 weeks.'

'I took responsibility for my own development and CPD and put myself on courses which I did in my own time.'

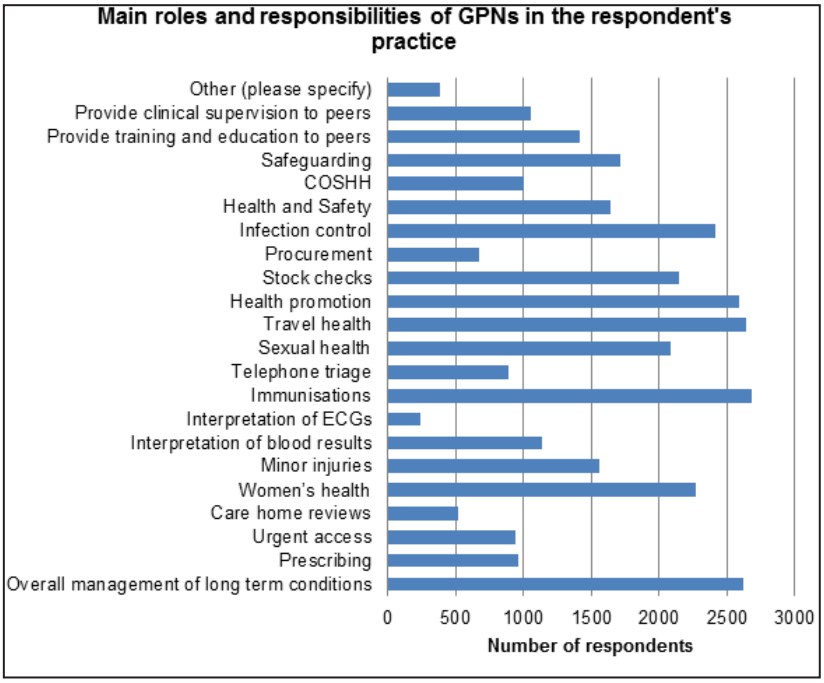
We also asked what professional development nurses undertook independently in order to prepare for their role. Common activities included extensive reading and research; training e.g. study days, courses, updates; speaking to other practice nurses or GPs; shadowing or observing staff in general practice; attending induction courses; and transferring experience from previous roles. About 8% of respondents said they did not do any preparation and many of these respondents emphasised that they learnt 'on the job'.

Respondents were asked if they had ever observed a GPN as part of their pre-registration community placements. 22% of respondents said yes, whilst the remainder said no.

Given that 90% of all clinical contacts take place in primary care (www.hscic.gov.uk/primary-care), it can be argued that more exposure to General Practice Nursing during initial nurse training would create a greater expectation of this as a career option at the point of qualification or in later years.

Roles and Responsibilities

Respondents were asked to indicate their main areas of practice. The chart below shows the areas of clinical practice most commonly undertaken by GPNs. It is significant when considering the pressure of demand on general practice (National Audit Office, 2015) that one of the most frequently identified areas of clinical practice is the management of long term conditions.



Other common areas of responsibility that were highlighted in the narrative data included wound care, ear care and anticoagulant monitoring. Phlebotomy, minor illness, smoking cessation and administrative reporting tasks were also mentioned. The QNI recognises the great breadth of knowledge required for the GPN role and the need for access to appropriate structured education and training. We are therefore developing new voluntary standards for General Practice Nurse Education and Practice, in partnership with QNI Scotland, to enhance the existing NMC standards for specialist GPN practice. This work builds on the development of the QNI/QNIS voluntary standards for District Nurse Education and Practice, published in September 2015: www.qni.org.uk/docs/DN_Standards_Web.pdf

Home Visiting

Respondents were asked whether they undertake home visits and 38.3% said they did. Tasks commonly undertaken in the home included management of chronic diseases, anticoagulant monitoring, flu vaccinations, bloods tests, blood pressure checks, ear care, spirometry, wound care, injections, ECGs, smears, urgent care and palliative care. Nurses also undertook annual reviews, holistic health assessments, care plans, falls assessments, admissions avoidance and learning disability

'More exposure to General Practice Nursing during initial nurse training would create a greater expectation of this as a career option.'

assessments in the home.

