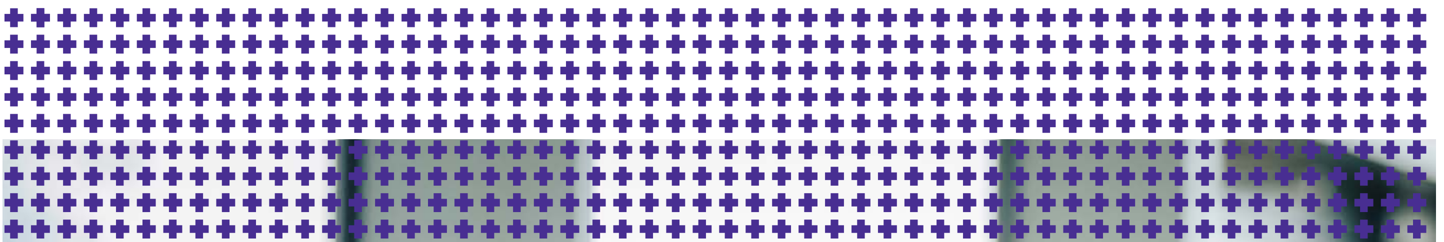
The General Practice Nursing Foundation School

A mixed method evaluation

2025



The Queen's Nursing Institute's International Community Nursing Observatory

The QNI launched the International Community Nursing Observatory (ICNO) in November 2019.

The ICNO analyses data and trends in the community nursing workforce data in greater depth, to aid understanding of the challenges faced by services. It will collate and analyse data about community and primary care nursing services at a regional, national and international level.

Professor Alison Leary MBE, Chair of Healthcare and Workforce Modelling at London South Bank University (LSBU) and a Fellow of the QNI is Director of the ICNO.

The idea behind the foundation of the ICNO originated from an independent strategic review conducted in 2018 by executives at Barclays Bank plc, through the 'Unlocking Insights' programme, led and managed by the charity Pilotlight. The 'Pilotlighters' at Barclays highlighted that data relating to the community nursing services workforce is often incomplete and this leads to barriers which prevent the progression of policy development, service enhancement and improvements to the care of individuals, families, carers and communities.

The ICNO seeks commissions designed to support data gathering and analysis that will provide evidence to enhance service planning and delivery in health and social care settings.

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About the General Practice Nurse Foundation School

The General Practice Nurse Foundation School (GPNFS) was developed to address the lack of a standardized and consistent approach in preparing new General Practice Nurses (GPNs).

The Staffordshire GPN Foundation School began operating in September 2023, designed for both newly qualified nurses and those new to general practice nursing. It utilises a centralised employment model on behalf of GP practices, with a 12-month fixed term training contract. Each trainee has a funded place on the Fundamentals of GPN university course and weekly sessions at the School. The complementary curriculum focuses on the core capability and career framework and includes a bespoke leadership programme, well-being, resilience, clinical supervision / peer support and clinical topics.

Acknowledgements

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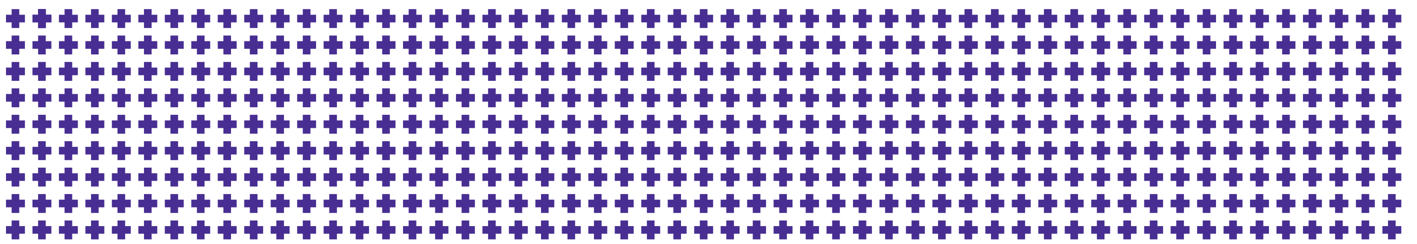
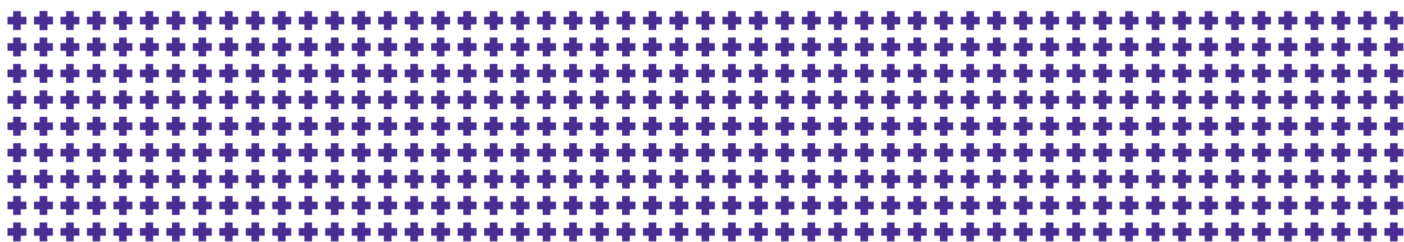


Contents

Summary of findings	5
1. Introduction	7
2. Methods	7
2.1 Aims and objectives	7
2.2 Methods and analysis	9
2.2.1 Ethical considerations and governance	10
2.2.2 Phase 1 Focus groups with GPNFS trainees	11
2.2.3 Phase 2 data collection and samples	11
2.2.3.1 Focus groups with GPNFS trainees	11
2.2.3.2 Interviews with stakeholders	11
2.2.4 Data analysis	11
3. Trainees' motivations, expectations and initial experiences in practice	13
3.1. Theme 1 The appeal of GP nursing	13
3.1.1 Type and range of nursing experience	13
3.1.2 Continuity and relationships	14
3.1.3 Personal experiences and family influences	15
3.1.4 Safe and supportive environment	15
3.1.5 Career opportunities	17
3.2 Theme 2 Barriers to GP nursing by traditional routes	17
3.2.1 GP nursing experience requirement	17
3.2.2 Perceptions of GP nursing and discouragement	18
3.2.3 GP nursing is a secret	19
3.2.4 Funding for GP nursing	19
3.3 Theme 3 The attraction of the GPNFS	21
3.3.1 Finding out about the GPNFS and the application process	21
3.3.2 Structure and features of the GPNFS	21
3.3.3 Organisation and support	22
3.3.4 Education and learning opportunities	22
3.4 Initial practice experience	22
3.4.1 Variability of practice experiences	22
3.4.2 Expectations and perceptions of GPN trainee	23
3.4.3 Role transition	25
3.5 Phase 1 focus groups summary	26
4. Trainees' perceptions and experiences of the GPNFS	26
4.1 Experiences of GP nursing	27
4.1.1 New learning for GP nursing	27
4.1.2 Experiencing care continuity and building relationships	29
4.1.3 GPN role and responsibilities	29



Contents continued

4.1.4 Discomfort about GP nursing	30
4.2 Trainee development	30
4.2.1 Competence and confidence	30
4.2.2 Leadership skills	31
4.3 Experiences of the GPNFS	33
4.3.1 Structure and support	33
4.3.2 Fellowship half days and peer support	34
4.3.3 Fundamentals of Practice Nursing course	34
4.4 Learning in general practice	35
4.4.1 Expectations of trainees	35
4.4.2 Being part of the general practice team and relationships	37
4.4.3 Support and supervision in practice	37
4.5 Employment and career options	38
4.5.1 Finding employment and negotiating terms	38
4.5.2 Career options as GP nurses	39
4.6 Summary	39
5. Stakeholders' views about the GPNFS and potential contribution	41
5.1 The GPNFS development	42
5.1.1 Drivers for the GPNFS development	42
5.1.2 Facilitators for the GPNFS development	47
5.1.3 Barriers and challenges for the GPNFS development	49
5.1.4 Aspirations for the GPNFS	50
5.2 The GPNFS elements	51
5.2.1 Structure, organisation and support	51
5.2.2 Fellowship half days and peer support	55
5.2.3 The Fundamentals in General Practice Nursing course	58
5.3 General practice placements	61
5.3.1 Preparation and support for general practices	61
5.3.2 Learning in practice and support roles	62
5.3.3 Supervision and assessment in practice	66
5.3.4 Integration into the general practice team	67
5.4 Benefits and value of the GPNFS	67
5.4.1 Development of competent, confident and employable GPNs	67
5.4.2 The value of the GPNFS to the primary care workforce	73
5.4.3 Summary	74
6. The development of professional practice.	77
7. Key messages from the evaluation	79
References	80

‘The trainees were very positive about the GPNFS structure, and the support provided, particularly by the GPNFS leads, crediting this support with their retention in GP nursing.’

Summary of findings

GP Nursing Trainees’ Views

The appeal of GP nursing

During the first focus groups at the start of the General Practice Nurse Foundation School (GPNFS), trainees discussed the appeal of GP nursing, noting aspects such as health prevention, continuity of care, and the opportunity to build relationships with patients. These aspects were revisited in the second focus groups, and for most trainees, they continued to be attractive. Trainees expressed enjoyment in the new learning opportunities, the variation in their roles, and the range of experiences they gained. Many appreciated the continuity of care they hoped for and the trusting relationships they were able to build with patients over time.

Surprises and Challenges

Some trainees were surprised by the level of responsibility and autonomy inherent in the GP nursing role. However, a few expressed discomfort about certain aspects of GP nursing, particularly its ‘behind closed doors’ nature, which they felt made it less open to scrutiny compared to hospital nursing. Additionally, trainees were taken aback by the business-oriented nature of general practices and sometimes felt uneasy about the associated financial perspectives.

Growth and Leadership

Trainees recognized significant growth in their competence and confidence as GP nurses, although they acknowledged there was always more to learn. Some felt they were already demonstrating leadership skills, while others believed they had not yet had the opportunity to apply these skills in practice. Using a validated instrument, it is possible to see that there was evidence of the development of professional practice over the assessment period, with the trainees self-reporting improvements in becoming more reflective in action rather than relying on retrospective reflection. There is a rise in confidence and a decline in stress and uncertainty, associated with taking on a new role.

Positive Aspects of the GPNFS Structure

The trainees were very positive about the GPNFS structure, and the support provided, particularly by the GPNFS leads, often crediting this support with their retention in GP nursing. Trainees found that the Fellowship half days, supervised practice as GP nurse trainees and the Fundamentals course, provided a balanced approach. The Fellowship half days were highly valued for their practical relevance, the application of theory, the opportunity for peer support and learning from external speakers.

General Practice Expectations and Team Integration

Initial concerns about the expectations of their employing general practices were revisited. Some discussions highlighted practices that did not always fully understand the GPN trainee role and the structured skills development it entailed. Feeling part of the general practice team was important, with some trainees feeling more integrated into their practices than others. Experiences with support and supervision varied; some had very positive interactions with mentors and supervisors, and the Retire and Return (R&R) nurse role was highly valued, although not all trainees had access to this additional support.

Future Employment and Career Aspirations

As the trainees considered their future employment as GP nurses, they anticipated negotiating terms and conditions. Many remained enthusiastic about the career opportunities in general

practice, an initial attraction for many. Trainees had aspirations for further development in specialisms, such as diabetes care, indicating a strong interest in advancing their careers within general practice.

Stakeholders' views

Drivers, challenges and aspirations

The General Practice Nurse Foundation School (GPNFS) was developed to address the lack of a standardized and consistent approach in preparing new General Practice Nurses (GPNs). Prior to the GPNFS, many GPNs were trained through various short courses with minimal support, leading to workforce issues such as high sickness rates, retirements, recruitment and retention challenges, and a general lack of awareness and barriers to becoming a GPN.

The GPNFS was initiated with significant local and national stakeholder support despite financial challenges. Engaging general practices, especially those in the independent sector, was another challenge. Stakeholders expressed aspirations for a secure, national, standardized GPN preparation pathway, ideally supported by a GPN Deanery.

Positivity about the GPNFS elements and support structure

Stakeholders positively reviewed the GPNFS's structure, highlighting the centralized recruitment and employment model, and the effectively balanced theory and practice. The support structure, including GPNFS leads, Fellowship half days, the Fundamentals course, and support from supervisors, mentors, and the R&R nurses, was crucial. The Fellowship provided additional learning, peer support, and clinical supervision, tailored to trainees' needs, with a focus on service development and leadership skills. The Fundamentals course was recognized for its established role in preparing new GPNs, and there was close collaboration between the GPNFS and the course leads during the GPNFS development.

Importance of general practice placements

Preparation and ongoing support for general practices hosting GPNFS trainees were vital. Effective communication with the GPNFS ensured practices could request additional support when needed. Stakeholders noted significant contributions of the R&R role to trainees' learning experiences and the importance of effective integration into practice teams

Competence, confidence and employability

The trainees' competence and confidence grew rapidly, with some already applying leadership skills. Stakeholders unanimously believed trainees would be employable upon completing the program, having gained the full range of required skills, with potential for further development in specialist areas.

Positive contribution to the workforce

The GPNFS was recognized by stakeholders for providing robust support and a structured pathway for developing new GPNs, reducing isolation, and establishing a valuable network. The programme was seen as a vital contributor to the primary care workforce, offering a reliable pipeline for recruiting skilled GPNs into general practices.

Sustainability

The practice learning environment was an essential component for completion of the programme and for retention. Features of the programme such as the R&R nurse were also seen as pivotal. These are factors which should be considered in terms of role sustainability or reproducibility.

‘The School was designed for both newly qualified nurses and those new to general practice nursing, organised in a similar way to the established GP training scheme and utilising a centralised employment model on behalf of GP Practices, with a 12-month fixed term training contract.’

1. Introduction

A national speciality training programme for doctors who wish to become GPs has existed for many years and yet for many new General Practice Nurses (GPNs) the training is still ad hoc and inconsistent. GPNs are core staff for General Practice and provide holistic, patient-centred and often complex, multi-faceted care across the whole age range and all fields of nursing. The role demands great flexibility and versatility, with a very broad knowledge base and clinical skills. However, the lack of standardised training can affect recruitment and retention of nurses in Primary care. This is important, as across Staffordshire, 47% of GPNs are over the age of 50 and this pattern is replicated nationally. The need for a structured training programme for nurses new to the GPN role was therefore clear. The main driver for the Staffordshire GPN Foundation School was to ensure that patients received safe, equitable care across the county of Staffordshire, and following the evaluation, to enable adoption of this training scheme across the country to provide a pipeline of GPNs for the future.

Following a successful proposal and consultation with many stake holders, including NHS England, Integrated Care Board (ICB), Integrated Care System (ICS) and The Queen’s Nursing Institute (QNI), the Staffordshire GPN Foundation School led by Rachel Viggars, Strategic Nurse Lead, GPN Foundation School Programme Director and Gill Boast, GPN Facilitator and Training Programme Lead GPN Foundation School commenced in September 2023. It was designed for both newly qualified nurses and those new to general practice nursing, organised in a similar way to the established GP training scheme and utilising a centralised employment model on behalf of GP Practices, with a 12-month fixed term training contract. This enabled the necessary structure and organisation, standardised pay, terms and conditions during the programme, quality assurance of learning environments and wrap around support. Each trainee has a funded place on the Fundamentals of GPN university course and in addition is able to attend the GPN School for one session a week. The school has a complementary curriculum focused on the core capability and career framework to enhance university sessions and includes a bespoke leadership programme, well-being, resilience, clinical supervision / peer support and clinical topics. Support in clinical practice is offered via Retire and Return nurse educators and GPN facilitators, to assist the Practice Assessor and Supervisor roles.

The scheme aimed to raise the profile of GPNs and value their unique nursing role. Ultimately it could facilitate progression along the career framework to Specialist Practice GPN or Advanced Clinical Practice roles and, in the future, could also incorporate training for health care support workers and nursing associates. On completion of cohort 1, the GPN Foundation School has an impressive 93% retention rate and is driving change to develop a national culture for GPN training and education.

The initiative appears to address many current workforce issues in general practice; it also appears to be beneficial to General Practice capacity. The QNI were asked to conduct an independent evaluation of the programme to determine why it was successful and what could be learned.

2. Methods

2.1 Aims and objectives

The aim was to explore perceptions and experiences of the General Practice Nurse Foundation School (GPNFS) from trainees’ and stakeholders’ perspectives.

The objectives were:

1. To explore trainees’ reasons for applying for the GPN foundation school and their expectations

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> ‘The scheme aimed to raise the profile of GPNs and value their unique nursing role. Ultimately it could facilitate progression along the career framework to Specialist Practice GPN or Advanced Clinical Practice roles.’

2. To explore trainees’ perceptions of how the GPN Foundation school has affected their overall confidence, competence, development and career plans
3. To explore GPN Foundation school trainees’ experiences of the different elements of the programme (including academic study, practice experience, mentorship and supervision)
4. To explore the views of a range of stakeholders about the GPN Foundation school and the potential contribution to the primary care workforce.
5. To assess the development of reflective professional practice over time using a validated instrument.

2.2 Methods and analysis

Data were collected in two phases through onsite focus groups with GPNFS trainees (Phase 1 and 2) and interviews with a range of other stakeholders on MS Teams (Phase 2). Table 1 summarises the data collection methods, participants and length of focus groups and interviews. All participants were assigned an identifier as shown; these are used in presentation of the results. Topic guides were used with follow up probes to explore responses in depth; see Appendix 1 for question/topic areas. The focus groups and interviews were all audio-recorded for transcription purposes.

Table 1. Data collection and participants

Phase 1 (September 2023)			
Participants	**Focus group identifier**	**N**	**Length (mins)**
GPNFS trainees: newly qualified nurses	FG1_NQN	8	65m
GPNFS trainees: new to practice nurses	FG1_NtoPN	7	66m
Phase 2 (March-July 2024)			
Participants	**Focus group identifier**	**N**	**Length (mins)**
GPNFS trainees: newly qualified nurses	FG2_NQN	8	66m
GPNFS trainees: new to practice nurses	FG2_NtoPN	5	72m
Participants	**Interviewee identifier**	**N**	**Length (mins)**
GPNFS leads (n=2) University Fundamentals course leads (n=3)	L1, L2, L3, L4, L5 NB L3 and L4 conducted together	5	24-60 mins (mean 41 mins)
Participants	**Interviewee identifier**	**N**	**Length (mins)**
GPs (n=3) Practice manager (n=2) Retire and return nurse (n=1) Retire and return nurse/supervisor (n=1) Practice mentor (n=1) Practice assessor (n=1) Lead practice nurse (n=1) PCN Business manager (n=1) GP partner (n=1) Business partner (n=1)	GPS1, GPS2, GPS3, GPS4, GPS5, GPS6, GPS7, GPS8, GPS9, GPS10, GPS11, GPS12, GPS13 NB Conducted together: GPS3 and GPS4 GPS7 and GPS8	13	12-35 mins (mean 22 mins)

In addition to the qualitative data collection and analysis, the trainees also participated in a longitudinal assessment of professional and practice development through reflective practice using the Reflective Practice Questionnaire (RPQ), a validated instrument developed for use in several industries including healthcare (Priddis and Rogers 2017). The RPQ was administered monthly for nine months over 2024.

The RPQ has the following domains:

Reflective-in-action (RiA)
- During interactions with patients I recognise when my pre-existing beliefs are influencing
- the interaction.
- During interactions with patients I consider how my personal thoughts and feelings are
- influencing the interaction.
- During interactions with patients I recognise when my patient's pre-existing beliefs are
- influencing the interaction.
- During interactions with patients I consider how their personal thoughts and feelings
- are influencing the interaction.

Self-appraisal (SA)
- I think about my strengths for working with patients.
- I think about my weaknesses for working with patients.
- I think about how I might improve my ability to work with patients.
- I critically evaluate the strategies and techniques I use in my work with patients.

Confidence – general (CG)
- I have all the experience I require to effectively interact with patients.
- I have all the practical skills I require to effectively interact with patients.
- I have learnt everything I need to know to effectively interact with patients.
- I have all the theoretical knowledge I require to effectively interact with patients.

Uncertainty (Unc)
- Sometimes I am unsure if my planning for patients is the best possible way to proceed.
- Sometimes I am unsure if I am interpreting my patients' needs correctly.
- Sometimes I am unsure how to handle the needs of patients.
- Sometimes I am unsure that I properly understand the needs of patients.

