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General Practice Nurse Education Fundamentals and Specialty Training

Independent Evaluation Report (Executive Summary)

University of Nottingham

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Executive Summary

Introduction

The University of Nottingham was commissioned by Health Education England (HEE) to evaluate GPNE (General Practice Nurse Education) at funded sites in the Midlands and East region. This was a two-part complimentary research project combining evaluation of '*Fundamentals'* training provision at local Universities and a new innovative specialty training route (GPN-ST).

The initial stages of the evaluation include a standardisation and variation study of 7 HEI (Higher Education Institution) sites running a HEE commissioned and funded course for general Practice Nurses called '*Fundamentals'*. The sites specified by HEE to be included in this evaluation were:

- Anglia Ruskin University (ARU)
- Birmingham City University (BCU)
- Bishop Grosseteste University (BGU)
- De Montfort University (DMU)
- University of Hertfordshire (UoH)
- Keele University
- University of Wolverhampton (UoW)

The second stage of the evaluation is a proof of concept evaluation of 3 sites undertaking a jointly HEE and NHSE/I commissioned and funded pilot model of GPN Specialty Training (GPN-ST). This pathway offered GPNE delivered by Universities in conjunction with local networks and provides both University education, but also external mentoring and funding for the post in the first nine months of practice. The sites specified by HEE to be included in this evaluation are:

- De Montfort University / Northampton Healthy Care Partnership (STP)
- Bishop Grosseteste University / Lincolnshire STP
- University of Hertfordshire / Bedford, Luton and Milton Keynes STP

The evaluation was conducted in 2019-20, reporting in summer 2020. This report presents the findings of both stages of the evaluation and supersedes the earlier interim report as it combines and builds on earlier findings. Each section of the report presents the findings of rich qualitative data collection and analysis. The Kirkpatrick (2006) framework for course evaluation presents a useful guide to findings, and further emergent arising themes are also explored. The case study findings are presented as a series of benefits and challenges in a cross-case thematic analysis. The recommendations arising from this report are summarised in a range of formats in the report summary including a theory of change, a 'how-to' guide and a draft policy brief.

Aims and Objectives

The evaluation team identified the following aims and objectives from the research specification and dialogue with the commissioning team.

Aim: To understand HEE commissioned general practice nurse education in the Midlands and East regions and in particular two key models of operation – University delivered *Fundamentals* training and speciality training (GPN-ST).

The objectives relating to the different models of operation.

In relation to *Fundamentals*:

- To define and understand the models of GPN *Fundamentals* in HEE commissioned schemes delivered by a range of Universities understanding standardisation and variance in course provision;
- To evaluate the outcomes of different GPN *Fundamentals* schemes at multiple levels including impact on students learning and behaviour and translating to outcomes for practice and patients;
- To establish and evaluate key relationships in the sector which act as affordances or constraints to workforce development. This includes relationships at the individual, practice and workforce development levels;
- To make recommendations about approaches to a standardised model of GPN *Fundamentals* training.

In relation to the GPN-ST, the scheme has the following objectives:

- To relate the above objectives with respect to the *Fundamentals* courses to the ST scheme;
- To understand and evaluate the scheme as a proof of concept;
- To generate recommendations based on evidence collected, to support future development in GPN-ST.

Background

A brief history of General Practice Nursing

General Practice has changed significantly since the start of the NHS 70 years ago. Each decade can be characterised by cultural characteristics. In the 1950s, most GPs worked in single handed practices. Nurses were introduced to General Practice in the late 1960s working predominantly as Treatment Room Nurses. This role expanded through the 1970s and 80s where nurses began delivering direct patient care including assessing and screening patients and making a significant contribution to health promotion such as contraception, weight loss, smoking cessation and travel health. In the 1990s, General Practice saw further significant change with Primary Care organisations given control over budgets to commission services for local populations. This new contract included a focus (through targets and incentives) on chronic diseases, cervical screening and vaccinations, with much of this work allocated by GPs to Practice Nurses. Increasing demand and a cultural change towards preventative over curative medicine ensured that the General Practice Nurse (GPN) role became upskilled and largely patient facing. From the early 1990s the Royal College of Nursing campaigned for the recognition of Specialty Training (ST) for GPNs. There was further change in the sector in the early 2000s with the introduction of the Quality and outcomes framework (QOF) and the introduction of the Health Care Assistant (HCA) role, which further solidified the GPN role within the General Practice workforce skill mix and hierarchy. Further changes in the past decade, including a change of Government leading to the development of Clinical Commissioning Groups (CCGs), HEE and the Local Education and Training Boards (LET-Bs), added to demand for, and upskilling of, GPNs. At the same time there were declining numbers of new GP trainees and resources in the sector.

The GP Forward view (2016) commits to a GPN development strategy emphasising the importance of the GPN role to the NHS. This is further supported by the GPN Ten Point Plan (2017). It is recognised that a third of the current GPN workforce are due to retire by 2020. There are issues noted with GPN recruitment but also problems in the employment structure which is not Agenda for Change (AfC) standardised and as a result there is wide variance of pay and conditions across the sector. The current study is located at a time when General Practice is under significant increased demand, suffering from recruitment shortages coupled with changes in funding and support models. Notwithstanding the climate, this is an exciting time for nurses who now have the potential to develop the breadth of their role across a wide range of patient facing interactions and increase the depth of their role into advanced level clinical practice, mentoring and leadership.

Introduction to *Fundamentals*

The *Fundamentals* training scheme is a University level short course for qualified nurses working in General Practice. The programme was originally devised and piloted successfully by Plymouth University as an introductory level course for GPNs to provide both theoretical and clinical learning which could be realised in practice with the support of a more experienced nurse mentor. HEE commissioned DMU to deliver and test the GPN Fundamentals training from 2012. In 2016, HEE adopted this model and commissioned Universities in the area to co-construct a localised version of the scheme. A regional team of Universities initially comprising of BCU, ARU. Wolverhampton, DMU, Hertfordshire and Staffordshire came together to co-construct a standardised *Fundamentals* course. BGU have independently developed their *Fundamentals* course, based on previous models and current courses, which ran for the first time in 2019. Whilst there is a theoretical agreement to a standardised model of *Fundamentals* it was also agreed that Universities could localise the content and delivery according to local academic and business needs. In the first 3 years of delivery there

have been over 500 GPNs successfully complete the *Fundamentals* course in the Midlands and East region.

This evaluation seeks to represent the experience of the *Fundamentals* course at each site, by all key stakeholders, identifying where variance occurs and evaluating the impact and outcomes of the course at both an individual and workforce level. The report makes broad recommendations from the research to inform future development of *Fundamentals* courses.

Introduction to GPN-ST

A specialty training route is utilised in a range of professions, most notably for trainee Doctors. There is significant evidence of the benefits of the specialty training model (McNaughton 2006) The RCGP has developed a strong framework and underpinning support mechanism for specialty training. (RCGP 2010) The GPN-ST route is based on the evidence based pedagogic framework which underpins the specialty training route for trainee GP Doctors.

This ST model is based on the evidence that learners need time to assimilate new theoretical knowledge and the opportunity to apply it in a scaffolded environment (Bruner 2009) in order to truly develop a link between theory and practice. Learners need opportunity to practice clinical skills initially under supervision, with reduced scaffolding as experience and confidence develop. Through ongoing formative and summative feedback with a mentor, specialty trainees have the opportunity to consolidate learning. Opportunity for reflection is essential and helps to build clinicians to become reflective practitioners. Furthermore, the pathway is a recognised 'first step' on a pathway which will develop a sense of lifelong learning and commitment to continued professional development essential for clinical practice. (RCGP 2016)

This evaluation seeks to represent the earliest experiences of GPN specialty training across pilot sites. The work engages with a wide range of stakeholders to understand similarities and differences across case study sites. The report makes recommendations about the benefits and challenges of implementing a specialty training pathway for GPNs.

Methods

The evaluation team approached the research from a primary care and health perspective with a deliberate outside and limited expertise in Nursing. The team therefore undertook an intensive ethnographic qualitative approach to the research being 'immersed' into the research context for a short intense period to become familiar with the context from an 'outside-in' perspective. Qualitative data was collected directly from site visits with underpinning evidence provided from observations of meetings and documentary analysis. Data were analysed using the NVivo analytical software package taking multiple approaches including an inductive review of a framework for course evaluation (Kirkpatrick 2006) as well as a deductive thematic analysis.