This question did not distinguish the frequency of home visits undertaken, and for some respondents this was a very occasional element of their role. The following comments illustrate the responses received about home visiting:

'But only occasionally. We are finding we have to take on more home visits as the DN team are being told that they cannot go to any patient who is not on their caseload so we have to go out to do ECGs, blood tests, annual reviews, flu vaccines, Doppler studies.'

'Occasional when patient is housebound – BP, asthma reviews, COPD reviews – the rest are done by District Nurse.'
'Do now have to do flu vaccines for residential homes and housebound patients, as community nurses no longer do as no time anymore.'

'Feel too much duplication. Lots of patients are under the district nurses/community matrons, and yet we're expected to visit the patients to perform long term condition checks for QOF. With the additional workload of doing childhood imms, we won't have any capacity to do home visits.'

Additional areas of responsibility

Respondents were also asked whether there were other areas of clinical practice that they considered GPNs should be responsible for. A common response was the management of long term conditions, particularly with regard to increasing the provision of care in the home for housebound patients and greater support in residential or nursing homes.

Other areas highlighted included minor illness and injuries; cancer care; mental health; contraception, including coil fitting; recruitment and training, for example of student nurses and HCAs; clinical strategy and decision making within the practice; and integration with district nurses and the wider community team.

Workload Pressures

The survey included an open question about the respondent's opinion of the appropriateness of the qualifications and training of the nursing team to meet the needs of the GP registered patients.
In the analysis of this narrative data, the comments of 55% of respondents referred to their team being without the right number of appropriately qualified and trained staff.

As the survey allowed open answers on this question, the range of negative responses was very broad, ranging from weakly negative to strongly negative. However the number and detail of these responses is a cause for concern.

Some of the respondents indicated that their premises would not allow for any expansion in numbers of staff. Others noted that they only had enough staff as long as no one was sick or on holiday. Others feared for the future as staff were due to retire and recruitment efforts were currently unplanned or had been unsuccessful. Others mentioned the growing local population or the increasing number of elderly and more acutely unwell patients attending the surgery, demonstrating an upward trend in demand for GPN services.

Some example comments included:

'NHSE formula suggests 25 nurse appointments per 1000 patient per week. This feels too little in an area of high deprivation and need for translation. Our consultation rate is twice the national average and our chronic disease lists are high. We are consistently looking at ways of managing care differently and tackling the wider determinants of health.'

'We are very lucky to have two excellent Health Care Assistants, but there is only so much they are able to do. As Registered Nurses our clinics are full up 2 weeks in advance, it is difficult for patients to access last minute appointments for things that need to be done ASAP such as Depo-provera injection. We are also losing many services in secondary care that are being bounced back to us, yet we receive no more funding or members of staff to facilitate those needs.'

'We have outgrown our surgery physically, we really need more nurses and the GPs acknowledge this but we have no physical space left to put them! We have