Job satisfaction (JS)
- My work provides me with a lot of fulfilment.
- My work means more to me than simply earning money.
- I enjoy my work.
- There are times when I find myself wishing that I did not have to go to work. (*reverse item)

Reflective-on-action (RoA)
- After interacting with patients, I spend time thinking about what was said and done.
- After interacting with patients, I wonder about the patient's experience of the interaction.
- After interacting with patients, I wonder about my own experience of the interaction.
- After interacting with patients, I think about how things went during the interaction

Reflective with others (RO)
- When reflecting with others about my work I become aware of things I had not previously considered.
- When reflecting with others about my work I develop new perspectives.
- I find that reflecting with others about my work helps me to work out problems I might
- be having.
- I gain new insights when reflecting with others about my work.

Desire for improvement (DfI)
- I think I still have a lot of things to learn in order to improve my ability to work with
- patients.
- I would like to learn new skills in order to improve my ability to work with patients.
- I desire more knowledge to improve my ability to work with patients.
- I desire more experience to improve my ability to work with patients.

Confidence – communication (CC)
- I think I am good at creating a safe environment so that my patients' feel comfortable enough to share information with me.
- I feel confident sharing my formulations with patients.
- I am good at providing clear messages to my patients.
- I am good at listening to my patients with genuine curiosity.

Stress interacting with patients (SiC)
- Sometimes after interacting with a patient I feel exhausted.
- Sometimes I find interacting with clients to be stressful.
- There are times when I feel distressed after communicating with a client.
- The pressure to meet the needs of my patients can sometimes feel overwhelming.

2.2.1 Ethical considerations and governance

The Health Research Authority decision tool was used to determine whether NHS Research Ethics Committee approval was necessary, confirming that NHS ethical approval was not required, as the project met the criteria for a service evaluation. The proposal and data collection tools were critically reviewed by the project team. The evaluation was conducted in line with good ethical practices, including voluntary participation, informed consent and data security, and participant information sheets were provided. All participants signed written consent forms prior to their focus groups and interviews, except for two interviewees who gave verbal consent. The consent forms were stored securely on a password protected computer and deleted at the end of the project. The evaluation was reported into the GPNFS Steering Group.

‘The main driver for the Staffordshire GPN Foundation School was to ensure that patients received safe, equitable care across the county of Staffordshire, and following the evaluation, to enable adoption of this training scheme across the country to provide a pipeline of GPNs for the future.’

2.2.2 Phase 1 Focus groups with GPNFS trainees

Phase 1 data collection focused on meeting objective 1. The focus groups were conducted with the GPNFS trainees onsite on 28th September 2023, which was the second week of the GPNFS. The aim was to capture the students’ reasons for applying for the GPNFS and their expectations. Focus groups have the advantage of enabling interactions between participants leading to discussion of a range of views (Kitzinger 1994). Focus group 1 comprised eight newly qualified nurses, who were registered in adult (n=7) and mental health nursing (n=1) fields. Focus group 2 comprised seven new to practice nurses from adult nursing (n=4), children’s nursing (n=2) and dual adult and children’s nursing (n=1). They had a variety of clinical experience, such as Accident and Emergency, medical and surgical hospital wards. Some had many years of experience whilst others only one or two years. The focus groups were carried out separately for these two groups, as their reasons for applying and the attraction of the GPNFS could differ. Participants with similar experiences may feel more comfortable to communicate with each other in focus groups (Stewart and Shamdasani 2015).

2.2.3 Phase 2 data collection and samples

Phase 2 evaluation data were collected in March-July 2024 and aimed to meet objectives 2, 3 and 4. There was a second round of focus groups with the GPNFS trainees, and individual interviews were conducted with three groups of stakeholders: the GPNFS leads, the Fundamentals course leads, and staff from general practices where trainees were placed three days per week for supervised practice.

2.2.3.1 Focus groups with GPNFS trainees

These focus groups were held on site on 21st March 2024 in the same fashion as in Phase 1. The newly qualified nurses group remained the same but two new to practice nurses had left the programme so there were five participants in the second focus group, from adult nursing (n=3), children’s nursing (n=1) and dual adult and children’s nursing (n=1).

2.2.3.2 Interviews with stakeholders

Interviews were conducted with the two GPNFS leads, and with the course leads from two universities where the trainees were studying their Fundamentals course for one day per week, alongside other new general practice nurses, who were not part of the GPNFS. A range of general practice staff (see roles, Table 1) were interviewed, from across four general practices from different areas of the county of Staffordshire, urban and rural.

2.2.4 Data analysis

The audio recordings were professionally transcribed and then checked against the audio-recordings and anonymised. The data were analysed using Braun and Clarke’s reflective thematic analysis approach (Braun and Clark, 2022, p.5), comprising: Phase 1: Familiarising yourself with the dataset; Phase 2: Coding; Phase 3: Generating initial themes; Phase 4: Developing and reviewing themes; Phase 5: Refining, defining and naming themes; Phase 6: Writing up. See Appendix 2 for further details.

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‘The objective for the Phase 1 focus groups was to explore trainees’ reasons for applying for the GPNFS and their expectations.’

The findings from analysis are presented in three sections:

- Trainees’ motivations, expectations and initial experiences in practice (Objective 1)
- Trainees’ perceptions and experiences of the GPNFS (Objectives 2 and 3)
- Stakeholders’ views about the GPNFS and potential contribution (Objective 4).

Data extracts are included for illustration, and these are attributed using the Table 1 identifiers.

3. Trainees’ motivations, expectations and initial experiences in practice

The objective for the Phase 1 focus groups was to explore trainees’ reasons for applying for the GPNFS and their expectations. The focus group also gave the chance to discuss initial experiences of the trainees. Table 2 presents the themes and sub-themes. The focus group data extracts are attributed as: FG1_NQN for new qualified nurses, and FG1_NtoPN for the new to general practice nurses.

Table 2. Phase 1 focus groups: Trainees motivations, expectations and initial experiences in practice

Themes	Sub-themes
The appeal of GP Nursing	• Type and range of nursing experience • Continuity and relationships • Personal experiences and family influences • Safe and supportive environment • Career opportunities
Barriers to GP Nursing by traditional routes	• GP nursing experience requirement • Perceptions of GP nursing and discouragement • GP nursing is a secret • Funding for GP nursing
The attraction of the GPNFS	• Finding out about the GPNFS and the application process • Structure and features of the GPNFS • Organisation and support • Education and learning opportunities
Initial practice experiences	• Variability of practice experiences • Expectations and perceptions of GPN trainee • Role transition

3.1. Theme 1 The appeal of GP nursing

In both focus groups, trainees discussed a wide range of features that attracted them to GP nursing; these different areas are presented next.

3.1.1 Type and range of nursing experience

The trainees talked extensively about the type and range of experience that GP nursing offered. Many had seen patients in secondary care which had triggered them to think about health prevention, and how they might make a difference working in general practice:

I noticed quite a big pattern in the hospital, there was a lot of care that could be prevented, especially in primary care, and that’s something that drove me. (FG1_NQN)

I felt it was the right field for me because I'm passionate about prevention instead of deterioration. (FG1_NtoPN)

Trainees discussed opportunities for health education in areas such as sexual health and inhaler management. There was enthusiasm about the new learning opportunities, for example, learning more about managing long-term conditions in general practice. The trainees discussed the variety of patients they would encounter over a day, and the range of skills they would use:

I liked the whole idea of being flexible with the skills you could have so for me, I love wound care but I also love sexual health. (FG1_NQN)

It's the variation of everything that you see, you can be doing baby clinics and the next appointment is smears, then it's blood pressure checks, so it's like, not quite knowing what's going to come through your door, it's quite exciting I think, for me anyway. (FG1_NtoPN)

As the trainees had previously been working in one field of nursing, the opportunity to work with people of different ages and across the lifespan, was a further attraction:

You get to see a person from birth to the end, you see them from every walk of life. I come from an adult [nursing] background, I haven't done anything when it comes to children and it's nice to have a change and look into that part of nursing. (FG1_NtoPN)

I really like the variety of general practice nursing because you work with all age groups, from young babies all the way to the elderly. (FG1_NQN)

3.1.2 Continuity and relationships

Some trainees had experienced a lack of continuity with patients in the hospital setting and hoped that general practice would offer the chance to follow patients up over time. They believed they would experience satisfaction as they had made a difference:

With practice nursing, you get to follow up on how your patients are doing and you get to see their progression, you get to see improvements. (FG1_NtoPN)

The trainees discussed that general practice offered the opportunity to build relationships with patients and families over time:

In general practice you could really know that person growing up throughout their life and seeing them go through different milestones of their lives. (FG1_NQN)

They hoped that they could offer reassurance through building relationships with patients and becoming a familiar face:

Hopefully your face will give them some reassurance, they'll be like 'Oh it's so and so and she was fine'. (FG1_NtoPN)

Trainees were aware of situations where patients were embarrassed to seek help and believed they could offer a non-judgmental approach and reduce stigma:

Going into that profession knowing I could help someone not feel judged and not feel the stigma for these certain topics. (FG1_NQN)

There was also awareness that general practice can make a difference to people by ensuring appropriate referrals:

In primary care, you are the gatekeepers of the NHS. We can make a lot of referrals as practice nurses which opens up a wealth of services. (FG1_NQN)

‘It’s the variation of everything that you see, you can be doing baby clinics and the next appointment is smears, then it’s blood pressure checks, so it’s like, not quite knowing what’s going to come through your door, it’s quite exciting I think, for me anyway.’

The idea of working more independently with patients on a one-to-one basis was also viewed positively. An experienced nurse considered that growing older had increased her feeling of attachment to her community: *‘as you get older, you get more of a sense of community and your surrounding area’ (FG1_NtoPN)*. Others had previous caring experience in the community which had drawn them towards general practice:

‘I really enjoyed going to people’s houses and meeting them and making a difference.’ (FG1_NQN)

3.1.3 Personal experiences and family influences

Some trainees referred back to their own experiences and those of their families, which had influenced their desire to work in general practice. Several had had positive experiences with practice nurses:

I really liked her [practice nurse] because we went for an asthma review or an immunisation but actually, she knew my children’s names, she asked how we were, she didn’t just do the task and send us away, she felt like part of the family. (FG1_NtoPN)

Others had had less positive experiences, for example, one trainee recalled a relative who the family felt had been let down by their GP practice. However, rather than deterring the trainee, this experience motivated her towards general practice nursing, with the hope that she could do better:

It didn’t put me off, it actually made me want to do it more because it is a fact that I could prevent someone feeling like that. If I can do something to be part of the situation then obviously I can help. (FG1_NQN)

A small number of trainees referred to general practice offering a better work-life balance, that would fit better with their family responsibilities.

3.1.4 Safe and supportive environment

Trainees believed that general practice would offer a safe and supportive environment for primary care. Some new to practice nurses had been feeling unvalued and unsupported in the hospital setting, making general practice more attractive. Trainees believed there would always be someone available who they could contact for support, in contrast to care in the community:

You are on your own but there are people around to ask for help if you need it, it’s sort of in-between, building that relationship but in a safer environment. (FG1_NQN)

Some NQNs had experienced a lack of support in the hospital setting and believed that they would be better supported in general practice, particularly with the package that the GPNFS offered. An NQN described her experience on her final placement, which had deterred her from taking hospital employment and increased her interest in general practice:

They chucked me in at the deep end, ‘well, you’re nearly qualified, you’ll be working here’, chucking all this stuff at me and I just thought: if this is what it’s like now and I’m not getting paid for it and I’m still a student, what are you going to do to me when I do work there? (FG1_NQN)

‘It doesn’t interest me being a Sister or anything like that eventually, I would like to go down the ACP prescribing route and this seems like a really efficient way of doing it, if you get the right support and GP practice, that’s something they can facilitate.’

3.1.5 Career opportunities

To many, general practice nursing offered interesting career choices, for example, specialising in long-term condition management or leadership roles:

Like long term conditions like asthma or diabetes or you could do more of the management side of it as well and become like a lead practice nurse so there are quite a lot of options. (FG1_NQN)

Trainees perceived general practice nursing offered more autonomy than was possible in the hospital setting:

I think the independence is something for me as well, like having had placements, I always thought I’d love to have my own clinic and stuff and realised that wards weren’t for me. (FG1_NQN)

Trainees believed general practice offered career progression not available in the hospital setting, such as advanced clinical practice and prescribing:

It doesn’t interest me being a Sister or anything like that eventually, I would like to go down the ACP [advanced clinical practice] prescribing route and this seems like a really efficient way of doing it, if you get the right support and GP practice, that’s something they can facilitate. (FG1_NtoPN)

An experienced RN described feeling that she had realised she needed a more varied role, which she believed general practice would offer: *‘I’d just outgrown the hospital’ (FG1_NtoPN).*

The trainees believed that the GPNFS would put them in a good position to take up a GPN post, especially as they were aware of shortages of GPNs in the workforce. A few expressed concerns about getting a GPN post at the end of the programme, but others believed support would be available to them to seek out and apply for available roles.

3.2 Theme 2 Barriers to GP nursing by traditional routes

The trainees discussed at length the barriers to applying for GP nursing in the traditional way: that GP nursing roles required experience and skills for that setting; negative perceptions of GP nursing and discouragement; GP nursing being hard to find out about – ‘a secret’; and that the courses have to be self-funded.

3.2.1 GP nursing experience requirement

Many trainees had looked for GP nursing posts but they found that most job adverts specified the need for previous GP nursing experience. There were discussions about how they could gain the experience without employment:

They didn’t want somebody without experience and they didn’t want to train somebody up that might potentially leave after a short while because of how expensive it is.

But how do you get experience if they don’t want to employ you? It’s very hard isn’t it? (FG1_NtoPN)

The trainees had been informed that practices needed GP nurses to be able to: *“hit the floor running” and you can’t do that, can you, because there is no way in to do that’ (FG1_NtoPN).*

The requirement for experience was a particular barrier for NQNs:

Everyone had to have experience [to apply for GP nursing]. It was one or two years' experience. Every application I went on to said you needed experience, will not accept newly qualified. (FG1_NQN)

NQNs had not been able to have GP placements during their pre-registration nursing programme, despite their requests:

I'd keep on pushing every year, please can I have a GP placement and you just get allocated where you get allocated. (FG1_NQN)

The NQNs had been told that general practices would not take students as they are private organisations and do not have staff who can supervise and assess students. After a great deal of persistence, one trainee had had a placement organised but this fell through at the last minute and so she was allocated to a community placement instead.

Trainees tried to gain GP nursing experience independently, locally or via personal contacts, with varied success. Several had asked if they could go into a practice to observe, or to volunteer, but this was declined, and many referred to GP nursing as a *'closed door': 'we're all eager to do this and we're trying our best and the door shuts'* (FG1_NtoPN). Some trainees discussed how they had proactively sought other community experiences that they hoped might put them in a better position to apply for GP nursing. However, they found that without having the specific skills desired, their community experience did not assist their case, for example:

I did community first responding, so that was adults obviously, and paeds as well, I did that for about a year, I did all the training, all voluntary. You are responding to emergency calls and I thought that's going to get me in. No. Because essentially I am paediatric trained and I don't do ECGs and I don't know how to do smears. (FG1_NtoPN)

Other experienced nurses had made numerous unsuccessful applications; reasons given included that they were: *'thinking like a hospital nurse, you have to learn to be more autonomous'* [others agreeing] (FG1_NtoPN).

3.2.2 Perceptions of GP nursing and discouragement

The NQNs felt they had been actively discouraged from GP nursing. They had encountered perceptions that GP nursing was less skilled and a role nurses take up near to retirement:

You get told that you are going to deskill yourself.

Yes, you only go to GPs if you are retiring soon.

It's a job that you do at the end of your career. [Yes, yes, all] (FG1_NQN)

The NQNs found there was an expectation that they would work in hospitals on qualifying:

They want to work you in a hospital basically.

Facilitator: Who was that coming from, that you must work in a hospital?

Everybody! [All, laughter]

If you tell anybody on the wards that you are going to go into community work, they just look at you as if you're… (FG1_NQN)

The NQNs had been offered financial incentives to take up hospital posts and some reported that they did not have to undertake interviews for these. Some had been promised a position after a

‘If you tell anybody on the wards that you are going to go into community work, they just look at you as if you’re…’

placement, and they did express some personal conflict about not taking up a post in the hospital where they had been based during their programme:

Let’s say you do your training in the hospital, they will say, we’ve got a preceptorship for you, we want to keep you, so they will prepare this months in advance and it sort of makes you feel guilty. [others agree] […] I was fighting with myself until the last minute thinking: do I stay in the job because they have guaranteed it me for so long or do I go and do something I actually want to do? (FG1_NQN)

3.2.3 GP nursing is a secret

The NQNs had found it difficult to even find out about GP nursing: *‘I had to fight to get any information on it’* (FG1_NQN). They therefore referred to GP nursing as being a ‘secret’:

If you try to find out how to get into it, it’s like this guarded secret [laughter, others agreeing] and nobody seems to have the answers. (FG1_NQN)

The NQNs reported that their pre-registration programme was almost entirely focused on hospital nursing:

I think that universities just prepare you for the hospital, 99% of your placements are ward based, one community placement, and that’s all that you know really. (FG1_NQN)

Once the NQNs had acquired their places in the GPNFS, they found people questioning how they had found out about GP nursing and got a place: *‘there’s that many people I’ve spoken to who say: how have you got that? It’s just surprising. It seems to be like a hush hush thing’* (FG1_NQN). As well as lacking placements in general practice nursing, they had encountered little theory-based teaching about general practice: *‘It’s never mentioned whatsoever [others agreeing]’* (FG1_NQN). One speaker about GP nursing was recalled but this was on the final day at university, which was considered much too late. The NQNs had therefore used other means to try to find out about GP nursing, including social media, but still found little information:

It is well guarded as to what they actually do, [laughter], you can find out little bits, oh they do this, but there is nowhere that gives you the full rundown of what a GP nurse does. (FG1_NQN)

They had concluded that GP nursing was hidden in society and received little media coverage: ‘There’s no mainstream coverage of it [GP nursing] anywhere’ (FG1_NQN). They referred to the numerous YouTube videos about nursing in hospitals in contrast to perhaps one on GP nursing.

3.2.4 Funding for GP nursing

In both focus groups, there was some discussion about funding issues for GP nursing. Some had investigated the courses required for GP nursing, looking at providers and the cost. However, many had heard that they would have to self-fund the courses, which they considered a barrier to GP nursing. Amongst the experienced nurses, some on higher grades had found general practices would not take them on as they assumed that they would have to match their current salary, even though the nurse would have been willing to start on a lower salary:

I had a phone call and they wanted to know what pay grade I was currently at and that’s what

‘The thing that gave me a glimmer of hope was because on the ad, it did specifically say it was open for newly qualifieds and that made me think well if newly qualified nurses who don’t have as much experience can apply, maybe I’ve got a chance as well.’

stopped them. That’s not necessarily what I would have expected, we’re getting paid less here, but that’s not what it’s about, is it? So, that closed that door for me. (FG1_NtoPN)

3.3 Theme 3 The attraction of the GPNFS

The trainees discussed how they found out about the GPNFS and the application process, the appeal of the GPNFS structure and features, the organisation and support, and the educational opportunities.

3.3.1 Finding out about the GPNFS and the application process

Some trainees had been actively looking for GPN opportunities and had come across the GPNFS through online platforms such as Indeed and NHS Jobs. Trainees described feeling hopeful about the GPNFS advert as it specifically included that NQNs could apply:

The thing that gave me a glimmer of hope was because on the ad, it did specifically say it was open for newly qualifieds and that made me think well if newly qualified nurses who don’t have as much experience can apply, maybe I’ve got a chance as well. (FG1_NtoPN)

Traditionally, GP nursing had been only open to adult field nurses, providing a deterrent to the trainees. However, the advert specifically referred to the GPNFS being open to nurses from all fields of nursing, which the trainees had found encouraging:

I had actually applied to get into GP surgeries before and never could as a children’s nurse and when I saw this I thought I’ll apply but wouldn’t get it but I’m here! (FG1_NtoPN)

Some of the NQNs had heard about the GPNFS through their universities and had been encouraged to apply:

I came across it at the jobs fair and it was me talking to my tutors, one in particular, who said, actually, this is a really good opportunity. Just go for the interview, go and see what you think. (FG1_NQN)

Some NQNs had not considered GP nursing previously and had planned to take a hospital post but coming across the GPNFS had triggered their interest. Another NQN had contacted her placement office about a GP nursing elective and had been alerted to the GPNFS. Some trainees encountered positive responses from other nurses about the GPNFS opportunity, which reinforced their decision to apply.