The University sites delivering *Fundamentals* were primary contacts for data collection for the first part of the evaluation, understanding *Fundamentals* delivery. Each site was approached by the evaluation team to arrange a visit and interview with the course lead and any other members of relevant staff and, where possible, students. Visits to sites were conducted in June and July 2019. The following figure summarises the visits undertaken to date.

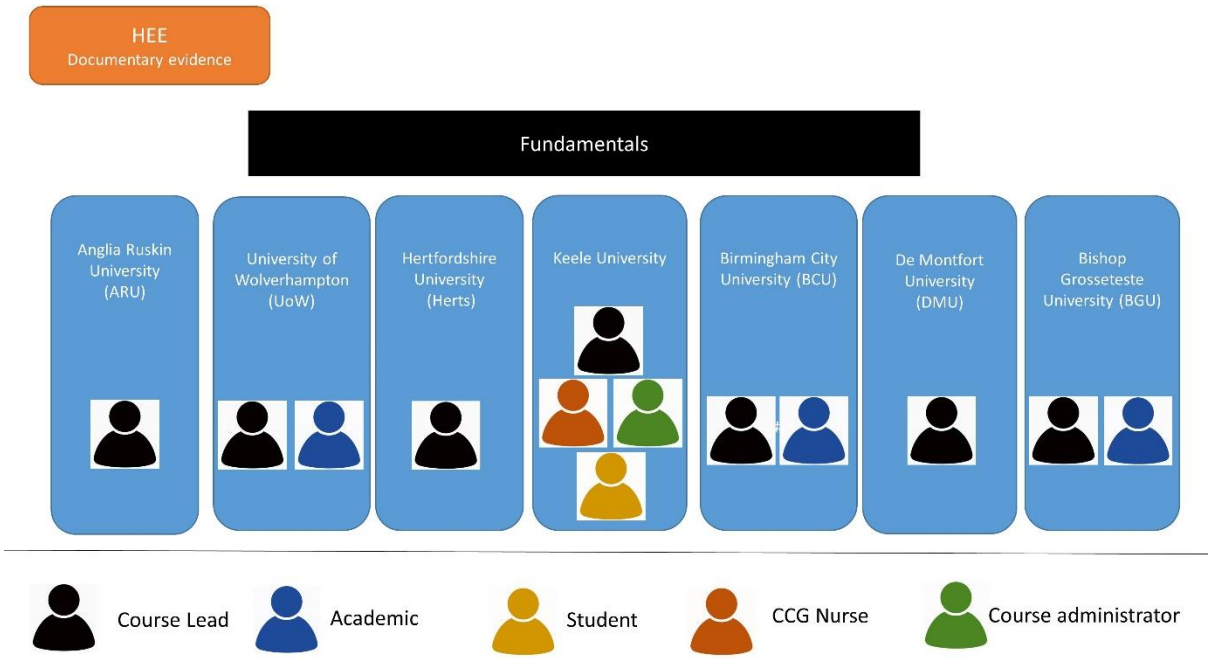


Figure 1. Data collection, stage 1 Fundamentals

The first part of the evaluation includes analysis of the following qualitative data collected:

- Interviews with 7 course leads
- Interviews with 5 additional University staff
- Interview with 1 student
- Meeting notes from 5 project meetings
- Documentary analysis of course material and internal feedback material

The second part of the evaluation includes wider examination of ST sites. The following diagram outlines the additional data which contributes to the full evaluation.

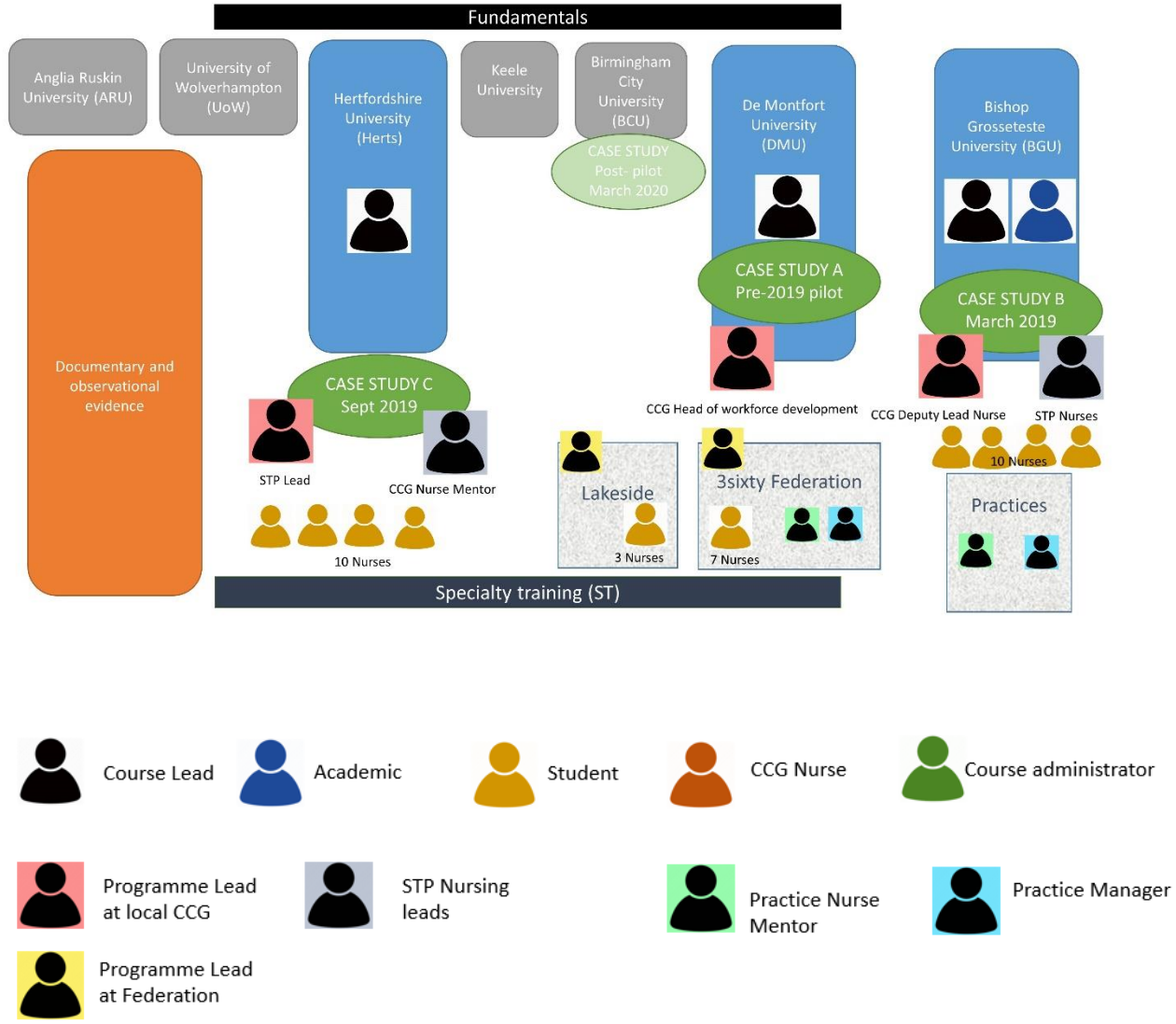


Figure 2. Data collection, stage 2 Fundamentals & Speciality Training

Initial visits to 2 sites were conducted in July 2019 and all sites were later visited throughout 2019 and 2020. The following diagram outlines the pilot STP sites explored in the final report.