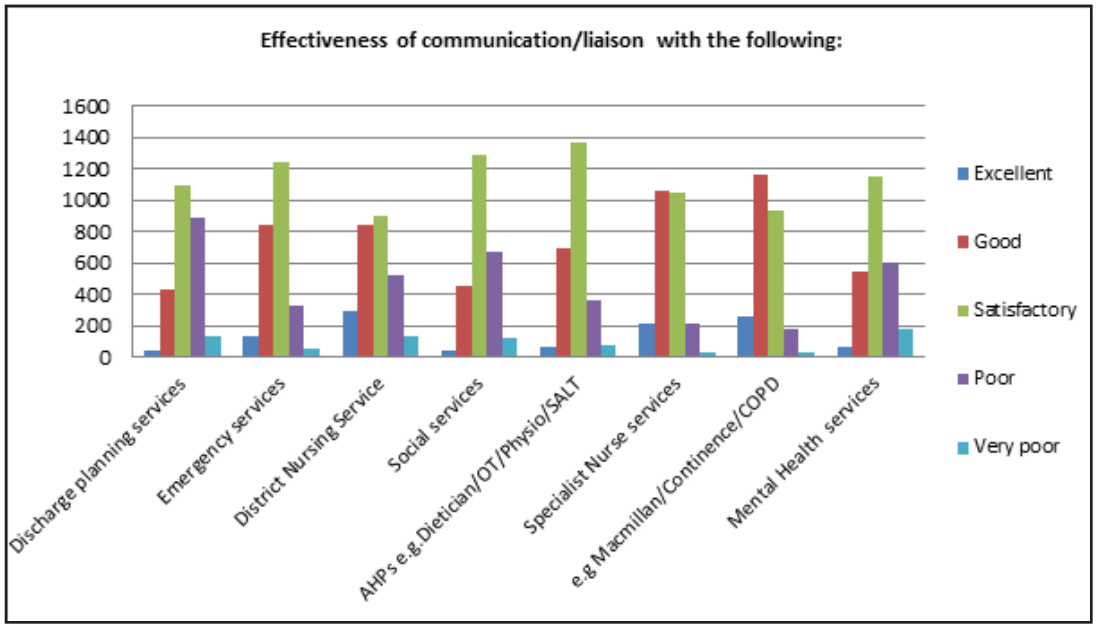
‘81.4% of respondents said they were able to refer directly to specialist services.’

been allowed to close the surgery registrations for 6 months as our [registered] list outstrips our building.’

Multidisciplinary working

The QNI’s survey of District Nursing (QNI 2014) highlighted major issues around multidisciplinary working and the problem of limited communication with some other services, in particular concerning hospital discharge. This was again shown to be an area of concern for GPNs when respondents were asked the question, ‘in your experience how effective is the communication/liaison with the following (services)?’

The responses are summarised in the chart below:



The comments highlighted that communication could be improved by using interoperable computer systems, having face-to-face meetings and co-locating services. Respondents also commented on the immense pressure that District Nursing teams are under, and that access to mental health services is particularly poor.

Whilst 81.4% of respondents said they were able to refer directly to specialist services and 93.8% indicated that they could initiate blood tests, the comments highlighted that overall, respondents were able to refer directly to some services only, some of the time. This demonstrates the variability in the way nurses in general practice are permitted to practice and the varied levels of autonomy given to use their professional assessment in referring patients to other services.

In relation to links with local care homes, respondents were asked about the policy of their practice to provide support to care homes, either with or without registered nurses. The comments revealed that support to residential homes (with no nurse present) commonly consisted of visits by GPs and District Nurses, less commonly visits by practice nurses, as well as some telephone advice. Support to nursing homes was mainly in the form of GP visits and telephone triage/advice.

61.6% of respondents said that they participated in strategy or development meetings in their practice, but just 9.6% of respondents represented General Practice Nursing at board level meetings, commonly for a CCG executive committee or CCG governing body.

Respondents were also asked if they knew how their work is measured by the practice, when reporting to commissioners. Over half of respondents to this question (56%) did not know and a significant number of people (1678) skipped this question. The Quality Outcomes Framework (QOF) (http://www.hscic.gov.uk/qof) was mentioned in 22% of answers, and other common responses included: feedback from patients, friends and family, inspections by the Care Quality Commission, clinical audit, activity data, patient outcomes, local and directed enhanced services (LES and DES), 360 degree appraisals, prescribing data, complaints, incidents, referrals, and hospital admissions.

General Practice Nurse skills

Respondents were asked for their views on the top three skills of General Practice Nurses. The most common responses included:

- Breadth of knowledge and skills (generalist specialist)
- Working independently/autonomously, including having confidence and using one's own initiative
- Communication and listening skills with those of all ages
- Flexibility and adaptability
- Managing long term conditions/chronic disease
- Building relationships and trust with patients, families and carers
- Keeping knowledge up-to-date, learning and evidence-based practice
- Health promotion and education
- Continuity of care, from 'cradle to grave'
- Holistic, patient-centred care
- Knowing when to signpost or refer on
- Team working
- Immunisations for children and travel
- Time management, prioritising and multi-tasking

There was a clear message that GPNs felt that the way in which their skills were developed and the training for this specialist role should be more standardised and that employment, terms and conditions and working practices should be agreed within all primary care services.