3.3.2 Structure and features of the GPNFS

An appealing feature was the structure of the GPNFS: the three days in practice, a day doing the University Fundamentals course, a half day Fellowship, with their peers, and half day self study:

I just thought it was perfect. Literally, everything is covered. They’re getting you trained; they send you to uni. You’re still getting paid. (FG1_NtoPN)

The programme being funded was an important feature for many trainees, especially new to practice nurses with financial commitments, who would not otherwise have been able to take up a place. Without the funding, trainees believed they would have had to take on additional jobs, adding extra pressure. However, for some new to practice nurses, the GPNFS salary was much less than they had been earning. Some NQNs felt the GPNFS structure was an ideal way to move from the university programme to employment. The programme being twelve months was also appealing as trainees felt they could commit and dedicate themselves to the programme.

3.3.3 Organisation and support

Trainees discussed that the support offered was particularly appealing, comprising support from the University, the Fellowship and through practice supervision and mentorship. They believed that their status as a trainee GPN would lead to additional support too and they felt there would always be people they could contact about any concerns. The trainees perceived that the Fellowship afternoons would be a platform to discuss issues and gain support from peers:

We can all come together and all talk about experiences and find out what's going on with one another, whether something's going well or not, as well as feel that we can come back and talk to somebody. (FG1_NQN)

The trainees believed that the GPNFS would promote networking opportunities, which they considered important for GPNs. The trainees had found the GPNFS leads to be enthusiastic and committed to the programme and its success. The trainees had had good experiences with the GPNFS to date, reporting responsiveness to emails, for example. They discussed feeling cared about as individuals: *'You don't feel like you are just a number, you are a person and they are invested in you'* (FG1_NtoPN). They had found the GPNFS to be very well organised, from the interview process onwards, which created a good impression and confidence in the programme: *'I felt if I would be successful, I would be in a safe environment'* (FG1_NtoPN). These first impressions had since been reinforced, creating reassurance about the GPNFS:

They seem so on the ball. I've never had this throughout my three years of training, where somewhere that's organised, wants you to come and has stuff prepared for you to learn. It's really refreshing and a nice experience. (FG1_NQN)

3.3.4 Education and learning opportunities

A further attraction of the GPNFS was the educational opportunity. The trainees were reassured that they would develop the competencies they needed and were studying for a university accredited course, so that on completion they could: *'Work like the nurses do in the practice, have their own clinics, be able to do what they do'* (FG1_NQN). Trainees looked forward to gaining the most up-to-date knowledge, learning more about long-term conditions and developing new skills such as carrying out smears, which they felt prepared them for a specialist role. Some experienced nurses were looking forward to returning to studying after a break:

For me it is more exciting really, stimulating your brain again, learning something new but learning it properly. (FG1_NtoPN)

3.4 Initial practice experience

The trainees in focus group 1 were only in their second week of practice placements but talked extensively about these initial experiences.

3.4.1 Variability of practice experiences

Some trainees had found their practices very supportive, with approachable staff:

The actual GP I'm at are absolutely amazing. They are so supportive and if I've got a question, it's never a silly question. They will sit down with me and they will go through something with me. (FG1_NQN)

One NQN had completed an elective at her practice and this seemed to have reaped benefits as she reported having her own clinics already. Some trainees found the practice was very organised and they were clear about the expectations: *'I know exactly who I'm with, what room I'm in and what time I'm in with them'* (FG1_NtoPN). However, some trainees had contrasting experiences, with a lack of plan or even off duty, and they were having to take the initiative:

I haven't got a plan, I haven't had my off duty this week on Monday and I've got a family. I've got no plan, I've got no vision. So, I am having to say can I sit with the diabetic nurse, can I sit in with this, but it's just not forthcoming. (FG1_NtoPN)

‘They seem so on the ball. I’ve never had this throughout my three years of training, where somewhere that’s organised, wants you to come and has stuff prepared for you to learn. It’s really refreshing and a nice experience.’

However, they were concerned about being seen to complain as they did not want to create a bad impression: *‘I feel like I am at their mercy’* (FG1_NtoPN). The trainees were aware that their relationship with the practice was important as they would be there for the duration of the programme. There was a suggestion for a more standardised practice experience, with practices sent a structured 4-6 week plan for the trainees, rather than the experience being left to the practice’s interpretation. One trainee was placed across two practices and found one was much more organised than the other. However, the R&R nurse had helped put a structure in for her, matching her university learning to practical experience.

Some trainees discussed a lack of support, which was in part due to a lack of nurses to mentor, supervise and assess them at the practice. Some trainees were already concerned about who would then sign off the competencies they had to achieve:

I am a bit worried that I don’t have the support to gain all the competencies that I want because they don’t even know who to assign me to. (FG1_NtoPN)

The trainees discussed that learning the computer system should be at the start of the placement as it was essential for them to document care: *‘The computer system is the first port of call, because if you can’t do that’* (FG1_NtoPN). While some trainees had already been introduced to the system, others had not. Trainees found support from the R&R nurse valuable and considered this should be available to all: *‘If one of us is getting that amount of support everybody should be getting the same experience really’* (FG1_NtoPN).

3.4.2 Expectations and perceptions of GPN trainee

The trainees talked at length about how they were perceived in the practice and the expectations of them, which some considered unrealistic. One area discussed was smears and some had found that GPs expected them to start carrying these out though they had not yet had the required training and supervised practice. Several had been told by GPs that they had learnt by *‘see one, do one’* and expected the trainees to do the same:

He said, okay, you can start doing smears. I said, no! ‘It’s the same as us, you see one, do one’. No! [laughter] He kept saying it and in the end I just shut up and then the nurses stepped in then and say, actually there is an actual course that they have to do. (FG1_NQN)

The NQNs were very aware that they had only just gained their nurse registration and were anxious not to put that at jeopardy by going above their competence: *‘You’ve got to say, that’s my PIN number, I’m not risking it’* (FG1_NQN). Several discussed they had been told that they would need to be assertive with the GPs, who would expect them to carry out work they were not yet prepared for: *‘I’ve been warned, you’ve got to say no to the doctors. They will try and give you more than you can do. [others: yes, yes]* (FG1_NQN)’. However, the trainees were aware of the importance of relationships within the practice, and GPs being partners, added a further dimension:

You’re meeting these people every single day and it’s working out that dynamic

A lot of them are partners as well

In a hospital you can challenge a doctor really but within a GP, you don’t feel you can really challenge a doctor, they are the owners really, aren’t they? (FG1_NQN)

‘He said, OK, you can start doing smears. I said, no! ‘It’s the same as us, you see one, do one’. No! [laughter] He kept saying it and in the end I just shut up and then the nurses stepped in then and say, actually there is an actual course that they have to do.’

The trainees also discussed how some nurses were unclear about their roles as trainees and how to introduce themselves to patients. Some had been introduced as trainee nurses or student nurses, creating the impression that were not yet qualified. Several had had to reassure patients that they were indeed qualified, and that some had many years of nursing experience: *‘I do feel a bit awkward if they just think I’m like a student nurse and I don’t have any history so I have to say: I am a nurse’* (FG1_NtoPN). However, others had more positive experiences with staff introducing them as: *‘a qualified nurse that’s just training and will be with the practice for a year’.* (FG1_NtoPN)

3.4.3 Role transition

For both groups, there was a role transition to be made. The NQNs were adjusting from being student nurses to registered nurses:

Your head is adjusting to the fact that you are now a nurse, and whenever my supervisor says to me ‘You are a nurse’ and I’m just like, I’ve still got that student head on. [Others agreeing ‘So do I] I think the fact that you still feel like you’re a student because you’re a trainee GP [nurse] so at the moment you feel a bit in limbo. (FG1_NQN)

Some NQNs had not yet received their PIN from the Nursing and Midwifery Council, which added some uncertainty about what they could currently do. As an example, trainees questioned whether without a PIN, they could carry out flu vaccinations and they discussed the lack of clarity about this. Some NQNs were aware of skills carried out by healthcare assistants, such as vitamin B12 injections, so they assumed that they could carry out these too, and certainly physiological measurements that they had carried out previously.

The new to practice nurses were adjusting from being confident registered nurses, some with many years of registered practice, to developing their competence and confidence in a new area of practice. For some, there was vulnerability about moving to general practice: *‘I’ve come from a secure job, a great team and I’ve stepped out and I guess I just feel really vulnerable’.* (FG1_NtoPN)

Some new to practice nurses were also wary of transitioning to study again, and the time management required for juggling academic work and practice. However they believed they had learnt how to learn skills quickly and apply learning in practice as well as already having skills to transfer to general practice:

You have already got the communication skills with people, you’ve got your basic nursing skills, you’ve got the information of whatever speciality you’re in. (FG1_NtoPN)

There was some concern that as experienced nurses, the practices might have higher expectations of them. However, they had learnt to be assertive about what they would or would not do: *‘You won’t get pressured when you’ve got experience of people pushing you and saying do it, do it, do it and you’ve learnt how important it is, to say no’* (FG1_NtoPN). They perceived a risk that NQNs would find it difficult to refuse but in the NQN focus group, trainees certainly discussed a strong awareness of not acting outside their competence.

3.5 Phase 1 focus groups summary

There were a number of attractions about GP nursing to the trainees, including the type and range of nursing experiences, the continuity and relationships with patients and families, the safe and supportive environment and the career opportunities in general practice. The trainees' personal and family experiences had also influenced their attraction towards GP nursing. However, the trainees discussed there were currently many barriers to taking up GP nursing. They had found that general practices only wanted to employ nurses who already had the required skills, which excluded both newly qualified nurses and those working in hospitals where the required skills are not commonly employed. In addition, general practices only wanted to employ nurses with an adult nursing qualification, excluding nurses who had qualified in other fields such as children's or mental health nursing. Newly qualified nurses, in particular, had been discouraged from GP nursing; they had encountered perceptions that GP nursing was a career for nurses nearing retirement. Furthermore, they had found it very difficult to find out about GP nursing, with most not being able to undertake a placement and a focus on hospital nursing within their pre-registration nursing curriculum. Funding for training as a GP nurse was another barrier, particularly for new to practice nurses with financial commitments.

The trainees discussed how they had found out about the GPNFS and had seen that, for the first time, there was an opportunity for them to go into GP nursing. The structure and organisation of the GPNFS, the support offered and educational opportunity were all attractive. The trainees had only just started their GP practice experiences but a key issue was around expectations of the trainee and their role and how they should develop the necessary skills. Having a clear structure from the start was important for the trainees, including aspects such as the practice's computer system. Both NQNs and new to practice nurses were having to make a transition into the role as a GPN trainee.

4. Trainees' perceptions and experiences of the GPNFS

The objectives of the second focus groups were to: 1) explore trainees' perceptions of how the GPN Foundation school has affected their overall confidence, competence, development and career plans, and 2) explore trainees' experiences of the different elements of the programme (including academic study, practice experience, mentorship and supervision). Table 3 presents the themes and sub-themes. The themes include data extracts for illustration, coded as: FG2_NQN for the newly qualified nurses, and FG2_NtoPN for the new to practice nurses.

Table 3: Trainees' perceptions and experiences of the GPNFS and their development

Themes	Sub-themes
Experiences of GP nursing	• New learning for GP nursing • Experiencing care continuity and building relationships • GPN role and responsibilities • Discomfort about GP nursing
Trainee development	• Competence and confidence • Leadership skills
Experiences of the GPNFS	• Structure and support • Fellowship half days and peer support • Fundamentals of Practice Nursing course
Learning in general practice	• Expectations of trainees • Being part of the general practice team and relationships • Support and supervision in practice
Employment and career options	• Finding employment and negotiating terms • Career options and aspirations

‘GP nursing is a completely different ball game and I, like the rest of us, don’t think I realised how much it entailed and how much you’ve got to learn on top.’

4.1 Experiences of GP nursing

Trainees discussed their experiences of GP nursing: the new learning GP nursing involved; experiencing care continuity and building relationships. They also discussed the role and responsibilities, and there was some discomfort about aspects of GP nursing too.

4.1.1 New learning for GP nursing

The trainees discussed the extent of the new learning needed to work in general practice, referring to the: *‘vast amount of knowledge that you have to absorb and so quickly’ (*FG2_NQN). New to practice nurses referred to the intensity of the learning required as GP nursing is: ‘a completely different environment than you’re used to’ (FG2_NtoPN). Some reflected that they had been naïve about just how much new learning would be:

GP nursing is a completely different ball game and I, like the rest of us, don’t think I realised how much it entailed and how much you’ve got to learn on top. (FG2_NQN)

Whilst the trainees reflected that they had learnt a great deal, they felt there was still so much to learn:

I feel I know a little bit about a lot of different things but I’m not an expert in anything so it’s like you have to get to grips with so many different things very quickly. (FG2_NtoPN)

The extent of learning was in part because each patient is so different: *‘Everybody is different, every condition can have its own differences in it, depending on the person’* (FG2_NQN). They had also realised the depth of knowledge needed to support people with long-term conditions, such as respiratory disease and diabetes. They were now more aware of the range of health issues they would need to understand, such as children’s health, sexual health and travel health. The trainees enjoyed the variety of GP nursing and that there was always more they could learn:

It’s a job that potentially you can’t get bored at because no day is ever the same, there is always something to learn and something to grow from. (FG2_NQN)

The trainees had looked forward to interacting with patients across the lifespan and some still enjoyed this opportunity: *‘when you’ve got a baby or a child come in, it’s a completely different world, so you get that variation throughout your day’* (FG2_NQN). A few found it challenging working outside their field of registration, although they had become more confident over time. Adult field nurses were aware that babies can deteriorate more quickly than adults, and during baby immunisation clinics, parents would often ask additional questions about baby care. However, their confidence for working with babies and children had developed:

Sometimes it is still challenging because I don’t have the extended knowledge to look after all aspects of care in children for example, but I’m working towards it so I think at some point I will have the capabilities to do more. (FG2_NtoPN)

Conversely, an experienced children’s nurse had found it challenging to adjust to caring for adults: *‘I’ve gone from knowing what I’m doing to no clue really’* (FG2_NtoPN).

Henri Le Sidaner

‘When patients get that level of comfort as well, it’s ‘Can you just …?’ Can you just check my weight, can you just check my blood pressure’. Which is nice I guess because at the end of the day if there is something to be worried about you can flag it.’

4.1.2 Experiencing care continuity and building relationships

Trainees had looked forward to greater care continuity than is possible in hospital. Most trainees were enjoying the opportunity to build relationships with patients and families in general practice, although for a few trainees, continuity was less as they worked across different practices. Trainees discussed how a trusting relationship developed:

It’s really nice to watch the family grow up and you get like a bond with the parent, and they come to you and they trust you, and it’s really nice to just develop that relationship. (FG2_NQN)

Some trainees had found that patients now asked for them by name and they believed patients appreciated seeing the same nurse rather than different nurses each time they attended. Trainees discussed continuity in areas where patients returned regularly, such as further blood pressure checks, blood tests, B12 vitamin injections or wound care. Some trainees discussed seeing the same patients regularly for their long-term condition reviews and follow-up appointments:

I get quite a lot of people coming back because they have long term conditions, COPD, multiple long term conditions, so they are in on an almost weekly basis. It might be bloods one time and then a couple of weeks later they need their review. (FG2_NtoPN)

Most trainees described building relationships with families as they returned with their babies for further immunisations, and they enjoyed watching these parents’ confidence develop. As an example of whole family care over time, a trainee described carrying out a whooping cough vaccination for a woman during pregnancy, then the baby’s immunisations, and then the woman’s smear. Trainees also found that as they developed relationships with patients, they would raise other health concerns too:

When patients get that level of comfort as well, it’s ‘Can you just …?’ Can you just check my weight, can you just check my blood pressure’. Which is nice I guess because at the end of the day if there is something to be worried about you can flag it. (FG2_NtoPN)

4.1.3 GPN role and responsibilities

The trainees discussed the extent of the GPN role and responsibilities involved. The NQNs believed this well exceeded what would be experienced in a hospital setting:

Just the scope of the role, it’s so huge and as a newly qualified going on the ward you would never have this much responsibility with patients. (FG2_NQN)

The NQNs were conscious of their newly acquired registration and the importance of not jeopardising this by taking on roles outside their competence: *‘if something goes wrong, it’s our PINs, it’s not the doctors’ PINs’* (FG2_NQN). There was awareness of the responsibility of being present with patients and needing to have the knowledge to address their concerns while they were in the surgery. Finding out what patients need could take time as it involved: *‘playing detective sometimes, not knowing, like what have they had, what do they need’* (FG2_NQN). The trainees discussed how on hospital wards, there was always other colleagues nearby but in GP

nursing, there was greater autonomy and they were alone with the patient: *'you are working on your own, you have to make decisions on your own'* (FG2_NtoPN).

Trainees discussed the confidence needed during consultations as patients then left the surgery and it was important they left with the right advice and signposting where needed. The new to practice nurses felt there was more pressure on them to know more, which could feel uncomfortable. Trainees had not appreciated the extent of the administration required, as there were often referrals or further follow-ups to organise. They also recognised the importance of effective time-management as they did not want to keep patients waiting for appointments.

4.1.4 Discomfort about GP nursing

In contrast with the many positive experiences discussed in both focus groups, some new to practice nurses discussed aspects of GP nursing that were less comfortable, often drawing on their hospital nursing experience as the standard. For example, new to practice nurses who were experienced in wound care questioned the quality of wound care in general practice and whether care standards were being compromised. There were some perceptions that their pre-existing skills, such as wound care, were not always valued in this new care environment.

Some trainees described general practice as being *'behind closed doors'* in contrast with secondary care as being *'very open book'* (FG2_NtoPN) and were concerned that standardised guidelines, such as those from NICE, were not always followed with local policy taking priority: *'I said I have the NICE guidelines here and she said yes, but you actually have to follow the local policies'* (FG2_NtoPN). They felt that GP nursing is '*not as under the microscope'* (FG2_NtoPN) and they stressed the importance of questioning standards where necessary: *'be very brave and bold, to open your mouth'* (FG2_NtoPN).

A children's trained nurse expressed that she missed children in general practice much more than expected and found that, apart from immunizations, she spent most time with adults with long-term conditions, who were: *'just so disempowered to help themselves or they don't want to [...] this is not what I thought it was going to be like'* (FG2_NtoPN). Trainees also discussed the pressures of GP nursing, with additional tasks for which no time was allocated, such as audits. One area that they had not appreciated was the focus on general practices as businesses:

The business side of GP world has been the biggest learning curve for me because I didn't realise how different it was from NHS and hospitals, it's completely blown my mind as everything is about money. (FG2_NQN)

Some trainees were uncomfortable about the allocation of set minutes for patients with certain conditions, as it felt like they were putting: *'a time on patient's worries or anxieties'* (FG2_NtoPN) and they considered this did not take into account individuality of patients: '*It's like one mould has to fit everybody'* (FG2_NtoPN).

4.2 Trainee development

The trainees discussed their development pertaining to their competence, confidence and leadership skills.

4.2.1 Competence and confidence

Some trainees, particularly the NQNs, discussed how they had felt like *'an imposter'* at the start, but patients trusted them because of their role and uniform: *'They put their trust in you because you're in that uniform and you're in that room'* (FG2_NQN). Trainees compared their competence and confidence now, in contrast to the start of their programme:

The fact that I am able to sit in a room with a patient now and go through a diabetic review from top to bottom, newly diabetics and explain what they should and shouldn't be doing and everything else, and I feel really confident to do that stuff now, whereas six months ago I wouldn't have had a clue. (FG2_NQN)

‘It’s really nice to watch the family grow up and you get like a bond with the parent, and they come to you and they trust you, and it’s really nice to just develop that relationship.’