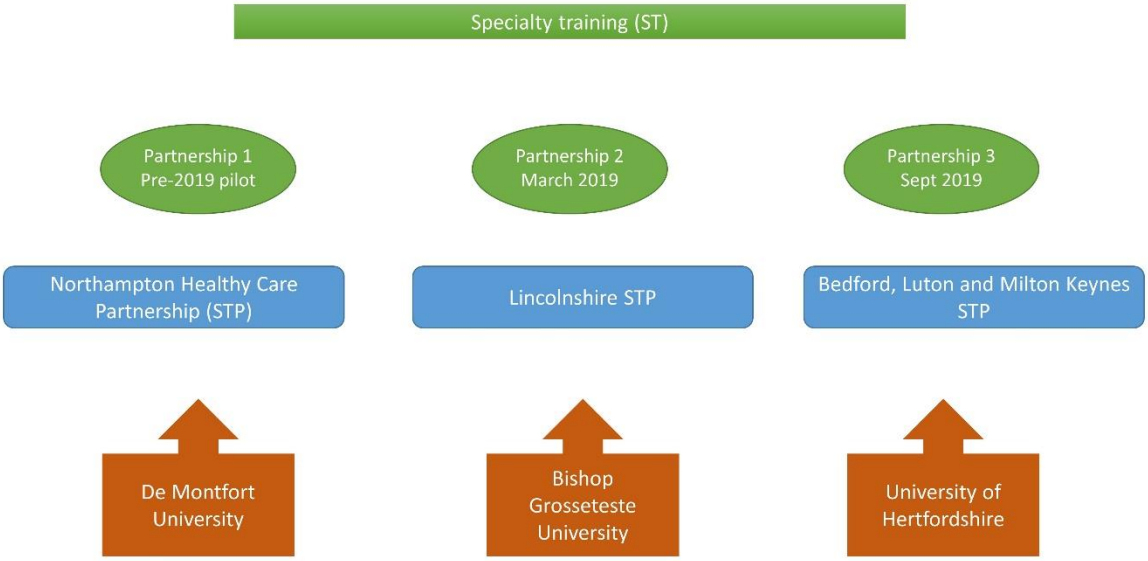


Figure 3. STP sites for full report

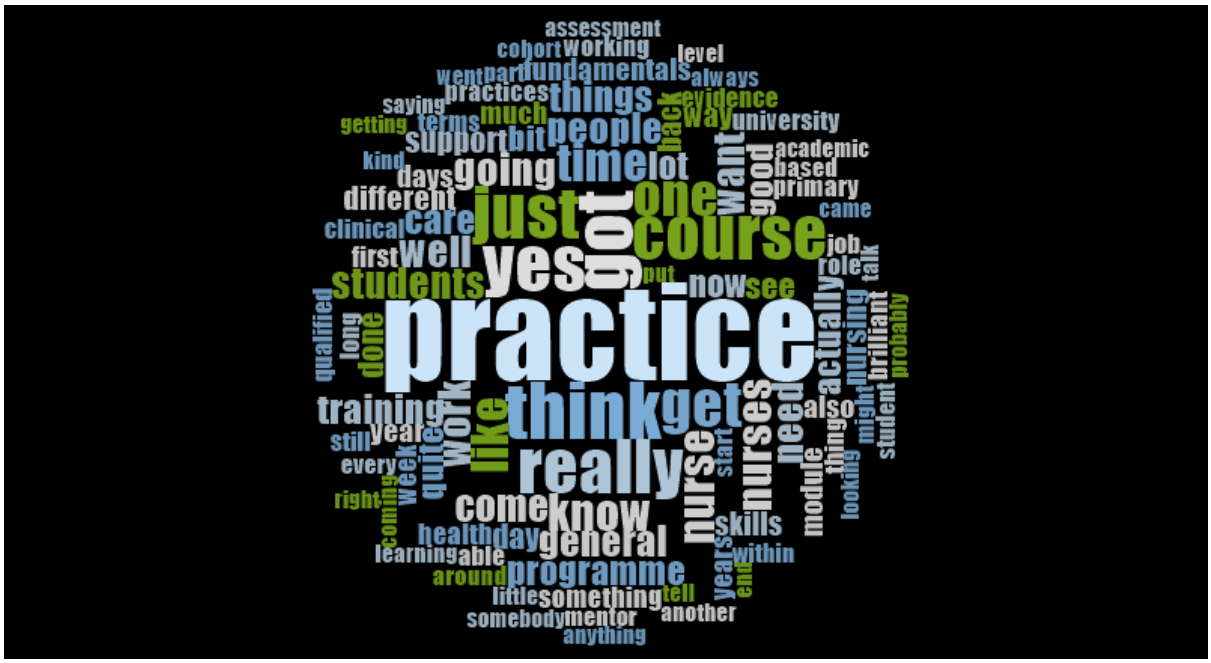
Results - Fundamentals

The full report provides a detailed case study of each site offering *Fundamentals* (see pages 14 to 68). This is useful reference data for the results which follow.

The results are presented in 3 sections:

- Standardisation and variation
- Course evaluation using the Kirkpatrick framework
- Emergent thematic ethnographic analysis

The following word cloud represents word count frequency data from qualitative interview data collected at Fundamentals sites.



Standardisation and variation

The following tables highlight the key similarities and difference between the courses. Tables 1a and 1b compare the organisation of the provision across sites. Table 2 provides a comparison of the topics covered by organisation.

Table 1a. Comparison of "Fundamentals" provision across providers

Standard	ARU	UoW	UoH	Keele	BCU	DMU	BGU
Credits (60)	30	60 (3 x 20)	30 (2 x 15)	60	60 (3 x 20)	60 (1 x 60)	60 (1 x 30, 2 x 15)
Duration of course delivery (9 months)	One semester 12 weeks	9 months	One semester 12 weeks	One year	9 months	9 months	9 months
Duration of course to achieve competency (9 months)	3 months	12 months	3 months	12 months	12 months	9 months	9 months
Start dates	September (P) January (P) April (c)	January - December	September January	September - August	September January April	September January	March (March-July, Sept-Nov)
Attendance (1 day per week)	1 day p/w	1 day p/w Jan - Sept	1 day p/w	1 day p/w Jan – Dec	1 day p/w (Alternate weeks)	1 day p/w (6 months plus tutorials)	1 day p/w
Total days	12	18	12	32	12x 2 (24)	17	32?
Internal mentor	Yes	Yes	Yes	Yes	Yes	Yes 1 day overlap pw	Yes
External mentor	No	No	CCG Nurse Leads support	Personal tutor visits with CCG Nurse Lead / ANP (CCG funding to extend)	No Uni staff link to support internal mentors	50 across East Midlands 15 hours per student Train the trainer	No Personal tutor

Table 1b. Comparison of "Fundamentals" provision across providers

Standard	ARU	UoW	UoH	Keele	BCU	DMU	BGU
Cohort size (10)	*10 funded (+ 2 self-funded) x 3 p/a*	*2017 6 (4) 2018 11 (10) 2019 17 (16)*	*10-12 each cohort*	*2016 9 (8) 2017 9 (8) 2018 8 (7) 2019 13 (12)*	*10-15 per cohort*	*40 Sept (20) Jan (20)*	*11 (1 self-funded)*
Retention / Completion	*100%*	*Above*	*100%*	*Above*	*95%*	*100%*	*Incomplete*
% Newly qualified (80/20)	*Increasing*	*Increasing*	*50/50*	*50/50*	*1-2 / 10 increasing to 6/20*	*50/50 (20 funded places p/a)*	*50/50? Some (unclear)*
GP Contribution	*Variable Some give paid time off others don't*	*Some GPs won't take NQs*	*Some GP funded, some CCG funded, some self-funded*	*CCG funds half salary (£10k) for NQs*	*30 hours mentoring plus 24 days off to attend University, in*	*1 day per week internal mentor £500 external mentor*	*No clear links*
Competencies	*RCGP Considering QI*	*RCGP*	*RCGP*	*10 signs off for key competencies (Imms, cytology)*	*RCGP 16 competencies*	*RCGP*	*RCGP QNI RCN*
Delivery locations	*Cambridge Peterborough*	*Wolverhampton*	*Hertfordshire*	*Stafford*	*Birmingham*	*DMU (mentoring across East Midlands)*	*Lincoln*