The following comments illustrate this view:

'All practice nurses should be working to the same structured guidelines, all GPs should understand these guidelines and support nurses just the same as all ward nurses have the same standards to work to, that way education needs would be clear and roles would be defined and pay could be standardised depending on skills.'

'Increasingly we are working with patients with multiple health conditions who previously would have been cared for within secondary care setting. We need to upskill GPN's, recognise this as a specialist arm of nursing and remunerate appropriately with consistency across the profession around titles, competencies and education.'

'I feel very strongly that there should be some standardisation of GPN education and training and that a recognised Practice Nurse Facilitator role in every area would co-ordinate this. In some areas GPNs work in silos with very little training (or competence) but as nobody asks nobody knows where as in other areas we are trained to Masters level, seeking out every opportunity to improve patient care and experience. As GPs mostly employ us there is very little overall governance. Maybe GP Federations and CQC will improve it, but CCGs should also be looking at the issue of GPN standards and succession planning.'

'I hope there will develop more specialist practice nursing degrees around the country so it can become a specialist area of the register, and that there becomes more regulation so you aren't at the mercy of what your GP employer wants to give you in terms of sickness, annual leave, pay etc. More regulation of that would be brilliant so that we are all rewarded equally for the level of work we do.'

'GPNs are at the mercy of their GPs and Practice Manager employers which means there is a lot of variation in pay, training, holiday, sick pay, indemnity cover etc. There are a lot of very good employers out there but likewise some are not so good. Some sort of standardisation should be introduced and GP's/ Practice Managers should be put under pressure/ encouraged to follow these standards with negative consequences if they don't otherwise they will ignore them!!'

'Practice nursing pay and conditions needs to be brought in line with Agenda for Change. Pay discrepancies vary too greatly between surgeries. There needs to be a basic Practice Nurse training before coming into General Practice or work with experienced nurses so they are safe to practice. As nurses progress or take on extra responsibilities their level/pay should reflect this.'

'GPNs are challenged by the indemnity issue; there is a risk charges may be passed directly on to individuals in some organisations. This would mean them facing

‘Although there is some overlap [between GPNs and DNs] each group has its own set of skills and the roles are certainly not inter-changeable.’

professional fees including NMC registration fee, indemnity cost, union fee and sometimes course fees. They do not have a formal pay structure (AFC); many have not seen pay rises for several years. Terms and conditions of employment for GPNs may well become focused via the various engagement and extended hours schemes as a consequence of collaborative practice - but if this isn’t managed well it may well become a career deterrent.’

GPN and District Nurse roles

When asked for views of the current trend in the sector suggesting that a General Practice Nurse might be able to undertake the work of a District Nurse and vice versa, the response was overwhelmingly negative. The respondents were emphatic about the differences in the two specialisms and the need for specific and appropriate preparation for each of the specialist roles. However, GPNs suggested that close working with DN colleagues would most effectively be achieved by co-location in the GP surgery.

The following illustrate the majority of responses:

‘Certainly they complement each other and shared care is practised. It makes more sense to me if the District Nurses are attached to a particular surgery where they can have access to the Practice Nurse team and the GP’s for meetings and discussions on difficult patients and their needs and how to resolve issues. In effect a multidisciplinary meeting which would help with clinical supervision and help the patient needs and outcomes.’

‘100 per cent not! The patients would not benefit. You would not be able to be “master” of either role. I would take early retirement if this change was implemented. For example, baby vaccinations - great skill and knowledge that is acquired over years not weeks is needed. There will be equivalent skills in district nursing that are gained by experience only.’

‘A practice nurse has a lot of areas to cover and so do district nurses to be interchangeable would mean less knowledge in each area where a practice nurse is expert at cervical screening could a district nurse become that experienced if not doing it daily and also district nurses are expert at leg ulcers as a practice nurse you would only know the basics and not become familiar unless you were dealing with that area of expertise regularly.’

‘Although there is some overlap, each group has its own set of skills and the roles are certainly not interchangeable. However, it would be useful to work much more closely or possibly belong to the same team which would enable the unique skills of each individual and team to care for patients who can attend the surgery and those who are housebound.’