The NQNs discussed how their competence and confidence had grown in specific skills such as cervical smears, diabetic reviews and immunizations. In addition, they discussed being better able to discern that something is wrong: *‘I can detect when I need to step a patient up, or on medication or get them a referral for a specialist service’* (FG2_NQN). They described observing, developing their knowledge and practising skills, to develop competence and confidence. Trainees also valued learning new skills and knowledge on their Fellowship afternoons and then applying their learning directly in practice. Some trainees felt they could share their new learning with colleagues at the practice with a good response to the updated information: *‘some of the nurses are really, really receptive to the information I’ve taken back’* (FG2_NtoPN).

However, whilst trainees’ competence and confidence had grown, they were aware that there was still more learning needed: *‘I have grown in confidence and grown in competence but there is still a long way to go’* (FG2_NtoPN). They were also aware of their limitations and felt confident to be open when they did not know the answer while taking further action:

I don’t feel upset or worried about saying actually, I’m sorry, I don’t know that, I can get you to talk to this person, or I can bring you back for this, and the confidence to be able to do that now has come out. (FG2_NQN)

4.2.2 Leadership skills

Another area of development pertained to leadership, though notably the NQNs more readily gave examples of how they had developed leadership skills. Several NQNs described taking on lead nurse roles in their practice due to colleagues’ absence. One NQN described leadership in terms of patient care and their own self-management:

We all take leadership over a patient’s care, so we’ve all done it in our own ways, and mainly we’ve done extra things in the practice as well and everyone has had to deal with difficulties on their own in the practices, also taking that leadership over your own self-care has probably developed over the past six months. (FG2_NQN)

Several NQNs had been involved in changing practice through sharing latest evidence and guidelines, and they recognised the importance of how they introduced this information to the practice:

It just gives you that little bit of confidence to say, actually other practices do it this way, these are the guidelines, why are we not doing it, and that professionality, to be able to say it in the correct way as well. (FG2_NQN)

Trainees also discussed the qualities required by a leader, such as trust and approachability:

They come to you because they trust what you know because they’ve seen you work and they know you are not going to judge them; you are not going to make them feel stupid because you don’t work like that. I think this course has taught me that more. (FG2_NtoPN)

However, some new to practice nurses, considered that in their current role as trainee, it was difficult to demonstrate leadership: *‘I do what I’m told to do but there is not enough space*

‘Those skills that you would usually have to sort out independently, if you were a practice nurse your GP would set you up, right, that’s the course, you go. Whereas the school does a layout, the training’s there, you’ve got the support, you’ve got your mentor.’

for leadership skills at all’ (FG2_NtoPN). Some had tried introducing new information to their practices but colleagues had not been receptive. These trainees hoped that they would be able to demonstrate leadership in the future:

I would hope that we can change things in the future when we are in a suitable position, that we will be able to make this change and inspire people. (FG2_NtoPN)

Trainees in both groups discussed a gardening project funded by QNI, which they believed was demonstrating leadership skills as it involved a project proposal, funding application, procurement, evaluation and dissemination. The project aimed to: *‘improve the mental health wellbeing and reduce stress and burnout among healthcare professionals’.* (FG2_NQN)

4.3 Experiences of the GPNFS

The trainees discussed at length the various elements of their programme: the GPNFS leads’ support; the Fellowship afternoons and peer support; and the Fundamentals of Practice Nursing (referred to as ‘Fundamentals’) course. Experiences of learning in general practice were also discussed extensively and are presented in a separate theme.

4.3.1 Structure and support

The trainees recognised that usually, new GPNs had to access the training required for the role independently and they appreciated that the GPNFS gave a structure, with the educational aspects, support and mentoring embedded:

Those skills that you would usually have to sort out independently, if you were a practice nurse your GP would set you up, right, that’s the course, you go. Whereas the school does a layout, the training’s there, you’ve got the support, you’ve got your mentor. (FG2_NQN)

The trainees unanimously appreciated the support from the GPNFS leads, and there were many comments about their passion, dedication and responsiveness to the trainees. The trainees considered the leads to be inspirational: *‘Their strive for gold standard and their passion and enthusiasm, it keeps us going’ (*FG2_NtoPN). Trainees described the leads as being like ‘guardian angels’ (FG2_NtoPN), who offered personalised support: *‘We have low days and they have literally mopped my tears up’* (FG2_NtoPN). Many considered that their support had been essential for their retention on the programme: *‘If we didn’t have the school I don’t think half of us would still be in the land of GP’* (FG2_NQN).

The GPNFS leads helped the trainees to understand the boundaries of their role so they could confidently convey this to their general practices, and they felt this gave them some protection from being pressured into skills they were not prepared for. Another NQN described how at her practice, nurses had left but the GPNFS leads had implemented additional support:

As a trainee and a newly qualified nurse I was just pushed into the deep end, but the school has come in and helped me when they can, as and when, and they’ve got a retire and return nurse come in to help me as well. (FG2_NQN)

4.3.2 Fellowship half days and peer support

The Fellowship half days were perceived very positively, providing additional learning to complement the Fundamentals and practice learning, and providing peer support, which trainees considered increased retention. The peer support element was an opportunity to discuss issues within the group: *'it's great to be able to come here and discuss our problems and see what everybody else is doing or going through'* (FG2_NQN). Trainees could clarify what they should be doing in practice, providing the confidence to express this to their practice.

The trainees recognised they all brought different experiences and they could learn from each other and offer support:

The school allows us 1) to connect and 2) to learn and grow from each other's skills. And just create that support network that otherwise we wouldn't get. (FG2_NQN)

The input on leadership had given them the skills to negotiate in their practices:

That's come a lot from the leadership things we've had about communicating and bargaining, I suppose, to be able to get what you need out of it. (FG2_NQN)

The Fellowship afternoons helped trainees to understand what best practice is and trainees could also bring back practice experiences to discuss in relation to best practice, which was particularly helpful where trainees were receiving conflicting information from their practices:

Foot checks document was one example, and one of my mentors, I said oh this is gold standard, we've learnt this and she said, well we don't do gold standard, this is primary care, get used to it type of thing. Then you come back and have that conversation with [GPNFS leads] and they say, no, actually, it is right to strive for gold standard, they are wrong. So, they lift your confidence back. (FG2_NtoPN)

Some trainees considered that the Fellowship afternoons were more valuable than the Fundamentals course, particularly as it was more applied to their practice: *'It's things that we deal with day in, day out'* FG2_NtoPN). Others believed the Fellowship afternoons filled in gaps and applied and consolidated learning from the Fundamentals:

The fellowship really has filled the gaps from the university course because without that I feel like I would have lost a lot of knowledge. (FG2_NQN)

The Fellowship afternoons included a range of external speakers, and trainees appreciated this additional input too: *'the people that have come in and taught us at the Hub have been very, very good'.* (FG2_NtoPN).

4.3.3 Fundamentals of Practice Nursing course

The trainees were all studying the Fundamentals course one day each week at a University. Although they were at different universities, the course still gave further opportunity for peer support, which was appreciated:

Although we're at different unis, there's quite a few of us in the year that go to [University] and we all see each other every Tuesday as well, so that's quite nice and on a Thursday we meet up as well. (FG2_NQN)

Some trainees found the theoretical component of the course stressful and suggested increasing the practical elements on the course: *'more practical aspects of what we're doing in the job that would be beneficial'* (FG2_NQN); *'It should be more your practical skills basically, a lot more in-depth stuff about wounds'* (FG2_NtoPN). They discussed invasive skills such as smears, for which they would have liked more practical experience through simulation, and they considered OSCEs would be beneficial too.

‘The fellowship really has filled the gaps from the university course because without that I feel like I would have lost a lot of knowledge.’

The different universities had varying programmes, so some covered skills such as smears earlier in the programme than others. Trainees believed there should be better alignment between the University courses. Others discussed that the Fundamentals course would be better delivered by the GPNFS, but there was also awareness that the courses had to be accredited academically. The trainees had found the information about contracts in the Fundamentals useful, as this was new learning.

4.4 Learning in general practice

Learning in their general practices is the largest part of the GPNFS programme and drew much discussion, with the main areas being: expectations of the trainees, being part of the team and relationships, and support and supervision in practice.

4.4.1 Expectations of trainees

In the first focus groups, trainees raised that some practices had unrealistic expectations of them. At these second focus groups, the trainees continued to discuss issues around expectations for example: ‘*the GPs kind of expect you – we’re qualified, so you know what you’re doing, get on with it type thing’* (FG2_NQN). There were some perceptions that understanding of their trainee roles had diminished as they had been there a few months now:

My surgery were brilliant at the beginning, but now I’ve been there longer, the doctors are like: you can do this, you can do that, you’ve been qualified this long now you should be doing that, and I’m like no, I can’t. (FG2_NQN)

Some trainees found that practices expected them to perform skills after attending a training session but without any subsequent supervised practice: *‘Your practice thinks that you’ve had two hours of training and now you’re fully fledged to be doing something’* (FG2_NQN). The trainees still found that some practices expected they could perform a skill after watching it once. Generally, they felt there remained a lack of understanding about their role as trainees: *‘the practices don’t understand that we’re trainees and we have to do this step by step’* (FG2_NtoPN). They contrasted these experiences with the supervision that GP trainees (registrars) received: *‘The regs come in and sit with them for hours, but we’re expected just to get on with it’* (FG2_NQN).

In addition, they found different practices had varied views about what the trainees should be doing: *‘we are all doing different things, some are allowed to do one thing, some aren’t’* (FG2_NtoPN). Trainees were aware that the GPNFS continued to remind the practices about their roles but still they were sometimes allocated to clinics that they had not yet been prepared for and had to inform the practices. Another aspect of variability was allocation of time slots for patients; some trainees considered that time allocated should be standardised between them:

I think it is important that if they take on trainees that they do standardise the clinic times. We’re trainees. Why is it okay that I have 40 minutes and you get 10 minutes? That is not okay. (FG2_NtoPN)

Trainees felt they should have longer allocated as they were still learning: *‘I need a bit of time to digest or go back over what I’ve just done and have I done everything?’* (FG2_NtoPN). The

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‘I think my practice has been very good in terms of introducing things, like at first there was more focus on hypertension and then I was independently doing hypertension reviews.’

trainees discussed the importance of preparation for mentors and the practices generally, as some had found the practices understood little about their programme:

Neither of them [practices] really knew what I was there for, what the programme was, what I was going to be doing and at what stage and it is still pretty ad hoc at the moment. They don’t really know where I’m at and what I’m doing. (FG2_NtoPN)

Trainees suggested that the practices needed more information and preparation about the GPNFS, including the trainee’s role and expected structure for them at the practice:

This is the role, this is what they can do for you and this is what’s going to happen in the next couple of months. And this is what we need you to do and your practice to do, and these are the hours they need and they’ve got to follow this structure. (FG2_NQN)

General practice staff discussed expensively the preparation and ongoing support received from the GPNFS and a structured approach for the first three months was now in place (see section 5.3.1).

4.4.2 Being part of the general practice team and relationships

Trainees discussed their experiences of being in a team at their practices and their relationships with colleagues. Some described very positive experiences: *‘where I am now I love it, I couldn’t fault it, everybody is nice, it’s such a supportive atmosphere’* (FG2_NQN). However, some trainees did not feel they were part of the practice team unlike other professional groups such as physician associates: *‘we’re not so much as part of the GPs’ team’* (FG2_NQN). Variation between practices was experienced too:

I do feel very supported by particularly the manager at one of my practices and I don’t think the manager at the other place has even spoken to me. (FG2_NtoPN)

There were some perceptions that relationships were affected by the business set-up of the practices, with nurses being employed by GPs. Some trainees perceived that the role of the GP nurses was poorly understood with a lack of appreciation of their role: *‘they’re not appreciated, they’re not given the right roles, they’re not given the voices that they need’* (FG2_NQN).

Some trainees described good relationships with GPs and felt able to approach them to discuss issues and ask questions. However, other trainees reported having little contact with GPs and partners, except at large practice meetings: *‘I could probably pass mine in the street and not recognise them’* (FG2_NQN).

4.4.3 Support and supervision in practice

There were many positive comments about the trainees’ mentorship and support in practice, for example: *‘My nurse is really good, and all of them to be fair, I could ask any of them anything and feel confident to do that’* (FG2_NQN). In some instances, however, it had been difficult to schedule time with mentors, particularly when there were staffing issues. Some trainees described support for developing their skills, for example:

I think my practice has been very good in terms of introducing things, like at first there was more focus on hypertension and then I was independently doing hypertension reviews. (FG2_NQN)
Trainees particularly valued staff who were approachable: *'I can knock on anybody's door and they'll come and help you'* (FG2_NQN). Others described how staff would make time to offer support:

She [lead nurse] always has the time to come and see me, and if I don't know something I can clearly just say I haven't got a clue what it is, and she will sit down with me and talk with me. She talks to me in a way that I know I can understand. (FG2_NQN)

Others, however, had different experiences and felt support was lacking: *'We don't have the support in our environment, somebody to help us when we are alone'* (FG2_NtoPN). Some trainees discussed variability between practice mentors and assessors, which they had discerned through talking to their peers:

I feel like everybody's different stories are: some have got it really well and they say I'm enjoying it and I've got it good whereas some of us, we haven't got it so good. (FG2_NtoPN)

Trainees highly valued the R&R nurse support in practice though their input seemed variable. One trainee described weekly support: *'I have one [R&R nurse] every Friday and she's fantastic'* (FG2_NtoPN). There were perceptions that some practices were unwelcoming towards the R&R nurses, as they would ensure learning was prioritised:

I know of other practices that have said, 'We don't want you.' [to R&R nurse]. They don't want them [trainees] to be learning, they just want workhorses. (FG2_NtoPN)

Some practices were perceived to see the R&R nurse support as optional and some mentors declined their involvement with the trainee.
If she's been employed to spend time with me and I'm not getting her, then that's not fair, is it? So, she could sit with me and do pill checks, contraception, diabetes and push me on quickly. (FG2_NtoPN)

Trainees felt that the R&R nurse might support trainee development as: *'I'm on my own doing NHS checks, day in and day out, ECGs'* (FG2_NtoPN).

4.5 Employment and career options

Trainees could see the need for GPNs and felt their role as trainees was contributing positively already:

A lot of patients are struggling to get in to see a nurse and they can't get in to see a doctor, so it's really helpful having us in the primary care setting to give them the help and advice they need. (FG2_NQN)

Trainees discussed two key areas: finding employment and negotiating terms, and career options as GP nurses.

4.5.1 Finding employment and negotiating terms

Trainees were conscious of having to find employment at the end of the programme and had been assured of support from the GPNFS. They were aware that they would need to negotiate their terms and conditions:

It's what you negotiate, isn't it? 'I want this admin time, I want to do this'. That's the difference with general practice, it's private and you have to negotiate what you want, you have to negotiate your terms and conditions which they have never hidden from us. (FG2_NtoPN)

Trainees discussed the type of practice they would prefer, with some preferring to work at a larger practice where there would be more support than in a small practice as a lone nurse. They

‘It’s what you negotiate, isn’t it? ‘I want this admin time, I want to do this’. That’s the difference with general practice, it’s private and you have to negotiate what you want, you have to negotiate your terms and conditions which they have never hidden from us.’

considered that taking up employment at a new practice was an unknown: *‘you don’t know until you start working with people’* (FG2_NtoPN). One of the trainees discussed the type of practice she would prefer:

I keep thinking I want to go somewhere where my wings are not clipped and they’re happy for me to be forward thinking and the dynamic person that I want to be. (FG2_NtoPN)

Some expressed they would take a cautious approach to ensure they found a practice where they would be comfortable:

You want to go somewhere that you enjoy and where you’re happy, ultimately, it’s about being happy with what we are doing day in and day out. (FG2_NtoPN)

The trainees, especially in the new to practice group, had varied views about their next steps, with some considering an agency or temporary post was a good way of finding a suitable practice, rather than taking up a permanent post from the start. Others expressed that completing the programme was their priority and they would then look for employment. One trainee was undecided about a career in GP nursing, because of the pay and conditions, and was also sceptical about there being posts in supportive practices for all the trainees but others were more optimistic about opportunities. Another expressed that starting a new post was always daunting:

When you start somewhere it’s always difficult, it’s like norm, all my life I’ve been facing that, so we have to be brave now when we start somewhere. (FG2_NtoNP)

4.5.2 Career options and aspirations

Many trainees were excited about future career options as GP nurses as the programme had introduced them to the different career paths and specialisms available:

You can specialise in one area like diabetes or respiratory or sexual health as well and women’s health, so there’s just so many options you can go down, or the advanced practitioner route is always available, so it’s nice to know that you can progress. (FG2_NQN)

Some trainees discussed the potential to do nurse prescribing, become a professional nurse advocate or advanced nurse practitioner (ANP), with some already investigating these possibilities. One of the trainees had entered general practice certain that she wanted to specialise in diabetes but was concerned about whether she would find a practice that would support her to follow this route. For others, career aspirations had changed since their experiences in general practice. For example, one trainee who was sure she wanted to become an ANP at the start had changed her views following her GP nursing experiences:

I’m not sure I want to be an ANP anymore because of the role the ANP does compared to a nurse and how not involved they are with the patients, whereas I’m really enjoying that in the role, being involved with the patients, so I’m actually looking at other routes. (FG2_NQN)

‘The trainees were very positive about the GPNFS structure and support provided, particularly by the GPNFS leads, and they believed this support had been instrumental for their retention in GP nursing.’

4.6 Summary

During the first focus groups, at the start of the GPNFS programme, trainees discussed the appeal of GP nursing (see section 3.1). At the second focus groups, these aspects were revisited and for most trainees, these factors continued to be attractive. The trainees were enjoying all the new learning opportunities and the variation and range of experience gained. Most had found the care continuity they had hoped for and enjoyed building trusting relationships with patients over time. Some trainees had been surprised by the level of responsibility and autonomy of the role and responsibilities of GP nurses. A few trainees were uncomfortable about some aspects of GP nursing. These mainly related to GP nursing being ‘behind closed doors’, with perceptions that it was less open to scrutiny than hospital nursing. Trainees had been surprised at the business orientation of general practices and there was sometimes discomfort about the associated financial lens. The trainees recognised the significant growth in their competence and confidence for GP nursing although they appreciated there was always more to learn. Some felt they were already demonstrating leadership, but others felt they had not had opportunities to apply these skills in practice yet.

The trainees were very positive about the GPNFS structure and support provided, particularly by the GPNFS leads, and they believed this support had been instrumental for their retention in GP nursing. The Fellowship half days were highly valued as the content extended their learning and was so relevant to their practice. They also appreciated the peer support offered and the range of external speakers. The Fundamentals course was a further opportunity for peer support, but some questioned the necessity of the level of theoretical content and they preferred the Fellowship half days, which were perceived as more practical. At the first focus groups, trainees conveyed concerns about the expectations of their general practices (see section 3.4.2). At the second focus groups, there were some similar discussions about practices that did not understand the GPN trainee role and the structured skills development. Feeling part of the general practice team was important to trainees, with some feeling more integrated into their practice than others. The trainees also had varied experiences of their support and supervision in practice. Some had very positive experiences with mentors and supervisors and the R&R nurse role was highly valued, though not all were able to access this additional support. The trainees were now considering their future employment as GP nurses and that this would involve negotiation of the terms and conditions. Many remained enthusiastic about the career opportunities in general practice, which had been an initial attraction of GP nursing (see section 3.1.5) and they had aspirations for further development, for example in specialisms such as diabetes.

5. Stakeholders’ views about the GPNFS and potential contribution

This section addresses Objective 5, which was to explore the views of a range of stakeholders about the GPN Foundation school and the potential contribution to the primary care workforce. Table 4 summarises the themes and sub-themes. Data extracts are included, identified as Lead1-5 for the GPNFS leads and Fundamentals course leads, and GPS1-13, for the general practice staff interviewees.

Table 4 Stakeholder interviews: themes and sub-themes

Themes	Sub-themes
The GPNFS development	• Drivers for the GPNFS development • Facilitators for the GPNFS development • Barriers and challenges for the GPNFS development • Aspirations for the GPNFS
The GPNFS elements	• Structure, organization and support • Fellowship half days and peer support • The Fundamentals in General Practice Nursing course
General practice placements	• GPNFS preparation and support for general practices • Learning in practice and support roles • Supervision and assessment in practice • Integration into the general practice team
Benefits and value of the GPNFS	• Development of competent, confident and employable GPNs • The value of the GPNFS to the primary care workforce

5.1 The GPNFS development

This theme includes four sub-themes that address the drivers, facilitators, barriers and challenges to the GPNFS, and aspirations for the GPNFS in the future.