Table 2. Comparison of "Fundamentals" course content across providers

	No. of modules	Childhood vaccination	Cervical sampling / cytology	Aural irrigation / wound care	Travel health	Contraception	Minor illness	Mental health	Long term conditions	Contribute to other qualifications?
ARU	1 x 30 credit (30) 12 weeks	YES	YES	YES	YES	YES	YES	YES	YES	30 credits at level 6/7
UoW	3 x 20 credit (60) 9 months	YES M1	YES M1	YES M2	YES M3	YES M3	YES M2 M3	YES M2	YES M2 + M3	3 modules successive Leads to University Advanced Diploma
UoH (BLMK)	1 x 15 credit (15) 12 weeks	YES	YES	YES	YES	YES	NO	YES	M2	PgC / Dip / MSc (60/120/180) Specialist Community Nursing (General Practice)
Keele	2 x 30 credit (60) 12 months	YES Using externals	YES Using externals	YES Using externals	YES Using externals	YES Using externals	NO	YES In house	YES Asthma Diabetes	This is a compulsory core module for a UG degree in clinical practice Gives a PG Cert in Practice Nursing
BCU	3 x 20 credit (60) 9 months	YES M1	YES M1	YES M1	YES M1	YES M1	YES M1	YES M1	YES M1 + M3	This is a top up degree 60 credits at level 6 so will top you up from a Dip to a BSc
DMU	1 x 60 credit (60) 9 months	YES Sept	YES Oct	YES Nov	YES Jan	YES Jan	NO	YES Dec	YES Nov / Dec	Delivered at level 7 required 60 credits at level 6 but assesses at RCGP/GPN L5
BGU	1 x 30 credit 2 x 15 credit (60)	YES M1	YES M1	YES M1				Full MHFA	YES M3	One intro module, Middle whole module is interpreting blood results, one module LTC

Tables 1 and 2 are supplemented by rich case study data presented in the full report. This data shows commonality amongst programmes but also variance. This variance is often attributed to the demands of general practice. The *Fundamentals* terminology has become diluted into a range of meanings from one module of 15 or 30 credits, either stand-alone or part of a wider scheme through to a full 60 credit Postgraduate Certificate (PG Cert) equivalent. Each course runs for one day per week however there is huge variance in student experience as some students are paid by the practice for this time, and others are not.

All courses agree that the course should be delivered over 9 months, although actual delivery models used vary. Several courses deliver the precise 9 months model of teaching whereas another offer a 9-month model in the form of 6 months of taught delivery followed by a period of tutor supported learning in practice prior to assessments. At one site the course is delivered over a much shorter period of time in a single semester (typically 3 months) because whilst the course team recognise the benefits of a 9-month course they are at odds with local demand from GPs. There is variance in the total number of teaching days offered by the Universities.

Most courses offer an agreed 60 credits, usually through 3 modules, with a third of each course dedicated to clinical skills development. All courses run for one day per week and usually deliver one module in the morning and a second in the afternoon. Many courses have a core module which runs throughout the course, a module dedicated to clinical skills and another which has a different focus.

There is agreement that core skills training (cervical cytology, immunisations, ear irrigation) need to be front loaded into programme delivery. 12 months is generally agreed as required time to complete a portfolio of smear tests, and only if training in this area is front loaded to allow time for valid samples to be collected and processed by the lab to meet the minimum number required to be signed off.

Course content is variable, and many 60 credit programmes share modules with other courses. Every course contains a module which measures the development of clinical skills according to a portfolio mapped to the Royal College of General Practitioners competencies (RCGP 2012), although the depth of engagement with the portfolio varies. Often there is an assessment with written reflection on clinical practice. Some courses favour an evidence-based practice approach (EBP) from the onset of the course where others see the course as preparation for further training in EBP.

Mentoring is provided by practice nurses and supported by university tutorial support. Some students also have access to external visiting mentors. A significant amount of tutor time is spent resolving issues in practice. Approximately 10% of students leave the course because they find that they do not wish to work in general practice.

All course leads agree that the course needs to prepare students to work confidently and independently and that a network of colleagues helps to support this aim. Most courses offer a continued network for the student to be part of a pathway to continue their education.

Kirkpatrick Course Evaluation

The Kirkpatrick model of course evaluation is an established tool for evaluating the outcomes of educational programmes at various levels. The following diagram is a visual representation of the framework and what is measured at each level.

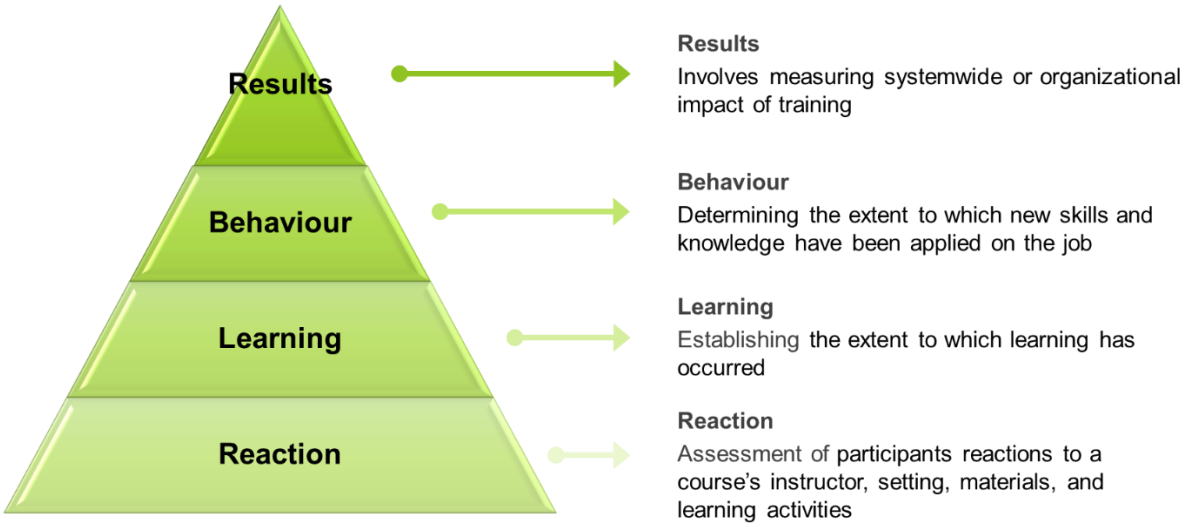


Figure 3. Kirkpatrick model of course evaluation (Rouse 2011)

Data collected for the evaluation was coded against this outcomes framework at one of the 4 levels. This section summarises the data for evidence of learning at each outcome level.

Level 1 – Reaction

Evaluation at this level considers evidence of participants' response to the course in terms of content, delivery and quality. Most students report high levels of general satisfaction with their course through standard university measures such as module and course evaluations. Most course leaders report minor specific issues with their course that students react negatively to and the way they try to resolve these issues. The issue of negative student responses to the early delivery of evidenced based practice and critical analysis reported at multiple sites. There is evidence that while students' early response to this is negative, they develop an awareness of the benefits a later stage. Recruitment of all courses is steady, and all courses fully recruit despite an often-short period in which to do so from course commissioning to commencement. The demand for the course therefore demonstrates a positive reaction to the course provision. This demand, however, takes time to build momentum in the nursing and general practice community. This is evidenced through low rates in early years rapidly increasing as the local community develops an awareness and understanding of the course. Retention is consistent across sites at 90%.

Level 2 – Learning

This level of evaluation relates to knowledge and skills gain in students and how these map to the programme and learning objectives. Evaluation at this level has clear and strong links to learning objectives and assessments used to measure these. Portfolios are used by every course to evidence skills development against the RCGP competencies. Whilst this encourages a level of standardisation between courses, there is also clear differentiation. Students are assessed in other areas of the course in a range of ways with wide variance and little commonality. Achievement levels are universally 100% and students on all courses who do not achieve required assessment levels are encouraged and supported to progress until they do achieve the required level.

Level 3 - Behaviour

Ensuring that learning develops changes in behaviour is closely linked to the chance to apply theoretical knowledge to practical experience. Learning of skills in all courses is measured in practice by the ability to be observed delivering those skills in practice by a more experienced mentor. This emphasises the importance of the practice mentoring role to the success of the course and the importance of a close relationship between the course delivery and opportunity to engage with mentors. The course provides an opportunity for ongoing consolidation of learning through peer group and expert discussion directly related to their own current practice. The University learning community also provides additional security and support for students working in an isolated environment. There is evidence from most courses that they teach practical, evidence-based practice approaches they can use and develop in their own future practice. These simple changes in behaviour encourage persistence of attitudes towards appropriate evidence-based practice. There is evidence that changes in behaviour during the course which benefit practice extend beyond changes in skills ability and into the domain of changes in values and attitudes. Students gain more from education than training in terms of behaviour change related to leadership, over time they evidence culture change as they acclimatise to the primary care culture and their role within it.

