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General Practice Nurse Education Fundamentals and Specialty Training

Independent Evaluation Report

University of Nottingham

June 2020

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A project funded by Health Education England

Cite as Mann, C., & Boyd, M. J. (2020). General Practice Nurse Education Fundamentals and Specialty Training: Independent Evaluation Report. Nottingham: Health Education England https://doi.org/10.17639/144B-9Z31

Contents

Abbreviations within this document

AfC	Agenda for Change (NHS Terms and conditions)
ANP	Advanced Nurse Practitioner
CCG	Clinical Commissioning Group
CPN	Community Psychiatric Nurse
DCN	Deputy Chief Nurse
EBP	Evidence Based Practice
GP	General Practice (General Practitioner)
GPN	General Practice Nurse
GPNE	General Practice Nurse Education
GPN-ST	General Practice Nursing -Specialty Training
HCA	Healthcare Assistant
HEE	Health Education England
HEI	Higher Education Institution
LET-B	Local Education and Training Boards
LMC	Local Medical Committee
NHSE	National Health Service England
NHSE/I	National Health Service England Improvement
NMP	Non-medical prescribing
NQN	Newly qualified nurse
PCN	Primary Care Network
PG	Postgraduate
QNI	Queens Nursing Institute
QOF	Quality and Outcomes Framework
RCGP	Royal College of General Practitioners
RCN	Royal College of Nursing
ST	Specialty Training
ST1	Specialty Training level 1
STP	Strategic Transformation Partnership

Ethics Statement

This study has been reviewed and given favourable opinion by The School of Pharmacy Research Ethics Committee (ref 007-2019).

As a directly commissioned evaluation report, HEE and NHSE/I were keen to understand the specific operation of a specific number of sites. In doing so we advised that it would be impossible to completely anonymise participants in the reporting of the work. This was advised to participants, who agreed to direct quotations from their interviews or focus groups to be reported to HEE and NHSE/I. All names presented in this work are pseudonyms to aid clarity of reading. Data will not be shared further by the University research team without anonymising.

Data presented is verbatim when presented indented with a name and speech marks in the following format

Speaker: 'This is what they said'

Or alternatively when presented in speech marks with a cited data source e.g.

'This is what they said'

Course Lead, Data Source 17

Data presented inside a text box is documentary data.

HEE and NHSE/I may wish to consider limiting the circulation of the full data in the report to participants.

Key findings can be shared to a wider audience, and anonymised to further protect participants, if required.

Audience Guide

The full report presents all data collected on both stages of the report. This is intended for the commissioners of the report, and others of their choice they wish to share with to facilitate the widest understanding of the research undertaken. However, this work has wide potential for impact and the authors make the following suggestions for sharing and disseminating the work.

It is acknowledged that not all key stakeholders are likely to have time to digest the full research document and may therefore require direction to separate key parts of the document relevant to themselves.

The introduction, background and methods sections are useful to any audience with a desire to understand the context and setting for the research as well as the methods undertaken.

The initial *Fundamentals* section is likely to be of key use to those with key roles in the delivery of the educational aspect of the course – i.e. course leaders, lecturers, and key link mentors. It would also be useful background reading for commissioners of education at CCG / STP level. For sharing to an audience beyond the participants, the commissioners may wish to consider further anonymising data presented.

The second GPN-ST section is likely to be of key use to those with key roles in the operational delivery of the course – i.e. NHSE/I, HEE, commissioners as an overview of the first three initial pilot schemes and lessons learned. This is an in-depth overview and comparison of the sites including detailed case studies. Further anonymising of data may be deemed necessary before sharing widely.

The full report presents all the data collected in the project which, whilst being necessary for the evaluation and reporting, may be an overwhelming amount of reading for those in busy day to day roles. To this end the report data has been summarised and can be read in a range of alternative ways.

The Executive Summary document summarises the key findings of the full report in a shorter and more digestible format with key recommendations. This may be the most useful alternative of the full report to share with stakeholders.

The 'how to' guide can be separated into a range of useful summaries depending on audience. This can be supplemented with anonymised case study data as supporting evidence.

The police brief is an example of how key data from the research can be summarised, alongside key recommendations, in the shortest most attention-grabbing format, to be shared with key audiences. The brief outlined is an example.