5.1.1 Drivers for the GPNFS development

Stakeholders described a number of drivers for the GPNFS development and these related to the current non-standardisation of GPN preparation and GPN workforce issues.

Non-standardisation of GPN preparation

The stakeholders referred to the long-standing issue of non-standardised preparation for GPNs:

Having a background in general practice nursing, when we came into the role it was very much a pick and mix of education and training for the role, so there was no standardisation, and there's still none 20 years later. (Lead1)

The GPN role includes many skills that are not gained through pre-registration nurse programmes nor through secondary care nursing experiences:

Nurses came out of secondary care, were thrown in at primary care and had never done a cervical cytology test, had never done baby imms, had never dealt with many of the things that practice nurses are expected to do. (GPS_7)

There has been no established and consistent way of developing the skills for the GPN role. Following piloting, the Fundamentals course was adopted by Health Education England from 2016 (Mann and Boyd 2020) to provide a structured pathway for GPN development, but this is not compulsory:

Employers can choose whether their nurses go on that or not or they can start them on the programme and pull them out. (Lead1)

‘Having a background in general practice nursing, when we came into the role it was very much a pick and mix of education and training for the role, so there was no standardisation, and there’s still none 20 years later.’

Some general practices refused to send GPNs on the Fundamentals course as they considered it too long. GPNs could drop out of the Fundamentals course and still continue as GPNs, with concerns about the quality of GPNs employed. Training time for GPNs is not protected and has to be negotiated in individual practices, leading to inconsistencies in preparation with many GPNs undertaking training in their own time. GPNs are sent on short individual courses for different skills:

They'd [practices] rather send them on a Child imms training for a couple of days, or a couple of days smear training and then that's it but there is so much more to it than that. (Lead5)

Stakeholders described the unstructured nature of such an approach:

Almost you'd made your own course up and you would go on an immunisation course somewhere or you would go on a fundamentals course somewhere, so it was a bit higgledy-piggledy. (GPS_13)

Practices searched for courses for their new GPN: *‘it would be piecemeal training, the odd course here and the odd course there’* (GPS_12). The consequences of this current non-standardisation were considered: *‘a recipe for disaster really*’ (Lead5). One GP explained the impact of recruiting GPNs who had been prepared at other practices through individual courses; quality was so variable:

You could have practice nurses come through individual practices, so someone might come to us and [we'd] say: have you done a fundamentals course, yes, tick; have you had some training internally; have you gone on a smears course, yes, tick; have you done your vacs and imms, tick, and then they would arrive and it wouldn't take long, but you'd say: hold on, I thought you'd done this or you'd done that. (GPS_13)

In addition, stakeholders believed that preparation of GPNs through individual courses could be prolonged as it was not always possible for the nurses to access the courses needed in a timely way, depending on what time of year they started: *‘you got this void, so what are we going to do to make them useful between now and then’* (GPS_5). GPNs then experienced difficulties getting competencies signed off and they lacked support for developing the skills in practice:

It took us a couple of years to get them [new GPNs employed] up-and-running – both of them – to feel that they were confident and competent. And it was trying to get people to come and do smears, people to do baby imms and that sort of thing, to support them in practice. And it was time consuming on the practice as well. (GPS_1)

This stakeholder had found that the GP nurses had to work more in a healthcare support worker role, which they, and their practices, found frustrating and was not cost-effective: ‘*As a GP, they got quite frustrated with it because they were expecting a practice nurse to be coming in, up-and-running’* (GPS_1).

Another stakeholder estimated that preparing new GPNs through individual courses would take around two years and that they would need to be supernumerary for the first six months; they

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‘They would not employ a doctor unless they had done the GP training scheme so really for safety, for patient safety, we need to think: why aren’t we doing it for nurses?’

considered the GPNFS structure and support would expedite the preparation process:

It may end up, for the majority of nurses, a shorter pathway because it’s more condensed and more intense than if it was somebody who was just put in a practice as fresh nurse and then having to pick it up from either another nurse or from another member of staff. GPS_7)

However, there were other stakeholders who gave experiences of new GPNs who had been able to make the transition to GP nursing successfully despite the lack of a structured programme: *‘Obviously hospital nursing is completely different to general practice, and their working is absolutely fine and they are doing great’* (GPS_11).

Some stakeholders compared GPN preparation unfavourably with GP preparation:

They would not employ a doctor unless they had done the GP training scheme so really for safety, for patient safety, we need to think: why aren’t we doing it for nurses? (Lead5)

It’s sort of unfair, compared to what my GP trainees get: they have three years and would probably like five. (GPS_10)

GPN workforce issues

Many stakeholders discussed the GPN shortages and the numerous challenges associated with GPN recruitment and retention; it was hoped that the GPNFS would provide solutions. Like the trainees (see section 3.2), stakeholders referred to the barriers encountered to enter GP nursing:

We know that there are people who want to do the job as a general practice nurse because the job is a fantastic job, but it’s really hard to get in. (Lead1)

Despite there being many general practice vacancies, often nurses could not find employment in the field without the required experience: *‘it’s always been that GPs have wanted nurses to be experienced and just be able to come in and run the clinics’* (Lead2). Like GPN trainees, the stakeholders referred to adverts for GPNs that required experience in key skills such as cytology, immunisations and long-term conditions review. However, some general practices had employed newly qualified nurses and there were some very positive comments about how they had developed within general practice, rather than being expected to work in secondary care first:

We’ve got two practice nurses that are newly qualified that came through the old route before the GPN Foundation and they are absolutely phenomenal in terms of they have some special interest areas in terms of diabetes and one is going into sexual health, they literally are just lapping it up. (GPS_13)

The nature of general practice as ‘a well-kept secret’ was also discussed, with a lack of awareness amongst nurses in other parts of the sector about what the role involves. It was also discussed that student nurses were rarely able to gain experience in general practices, leaving them unaware of the role and whether they would like to work in this field*: ‘It isn’t a role that everyone wants to do and unless you have had a placement there you don’t really know’* (Lead1). A GP made a similar point, arguing for student nurses to be primarily based in general practice: *‘they could spend time*

doing some placements in the hospital, but be primarily focused on general practice' (GPS_12). Since the GPNFS starting, there had already been a greater drive to place student nurses in practices for a short placement, particularly where there were trainees in place as: *'we know student nursing placements have an impact on recruitment and retention into the sector'* (Lead1).

Many stakeholders mentioned the shortage of GPNs in the workforce with high sickness rates and vacancies, large numbers retiring, poor retention and a lack of a pipeline of new GPNs to fill the gaps. A business partner described that currently, practices were: *'robbing Peter to pay Paul: we just move the problem from one practice to another practice'* (GPS_7). When a vacancy occurred, practices relied on recruiting a nurse from another practice:

You hope that one of the nurses in one of the other practices isn't happy or wants to come – or it's close to home for her or something like that. Because the nurses just go around. (GPS_7)

One stakeholder explained that without support, GP nursing is: *'just not an appealing option'* (Lead2). In addition, retention was poor and from exit interviews, reasons for new GPNs leaving were explained, which included lack of support, unreasonable expectations and isolation:

It is around lack of support, being asked to work outside of competencies and just feeling so isolated and the lack of support and training really. (Lead1)

Many stakeholders reiterated that the lack of support for new GPNs was a major issue in retention. The general practice environment was considered high pressured and there was a lack of resources to supervise and assess new GPNs, who could feel isolated, particularly if they are not released to take up the Fundamentals course. Even for those who are supported to take up the Fundamental course, they may lack support in practice, particularly as part of a small team: *'Where do they go with their queries? Who understands their role? Who understands their learning needs?'* (Lead2). Thus, retention on the Fundamentals course could be poor due to lack of support and other workforce issues:

One of them, the practice terminated their contract, partway through on the basis that they wanted a more experienced nurse, even though they signed up to a funded programme that they were going to support an individual. And the others were just generally struggling in terms of the support they got in practice. (Lead2)

A number of stakeholders referred to the potentially isolating and lonely nature of GP nursing: *'I think practice nursing is very well known for being quite a lonely role'* (GPS_6). However, some stakeholders considered that the culture of the practice affected levels of support too:

I know some practices may put the nurse in a room and leave them to get on with it, kind of thing. Personally, that isn't the way that my practice operates and I don't think it's the right way. (GPS_7)

Stakeholders discussed the nature of general practice, and the importance of GPNs having access to support with decision-making:

I do worry sometimes, when we recruit, that I'll find that nurses have been left without support or without that kind of – I guess – encouragement to ask. Because that's a scary thing: making a clinical decision and not knowing you've got that back-up or that it feels like a team. (GPS_10)

With the loss of experienced nurses through retirement, there was a lack of support available to new GPNs, who could feel very isolated: *'it can be quite lonely and you are having to think on your feet and make decisions there and then'* (Lead5). The problems were particularly acute for new GPNs recruited to practices as lone practice nurses. Stakeholders considered that with pressures on primary care, practice staff did not have the time to support new GPNs with the risk that they would quickly leave; it was hoped that the support structure provided by the GPNFS would address this issue: '*these [GPN trainees] will go in and they won't leave: they'll be a good member of staff for them'* (GPS_1). A GP shared experiences of recruiting and training new GPNs prior to the GPNFS:

‘I do worry sometimes, when we recruit, that I’ll find that nurses have been left without support or without that kind of – I guess – encouragement to ask. Because that’s a scary thing: making a clinical decision and not knowing you’ve got that back-up or that it feels like a team.’

With the nurse we took on who was new to NHS primary care [non GPNFS trainee], we tried to do that [support] in-house, but, without that support and back-up. So, ‘it’s ok not to know everything, you take this section first’ … I think she, perhaps, put herself under pressure. (GPS_10)

There were views that the GPN role was not always appreciated, especially as there were now such a range of professions within general practice:

There’s so many roles and possibilities within general practice: we just need general practice to actually see the GPNs’ value in terms of the service that they offer. (Lead2)

One stakeholder emphasised the value of GPNs, referring to their impact on quality and income to practices, but also pointing out their role within the multi-disciplinary team as GPNs are:

Super connectors of everybody else, so every other role that’s working in primary care needs a GPN, because they connect everybody. A GPN is such a generalist that they can do so much of the role; a lot of the other roles are very specific so they don’t overlay. (Lead1)

A GP also referred to the importance of recognising the professional role of the GPN and expressed concerns that: *‘we are in danger of de-professionalisation of primary care’* (GPS_10). Stakeholders considered that there was a lack of understanding of the GPN nurse role: *‘even with really understanding GPs, they don’t really understand the role of the general practice nurse: it’s not their role’* (Lead2). A GP echoed this point from their own experience: *‘I think for me, the recognition of what practice nurses do, in some ways it’s taken me a long time as a GP’* (GPS_13).

The need for change to address these workforce issues was summarised by one stakeholder:

There’s no point just keeping doing what we’re doing and it’s not working, we have to make change don’t we, if we keep recruiting nurses in the same way and treating them in the same way then we’ll get the same answer and we’ll still not have retention. (Lead1)

5.1.2 Facilitators for the GPNFS development

The drivers led to the GPNFS leads developing a business proposal and they had found good support from other stakeholders who had been: *‘on board with our vision’* (Lead1). The support included the local Primary Care Networks (PCN), the Staffordshire Training Hub, Staffordshire and Stoke Integrated Care Board and local universities, and national support from NHS England and the Queen’s Nursing Institute (QNI). Having these major stakeholders onboard meant that while finance remained a challenge, funding could be accessed sufficiently to launch the GPNFS. An example of support gained from local stakeholders included: *‘She [the GPNFS lead] had the passion and I supported her from a GP First perspective as the director responsible’* (GPS_7).

It was clear that leading the proposal to fruition had required determination and passion for the development:

When they [stakeholders] realise you’re not going to go away and you’ve got that passion about what you’re trying to do and you’ve got that real reasoning behind it, then suddenly you get

The Effects of

> ‘Having our nursing team being in an educative role keeps them up to speed and it encourages them, and they learn from new things that are going on.’

people on board with you and they get dragged along as well. (Lead1)

The GPNFS development involved liaison with multiple stakeholders including general practices and primary care networks (PCNs), promoting understanding of the GPNFS and willingness to take on GPN trainees:

We normally discuss it with the Partners and the Senior Nurse because obviously she is going to have a lot of dealings with them because obviously they have got to be signed off, so yes, we had a discussion and we were happy to have them. (GPS_11)

Some general practice staff referred to succession planning being a factor in their decision-making. A practice manager highlighted that general practices should be willing to invest in the workforce and spoke positively of their experiences:

I understand some practices are not willing to take on but I think it’s a good experience, from my point of view I don’t have anything negative to say, it’s all positive. (GPS_11)

A GP explained that their general practice already had an educational ethos and therefore taking a GPN trainee was not a major decision:

For us it wasn’t a big shift, so we already had the people, the support; the idea of what we’re going to do when, was already in place. (GPS_13)

There were considered to be benefits to the general practice team of having trainees within the general practice:

Having our nursing team being in an educative role keeps them up to speed and it encourages them, and they learn from new things that are going on. (GPS_12)

5.1.3 Barriers and challenges for the GPNFS development

The GPNFS leads referred to how the development had been stressful at times and needed considerable determination and persistence. The key challenges were identified as finance, employment, and general practice and PCN engagement. The cost to the PCN had to be agreed by all members. With current funding issues in primary care, agreeing the financing was challenging: *‘They cost money and that’s difficult because general practice at the moment is in a difficult state’* (GPS_12). It was considered important, therefore, that general practices appreciated the GPN role: *‘that’s always going to be the challenge: that practice itself actually sees the value of this role’* (Lead2). It was pointed out that GP trainees have their salary funded nationally but for GPNs, there were legal barriers to a similar structure: *‘We were told this was to do with law and it would require a change in the law to be able to get nurses’ salaries included in this kind of training scheme’* (Lead1).

Engaging general practices was also challenging, with one factor being that general practices are in the independent sector, so even national support was not sufficient: *‘Because it’s independent sector it is not necessarily seen as NHS England’s domain either’* (Lead5). Whilst sufficient practices had engaged in the first year of the programme, these were only a small proportion of the total number: *‘considering we have got over 140-odd GP practices, we have only got 15*

on board for the first cohort' (Lead5). However, there had been more interest for the Cohort 2 trainees from general practices: *'they're a little bit more willing to have the conversation'* (Lead1). A practice manager had been approached by other practices about recruiting their GPN trainee and she advised them that they needed to invest:

I've told them [other practice], you need to take on a GPN [trainee] because that's somebody who can have a role going forward with you. So, yes, you have got to invest a little bit but at the end you've got a practice nurse at your practice. (GPS_11)

However, this practice manager highlighted that some general practices did not have nurses who could supervise GPN trainees, posing another barrier. There was recognition that some general practices may be wary of losing control, as the recruitment and selection is conducted through the GPNFS:

Practices don't generally like losing control of who they're getting and if they're paying the salary some of them think: do we get a say in who is coming. So that's been a lot of partnership working to get over those kind of challenges. (Lead1)

This stakeholder recognised that it could be 'quite a big ask' of general practices for them to give up the control that they had previously had, especially being independent sector as: *'nurses have very much been under the control of a practice over the years'* (Lead1). Similarly, a general practice partner identified a disadvantage of the GPNFS as being the need to liaise over decision-making about the GPN trainee: *'we might have to say we'll just need to check that out with them because they need to be aware, whereas normally we would have just made that decision'* (GPS_5).

5.1.4 Aspirations for the GPNFS

Many stakeholders discussed aspirations for how the GPNFS should develop in the future. It was considered that there needed to be a long-term vision around GPN preparation: *'we have to look ahead, we need to look five years, ten years, fifteen years ahead'* (Lead1). As the GPNFS was only available to a small number of GPN trainees, there were hopes that it could, in the future, become the established way of preparing GPNs, so that there was equity of experiences across new GPNs:

I think the GP Foundation School needs to be a bit more widespread, it would be nice for all practice nurses to get that extra level of support rather than a select few. (Lead4)

There was acknowledgement that currently within Staffordshire, there were trainees from the GPNFS studying the Fundamentals alongside other GPNs and so: *'from a fairness point of view it would be better that everyone gets the same, like the GP training school*' (Lead5). There was emphasis on valuing the GPN role in the same way that GPs are valued:

They've done it with GPs, we need to put value in GPNs, they are core members of primary care staff, we need a way of ensuring quality, competent, safe practitioners. (Lead1)

Others considered that this approach should be national, as the issues around GPN preparation were across the country: *'nurses across the country are all in the same predicament really'* (Lead5). It was considered that there should be national alignment between GP and GPN preparation:

We want this programme to roll out regionally and we want it to be national, and what we want people to see is that when anybody comes into the general practice nursing role, they should come through a programme like this, like the GPs do. (Lead1)

A general practice business partner emphasised the importance of the GPN role: *'We need nurses in primary care the same as we need doctors in primary care'* (GPS_7). It was hoped that that new GPNs would be recruited from those graduating from the GPNFS, so that all new GPNs have been through standardised preparation and support. In that way, there would be succession planning inbuilt rather than recruitment being reactive as currently:

'I think the GP Foundation School needs to be a bit more widespread, it would be nice for all practice nurses to get that extra level of support rather than a select few.'

Workforce cannot be developed in six months, we can't say my nurse is leaving, I need a new one next week and expect a person coming in to be able to do the job, we have to foreplan, workforce planning cannot be done in the short term, we have to look ahead. (Lead1)

There had already been sharing of the GPNFS development regionally and nationally through conferences, with considerable interest. However, funding remained the challenge and secure financing was essential for sustainability of the GPNFS, achieving a national approach and, ideally, achieving a GPN Deanery:

In an ideal world we'd have a GPN deanery, that's where we need this to go and we need national support for that because the finance is always tricky and the way the NHS is now it is difficult, but we have to put value into nursing. (Lead1)
Other ideas for further development of the GPNFS included more interdisciplinary learning with GPs as:

We need to make sure that the core roles of general practice, the very core doctor and nurse roles, are trained properly and why not do some of it together for the core roles? (Lead5)

Furthermore, the student nurse associate programme could be integrated into the GPNFS as a career pathway, thus ensuring that: *'we can protect that career pathway and make sure that roles are being used in the right way'* (Lead1). However, a GP highlighted that there are a range of roles in primary care and that all roles needed protection, not only GP nurses as: *'the workforce really should be designed to meet the need of what we need to deliver'* (GPS_13). One stakeholder considered that the GPNFS should be a two year, rather than one year programme, so that new GPNs could then apply their learning while still being supported in practice. Another stakeholder suggested that rotation placements for trainees would broaden experience and provide better preparation for working within a PCN.

Several stakeholders emphasised the need for central funding for GPN preparation, as for GP trainees, believing that currently, the cost to general practices and PCNs could be prohibitive; central funding would encourage more practices to be involved: *'that opens opportunities for more practices to look at whether or not they would like to come on board with it'* (GPS_7). A key consideration was that general practices valued the GPNFS: *'more than anything, it needs the backing of general practice itself to see its value'* (Lead2). It was emphasised that collaboration with GPs was essential, as they are employers of GPNs.

5.2 The GPNFS elements

The stakeholders discussed the structure, organisation and support offered through the GPNFS, and the contribution of the Fellowship afternoons and the Fundamentals course. General practice placements are discussed in a separate theme.

5.2.1 Structure, organisation and support

One stakeholder considered that the whole approach of the GPNFS gave a sense of value to the GPNs, providing a positive ethos about the opportunity:

'You've been invited into this opportunity: it's a great opportunity. We really want you to succeed':

‘They’ve got the right peer support in progress, we reduce the isolation, we reduce the reasons why people leave really quickly.’

the value of the general practice nurse: all of those things have completely shifted the way that they feel about it before they start. (Lead2)

The structure of the GPNFS was informed by previous experiences of different programmes for developing GPNs locally and nationally. One feature of the programme is the protected study time, including the Fellowship half days (see section 5.2.2) and the Fundamentals course (see section 5.2.3). There were a few comments on the impact of this time release from the practice. One stakeholder commented that the study time was good for the trainees but not necessarily for the practice. A business partner’s initial impressions were that trainees seemed to be out of the practice frequently, but this view seemed part of adjusting to the new model: *‘now that we’ve got through eight or nine months of doing it, it’s something I think you need to accept’* (GPS_7).