Level 4 – Results

There is evidence that some of the *Fundamentals* courses which feature leadership and evidence-based practice approaches facilitate changes in values and attitudes that will have long term benefits for primary care and patients. The impact of the *Fundamentals* course on workforce development can be clearly identified. Over the last 5 years more than 500 skilled and trained work-ready nurses have joined primary care (in the Midlands and East) who otherwise may not have had an opportunity to do so, or who might have done so with less education and support. Data collected by practices and shared with the evaluation team suggest that initial 'results' are positive. This is evidenced by practice managers and GPs who are impressed with the effectiveness of a general practice nurse who has been on the *Fundamentals* training (especially when comparing this to the alternatives.

In summary, there is evidence that all courses contribute to learning at all levels of Kirkpatrick's' evaluation model.

Emergent ethnographic thematic analysis

The benefits of the educational experience afforded the *Fundamentals* courses extends beyond the learning that can be categorised by Kirkpatrick's course evaluation framework and it is vital that these elements are not lost in a framework evaluation. There is also evidence of constraints on the course.

This section of the report therefore details some of the key additional benefits of the educational offering given by the *Fundamentals* programme that extend beyond the learning that might be gained from on-the-job training alongside some key barriers and constraints.

Community of Practice

There is evidence across all courses that students gain significant benefits from being part of a learning community providing opportunity to discuss and consolidate learning and share experience with peers at the same stage of development. This is important to ensure that the learning is contextualised in the broader area of primary care not simply the practice where the student nurse works. The community of practice and especially the support provided by the course enables students to navigate the complex employment system operated in primary care and is actively growing as nurses pursue a pathway through general practice nurse education. There is evidence that students need, and benefit from, the community of practice beyond the *Fundamentals* course. Further, there is evidence that experienced nurses add value to the newly recruited nurses and there is a benefit to mixed cohorts. All courses have a WhatsApp™ group which remains in use as a network for the students after the course.

Safety

There is evidence that the *Fundamentals* course offers a safety net in terms of knowledge and support that students need when first working in primary care. There is also data that the course-based education afforded benefits over standard training courses in terms of practising safely.

Changing roles and culture

Data shows evidence of a culture change in primary care and the way in which the primary care nurse role has changed and is still developing. General Practice in the UK is in a state of constant flux and understanding and adapting to this new cultural environment is viewed by stakeholders as a vital function of the *Fundamentals* course. The course plays an important stabilising role and source of updated information at a time where primary care roles and culture is evolving.

Workforce development

Key stakeholders involved with the *Fundamentals* course recognise the benefits of the course on workforce development. The *Fundamentals* course offers a new alternative to the standard entry from qualification solely into secondary care. There is significant evidence that *Fundamentals* courses attracts new nurses into general practice which has benefits for availability of staff.

There is evidence to suggest that due to the nature of the independent business model, general practice focus more on the development of their local staff than the general practice workforce in general. There is also evidence that where the practice has a strong understanding of and commitment to the development of general practice, this has benefits for the nursing workforce and for the practice who retain staff.

Practice Barriers

Practice barriers emerged from the research as the most significant unplanned theme from the data. These barriers can be summarised as follows

- Lack of financial / time support from practice for education
- Variation in salary, reward and support between practices
- Lack of understanding of or support for training role
- Lack of time for mentoring
- The need for resilience
- Localised response to workforce needs

Results – GPN-ST

The GPN-ST scheme is running with evidence of positive outputs and some initial signs of the start of cultural change. There is some resistance to this change, but this is effectively countered by those willing to be 'early adopters' of the innovation.

Key similarities and differences between the schemes which may impact the outcome are useful to note as points of reflection for future decision makers seeking to replicate the benefits of the scheme. Challenges and benefits identified provide an initial insight into the learning from the early stages of the pilot rollout. Each are separated into the stages of planning, operationalising and outcomes from the pilot.

Planning

All sites had shared tangible aims of increasing the number of trained and work ready GPNs in the primary care workforce.

The aims of the trainee GPN stakeholders tended to be to develop their career and have variety in their role. Several of the GPNs identify a desire to grow as advanced practitioners, mentors and leaders.

Lead time into the scheme was raised as threat to the scheme at all sites. Delays arose in all rollouts and must be expected and anticipated in order to mitigate effects as far as possible.

Each site developed different models and later sites benefitted from the learning of earlier sites. Centralised reporting and feedback are an important function in supporting sites preparation for delivery. Furthermore, task and finish groups ensure regular contact as well as reporting.

The complexity of funding the scheme was a minor barrier to the overall delivery but generated significant learning points.

HEIs are key stakeholders in this scheme and play a vital role in Nursing development. Relationships between local HEIs and CCGs/STP s and appropriate networks are vital to the success of schemes. Courses were commissioned directly by HEE with no direct input from workforce development. Often courses were run with limited direct communication between the HEI and the CCG/STP leads. There was therefore evidence of misunderstanding and miscommunication and little evidence of understanding of mutual needs, benefits and opportunities. Where existing partnerships were in place, the time taken to negotiate implementation was much faster and there were less misunderstandings about expectations. Also, where less layers of staff were involved the faster the implementation. However, implementation was often limited by fixed factors outside the control of the project managers which need to be accounted for – for example serving extended notice periods. Where established Fundamentals courses were utilised in the partnerships (DMU/Northants and UoH/BLMK) this enabled courses which met the needs of the scheme to be 'up and running' quickly.

Operationalising

Each scheme took a different approach to recruitment and employment of GPN trainees. It is recognised that schemes need to be localised according to local supply and demand. This section presents outline timelines and SWOT analysis of each model in order that any future iterations of the scheme or parallel schemes can share the learning from this multi modal pilot. The following outlines the SWOT for each case study site alternative approaches to recruitment.

	Strengths	Weakness	Opportunities	Threats
Case Study A **Northants CCG** **DMU** **Lakeside/3sixty federations**	Fast recruitment process CCG staff provisionally matched candidates to practice sites Practice sites approved appointments in interview Consistency in cross-scoring candidates in interview 40 GPN applicants for 10 posts Diverse cohort from range of backgrounds including NQNs	Some GPN applications from outside the area (invited to assessment but not willing to relocate so withdrew) Two different interview dates inconvenient for applicants Not enough time for notice periods leading to overuse of annual leave or delayed start or some starting course before job No recording of unsuccessful candidate for future opportunities	Key networks exist for recruiting practices and promoting vacancies, Existing partnerships with innovative Federations, Key staff already in place in Federations,	Tight turnaround less opportunistic for NQs ending course. Variation in offers made (salary, benefits) Late starting trainees could learn less (mitigated) Lack of local workforce data to measure benefits
Case Study B **Lincs STP/CCG** **BGU**	GPN adverts generated national interest Communication through local courses generated NQ interest 68 applicants for 10 posts Diverse cohort from range of backgrounds including NQNs	Some GPN applications from outside the area (one offer made but not willing to relocate so withdrew) Recruited trainees before course provider or practices Tight turnaround of meant some practices interviewed trainee outside their area No recording of unsuccessful candidate for future opportunities No planning for additional (centralised) resource requirements in advance leading to delays	New partnerships established for future iterations Good quality iterative learning points recorded by all stakeholders	Practice staff may not have met GPN before appointment Variable offers, often to match previous position, (salary, benefits) External consultant federation project staff and NHS staff short term appointments Lack of local workforce data to measure benefits Centralised HR delays can cause financial hardship and distress

Case Study C **BLMK STP** **UoH**	PR company generated 80 applicants for 10 posts Practice sites approved appointments in interview Longer lead time to respond to arising issues Diverse cohort from range of backgrounds including NQNs	Spend less time on advertising and more on selection No recording of unsuccessful candidate for future opportunities	PR company generated positive press New partnerships established for future iterations Good quality iterative learning points recorded by all stakeholders	Cost of PR company and lack of ongoing link to applicants Lack of local workforce data to measure benefits

The following table outlines the employment models at each site and their corresponding SWOT.