Therefore, there are a wide range of ways the data collected from this research can shared with a wide audience, depending on the needs of the audience.

For example, a training hub may be sent the operational 'how-to' guide supplemented by the three pilot GPN-ST case studies. An educational establishment may request the education 'how-to' guide and *Fundamentals* case studies. For further reading they may request the '*Fundamentals'* section of the full report, or the Executive Summary. Alternatively, a GP Federation may request the practice 'how-to' guide supplemented by the policy brief.

The authors recommend the academic publication of work which represents the key findings of this research for General Practice to contribute to the ongoing debate and development of the role nationally.

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 HEE funded Specialty training (GPN-ST).

The objectives relating to the different models of operation.

In relation to *Fundamentals*:

- To define and understand the models of GPNE *Fundamentals* in HEE commissioned schemes delivered by a range of Universities understanding standardisation and variance in course provision;
- To evaluate the outcomes of different GPNE *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 GPNE *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.

These objectives are realised through this report.

Background

A brief history of General Practice Nurse Education

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.

There are high levels of turnover in Nursing (Ipsos Mori 2016) and significant reductions in the available workforce (Buchan & Seccombe 2018) in particular since the removal of the bursary for training, significant reductions in Nursing trainees (Marsden 2020). This has had an impact on General Practice which has a significant number of nurses who will retire in the next ten years (QNI 2015).

Given the increase in demand and reduction in supply, it has never been more important to focus on recruitment and retention of GP nurses.

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.

The following map demonstrates the geographical location focus for the work

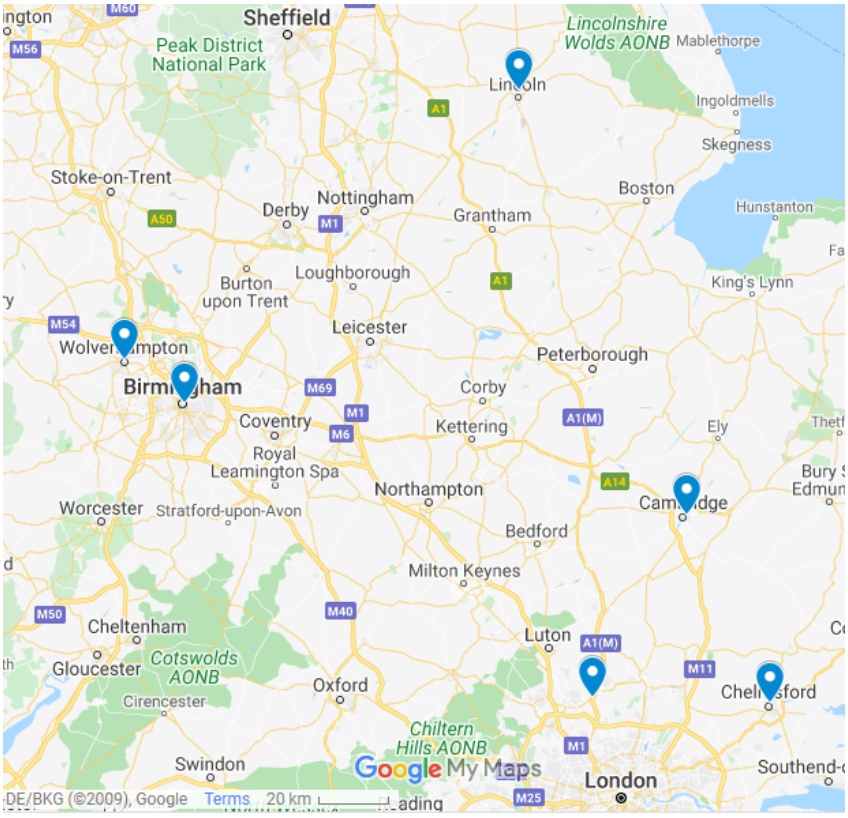


Figure 1. Location of Fundamentals delivery sites (HEE Midlands and North)

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 analysis was conducted using the NVivo analytical software package and 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.