The features of the GPNFS were set up to remove reasons for poor retention, which include isolation and lack of support: *‘They’ve got the right peer support in progress, we reduce the isolation, we reduce the reasons why people leave really quickly’* (Lead1). A small cohort of GPNs had been prepared locally with a similar scheme some years previously in North Staffordshire, and there had been good retention in general practice: *‘so we knew it did work’* (Lead5).

Overall, stakeholders commented very positively on the structure in place through the GPNFS, in which nurses were employed in a training post through a centralised employment model, which is similar to that for GP trainees. This means that all the trainees are paid the same training rate with standardised pay and conditions, which removes the competition between the practices during the training year. The PCNs and general practices have to commit to paying the trainee’s salary during the training year, but they receive a supervision grant to support the practice supervision. It was acknowledged that for experienced nurses on higher Agenda for Change pay bands, taking up the post will mean a drop in salary. The centralised employment model means that the GPNFS manage recruitment, rather than individual general practices:

We’ve got control, if you like, in terms of the trainees, who has been recruited, that they’re the right quality of candidate, they’ve got a genuine interest in general practice nursing for the right reasons. (Lead1)

The recruitment through the GPNFS moved the associated employment processes away from the general practices, and some acknowledged the advantages:

General practices are independent employers and you take a risk on when you employ someone, and you hope you’ve made the right decision, whereas all that was done by them [the GPNFS]. (GPS_5)

There was no obligation on either side for the trainee to remain with that practice after the training year, which a GP partner considered had some advantages:

I suppose the easy thing for us then is to say after that year: does she suit us, does she fit into our team, and so if she doesn’t then there’s no hard feelings, you’ve done what the ask was which was to train and support them, and if it hasn’t worked out at your practice for whatever reason, for them and for us, because ultimately they might not want to stay either. So that’s quite a nice relationship I feel. (GPS_5)

There were positive comments from the general practice stakeholders about the quality of the

GPNFS recruitment processes. In placing trainees into general practices, the GPNFS considered the size of the practice and support available, and tried to ensure the trainees were not having to commute too far from home. As the general practices were not involved in choosing their trainees, it was important to try to achieve a good match between the trainees and practices.

What is really important for us is to try and match somebody to the characters of a practice as best we can, so we do get to know our practices and what kind of person we think will thrive in their environment. (Lead1)

General practice stakeholders expressed confidence that the GPNFS knew the individual practices well enough to make suitable matches with trainees:

I think the GPN School has got quite a good insight into practices so I feel like when they're looking at candidates, they will know which practices are maybe stronger in supervision and education maybe, and I know they look at where people live. (GPS_5)

There were plans to enhance interview and selection processes further for the next cohort to ensure the trainees had good insight into general practice, get to know the candidates better and optimise the matching between the trainees and general practices, enabling the trainees the opportunity to excel. The plans included initial shortlisting, then a face-to-face group day with activities, prior to individual interviews.

The structure of the GPNFS, which builds in the Fundamentals course and Fellowship half days, removes the onus on practices to source training courses for their new GPNs: *'In some ways it makes it much easier because previously we would have to find courses'* (GPS_13). General practice stakeholders commented positively on the sequencing of the programme meaning that trainees were quickly prepared for skills that they could then apply in practice. Previously nurses had to wait longer to access the courses needed:

So initially to make a difference they looked at children's vaccinations, so quite quickly we were able to support and supervise that to get it up and running and seeing children, so that was fantastic. Whereas previously to this you may have needed to sign up to a two-day immunisation course and then waiting three months for the course. (GPS_5)

One general practice stakeholder considered that undertaking smear tests should be earlier in the programme to allow enough time for trainees to carry out the number of supervised smears required. However, highlighting the contrast between different size practices and experience available, another stakeholder expressed that as large practices may have dedicated clinics for skills such as smear tests, these practices could complete supervised practice for trainees more quickly, enabling quicker progression: *'it's not a criticism of the set-up, but does it truly fit with our needs?'* (GPS_13). However, it was believed that the GPNFS was designed to meet the needs for traditional practices, rather than large practices with additional facilities.

A few general practice stakeholders highlighted that the centralisation meant some trainees having to travel some distance for the Fellowship half days, so the morning in the general practice was shortened. Stakeholders highlighted that as the practices are paying for the trainees but do not have the control over them, it is essential that the GPNFS are clear on their governance, and they expressed the expectation that the GPNFS would be ensuring that the trainees are achieving the requirements needed to be competent and employable GPNs.

There were many positive comments from stakeholders about the GPNFS having a good balance and being well planned and organised. It was felt that the GPNFS development had taken into account feedback from stakeholders:

They did ask us on feedback about what bits would be really integral to help them settle, and so that certainly appears like it was listened to because it's very clearly mapped out, so you do get the best from them. (GPS_5)

Stakeholders commented that the GPNFS is preparing trainees to be competent GPNs:

'What is really important for us is to try and match somebody to the characters of a practice as best we can, so we do get to know our practices and what kind of person we think will thrive in their environment.'

It's giving them all the competencies and confidence to be able to go out in that workforce and look after our really vulnerable and complex patients that are out there, that are needed: being proactive. (GPS_1)

An important component of the GPNFS is the support structure, which includes the GPNFS leads, the peer support through the Fellowship half days, the support through the Fundamentals course and the support from supervisors, mentors and R&R nurses. This support structure was described as: *'wrapped around'* the trainees and a *'safety net',* especially for newly qualified nurses (Lead2). Trainees discussed the support from the GPNFS extensively (see section 4.3.1) and stakeholders also emphasised the importance of the support element. Some trainees had discussed that the GPNFS support was essential for their retention and stakeholders echoed this view:

You can see when they're down, you can see why people leave the job and we've managed to support them to the point where they're back up on a high again and they've stayed and they're actually loving what they're doing. (Lead1)

There was an emphasis on the well-being of the trainees, recognising that the GPN role can be overwhelming for new GPNs. Where issues arose in practice due to sickness or loss of GPNs to support trainees in practice, stakeholders recalled that the GPNFS were able to step in with additional support: *'she has had that back-up, which is good'* (GPS_10). The support to enable the general practices to continue to host the trainees, even when encountering challenging circumstances was emphasised: *'the practices feel supported in the challenges that they face as well by us putting in additional support'* (Lead1). It was explained that the GPNFS has also tried to support new GPNs who are not part of the GPNFS, who gained from peer support with the trainees, and some problems could be addressed:

They've been able to share the problems they've had in practice and we've been able to resolve some of the things for them and talk about the best way round it. (Lead5)

5.2.2 Fellowship half days and peer support

Stakeholders extensively discussed the Fellowship element of the GPNFS, with both the additional learning to complement the Fundamentals course and the peer support being key strengths:

I do know that the Fellowship is where they meet up, they get that rapport, they get that support and they get the learning from the Fellowship as well. So I think the Fellowship is one of the best things from it, really. (GPS_1)

The Fellowship learning was aimed at assisting trainees with applying theory to practice and the benefits were emphasised: *'It really does help to consolidate that learning so that it's not quite so strange when they hit the GPs'* (GPS_9). The Fellowship half days included the flexibility to address the trainees' learning needs: *'The beauty of the school curriculum is that it can be flexible to include extras as needed, which is important'* (Lead5). Examples were additional input on disability and addressing new government priorities. In response to trainees' requests, additional

‘We’ve been able to draw on some really experienced nurses to come in and speak as part of the programme that have been really inspirational […] normally nurses wouldn’t have had that opportunity to hear that and to have those conversations and to ask those questions.’

learning on wound care, hypertension management, chronic swelling and lymphoedema were added. There is a clinical topic of the month identified and patient safety is threaded throughout the Fellowship. For future cohorts it was recognised that further input from patients and practice managers would be valuable. It was important that the Fellowship content did not replicate learning on the Fundamentals course. Instead, the Fellowship half days aimed to add further depth and apply learning to practice, particularly where there were topics trainees were struggling with:

How has uni gone this week, is there anything in particular that you’ve struggled with that you need a bit more time on and then I can plan that into a bit of time in the curriculum. (Lead5)

A general practice-based stakeholder had found their trainee appreciated the Fellowship half days as an opportunity to reconnect and raise any concerns: *‘With the regular check-ins each week, that’s a great time to clear up any queries or questions and things’* (GPS_6). The Fellowship half days also aimed to broaden out the learning:

They’re getting extra theory relating to the clinical practice and relating to the role that they do from the GPN School as well: it’s not all just from the course that we offer at [HEI]. (Lead2)

National policy and resources from the QNI are also used for determining the content, and guest speakers are invited:

We’ve been able to draw on some really experienced nurses to come in and speak as part of the programme that have been really inspirational […] normally nurses wouldn’t have had that opportunity to hear that and to have those conversations and to ask those questions. (Lead1)

There was an emphasis on service developments and developing leadership skills too, which were additional to the Fundamentals course. The Fellowship also included aspects specific to general practice including working in the independent sector, the general practice contract and the role of integrated care boards. It had been found that trainees were unprepared for the business side of general practice and that there was some associated unease so content about the independent sector was a helpful addition. Developing consultation skills for general practice was a further topic included, which addressed time management too:

They are very aware they have got an appointment system to keep to. Whilst some patients will take a bit longer than you’ve been given, you have got to manage your time quite well so we’ve talked a lot about how you would manage things and prioritise things. (Lead5)

There had been three shared learning sessions with GP trainees: *‘that’s really broken down some of the barriers between the two roles and the value between each other’* (Lead1). These joint sessions on topics common to GPs and GPNs were well received and it was hoped to extend these opportunities for the next cohort. The clinical supervision as part of the Fellowship was considered invaluable and supported well-being as well as being linked with the Professional Nurse Advocate role, which was introduced during the Fellowship. Clinical supervision provided a safe space for the trainees to ask questions, and it was hoped that trainees would appreciate the value and negotiate clinical supervision time when they apply for GPN posts. A GP emphasised

the value of reflective practice that was offered by the Fellowship, aligning this with opportunities offered to GP trainees as: *'the GP trainees that I've seen that excel, they're the ones that are using that [reflective practice] and benefiting from it'* (GPS_10).

The Fellowship half days offered a safe environment for the trainees to share experiences and support from their peers:

Getting peer support and getting an opportunity to get together with peers is really important when you're learning. (GPS_12)

A 'burning issues' session was included to give trainees opportunities to discuss any concerns and to learn from each other. Previously, new GPNs, especially at small practices, could be isolated and lack peer support, in contrast to the GPN trainees who gained peer support through the Fellowship:

They share their challenges, they're not isolated like previous groups of GPNs. GPNs have generally been employed at any time of the year so you might feel like you're the only new starter (Lead1)

General practice-based stakeholders had observed the value to their trainees of being able to share experiences: *'Being able to liaise and communicate with her peers definitely helps make sure that things are being done properly and how they should be'* (GPS_6). This regular contact during the Fellowship enabled the trainees to grow together as a group and feel part of a network: *'There's a real collegiate sense amongst them. And I think a lot of that comes from the fact that they've done a lot of stuff together outside of the university'* (Lead2).

5.2.3 The Fundamentals in General Practice Nursing course

Stakeholders expressed positivity towards the Fundamentals course which was well established as a pathway to prepare new GPNs:

We do want people to be trained in the right way, standardised and with a qualification at the end of it to value the role of a GPN, so Fundamentals goes without saying. (Lead1)

However, as discussed in section 5.1.1, it was not mandatory for new GPNs and there were concerns that it was not sufficient for preparing new GPNs on its own:

We know it's the right thing to do, we know it should be gold standard, and it does vary across areas, but on its own it's not enough, it needs to be part of the package. (Lead1)

The Fundamentals course included links with the Training Hub, and there were practice education facilitators to support students on the course. The GPNFS leads had collaborated with the universities that deliver the Fundamentals course during the GPNFS development. There was already an established relationship between the GPNFS leads and Fundamentals course leads. Discussions included how the GPNFS could best run to incorporate the Fundamentals course and provide support to trainees. There were discussions around logistics including choice of days and content sequencing:

Things that would allow them to run the school for the benefit of the students really, so that they could see where certain things would fall and how that would help with practice. (Lead2)

There was positivity about the communication and collaborative working, which was considered essential for success:

We keep each other informed of what's happening with our students so the communication is quite liquid I would say between the two of us, so from our experience as a university it's been very professionally run. (Lead3)

Fundamentals course leads described ease of contact, regular meetings and liaison with the

‘They share their challenges, they’re not isolated like previous groups of GPNs. GPNs have generally been employed at any time of the year so you might feel like you’re the only new starter.’

GPNFS leads, to ensure there was no duplication of learning and they described contact as easy. There were a few challenges identified and compromises necessary with timetabling, especially as there was external involvement in timetables. The sequencing of content on the Fundamentals to meet the needs of general practice is an important consideration for course leaders, for example, they aimed to include immunisation and cytology early in the course. However, being a university validated course, there were certain constraints for course leaders, as modules had to be based in a specific pathway and could not be simply removed, especially as academic processes and approvals needed to be followed to make changes.

It was recognised that the Fundamentals course was demanding, especially with all the learning in general practice too, and some trainees had needed assignment extensions. One general practice stakeholder had found their trainee struggling with the academic side initially, but she had actually progressed well. It was acknowledged that the Fundamentals course aimed to prepare new GPNs and was a foundation for further learning:

You can’t become an experienced practice nurse in the space of twelve months and that’s never, ever, the intention to try and suggest that individuals can. It’s about giving them that fundamental introduction to being competent. (Lead2)

However, it was believed that some general practices did not recognise the role of the Fundamentals course, believing that the course input alone was sufficient to prepare GPNs for certain skills:

I think a lot of practice managers and practices are very mystified by the Fundamentals course. They think one day on contraception is going to allow you to do it the next day or immunisation in a baby clinic the next day; it’s not about that. (Lead3)

Fundamentals course leads had to manage modules with both GPN trainees who were part of the GPNFS and new GPNs who were not. They described being aware that the GPNFS trainees had additional input and support but had ensured that they had not illuminated these differences during the course and focused on delivering the Fundamentals course, and providing equal levels of support, which included liaison with clinical practice facilitators (CPFs):

We treat everybody the same so, all of the 14 students that I have, I make sure I have interacted with CPFs and their mentors to make sure and if they are having problems then they keep me informed. (Lead3).

Course leads reported not being aware of any differences between the two groups of students on their modules.

5.3 General practice placements

Placements in general practices comprise the largest component of the GPNFS package and drew a great deal of discussion. Whilst new GPNs can be recruited into any general practice, regardless of the ability to support their development, the GPN trainees are only placed in general practices that meet a certain standard and can provide supervised practice:

‘You can’t become an experienced practice nurse in the space of twelve months and that’s never, ever, the intention to try and suggest that individuals can. It’s about giving them that fundamental introduction to being competent.’

The supervision and practice, we know that without it people will leave, they don’t feel safe in practice, they need somebody there to tell them and guide them in the right way and that quality assurance of that learning environment is key. (Lead1)

The areas discussed included the preparation and support for general practices taking the trainees, learning in practice and support roles, supervision and assessment in practice, and integration into the general practice team.

5.3.1 Preparation and support for general practices

Stakeholders described the preparation for general practices for taking on the GPN trainees, and the ongoing support provided. There were very positive comments about the GPNFS, including that they were very up-to-date and understood the primary care drivers very well. The preparation was considered comprehensive with regular information via email, presentations about the GPNFS and Teams meetings.

General practice staff described effective communication with the GPNFS and they had been able to contact the GPNFS if they needed any support, for example, with specific skills assessment, or ongoing support as needed: *‘If we’ve had an issue then we’ve been able to contact [GPNFS lead] direct and she’s been able to signpost us from there’* (GPS_12). Another GP described accessing initial support from the GPNFS to ensure they were preparing a robust programme for their GPN trainee and they later contacted the GPNFS for additional support for their trainee:

We had a period of time where the lead nurse went off sick and I just emailed the team and they made sure that [trainee] had that extra back-up. So they’ve been fab. (GPS_10)

The GPNFS leads set up a WhatsApp group for supervisors so there was direct communication. There are monthly meetings for the R&R nurses, who also have a WhatsApp group so they can share issues or ask for support: *‘If I’ve got a problem or anything, I just go on the WhatsApp, and somebody will always come back’* (GPS_1).

The GPNFS leads had sometimes found communication with PCNs and practices challenging as they were so busy and gaining responses could be difficult. There had been some quality assurance issues to address with some practices. In most cases, the practices were very responsive: *‘we’ve managed to sort it out and it’s been done on a very professional, calm level’* (Lead1). There were a few cases where staff had been less receptive, which was found stressful to deal with.

For trainees experiencing problems in practice, there is a quality assurance process, where they first discuss concerns with their supervisors. If the issue cannot be resolved, the trainees contact the GPNFS who arrange a meeting with the practice, and usually issues can then be resolved:

Generally, once we’ve got involved the practices have improved things for the trainee, they have listened and they have been prepared to make a few changes. (Lead5)

One example was around trainees having standardised, longer timeslots for consultations:

Making sure you've got the right time, it's our job to support them and if we are not aware of it then we can't help but we dealt with that. (GPS_11)

Another practice issue raised was about giving the trainees too many responsibilities too soon; GPNFS leads had to intervene with guidance: *'we have had conversations with supervisors around, oh we think that's a bit too quick'* (Lead1). The GPNFS leads worked with supervisors to support action plan development for some trainees, as well as clarifying expectations of the trainees on some occasions. There were times where supervisors were guided to push trainees further, and GPNFS leads had supported with action plan development:

We have had to put in place action plans for some of the trainees to help them move on a bit because some of them have been a bit stuck but we've also used that to help the practice really. We've not used it in a critical way for the trainee but we've used it to try and help everybody so that things can start to progress a bit more. (Lead5)

In response to supervisors and to clarify expectations of the trainees, the GPNFS leads had now developed a guide for the first three months, linked to the trainees' learning in the Fundamentals course and Fellowship:

So we would expect them to be doing their baby immunisations independently by Christmas, their cytology by Easter, those kinds of things that give supervisors in practice a bit of a trajectory of what to expect. (Lead1)

On rare occasions, issues could not be resolved and one trainee was moved to another practice to ensure they were placed in an appropriate learning environment. GPNFS leads considered that in some situations, trainees would have left GP nursing, had they not been able to access support from the GPNFS. Nevertheless, there had been two trainees, both new to practice, who left the programme. One had missed her field of practice more than expected; the other left despite additional support from the GPNFS: *'We did put an action plan in place and she did make quite a lot of progress but she still made the decision not to stay'* (Lead5).

5.3.2 Learning in practice and support roles

Learning in practice was recognised as essential and irreplaceable:

The clinical time in practice is absolutely vital, I think, you can't really learn it from simulation and things like that, you've got to actually be there with the patient who will throw all sorts of things into the discussion. 'Oh, whilst I'm here can I just talk about this and that and the other'. (Lead5)

A Business Partner emphasised the importance of recognising that the trainees should be learning and developing in general practice, rather than being used as 'work horses':

So 'They can do bloods,' 'They can do this,' 'They can do that.' So the competence on a fairly low threshold of jobs that, basically, maybe, a senior HCA could do and they just make them do lots of it. And that's got to be avoided at all costs because that isn't the ethos and that isn't why we had the Foundation School in place. (GPS_7)

The GPNFS described the expectations for the trainees to develop over the twelve months, rather than just *'being thrown in at the deep end'* (Lead1). At the initial focus group with trainees, there were discussions about making the transition into their trainee role in general practice (see section 3.4.3). Stakeholders recognised that newly qualified nurses were making the transition from being student nurses and needed preceptorship, while the new to practice nurses also had adjustments to make, especially if they had been in senior hospital roles. A GPNFS lead had found that newly qualified nurses had less preconceptions and were very motivated: *'you've got a nice clean slate'* (Lead1). New to practice nurses could be surprised by the nature of GP nursing: *'the new to practice ones sometimes are in a bit of shock about what the job actually is'* (Lead1).