	Strengths	Weakness	Opportunities	Threats
Case Study A **Northants CCG** **DMU** **Lakeside/3sixty federations**	GPN ST trainee is employed and placed into practice ***by Federation, employed by individual practices***	Variable pay, terms and conditions between practices within Federations, and between Federations	Negotiating individual packages Weekday working hours Opportunities to develop	GP not equitable with AfC Nursing not equitable with many other professions Secrecy around T&Cs Pay cut for experienced nurses to become trainees from secondary to Primary Care No established pathway for development

Case Study B **Lincs STP/CCG** **BGU**	GPN ST trainee is employed and placed into practice ***by CCG*** at a rate matching previous terms	Variable pay, terms and conditions with likely **reduction** at end of course Additional support required for transition into employment	Negotiating individual packages Weekday working hours Opportunities to develop Support through scheme continues into new employment University Masters course pathway	GP not equitable with AfC Nursing not equitable with many other professions Secrecy around T&Cs Pay cut for some transition from traineeship to employment causing retention issues No established pathway for development
Case Study C **BLMK STP** **UoH**	GPN ST trainee is employed and placed into practice ***by individual practices,*** often at a rate matching previous the	Variable pay, terms and conditions with likely **reduction** at end of course Additional support required for transition into employment	Negotiating individual packages Weekday working hours Opportunities to develop Support through scheme continues into new employment	GP not equitable with AfC Nursing not equitable with many other professions Secrecy around T&Cs Pay cut for some transition from traineeship to employment causing retention issues No established pathway for development

Despite operationalising different employment models, similar outcomes were experienced showing that all models can be successful.

There was evidence across multiple sites which suggested that there were a wide range of providers offering training badged as 'General Practice Nurse Education'. GPs, Practice managers and practitioners were all identified as having some level of responsibility for awareness and appreciation of training offers for general practice staff.

A brief competitor analysis was undertaken identifying a competitive marketplace for GPN training. Within the national market for GPN training and education is huge variance and very little standardisation. While the fundamentals model is well known in the local area, its distribution further afield is under an even wider branding of a 'Foundation' course. Cheaper alternative training models as cheap as £800 and as short as 3 days are on offer in the marketplace. While there is little evidence of the effectiveness of such training, it remains on offer and in demand due to the needs of primary care and difficulties of recruiting staff and meeting demand. There is evidence that while there may be an initially higher investment in the fundamentals course over competitors, the return on investment is realised as a much higher rate through confident, safe practice and developing future leaders.

At each site students were offered two types of mentoring – practice and external mentoring. practice mentoring was uniformly provided by an experienced practice mentor. Variable levels of support were experienced. Most practice mentors offered successful scaffolding for GPN trainee learning. Where problems were experienced with practice mentors, they were resolved with support from STP/CCG/Federation leads or university mentors.

Whilst mentoring supports the education of GPNs, there is evidence that they require additional support from the Nursing networks that exist, in particular in transition into employment and beyond the scheme whilst there are no standardised pathways for development.

Each scheme had different management and relationship models as presented in the case study data and this had an impact on the operationalisation of the scheme. There is evidence that ongoing communication between key stakeholders and the establishment and facilitation of key networks is therefore vital to the success of schemes. The task and finish group were the leading source of guidance and regulation to the scheme.

Relationships take time to develop and therefore those programmes built on existing relationships were successful more quickly where others may need longer to develop. The use of short-term and contract staff is prohibitive to this aim.

Outcomes

The commissioning of an independent evaluation of both the *Fundamentals* scheme and the pilot scheme is an important step to understanding what works best for GPNE and how the innovative ST pathway can contribute to culture change in Primary Care. It is envisaged that this work will provide important evidence to share with key contacts and contribute to the diffusion of this innovation.

The scheme clearly meets the workforce related aims of supplying trained work ready GPNs into the local primary care workforce. 10 places were on offer at each site and at least 9 new nurses entered the workforce in each area.

GPN-ST trainees have been recruited from a wide range of backgrounds, with broad ranging work histories and varying levels of experience. This evidence is proof of the concept that nurses from any previous background can transfer into the GPN role. Analysis of themes arising in student motivation show that many experienced nurses desire the opportunity to provide ongoing support to patients, and have a varied workload, as well as appreciating the lack of shift work. This may be useful evidence to use in marketing the position to future trainees. There is evidence from all sites of proof of concept that general practice is suitable setting for newly qualified nurses. Marketing directly to qualifying and return to practice nurses has been successful.

There is evidence the ST pathway develops a broad range of transferable skills along with a support net for GPN students that has not existed previously. There is evidence of desire by practice staff for the scheme rolled out more widely for broader benefit. There is also evidence that the scheme meets workforce needs but needs to continue to be sustainable with development of GP and nursing generally. These incudes future fellowship funding for GPNs and developing the MDT. There is recognition that GPNs will work in a diverse and developing MDT.

There is a recognition that negotiating salary and terms and conditions in general practice can be competitive and as a result, secretive. There is evidence that STP/CCG staff play a vital role in supporting students to negotiate beneficial contracts. Most GPN trainees will take a pay cut, based on the recognition they have other possibility such as growth. STP Nurse leads play a crucial role in highlighting the benefits of the potential for development in the role, that may not exist in other domains.

GPN-ST is a first step on a career as a GPN and the stakeholders recognise the need for a standardised pathway of development. There is evidence of a developing pathways for GPNs and the ST model seems the perfect fit for entry level GPNs and a building block to further routes of development. It is recognised by practices and STPs that pathways for development are linked to retention of GPNS in the sector.

Recommendations

This section outlines the key recommendations arising from the research. The recommendations form the 'how-to' output targeted at key stakeholders which appears as a key output in the appendices of the full report.

Allocating and managing responsibilities

Recommendations

- *Clearly establish project management roles and responsibilities*
- *Establish and commit to regular timely meetings between top tiers of project management (CCG/STP and Federation or lead nurses)*
- *Where there is no interim (Federation) level support, CCG/STP nurse leads should be in place early and will have key responsibility for communication between CCG/STP leads and practice sites and GPNs.*
- *Workforce modelling at local and regional levels should feed into the scheme. The scheme requires frequently updated statistics for accurate project evaluation. Consequently, the scheme should connect with and encourage developments in local workforce modelling.*

Project Planning / Suggested timelines

Recommendations

- *Project managers need to manage timelines with flexibility and realism and according to local needs*
- *Commissioners need to recognise the realistic minimum time requirements for success*
- *Project managers need to recognise, manage and be responsive at critical points*
- *Project should plan for heavy early workload commitment; consultants can be used where required but sufficient communications and handover is required*

Recruitment

Recommendations

- *Recruitment is a process which takes a minimum 6 months and ideally setting up a scheme will have a 9-12-month lead time in advance of the course and trainee jobs starting*
- *Recruitment is a time intensive period for project managers*
- *Jobs should be advertised through NHS jobs and local networks*
- *Jobs can be advertised to NQNs in conjunction with local HEIs*
- *Agencies can be used to support recruitment which will increase number of applicants but has risks of cost, time and restrictions on transfer of information*
- *Practices should be recruited in advance of GPNs, or alongside, in order that practices can be involved in interviewing*
- *Project managers who will be involved in supporting the scheme longer term should be involved in interviewing candidates to facilitate development of trust in relationships*
- *Successful schemes shortlist and interview GPNs with staff from CCG/STP and usually provisionally match GPNs to practice sites ready for final interviews/rubberstamping*
- *HR support is required in creation of contracts, negotiation of terms and conditions and pre-employment checks – this support should be identified early, and time created to complete recruitment tasks.*
- *Time from advertising posts through to interviewing and making offers is a minimum 3 months, allowing for holidays and absences. Practices prefer longer lead times in order to arrange their involvement.*
- *Time from making offers to starting courses/posts must be a minimum of 3 months to allow for band 6 notice periods and mitigate the need for unpaid leave or late starts for GPNs*
- *Salaries will be individually negotiated. Where experienced nurses have salaries matched, they will likely experience pay reductions in future transitions into the role.*

Employment models

Recommendations

- *Clear communication to practices of employment models at an early stage coupled with ongoing communications about their individual requirements*
- *Support from HR will be required*
- *CCG employed sites require additional transition support at project end*

Education

Recommendations

- A standardised model of *Fundamentals* course as gold standard
- Promotion of *Fundamentals* + ST as parallel to GP ST1 training
- Consideration by the regulator in recognising *Fundamentals* + ST as a specialist pathway worthy of annotation on the nursing register
- *Fundamentals* should represent the first step on a pathway of development for GPNs
- Further research should be undertaken into pathways for GPN development
- Early and ongoing discussions between HEIs and STP/CCGs required
- STP/CCG should be educated about *Fundamentals* and the differences with respect to cheaper alternatives

Mentoring

Recommendations

- Agree mentoring model and implement from scheme outset
- External mentors should have a tripartite relationship with practice mentor and trainee
- External mentor should support trainee integration into role and community
- External mentor should be a practising nurse, not academic
- Shared commitment towards building a community of practice - mentor should support trainees to engage with wider network of GPN

Evaluation

Recommendations

- Coordinated formative evaluation is important to inform scheme development
- Task and finish facilitated formative evaluation of project management
- Summative data is basic and can be developed when workforce modelling develops
- Qualitative data should be collected through exit interviews to inform future publicity and learning

Summary

The following word cloud represents data collected in word frequency and highlights the key themes arising from this research across all data.