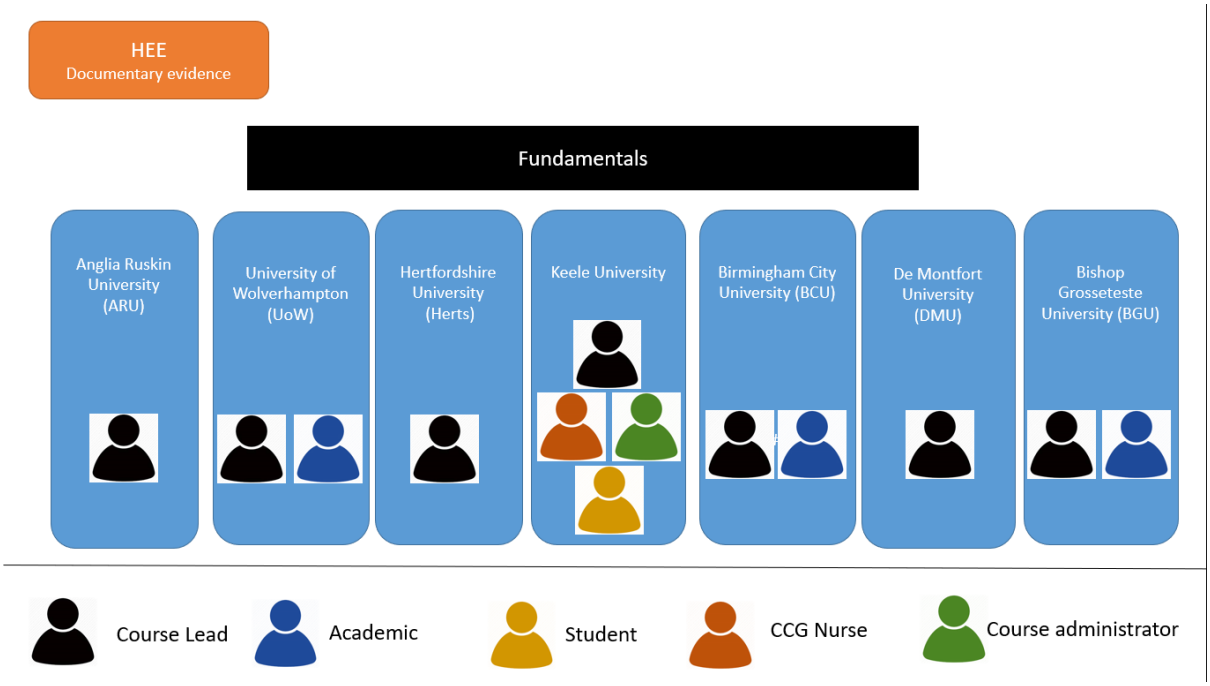


Figure 2. Data collection, stage 1 Fundamentals

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 which are included on the following diagram