Some trainees had encountered challenges in their general practice, particularly where there had

‘So ‘They can do this,’ ‘They can do that.’ So the competence on a fairly low threshold of jobs that, basically, maybe, a senior HCA could do and they just make them do lots of it. And that’s got to be avoided at all costs because that isn’t the ethos and that isn’t why we had the Foundation School in place.’

been staffing issues, with impact on support available: *‘They have had a very hard time in their placement area, they have perhaps had their lead nurse go off sick and have suddenly had to step up’* (Lead5). Support in practice was considered essential for the trainees to develop and also for their retention. Drawing on previous experiences with the Fundamentals course, one stakeholder asserted:

We know that the students that succeed the best and stay in the environment are the ones that are well supported while out in practice. (Lead2)

General practice stakeholders discussed the ways they approached optimising the experience for the trainees. For example, one practice that had an extensive multidisciplinary team, facilitated the trainee to spend time with different disciplines who work in various specialities, such as mental health and sexual health: *‘So [trainee] has been able to have exposure to all these clinicians and be able to see where her potential role would fit into that’* (GPS_4). Practice managers were involved in induction and designated GPNs worked with the trainee to ensure there is now an appropriate plan to enable trainees to achieve the required competencies:

They work between them to make sure that they worked along the right kind of pathway, the rotas were right and we were hitting the training marks that we needed to. (GPS_7)

It was recognised that each trainee brought different experiences and it was considered important to acknowledge this prior learning:

They will have picked up skills that they are transferable into practice nursing that means then you haven’t got to start at the very beginning on certain things. (GPS_7).

Some general practice-based stakeholders commented positively on the experience that new to practice nurses brought with them: *‘she’d already got some experience and knowledge behind her’* (GPS_8).

The impact of the trainee’s placement being across two practices was discussed, with the view that this adversely affected the trainee’s confidence. There were different ways of working at the two practices and supervisors at one practice seemed reluctant to accept the trainee assessment from the other practice. The trainee had to be assessed again on certain skills so that supervisors felt confident in her ability: *‘Oh, you’ve been signed off on that. Well, I haven’t seen you do that’* (GPS_6). The supervisors considered that the trainee would have progressed more quickly if based at one practice. Other general practice stakeholders expressed similar views; whilst they understood the PCN decision to take this approach, there was an impact on the general practice, with catch-ups needed: *‘I think it would have been, probably, more beneficial to have a single nurse at a single site’* (GPS_7).
The various support roles at the practices for trainees were discussed. At one of the practices, a lead support nurse was appointed to support not just the trainees but other students too, such as the student nursing associates. The lead nurse could have an oversight of all the support needs within the practice: *‘they all come under my umbrella and I deal with all of those’* (GPS_9). GPs described supporting the trainees when in the duty doctor role: *‘obviously, as duty doctor – when*

‘Feedback that we’ve had, is that they have had a lot of support and they’ve got somewhere to go to and that has been really important to them as a learning point as well.’

I’m on duty – if she needs any support with any unwell patients, then I’m involved ad hoc as well’ (GPS_10). A practice manager also explained that there was always a GP that other clinical team members could contact for support with patients, rather than the patient having to rebook another appointment. Positive feedback from students and trainees had been received:

Feedback that we’ve had, is that they have had a lot of support and they’ve got somewhere to go to and that has been really important to them as a learning point as well. (GPS_11)

Practice managers had also offered direct support to the trainees: *‘if there are any issues they can come to me and I can address them’* (GPS_11).

One of the ways the GPNFS ensured support in practice was through the appointment of experienced practice nurses who had recently retired: R&R nurses. Like the GPN trainees, the stakeholders held very positive views about the R&R initiative:

The school was particularly attractive in the fact that we knew there was going to be offer of these retire and return nurses who were very, very experienced nurses who were going to be supporting the new students out in practice. (Lead2)

The R&R role was considered to have made a significant contribution to the trainees’ learning experiences and had facilitated practices being able to host newly qualified nurses: *‘that experience from the retire and return nurses makes that possible’* (Lead2). One of the general practice supervisors explained that they explored the support available to the practice before agreeing to take on a trainee, as they were short of GP nurses at that time. The availability of an R&R nurse was key to their decision:

We were really keen to do it but I didn’t know if I was going to be able to have the back-up of the clinical team at that time. So, with understanding the role with [GPNFS lead] and then understanding what back-up we could get from the Retire and Return Nurse scheme to come and supervise, we made a decision that we would go ahead whilst actively trying to recruit in our nursing team. (GPS_10)

The goal is that each PCN has a R&R nurse, who could support the nursing workforce with education support, supervision and assessment. There was recognition of the pressures that general practices work under, impacting on capacity to supervise new GPNs, and the R&R nurses were found to be: *‘instrumental in the support for practices’* (Lead1). Practice supervisors and mentors commented positively on the additional support trainees gained from the R&R nurses. One of the R&R nurses explained that they initially worked with each trainee one day per week but as the trainees developed through the programme, the trainees needed less direct support, but they were available as needed. This R&R nurse described how they approached the trainees’ development and observed their progress:

It’s like nurturing. It’s like from novice to expert. And you can see them really coming along. And they’re really gaining in confidence. (GPS_1)

The R&R nurses aimed to link the trainee’s practice learning with their learning from the

Fellowship and Fundamentals, assisting with applying theory to practice. Where practices were facing additional challenges, such as staff sickness, impacting on the support they could offer trainees, the R&R nurses could be drawn on to provide additional support to trainees who were struggling. They could signpost the trainees to resources and additional learning available, for example: *'I've seen courses on the internet from the training Hub: different courses. I've always signposted them to them'* (GPS_1). There was recognition that it was a big transition for nurses used to working on hospital wards to being on their own with patients in general practice; this was an area R&R nurses supported them with: *'it's a lot of lone working and it's supporting that lone working with them as well'* (GPS_1). At one practice, one of the GPNs had taken on the R&R role in addition to her usual role and felt the additional support possible had benefitted the trainee: *'she's been a little bit more fortunate because she's had access to me a bit more'* (GPS_3). At another practice, there had been R&R nurse support in setting up an appropriate timetable for the trainees; the general practice staff believed that, without the R&R nurses, supporting the trainees would have been more difficult: *'without her I think it would have made life a lot harder for us'* (GPS_8).

5.3.3 Supervision and assessment in practice

The practice supervisors and mentors had had previous training for these roles and several mentioned this was undertaken through local universities, as they were supporting Fundamentals students. These courses were not, however, specific to the GPNFS trainees but covered principles broadly and could be applied to any student or trainee. The practice supervisors discussed their approach and experiences with the trainees. A supervisor recalled the initial 'meet and greet' with the trainee that they set up before the trainee started, which helped clarify expectations and to deal with questions: *'It was an opportunity for [trainee] to iron out any queries, questions or just to reassure her for any concerns as well'* (GPS_4).

A clinical assessor described tripartite meetings with the trainee and supervisor to monitor their trainee's progress and development. One of the goals was to ensure the trainee was gaining the necessary experience and exposure to the different areas of practice needed. One assessor described how they tried to approach the trainee as an individual rather than being too prescriptive about their learning. As their trainee had become more independent, they ensured she had the extra time needed at that stage for appointments:

We then gave her extra time, we gave her extra block offs, so all the way along we've given her that support that she's needed. And as well as reinforcing to [trainee] that it's for her as well to come to us if she feels that she's struggling, it's a two, three way sort of pathway for me. (GPS_4)

Another supervisor similarly described taking an individual approach to their trainee:

I will guide them as much as need be and I will give them whatever they need to help them to learn. But I'll let them guide as to how much they need me. (GPS_9)

A supervisor described that with any new GPNs, they initially set up a countersign so they can check their consultations and similarly, they had set this up for the GPNFS trainee. However, their trainee was now at stage where the countersign could be removed: *'we're just talking about perhaps taking her off that now because she's doing so well'*(GPS_3). The counter-sign facility enabled the supervisor to provide feedback on her consultations, which was considered important for learning, and recognising the trainee's strengths:

I think it is nice to get some positive feedback along the way as well, and some of the things that she's picked up with some of the patients is really good, and it's about praising them that they've recognised that this needs to be addressed or signposted. (GPS_3)

Certain skills required specific assessment and this supervisor had been able to access an external assessor to assess the trainee taking smears. Another general practice supervisor explained that they had now undertaken the cervical cytology mentorship course so they could assess the trainees. Some supervisors and assessors described how they tried to align their trainee's practice learning with the learning from the Fellowship and the Fundamentals, for example:

‘I think it is nice to get some positive feedback along the way as well, and some of the things that she’s picked up with some of the patients is really good, and it’s about praising them that they’ve recognised that this needs to be addressed or signposted.’

If we know that they learn about long term conditions, particularly asthma, then I’ll try and support that in clinical practice at the same time and I think that’s really valuable to the student as well, because it’s putting that theory into practice. (GPS_4)

5.3.4 Integration into the general practice team

Many of the general practices made positive comments about the trainee’s integration into the team:

She’s worked very well in all aspects, really: being part of the team; she’s always looked like she’s enjoyed what she was doing, got on well with the team. (GPS_8)

One of the stakeholders considered that their practice was welcoming and helped new staff integrate:

It’s an inclusive team. I think we welcome people in and try to make sure they feel as though they’re embedded in the team and part of the team and have got a say and a function as well. (GPS_7)

A GP described the interaction between different staff within the practice: *‘we tend to mingle quite a bit more, so we have quite a lot to do from a professional and a group working point of view’* (GPS_13). This GP described how different team members were involved in clinical reviews within the practice. Whilst some trainees described GPs not knowing them (see section 4.4.2), this GP knew the trainees by name and chatted socially with them, and trainees could directly approach them. They considered this approach related to the culture of the practice: ‘*I don’t know if that’s different elsewhere, but I think that’s part of the culture that we have within our practice’* (GPS_13). Another GP described how their trainee had been involved in clinical meetings: *‘she’s been fabulous: really keen to contribute’* (GPS_10). This GP described the practice as being interested in education and supporting staff: *‘we want to show this is a good place to come and develop your career’* (GPS_10).

5.4 Benefits and value of the GPNFS

The benefits discussed related to two areas: the development of a competent, confident and employable GPN, and the value of the GPNFS to the primary care workforce.

5.4.1 Development of competent, confident and employable GPNs

There were many positive comments from general practice staff about the trainees’ competence, which particularly focused on their skills development and being up to date. The GPNFS leads had received very positive feedback about the trainees from general practices. One stakeholder considered their trainees were more confident and competent than new GPNs employed by practices previously. They considered the trainees near to achieving all the required competencies, which included long-term conditions management, for example:

A patient’s come in for a COPD assessment. They will pick up everything: they will do all the assessment that’s required; they know where to refer on to pulmonary rehab or if they need the GP; they know the red flags to look for. (GPS_1)

‘We see the same mums coming in for the checks and the rapport that they’ve gained within the practice is really good with the patients and the carers really.’

Furthermore, the trainees were displaying confidence and ability to build rapport with patients and gain their confidence:

We see the same mums coming in for the checks and the rapport that they’ve gained within the practice is really good with the patients and the carers really. (GPS_1)

Another stakeholder commented positively on their trainee’s interactions with patients: *‘She’s brilliant with patients: she knows how to manage different personalities and different moods’* (GPS_6). There were also positive experiences about trainees’ rapid progression, with one stakeholder wondering if the additional support provided had influenced the speed of development:

She’s self-sufficient in most areas. I think she’s progressed through childhood immunisations and she’s completed her smear training, she’s just waiting to get her pin and things for that, so I think she’s done very well, whether that is the extra support she’s been given. (GPS_3)

A further factor related to students as individuals and their attitudes to learning. One stakeholder commented on the motivation and keenness of their trainee: *‘She’s done really well in her development and credit to her because she’s been the drive’* (GPS_4). Whilst confidence was important, stakeholders commented that their trainees were also aware of their limitations: *‘She’s good at understanding what isn’t her remit. And that’s really important, isn’t it, for a lifelong career’* (GPS_10). Some general practice stakeholders mentioned that their trainees were newly qualified and they appeared impressed by their development:

She’s very confident and competent, and our candidate is newly qualified so she literally picked up her nurse PIN and started, and she had no primary care experience, in fact she’s mental health trained so she had no experience, but we’ve had no issues at all, and whether we’ve been really lucky, but she’s been fantastic. (GPS_5)

Another general practice stakeholder commented that their trainee is very proactive about extending her learning: *‘she does more than she needs to do’* (GPS_6). A stakeholder who was supporting two trainees commented that both were achieving what they needed to, were improving every week and would be ready to work as qualified GPNs. A GP commented on their trainee’s steady development: *‘I’ve watched her gain her skills in each area appropriately. By the time she’s finished each section, she’s been very confident’* (GPS_10). This trainee was compared very favourably to a previously employed new GPN: *‘the GPN trainee’s confidence and robust skills, yes, it really outweighs that progress’* (GPS_10). This GP had concluded that the robustness of the GPNFS programme with the inclusion of leadership skills, had been key to the trainee’s development. A practice manager reported positive feedback from both colleagues and patients about the trainees:

The amount of feedback we have had about the GPN, she is doing really well. The patients love her, her communications skills, her clinical skills. From a patient’s point of view, we have had no problem because she is so caring and compassionate about what she does. (GPS_11)

The GPNFS leads had been able to observe the growth in confidence from the trainees’ initial interviews to their current stage of development:

Those first days when they've done their first childhood immunisations and it's such an achievement for them or they've done their first smear by themselves, the excitement of having their own clinic, you can see that, and the impact that they're having on patients is really improving their confidence as well. (Lead1)

Positive feedback from patients and colleagues increased the trainees' confidence: *'it's almost like you watch them flourish'* (Lead1). The leads observed a drop in confidence initially, especially for new to practice nurses, who were experienced nurses in a different clinical setting. However, these nurses did have lots of transferable skills and their confidence soon grew back. There were also comments about trainees' awareness of how much more they still needed to learn, as the trainees are faced with such a range of patients: *'a tiny baby right through to somebody at end of life really and anything in between'* (Lead5).

Leadership development was included in the Fellowship and a GPNFS lead commented that they had observed leadership potential amongst the cohort: *'We can definitely see some real career driven leadership potential within the group'* (Lead1). As an example, trainees had got involved in projects, with two from the group successfully applying for a QNI grant to support a gardening scheme, with the aim of promoting well-being amongst community staff. General practice staff were aware of the project and also commented positively about their trainees' involvement: *'it seems to be doing really well'* (GPS_6). Leadership skills had been linked in with improvement skills, with trainees being encouraged to recognise how they could take the lead at what ever level they were working and: *'push for some improvements in lots of different ways'* (Lead5). Some general practice staff had found their trainees were contributing improvement ideas, for example:

She's already got the mindset to pick up quality improvements or issues and report them in the right way: to speak up at clinical meetings. It doesn't feel like she sees herself as a junior member of the team, which she shouldn't be: she's a professional and she's fully qualified. So, I think that's reassuring from that leadership perspective. (GPS_10)

A GP gave a specific example of an improvement project that a trainee undertook around smears for people with ethnic minorities: *'it's quite hard for us to reach those people, and we are going to adopt what she's done, so that's been really useful'* (GPS_12). Other examples of leadership given were around providing guidance to healthcare support workers in the practice. Some general practice staff, however, considered that it was early days for the trainees to show leadership skills: *'I think [trainee] has to be comfortable doing what she's doing in the role that she's doing before that leadership starts showing'* (GPS_4). Another considered that as they were based at a large practice with many staff, it was more difficult for their trainee to demonstrate leadership skills and might take longer.

Stakeholders unanimously considered the trainees would be employable at the completion of the programme as they were coming in with the full package of skills and would be assets to their practices:

If I was a GP, I would bite the hand off any of them, to be honest because, they're great students and they're progressing really well across all aspects. (Lead2)

Whoever employs [trainee] will be very lucky because I think she's brilliant. Yes, she's definitely got the ability to excel at what she's doing. (GPS_3)

A general practice stakeholder believed that the GPNFS will become the 'gold standard' for new GPNs and so those completing the programme will be highly employable. A GPNFS lead commented that the cohort are committed to general practice as a career and value the impact of the GPN role. The twelve month programme would develop employable GPNs, who would then continue to develop:

You can't learn to be an amazing GPN in 12 months' time, but they can come in and function as a general practice nurse. Obviously, they have their skillset to deliver patient care so that they are

‘Those first days when they’ve done their first childhood immunisations and it’s such an achievement for them or they’ve done their first smear by themselves, the excitement of having their own clinic, you can see that, and the impact that they’re having on patients is really improving their confidence as well.’

useful to practices, so they’re very employable. I think they will be highly sought after. (Lead1)

A business partner considered the trainees would need to do some final learning within the practice they became employed: *‘that last bit, with any nurse, will be tailored towards the practice; it will be tailored about how they work’* (GPS_7). Experience over time would be important for their growing development:

It’s just experience then, so they’ve got the basics of it, but it’s only then after time in post, like anything, that you meet more of the same scenarios with slightly different twists to them. (GPS_12)

Clinical supervision was considered important for the trainees once employed as GPNs, and trainees would need to gain familiarity if working in a new practice:

If they’re not staying where they’ve done that training they would need that to settle in in a different area and their ways of working. But they come out pretty well rounded. (GPS_5)

A GP considered that the trainees should avoid working in practices where they would be working alone as: *‘Straight after the course you probably need to have at least another nurse to be bouncing things off’* (GPS_12). Likewise, some trainees expressed that they would not wish to work in as a sole GPN for their first position (see section 4.5.1). A further aspect for the trainees to consider was pay and conditions, which affects GPN retention within practices:

Terms and conditions are at the mercy of your employer and some of those are a lot better than others. We still tend to see a lot of movement, then, between practices on the basis of what the terms and conditions would be. (Lead2)

Some general practice staff expressed regret that they had no current vacancies to offer their trainee: *‘It’s just a shame because she’s built up relationships with people and knows how the practice works’* (GPS_8). However, it was hoped that if the trainee has a good experience, she might come back to the practice when a vacancy does arise. A GP commented that unfortunately their trainee could not stay due to personal circumstances but they would have been keen to employ her:

I do think we’ve invested in this and it would be nice to have a year of her, fully-fledged as a backing for the team. But that’s her personal circumstances. (GPS_10)

The stakeholders acknowledged that the trainees would build on their foundation and they would have support during a second Fellowship year as they consolidated their skills. The Fellowship half days had included career opportunities and it was anticipated that the trainees would develop further, some within specialist practice, for example, in long-term conditions such as diabetes, respiratory conditions, women’s health or first contact care. The development that trainees would undertake depended on their individual interests and the practice where they were employed. A GP explained their approach to developing new GPNs, considering the practice’s aspirations for patient services and the GPN’s interests, and supporting access to further specialist training:

STAFFORDSHIRE GPN FOUNDATION SCHOOL

Induction Package

In conjunction with NHSE & North Staffordshire GP Federation

PN Foundation School Programme
rector: Rachel Viggars
aining Lead: Gill Boast
lministrator: Katy Edgington

'You bring in brand-new nurses from university or from different areas of ward work, coming into the community, who, then, would have been floundering when they first came into practice, whereas now, they're not. They'll be coming in straightaway, up-and-running for them.'

'What area do you like? How can we support in this?' (GPS_10). Other areas for development included understanding population data to inform services, and policy development.

Stakeholders pointed out that courses were available via the Staffordshire Training Hub and GPNs could access these to support development. There are career options such as professional nurse advocacy, which trainees were introduced to, and some trainees had already shown interest in specialist or advanced practice. Trainees had also been introduced to opportunities for senior nurse roles in the PCN as future career options. Prescribing was a further area for development identified, with a GPNFS lead highlighting:

Ultimately they will need to be prescribers really, even for managing the long term conditions you need to be able to prescribe and not keep sending it over to the GP to sign off when they've not seen the patient. It does need to be that way but it is quite an advanced role really and that's why it needs a proper backbone to it which I hope we have put in this year to prepare them to step up to that level of practice. (Lead5)

5.4.2 The value of the GPNFS to the primary care workforce

The GPNFS provided the support and structure to develop new GPNs, whether newly qualified or new to practice:

You bring in brand-new nurses from university or from different areas of ward work, coming into the community, who, then, would have been floundering when they first came into practice, whereas now, they're not. They'll be coming in straightaway, up-and-running for them. (GPS_1)

Thus, the GPNFS provided opportunities for nurses to enter general practice, who would not have been able to previously: *'it's getting fresh blood, people who would have maybe not had the chance otherwise'* (GPS_3). The GPNFS facilitated the employment of newly qualified nurses in general practice, as it provided the necessary support structure:

I think the biggest appeal is for the newly qualifieds being supported, coming into general practice, really, and recognising it is a career opportunity. But they know they've got that support from the school. (Lead2)

GPNs have traditionally been at risk of isolation, and it was hoped that the GPNFS programme would have established a network that trainees could draw on for support in the future: *'they have got an alumni they can go back to and get support from'* (Lead4).