The ST scheme clearly meets the workforce related aims of supplying trained, work ready GPNs into the local primary care workforce. 10 places were on offer at each site and at least 9 new nurses entered the workforce in each area. GPN-ST trainees have been recruited from a wide range of backgrounds, with broad ranging work histories and varying levels of experience. This evidence is proof of the concept that nurses from any previous background can transfer into the GPN role.

The evidence collected from three sites with distinct operational differences affords a unique insight into a range of opportunities for project implementation. There are key lessons around recruitment including the importance of allowing sufficient time for students to service notice, and the required front loading of project management resources to facilitate an often-speedy required turnaround. There are a range of employment models outlined and associated benefits and challenges.

The *Fundamentals* model outlined - of 9 months of teaching, delivered over a minimum of 36 days and comprising 60 credits in 2-3 modules with at least a third focus on clinical skills is agreed by several of the course teams and is an agreed outcome of the original *Fundamentals* planning group. Variation from this arises as a result of misconception and external demand. There is no overarching mechanism to regulate course content or delivery.

All sites agree the course should provide a key overview of skills front loaded into the course which can be developed through experiential scaffolded learning in practice. This includes immunisations, cervical cytology, contraception and travel. All sites agree the course delivers learning beyond skills and into knowledge and wider transferable skills such as resilience and leadership. It is recommended that the 9-12-month model of delivery one day per week including all key RCGP competencies and assessed by portfolio and other academic means are preferred.

The content of the course should include a core and broad introduction to GPNE, assessed in a way which is useful to the student and practice. The course should measure skills development against the RCGP competencies and use mentors to support this development. To ensure deep learning it is vital that there is an opportunity to directly link theory to practice.

Fundamentals should be a pathway bridging the gap for any qualified nurse (newly qualified or practising in another area) to begin working as an independent member of staff contributing directly to patient care and practice targets.

Fundamentals courses should continue to offer a community of support and provides the opportunity to underpin cultural change towards education and leadership for GPNs.

The evidence suggests variance from this model whilst appearing responsible to employer needs is detrimental to the broader development to the nursing profession and should be discouraged.

It is recognised that an underpinning culture change will be required to facilitate this level of development, but it is acknowledged that this is the long-term aim of stakeholders in this programme.

At each site students were offered two types of mentoring – practice and external mentoring. practice mentoring was uniformly provided by an experienced practice mentor. Variable levels of support were experienced. Most practice mentors offered successful scaffolding for GPN trainee learning. Where problems were experienced with practice mentors, they were resolved with support from STP/CCG/Federation leads or university mentors. External mentors were effective when in tripartite relationships supporting students. External mentors provided access for students to important nursing networks. Support for students was provided at STP/CCG level and this was important in transition to employment and ongoing into their roles.

The scheme clearly meets the workforce related aims of supplying trained work ready GPNs into the local primary care workforce. 10 places were on offer at each site and at least 9 new nurses entered the workforce in each area.

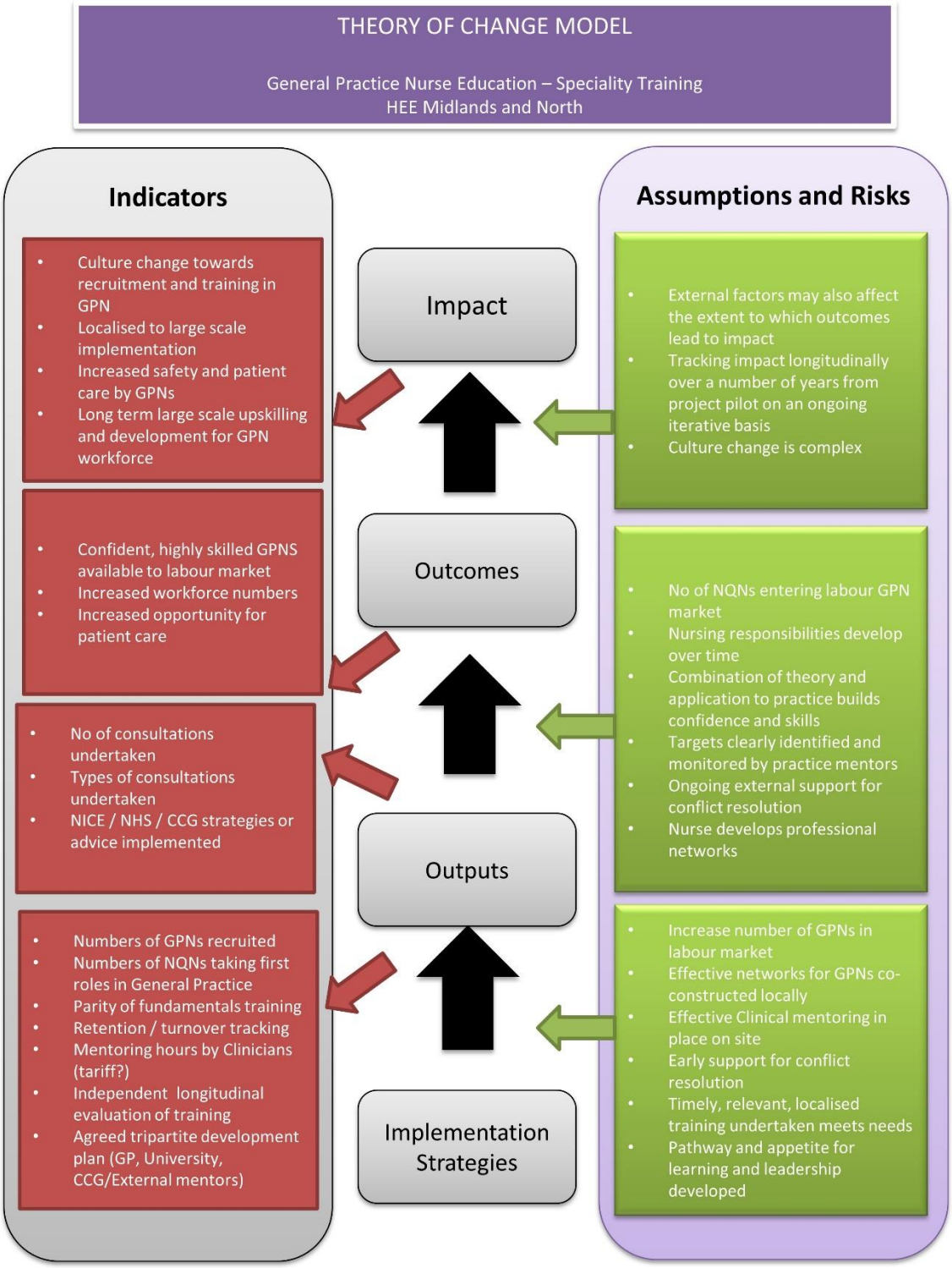
GPN-ST trainees have been recruited from a wide range of backgrounds, with broad ranging work histories and varying levels of experience. This evidence is proof of the concept that nurses from any previous background can transfer into the GPN role. Analysis of themes arising in student motivation show that many experienced nurses desire the opportunity to provide ongoing support to patients, and have a varied workload, as well as appreciating the lack of shift work. This may be useful evidence to use in marketing the position to future trainees. There is evidence from all sites of proof of concept that general practice is suitable setting for newly qualified nurses. Marketing directly to qualifying and return to practice nurses has been successful.

There is evidence the ST pathway develops a broad range of transferable skills along with a support net for GPN students that has not existed previously

Appendices

Theory of Change

The evaluation leads to the identification of a theory of change model for the culture of education of general practice nurses as illustrated below.