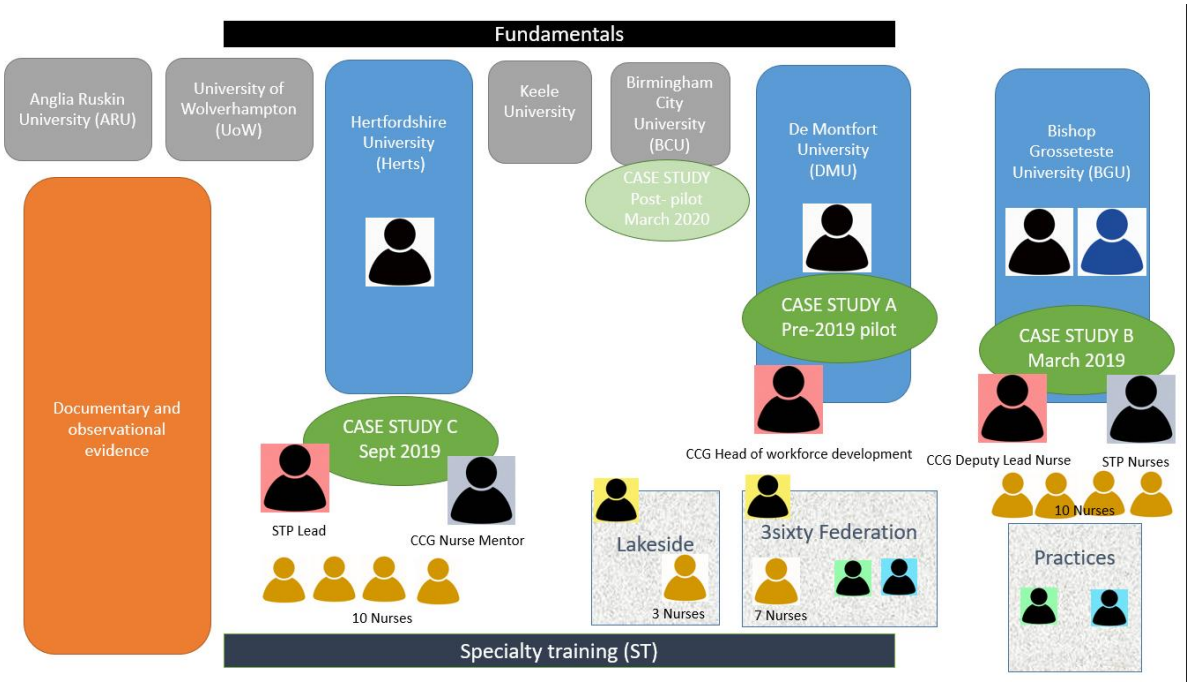
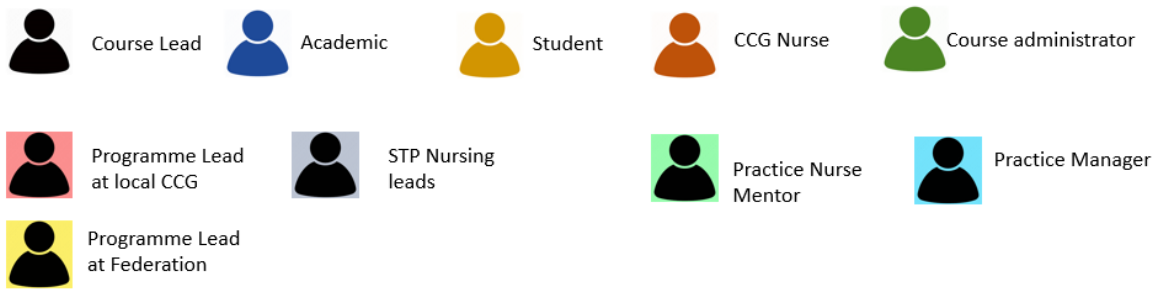


Figure 3. Data collection, stage 2 Fundamentals & Specialty Training. Pictorial representations are listed below:



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 which will be examined further and explored in the final report.