The GPNFS provides a pipeline for recruitment of skilled GPNs into general practices, which could address the recruitment issues:

It's a great way of having a constant pipeline of new staff coming into the roles because it's been very hard to recruit, it isn't easy anymore when you have got a vacancy to find someone who has got the skills that can come and do. (Lead5)

It's about having workforce for the future; the programme is designed very much, so they will be

ready to go nurses at the end of it in general practice. (GPS_12)

There were many positive comments about the GPNFS being the right approach for preparing GPNs in future: *'we do need practice nurses and this is the right way forward. I definitely do think this will make a massive difference'* (GPS_11). The GPNFS was considered to deliver a robust and standardised programme, which general practice-based stakeholders valued: *'it [GPNFS] affords structure and quality. You know that you're getting a quality product at the end of it'* (GPS_12). One general practice stakeholder reflected on various previous GPNs the practice had employed, and considered the GPNFS had prepared their trainee more quickly for the role, than previously, when practices employed new GPNs who they had to train: *'the training and support that the practice had to put in took longer'* (GPS_7).

Several stakeholders highlighted the need for a long-term strategy for the primary care workforce to meet population needs. It was suggested the GPNFS could contribute across the whole nursing workforce within general practice:

It's supporting healthcare support workers, the whole of the nursing workforce, it's not just GPNs, and because we link with the retire and return it's looking at those experienced, knowledgeable nurses and about sharing their knowledge and putting value into their roles. (Lead1)

In addition, the GPNFS supports the role of the GPN in primary care, at a time when there are a range of other roles being instigated:

There's lots of wider clinicians now that are coming in and as we know all the skills are interlinking and are very fluid, so I think the school is a great support mechanism. (GPS_4)

A practice manager considered the investment from participating practices was worthwhile:

As a long term investment they'll be worth it, yes. I can talk from experience; it is definitely so. I think it's a really good way of moving forward for the workforce. (GPS_11)

Some general practices could already see the direct benefits to their workforce, as the GPNs would be ready to fill vacancies that were arising: *'Two of the practices [in PCN] have ended up with nursing shortages, which are now beautifully filled'* (GPS_12). However, a stakeholder from a large general practice considered that while the GPNFS process worked well for them developing new GPNs but for small practices, it may not be practical to wait to fill a vacancy with a new GPN from the GPNFS: *'they need a nurse there and they need them doing smears and they need them doing vaccinations […] I'm not sure whether smaller practices that might put them off'* (GPS_5).

5.4.3 Summary

The drivers for the GPNFS included that there has been no standardised or consistent approach to developing new GPNs. Whilst the Fundamentals course has been established as an educational pathway for several years, this is not compulsory. Many GPNs are instead prepared through a variety of short courses, and support for new GPNs to develop has been mainly absent, even though the role can be isolated. In addition, there are acute GPN workforce issues, including high levels of sickness and retirement, challenges in GPN recruitment and retention, a lack of awareness about the GPN role, and barriers to becoming a GPN. The GPNFS was established following a business proposal developed with local and national stakeholder support and collaboration. Financing of the GPNFS was a major challenge but was accessed sufficiently to launch the GPNFS. Engaging with general practices was a further challenge, particularly as practices are based in the independent sector. Stakeholders discussed future aspirations for the GPNFS, including a long-term vision for GPN preparation with secure funding for a national, standardised approach and, ideally, a GPN Deanery to align with GP preparation.

The stakeholders were very positive about the GPNFS structure, including the centralised recruitment and employment model. The GPNFS was considered to provide a good balance

> ‘It’s about having workforce for the future; the programme is designed very much, so they will be ready to go nurses at the end of it in general practice.’

of theory and practice, and was perceived to be well planned and organised. An important component is the support structure, which includes the GPNFS leads, the Fellowship half days, the support through the Fundamentals course and the support from supervisors, mentors and R&R nurses. The Fellowship element includes additional learning to complement the Fundamentals course and support application of theory to practice, peer support, and clinical supervision. The Fellowship half days included the flexibility to address the trainees’ learning needs and had a focus on service developments and leadership skills. Stakeholders expressed positivity towards the Fundamentals course which was well established as a pathway to prepare new GPNs. There had been close collaboration between the GPNFS leads and Fundamental course leads during the GPNFS development.

The stakeholders discussed the preparation and ongoing support from the GPNFS, for general practices that were hosting the GPNFS trainees. General practice staff described effective communication with the GPNFS and they had been able to contact the GPNFS if they needed additional support. Learning in practice was recognised as essential for the GPNs’ development and general practice staff discussed the ways they approached optimising the experience for the trainees, including the various support roles. One of the ways the GPNFS ensured support in practice was through the appointment of experienced practice nurses who had recently retired: R&R nurses. The R&R role was considered to have made a significant contribution to the trainees’ learning experiences and had facilitated practices being able to host newly qualified nurses, especially where challenges arose. The practice supervisors discussed their approach and experiences with the trainees. They aimed to ensure the trainee was gaining the necessary experience and exposure to the different areas of practice needed. Many of the general practices made positive comments about the trainee’s integration into the team and general practice staff considered the culture of the practice affected integration.

There was considerable positivity about the trainees’ competence and confidence, boosted by the feedback from patients and general practice staff. General practice staff had found the trainees progressed rapidly and some trainees were already applying leadership skills, especially around improvement ideas. Stakeholders unanimously considered the trainees would be employable at the completion of the programme as they would have attained the full package of skills required. It was anticipated that the trainees would develop further, some within specialist practice. In terms of contribution of the GPNFS to the primary care workforce, the GPNFS provided the support and structure to develop new GPNs, whether newly qualified or new to practice. The GPNFS programme establishes a network for GPNs to continue to draw support from, thus reducing isolation. The GPNFS was considered to deliver a robust and standardised programme, which general practice-based stakeholders valued and could provide a pipeline for recruitment of skilled GPNs into general practices.

6. The development of professional practice.

To understand how the trainees developed facets of professional practice over time, a longitudinal RPQ was used to assess at monthly intervals over ten months (n=14). The RPQ (Priddis and Rogers 2017) is a self-assessment of different domains of professional practice including reflective practice and the development of professional judgement. Reflective practice is a powerful tool for personal and professional development. By regularly engaging in reflection, individuals can learn from their experiences, improve their practice, and ultimately become more effective in their roles.

‘There’s lots of wider clinicians now that are coming in and as we know all the skills are interlinking and are very fluid, so I think the school is a great support mechanism.’

There are substantial benefits to developing reflective professional practice, particularly where judgement or complex decision making is a key facet of work (Schon 1983, Brandt 2017). These include:

- Improved Decision-Making: By reflecting on past decisions, its possible to identify what worked well and what didn’t, leading to better choices in the future. The benefits include:
- Personal and Professional Growth: Continuous reflection helps people to understand their strengths and limitations, leading to targeted personal and professional development.
- Enhanced Problem-Solving Skills/critical thinking: Reflective practice encourages a deeper analysis of problems, promoting innovative and effective solutions.
- Emotional Intelligence: Understanding one’s own emotions and reactions through reflection can improve emotional intelligence, leading to better interpersonal relationships.
- Adaptability: Reflective practice helps people learn from experience, increasingly the ability to be adaptable to new situations and challenges.

Much of this is reiterated in Benners classic work applied to nursing “From Novice to Expert” (Benner 1984)

The RPQ was administered to the group (n=14) monthly for nine months. Due to the small sample size descriptive statistics were used but there was good internal validity (Cronbach α >0.9).

The domains assessed are:

- Reflective-in-action (RiA) This occurs during the experience itself, where practitioners make adjustments in real-time. It involves being aware of actions and their impact as they happen. It is often cited as a marker of worker proficiency, moving beyond competence (Benner 1984)
- Reflective-on-action (RoA) This occurs after the experience. It involves looking back on what happened, analyzing decisions, and considering what could be done differently in the future.
- Reflective with others (RO)
- Self-appraisal (SA) Recognizing own biases, emotions
- Desire for improvement (DfI)
- Confidence – communication (CC)
- Uncertainty (Unc)
- Stress interacting with clients (SiC)
- Job satisfaction (JS)
- Confidence – general (CG)

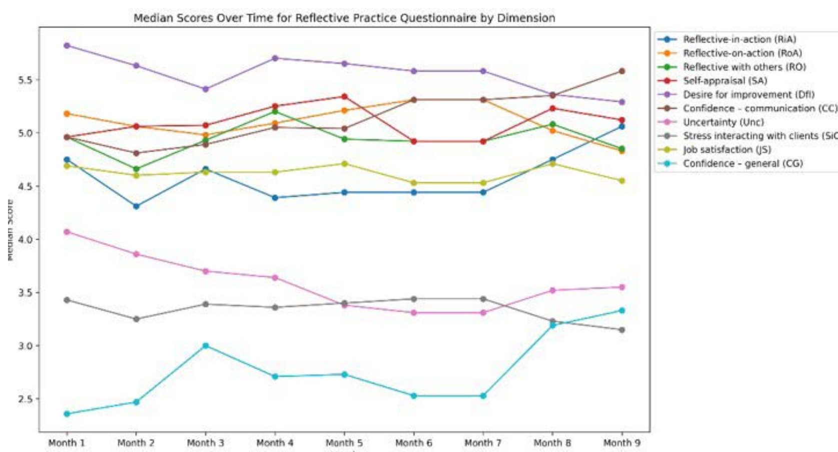
Table 5 Mean scores and standard deviation over time.

Descriptive statistics for reflective practice questionnaire by dimension (n = 14)	Month 1		Month 2		Month 3		Month 4		Month 5		Month 6		Month 7		Month 8		Month 9	
	X̄	σ	X̄	σ	X̄	σ	X̄	σ	X̄	σ	X̄	σ	X̄	σ	X̄	σ	X̄	σ
Reflective-in-action (RiA)	4.75	0.96	4.31	0.89	4.66	0.88	4.39	1.15	4.44	0.87	4.44	1.08	4.44	1.08	4.75	1.03	5.06	0.94
Reflective-on-action (RoA)	5.18	0.72	5.06	0.72	4.98	0.70	5.09	0.92	5.21	0.46	5.31	1.06	5.31	1.06	5.02	1.23	4.83	1.17
Reflective with others (RO)	4.96	0.79	4.66	1.04	4.93	0.91	5.20	0.72	4.94	0.87	4.92	1.02	4.92	1.02	5.08	0.88	4.85	1.21
Self-appraisal (SA)	4.96	0.74	5.06	0.80	5.07	0.81	5.25	0.69	5.34	0.62	4.92	1.08	4.92	1.08	5.23	0.67	5.12	1.02
Desire for improvement (DfI)	5.82	0.39	5.63	0.49	5.41	0.65	5.70	0.46	5.65	0.56	5.58	0.60	5.58	0.60	5.36	0.56	5.29	0.72
Confidence – communication (CC)	4.96	1.00	4.81	0.64	4.89	0.70	5.05	0.88	5.04	0.63	5.31	0.86	5.31	0.86	5.35	0.62	5.58	0.57
Uncertainty (Unc)	4.07	1.20	3.86	1.10	3.70	1.22	3.64	1.03	3.38	1.01	3.31	1.17	3.31	1.17	3.52	1.15	1.12	3.55
Stress interacting with clients (SiC)	3.43	1.29	3.25	1.50	3.39	1.34	3.36	1.10	3.40	1.30	3.44	1.54	3.44	1.53	3.23	1.42	3.15	1.27
Job satisfaction (JS)	4.69	1.49	4.6	1.34	4.63	1.38	4.63	1.22	4.71	1.33	4.53	1.46	4.53	1.46	4.71	1.34	4.55	1.37
Confidence – general (CG)	2.36	0.49	2.47	0.76	3	0.97	2.71	0.87	2.73	0.79	2.53	0.65	2.53	0.65	3.19	0.93	3.33	0.92

Presented graphically (Figure 1) we can see the following changes over time (median score). Although these are descriptive statistics, we can see the trends associated with developing professional practice.

There is an increased 'reflection in action' score and a decline in reflection on action score which points to developing into a proficient (rather than competent) worker. There is a rise in confidence and a decline in stress and uncertainty.

Figure 1 Median RPQ score for the group over time.



‘I think the idea of ARRS roles in General Practice is a good one sadly they aren’t actually ‘Additional’. They are usually a lesser skilled and cheaper replacement for an outgoing member of staff. This in turn just puts more pressure on the registered clinician to oversee their work.’

7. Key messages from the evaluation

- GPN recruitment and retention is challenging – GPNFS provides access, structure and a pipeline of GPNs prepared in a standardized and quality assured way.
- The Fellowship afternoons provide peer support and learning to complement the Fundamentals course.
- The practices taking part felt well prepared and supported by the GPNFS. The R&R nurses were unanimously well received by trainees and stakeholders, although not all trainees had access to them.
- Quality of supervision and support for trainees in practice is critical – both trainees and stakeholders considered that GPNFS input is essential for trouble shooting and support for trainees and the practices.
- Some practices initially needed better understanding of the GPN trainee role and the expectations for their development but the GPNFS was able to provide the necessary guidance to the practices and the ongoing support needed.
- Trainees appreciated feeling part of the general practice team and stakeholders also considered integration into the general practice team was important.
- Stakeholders unanimously considered that the GPN trainees were competent, confident and employable. The GPNFS was considered by some stakeholders to develop competent GPNs more quickly than was possible prior to the GPNFS. Some trainees were already demonstrating leadership skills and had contributed to service developments. Trainees also reflected positively on their development and confidence.
- The trainees were generally enthusiastic about GP nursing and could foresee career pathways for themselves in primary care.
- There was evidence of development of professional practice over the assessment period, with the trainees self-reporting improvements in becoming more reflective in action rather than retrospective reflection.
- Trainees reported a rise in confidence and a decline in stress and uncertainty, associated with taking on a new role.

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Appendix 1 Focus group questions/interview topics

Responses were explored in depth with follow-up probes

Participant group	Focus group/interview question areas
GPNFS trainees	Phase 1 • What made them interested in general practice nursing? • What were their reasons for applying to the GPN Foundation School? • What are their expectations of the GPN foundation school? Phase 2 • How do participants feel now about the appeal of GP nursing? • How has the GPNFS affected trainees? • What have been the trainees' experiences of the different elements of the programme?
GPNFS leads	• The rationale for the GPN Foundation School • Experiences of the first year, and how the trainees compare with other new practice nurses. • Experiences of how the GPN Foundation School elements have supported trainees' development • Views on the trainees' future career as GP nurse • The potential contribution of the GPN Foundation School to the primary care workforce.
University Fundamentals course leads	• Experiences of the GPN Foundation School over the first year, and how the trainees compare with other new practice nurses. • Experiences of how the GPN Foundation School elements have supported trainees' development • Views on the trainees' future career as GP nurse • Potential contribution of the GPN Foundation School to the primary care workforce.
GP staff	• Their role with the GPN Foundation School and supporting trainees • Overall experience of the GPN Foundation School • Their experience of the GPN trainee(s): development and performance; • Any comparisons with other new GP nurses they have supported/employed; • Views on how the different elements of the GPN Foundation School have supported the trainee; • Views about the GPN Foundation School trainee's future career as a GP nurse; • Potential contribution of the GPN Foundation School to the primary care workforce

Appendix 2 Thematic data analysis phases and study application (Braun and Clarke, 2022)

Phase	Application
1. Familiarising yourself with the dataset	Immersion in the data through reading the transcripts and listening to the audio recordings.
2. Coding	Data were systematically coded, line by line, using inductive codes derived from the data, to capture meaning and concepts. New codes continued to be added throughout the coding process. The whole data set was reviewed in line with the final set of codes. Data segments for each code were compiled.
3. Generating initial themes	Codes with similar meanings/concepts were clustered and then potential themes identified, with relevant coded date collated for each candidate theme.
4. Developing and reviewing themes	The dataset and coded data extracts were reviewed against the candidate themes and reviewed for fit. The core focus, scope and viability of each theme and sub-theme was reviewed and relationships between the themes was considered
5. Refining, defining and naming themes	The themes were further reviewed to ensure each was clearly demarcated with a strong core concept. Informative names for the themes and sub-themes were developed
6. Writing up	The themes and sub-themes were written up, with data extracts for illustration.

Appendix 3 The Reflective Practice Questionnaire (Priddis and Rogers 2017)

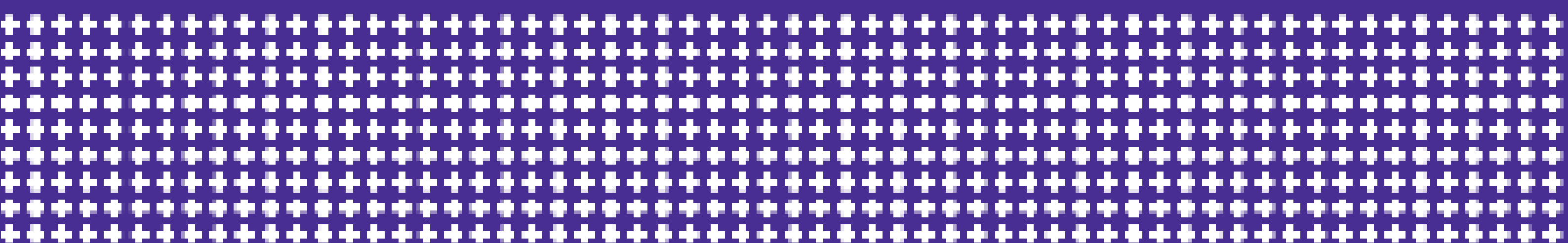
		Not at all,	**Slightly**	**Some-what**	**Moder-ately**	**Very Much**	**Extreme-ly**
RiA	During interactions with patients I recognise when my pre-existing beliefs are influencing the interaction.						
	During interactions with patients I consider how my personal thoughts and feelings are influencing the interaction.						
	During interactions with patients I recognise when my patients's pre-existing beliefs are influencing the interaction.						
	During interactions with patients I consider how their personal thoughts and feelings are influencing the interaction.						
RoA	After interacting with pa-tients I spend time thinking about what was said and done.						

	After interacting with patients I wonder about the patients's experience of the interaction.						
	After interacting with patients I wonder about my own experience of the interaction.						
	After interacting with patients I think about how things went during the interaction						
RO	When reflecting with others about my work I become aware of things I had not previously considered.						
	When reflecting with others about my work I develop new perspectives.						
	I find that reflecting with others about my work helps me to work out problems I might be having.						
	I gain new insights when reflecting with others about my work.						
SA	I think about my strengths for working with patients.						
	I think about my weakness-es for working with patients.						
	I think about how I might improve my ability to work with patients.						
	I critically evaluate the strat-egies and techniques I use in my work with patients.						
DFI	I think I still have a lot of things to learn in order to improve my clinical practice.						
	I would like to learn new skills in order to improve my ability to work with patients.						
	I desire more knowledge to improve my ability to work with patients.						
	I desire more experience to improve my ability to work with patients.						

CC	I think I am good at creating a safe environment so that my patients' feel comfortable enough to share information with me.						
	I feel confident sharing my formulations/decsions with patients.						
	I am good at providing clear messages to my patients.						
	I am good at listening to my patients with genuine curiosity.						
Unc	Sometimes I am unsure if my planning for patients is the best possible way to proceed.						
	Sometimes I am unsure if I am interpreting my patients' needs correctly.						
	Sometimes I am unsure how to handle the needs of patients.						
	Sometimes I am unsure that I properly understand the needs of patients.						
SiC	Sometimes after interacting with a patients I feel exhausted.						
	Sometimes I find interacting with patients to be stressful.						
	There are times when I feel distressed after communicating with a patients.						
	The pressure to meet the needs of my patients can sometimes feel overwhelming.						
JS	My work provides me with a lot of fulfilment.						
	My work means more to me than simply earning money.						
	I enjoy my work.						
	There are times when I find myself wishing that I did not have to go to work.						
	I feel respected by other team members						

NTA Awards Nursing in Primary Care 2024, Cohort 1

Cohort 2 induction



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