How to Guide

The recommendations outlined above are summarised in a 'how-to guide' for key stakeholders in the appendix of the main report. There is some repetition wihtin the document which it is anticipated will be circulated in component parts to the relevant stakeholders.

Feedback on development in the spirit of co-production is welcomed.

Policy Brief

The content of this policy brief is draft only. It is suggested that this document is an example and outline and should not circulated without further investment from communications and policy impact expert input to formalise the key messages and required audience and to ensure the use of key visual methods to disseminate data.

University of Nottingham
UK | CHINA | MALAYSIA

NHS
Health Education England

DEVELOPING NURSES WHO WORK IN GENERAL PRACTICE

This policy brief summarises current policies and practice for General Practice Nurse Education. Research was undertaken on pilot innovation work in developing General Practice nurses (GPNs). Data was collected across the Midlands and East regions from experienced and trainee GPNs as well as CCG/STP and practice staff. Findings highlight the importance of a standardised pathway of development for GPNs to support their recruitment and retention. These findings are consistent with national research in this area.

Key facts about the GP workforce

- One third of the current GP workforce are due to require by 2020[1]
- Applications to Nursing courses are falling year on year
- Few new Nursing recruits enter general practice
- There are high levels of unfilled Nursing vacancies (41,000 in 2018 – more than 1 in 10 Nursing posts)[2]
- Patient numbers and demand for appointments is increasing
- The mix of professional staff types in General Practice is increasing
- Patient demands are increasing
- NHS strategy documents support the development of the General Practice Nurse role [3,4]

Comparison of development pathways for GP Staff:

GP Doctor: 2/3 years salaried ST training with day release and mentoring support

GP Pharmacist: PG experience, 1 year salaried training with 50+ days of training and mentoring support

GP Nurse: NO STANDARDISED ENTRY ROUTE

Comparison of Nursing role T&Cs :

Secondary vs Primary

Secondary care: NHS Agenda for Change

Primary care: No standard, great variability

[1]Rimmer, A. (2015) A third of GPs are considering retirement, BMA survey finds, BMJ 2015;350:h2037
[2]Buchan, J., Charlesworth, A., Gershlick, B. and Seccombe, I., 2019. A critical moment: NHS staffing trends, retention and attrition. *Health Foundation*.
[3]NHSE (2016) Five Year Forward View
[4]NHSE (2018) General Practice ten point plan

TRAINING AND EDUCATION FOR GENERAL PRACTICE NURSES

Our research identified a large number of unregulated providers offering training courses for General Practice nurses. Courses ranged from 1 day to 1 year and cost from £80 - £8000.

FUNDMENTALS OF GENERAL PRACTICE (Postgraduate Certificate in General Practice Nursing)

Nursing leaders have worked collaboratively to develop a broad standard for General Practice Nurse Education.

The key course components are agreed as follows:

- PG Cert level University delivered course 60 credits
- 9 months in duration
- Front loads key clinical skills learning including
  - Cervical cytology
  - Immunisations and Vaccinations
  - Travel health
  - Contraception* (*not on all courses)*

The outlined Fundamentals training course has run full recruited programmes at 10 sites across NHS Midlands and East. Feedback

WHAT DO FUNDAMENTALS COURSES OFFER THAT OTHER COURSES DON'T?

- A recognised standard across General Practice
- Time for consolidation of learning – application of theory to practice
- Scaffolded learning through practice and University mentoring
- Development of an evidence based approach to clinical skills
  - Connected to the latest in cutting edge research
  - Projects based in real world experiences to benefit the practice
- Development of leaderships and education skills to develop the GPN sector further
- Increased job satisfaction

CHOOSE FUNDAMENTALS AS THE MINIMUM ENTRY REQUIREMENT FOR GP NURSES

The standards she has achieved through the GPN course have enabled us to now offer her permanent employment at the end of the course

Practice Manager

'I wanted to come into general practice because it is a bit more like intimate, you can have those relationships with the patients and follow their care through.

GPN Trainee

TOWARDS SPECIALITY TRAINING FOR GENERAL PRACTICE NURSES (GPN-ST)

The evaluation collected evidence that a specialty training route for GPNs clearly meets the workforce related aims of supplying trained work ready GPNs into the local primary care workforce. 10 places were on offer at each site and at least 9 new nurses entered the workforce in each area.

GPN-ST trainees have been recruited from a wide range of backgrounds, with broad ranging work histories and varying levels of experience. This evidence is proof of the concept that nurses from any previous background can transfer into the GPN role.

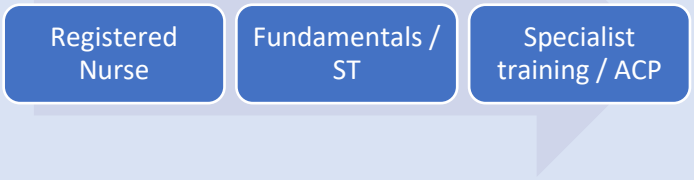
Analysis of themes arising in student motivation show that many experienced nurses desire the opportunity to provide ongoing support to patients, and have a varied workload, as well as appreciating the lack of shift work. There is evidence from all sites of proof of concept that general practice is suitable setting for newly qualified nurses. Marketing directly to qualifying and return to practice nurses has been successful.

There is evidence the ST pathway develops a broad range of transferable skills along with a support net for GPN students that has not existed previously.

There is also evidence that the scheme meets workforce needs but needs to continue to be sustainable with development of GP and nursing generally. These incudes future fellowship funding for GPNs and developing the MDT. There is recognition that GPNs will work in a diverse and developing MDT. There is evidence of desire by practice staff for the scheme rolled out more widely for broader benefit.

> *With the increase in GP Practice workload and working hours, the extra nursing capacity our GPN trainee brought has already enabled us to relieve some of this strain (at little / no training cost to us) and with continued employment she will hopefully be working with us in general practice for many years to come; for us this was successful recruitment without having had to 'rob' a Practice Nurse from another practice, something which generally just results in moving the recruitment gap instead of filling it. I would encourage any Practice that is looking to recruit a Practice Nurse in the near future (or for the future) to seriously consider recruiting from this GPN pool and to do so with the confidence that while the nurses may not have many years of Practice (ours only had 3 years post- qualifying as a nurse), they are very well trained and qualified to do what we ask of them and, add to that, as new entries into primary care they come with enthusiasm and new ideas*
>
> *Practice Manager Testimonial*

A pathway for General Practice Nurse Education



'Well I hope we start bringing in people young and we have a clear training pathway through apprenticeships and things, from the health care assistant, nursing associate through to qualified nurse with a specific branch for practice nursing and if people want to stay in general practice, I would love to see that.'

Experienced GPN and practice mentor

THEORY OF CHANGE MODEL

General Practice Nurse Education – Speciality Training
HEE Midlands and North

Indicators

- Culture change towards recruitment and training in GPN
- Localised to large scale implementation
- Increased safety and patient care by GPNs
- Long term large scale upskilling and development for GPN workforce

- Confident, highly skilled GPNS available to labour market
- Increased workforce numbers
- Increased opportunity for patient care

- No of consultations undertaken
- Types of consultations undertaken
- NICE / NHS / CCG strategies or advice implemented

- Numbers of GPNs recruited
- Numbers of NQNs taking first roles in General Practice
- Parity of fundamentals training
- Retention / turnover tracking
- Mentoring hours by Clinicians (tariff?)
- Independent longitudinal evaluation of training
- Agreed tripartite development plan (GP, University, CCG/External mentors)

Impact

Outcomes

Outputs

Implementation Strategies

Assumptions and Risks

- External factors may also affect the extent to which outcomes lead to impact
- Tracking impact longitudinally over a number of years from project pilot on an ongoing iterative basis
- Culture change is complex

- No of NQNs entering labour GPN market
- Nursing responsibilities develop over time
- Combination of theory and application to practice builds confidence and skills
- Targets clearly identified and monitored by practice mentors
- Ongoing external support for conflict resolution
- Nurse develops professional networks

- Increase number of GPNs in labour market
- Effective networks for GPNs co-constructed locally
- Effective Clinical mentoring in place on site
- Early support for conflict resolution
- Timely, relevant, localised training undertaken meets needs
- Pathway and appetite for learning and leadership developed

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