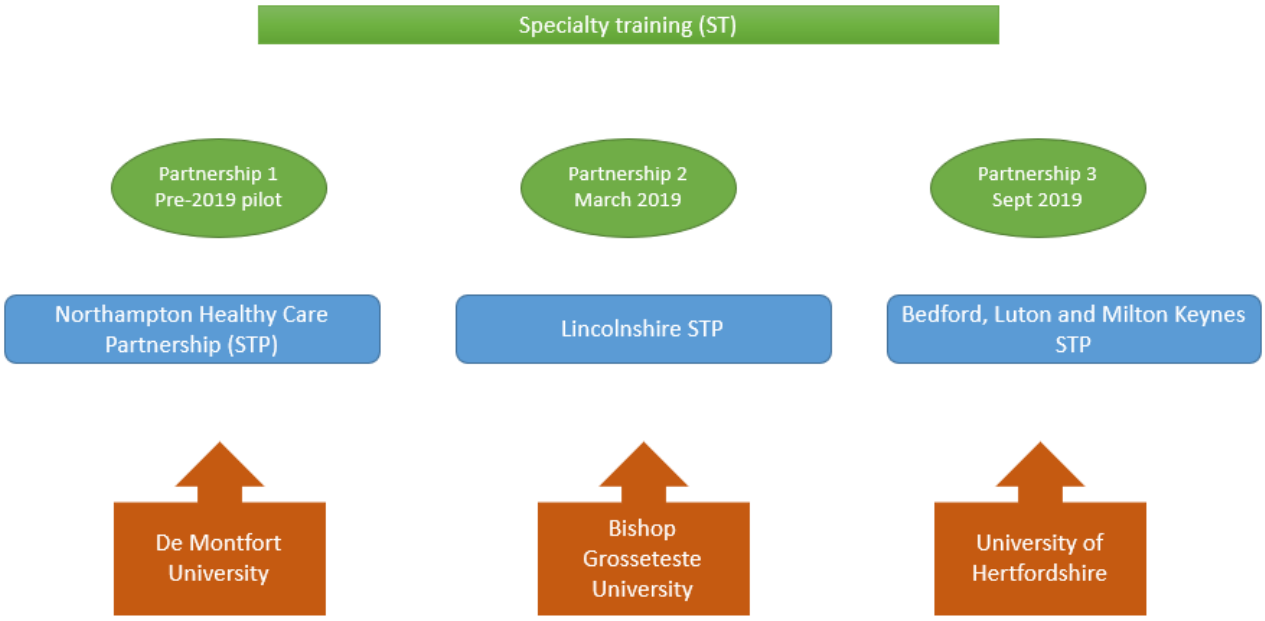


Figure 4. STP sites for full report

A full breakdown of qualitative data and participants is available on request.

Introduction to Results

The findings from the research are presented in two key sets of results – this enables the later findings which emerged from the Specialty Training arm of the research to build on the earlier findings about fundamentals. It will be useful for all key stakeholders on either or both sides of the research to gain an appreciation of the full extent of the pilot projects and proof of concept work.

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

Figure 5. Word cloud representing word count frequency data from qualitative interview data collected at Fundamentals sites.

Results - *Fundamentals*

The first part of the *Fundamentals* results section presents a case study of each site and uses raw data to illustrate how the course is operationalised at each site. This is presented to provide evidence for objective 1 to define GPNE models of delivery for the *Fundamentals* course.

The second part considers the data mapped against the Kirkpatrick (2006) model of course evaluation to highlight the various levels of learning on the schemes.

The third section of these results seeks to evaluate the link between GPNE models and outcomes and includes an emergent thematic analysis of key issues arising from the data and directly related to the outcomes of the scheme.

The fourth and final section of this initial results section considers alternative models and definitions of the *Fundamentals* programme in order to make recommendations about standardisation for delivery, content and pathways.

Objective One - Standardisation and Variation

Overview

A visit to each site was undertaken which examined the key characteristics of course delivery. This data is presented in this section in three ways – firstly as a table giving an overview of key characteristics, secondly as a series of case studies outlining primary data to underpin understanding of the models of education in operation and finally a presentation of thematic analysis of key issues leading to an overall conclusion.

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

Case Study - Anglia Ruskin University (ARU)

Course Delivery Team

Joan Anderson is the course lead. Joan started as a Practice Nurse in the 80s, one of the first Practice Nurses. She has 30 years' experience as a Primary Care Nurse, 11 years as an Advanced Nurse Practitioner and is a prescriber. Joan managed a department of 7 nurses but felt there was limited further career progression possible within Primary Care so moved to University in 2016. When first employed by the University Joan taught for 3 days per week at the University and continued in practice for 2 days a week. She felt this was useful as she could offer additional mentoring in her practice role if students needed it. Unfortunately changes in insurance meant that the cost for my nursing insurance went up to £2000 and the practice were not willing to pay so Joan moved to a 0.8 role at the University. Alongside being the module lead for 'Fundamentals of Practice' Joan is module tutor for the Advanced Nursing Practice, co-lead on the clinical skills, and delivers on non-medical prescribing and minor illness modules at post graduate level.

Cynthia Grove delivers the course in Cambridge. Cynthia is an experienced Practice Nurse and Midwife. Joan suggests that it was difficult to recruit Cynthia as in Cambridge GPNE is not a priority in Primary Care.

Course Delivery

The 'Fundamentals in Practice' is a 15-credit module (L6/7) delivered over one trimester / 12 weeks which includes 12 days total delivery. Support learning materials are provided on a Canvas learning platform. The course has run for many years with Joan as course lead for the last 3 years. The courses run 3 times per year – in September and January from Peterborough and in April from Cambridge (about an hours' drive from ARU). Although there are currently no follow-on courses, there is currently an interprofessional learning continuation pathway under development.