‘Don’t agree, would only cause increased pressure on the nurse... try to spread us too far you dilute our skills, we then become good at very little but poor at a lot.’
‘Having had a dual role for a number of years there had been advantages with this, but as district nursing and practice nursing has changed immensely over the recent past trying to keep up with knowledge and skills needed for both roles would be very difficult in order to give a quality service for patients.’

‘I believe some aspects of our roles are similar, however many are very different and if roles are to be interchangeable a great deal of extra training, support and organization needs to be put in place.’

‘I feel there are many aspects where the roles are interchangeable but not in all areas and to make a generic community nurse would dilute the care they currently give. I feel we all work closely together at present and can support each other’s roles but the roles should be kept separate as patients’ needs can be complex and I don’t feel we would be able to give a good service if we needed to cover all areas of care given at present.’

‘I think the roles are too specialised, it would be impossible to learn all that was required. Instead they should share skills and work as a team but this is impeded at the moment due to General Practice Nurses being employed by independent providers, the issue of who is paying for their time gets in the way.’

‘Rather than the role be interchangeable I think there needs to be a better understanding of each other’s



‘There is much that needs to change to both plan for the next generation of nurses and to support those who make up the current workforce in primary care.’

role and how we can complement each other - the landscape has clearly changed from when I first started when this was the case - it’s very much about what has been commissioned rather than a common sense approach to using resources more effectively.’

‘We would never ask an ITU nurse and a general medical nurse to have interchangeable roles so why as DN and PN to do this. Just because we work in the community does not mean that our roles are the same. We have unique skills which are specific to general practice just as DNs’ skills are specific to their role. If the long term strategic plan is to have interchangeable roles this would require training and supervision.’

‘I would like to see [District Nurses] and [GPNs] working together to manage “the practice population” as often their housebound status can change. I would like to see [District Nurses] undertake training we as [GPN] have undertaken and manage their caseloads accordingly. I would like more regular meetings and a more collaborative approach.’

This provides conclusive and overwhelming evidence from the practitioners that the specialist roles of the GPN and the DN are not interchangeable.

This is a critical message for consideration by policymakers and those who are involved in creating new service models within vanguards in England.

6. Conclusion

The report provides a clear and detailed illustration of the current challenges being experienced by the General Practice Nurse (GPN) workforce. It provides a picture of a very skilled nursing workforce, enjoying their work with local communities and colleagues, but understanding that there is much that needs to change to both plan for the next generation of nurses who are needed in general practice and to support those who make up the current workforce in primary care.

Workforce is a pressing issue, with more than a third of current GPNs due to retire by 2020. This situation is generally well known by individual employers who are finding it increasingly hard to fill nurse vacancies in their practices. However, this report provides employers, service and education commissioners with conclusive data on the challenges of succession planning for the GPN workforce and the need to develop a robust strategy which will enable the workforce to be replaced with competent practitioners as the current workforce retires.

There is a need for appropriate preparation and support for those who are new to general practice, with a career structure that meets the needs of the registered population and is supported by appropriately commissioned education. In England, the GPN Career pathway published by Health Education England (HEE) in October 2015 will assist in articulating the GPN career and the expected skills and competencies at each level. There is now an urgent need for this framework, and the equivalent in the other three UK countries, to be translated into commissioned education and training for the new and existing GPN workforce across the UK.

The potential for the GPN workforce to meet the needs of the population is extensive, particularly in relation to health promotion, supported self-care, illness prevention, early identification of health issues, referral to other services, management of long-term conditions, and holistic support for the individual, family and carer.

Within primary care, GPNs are available for every member of the local population registered with the general practice service. They have the potential to support their GP colleagues in the team to a greater extent than they do currently; many already have the skills to not only assess patients, but to diagnose, prescribe and refer to other services.

It is vitally important that this highly skilled, competent and professionally regulated part of the workforce is given due consideration in the design of new models of primary care.

With appropriate education and training, a greater number of nurses working in primary care can develop these skills, which will help to address the current shortage of General Practitioners and provide an appropriate alternative to a GP consultation. With

just 10% of GPNs holding the NMC recordable specialist practice qualification in practice nursing (NMC 2001), there is an urgent need to enhance the existing NMC standards to ensure that they reflect the current education needs of the GPN workforce.

In support of succession planning and inspiring the next generation of nurses to select a career in General Practice Nursing, more exposure to primary care is required for student nurses. This includes an increase in the number of substantive placements with GPNs for those student nurses who have expressed an interest in a career in primary care. However, this cannot happen without an increase in the number of suitably qualified GPN mentors.

There is also a need to provide support to those who enter General Practice Nursing as a first post or after a career elsewhere in nursing. The environment of care and the scope of practice are like no others in nursing and require a period of transition and supported skills development.

That General Practice Nursing is a specialist area of nursing is in no doubt after the analysis of the data provided. It is recognised by the NMC as a specialist area of practice and this position is supported by the evidence in this report. Indeed, with a picture of increasing responsibility and more complexity in clinical practice, it requires more specialist skills than ever before.

The suggestion that this is a role that could be combined with District Nursing to create a generic community/primary care nurse was largely met with incredulity. District Nursing is a specialist area of nursing in its own right and it was considered by the GPNs that it would be clinically unsafe to attempt to span both roles. There was, however, recognition that the reinstatement of co-location of their District Nurse colleagues (in cases where the District Nurse teams had been relocated) would enable closer team working and benefit the patients and carers known to both teams.

With more than 3,400 respondents from across all geographical areas, there can be confidence that the data presented here are broadly representative of the General Practice Nurse population in the UK and the QNI call for co-ordinated actions to be taken to address the issues identified in the report.

7. Required Actions

1. Consideration of the current and potentially greater contribution of General Practice Nurses, including Nurse Practitioners (NPs), in meeting the health needs of local populations, particularly in the context of declining numbers of General Practitioners.

2. A robust workforce plan nationally, regionally and locally to determine the numbers of GPNs (including NPs) required, to facilitate the development of the next generation of General Practice Nurses to meet the health needs of local populations.

3. An increase in the profile of General Practice Nursing as a specialist area of nursing and a rewarding career option for all – including a target audience of applicants for nursing, student nurses and qualified nurses working in other areas.

4. An increase in the number of substantive student placement learning opportunities for student nurses who express an interest in pursuing a career in primary care, supported by an increase in the number of qualified mentors in the existing GPN workforce.

5. Structured support for those who are new to General Practice Nursing, including mentorship or preceptorship and appropriate support for skills development.

6. At a local level, give consideration to the terms and conditions of the GPN workforce to ensure that they are commensurate with the scope and responsibilities of the role. This may include a benchmarking exercise locally, regionally and nationally.

‘That General Practice Nursing is a specialist area of nursing is in no doubt after the analysis of the data provided.’

8. References

The Primary Care Workforce Commission, 2015. The future of primary care.
https://hee.nhs.uk/sites/default/files/documents/The%20Future%20of%20Primary%20Care%20report.pdf

NHS England, 2014. The NHS Five Year Forward View.
https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

QNI/QNIS, 2015. The QNI/QNIS Voluntary Standards for District Nurse Education and Practice.
http://www.qni.org.uk/docs/DN_Standards_Web.pdf

RCN, 2010. Practice nurses in 2009.
https://www.rcn.org.uk/professional-development/publications/pub-003583

RCGP, 2014. Overview of 2014 General Practice Nurse Survey Report.
http://www.rcgp.org.uk/membership/practice-team-resources/~/media/Files/Practice-teams/Overview%20of%202014%20General%20Practice%20Nurse%20Survey%20Report.ashx

National Audit Office, 2015. Stocktake of access to general practice in England.
https://www.nao.org.uk/wp-content/uploads/2015/11/Stocktake-of-access-to-general-practice-in-England.pdf

Pride in General Practice Nursing

We asked what respondents were most proud of as a General Practice Nurse. The responses are shown in this word cloud, where the size of the word corresponds to the frequency of its use in the answers to this question.



The Queen's Nursing Institute
1A Henrietta Place
London W1G 0LZ

020 7549 1400
mail@qni.org.uk
www.qni.org.uk