> *'I feel that we need it. It used to fit into the primary care pathway but that has gone by the way, so we are developing a new pathway. It is going to be with health visitors, district nurses, anybody in Primary Care basically, something for the future.'*

Currently for specialist progression students are encouraged to attend the diabetes or asthma modules available through Warwick University or alternatively complete non-medical prescribing at ARU. 2 recent GPN *Fundamentals* students are on the Non-medical Prescribing (NMP) course. Joan and team are considering 'intermediate' and 'advanced' modules as follow on from the *Fundamentals* course and will be using QNI competencies for advanced nursing to see if that can be facilitated through this development. Her team will also develop a programme for Healthcare Assistants.

Course Content

The course includes introductory material and skills training in Childhood immunisations, cervical cytology, ear care, travel health, contraception, minor illness, mental health and long-term conditions. Diabetes was included but withdrawn since student previous experience was so variable and this will now go into an add-on module. ARU has a person in a role responsible for organising

speakers and workshops including cytology and arranging links to laboratories. Joan delivers immunisation training and there is a cervical cytology trainer working for the University. Wider speakers are used to contextualise learning outside of the Nursing and University contexts.

> *'Quite often with this I will open it up for a couple of places for external people, because I think it also shows them that other people are doing Imms and vacs. District nurses, we have had a couple of days where we have had prison nurses, sexual health nurses because they are doing HPV, we have had a few midwifes so it really broadens their horizons in immunisations that they are not the only ones doing it.'*

Where possible Joan uses expert speakers from within the University

> *'I get paediatric nurses to talk about assessments of the child. Care of the elderly, I have got a district nurse who runs the course and comes in to talk about the elderly assessment. I have got mental health nurses to come in and talk about that and somebody who does respiratory, she does it at PhD level, I get her to come and do that, so I use their expertise.'*

The course offers education around resilience and working in the Primary Care environment.

> *'We talk about the union, we talk about indemnity insurance, we talk about the whole structure of Primary Care so that you are not alone in Primary Care, there are people. I have a lovely lady who comes in, she is on various committees, she is an important district nurse and she comes in and gives us an integrated view of the whole of the NHS.'*

Course feedback is largely positive, although changes to University feedback systems to be wholly online has caused some disruption. Joan collects feedback directly from students and tries to implement this in course development.

> *'The only negative feedback I got from this session was about the critical analysis, they felt that they needed to be spoon fed about the critical analysis. Which is something I am going to be thinking about for Tri 1 because every time they say something to me, I do alter it for the next trimester.'*

Competencies

Students work towards achieving the RCGP competencies and Joan is looking and QNI competencies to see if they can be integrated into the course too. Students have a portfolio to complete with blue (core) competencies and yellow (optional) competencies. They are shown how to complete it on the first session and each teaching session includes a discussion of portfolio profession. Students are encouraged to learn new skills then gain immediate practice experience.

> *'Yes, like the immunisation one they are all given a little booklet. This is something we devised ourselves that we feel they need to know; we ask them to go back with their mentors and do at least 10 immunisations.'*

Assessment

The module is assessed through a presentation which is teacher assessed and graded. The presentations are recorded for external verification. There are different criteria depending on whether assessment is level 6 (those without a degree) or level 7 (postgraduate).

Presentation was chosen as the assessment method for its potential to be useful in practice.

> *'I want to get them talking, I want them to have a voice because Practice Nurses traditionally haven't had a voice and I think a presentation is important for them.'*

> *'Well basically because we felt one of the skills that Practice Nurses were going to have to have is to speak up for themselves. We wanted to give them a voice because in General Practice we really are the people who nobody cares about. The practice managers don't see them as a benefit, GP's just see them as part of the work force probably semi-skilled. We need them to show, look I am a person, I need to speak up and I am trying to develop their confidence, trying to develop their resilience.'*

The content of the presentation is related to the role and personalised by the students

> *'We like them to have an overview of the NHS, what the drivers are for their role. We want them to look at health promotion. We want to look at the skills of the Practice Nurse and we get them to choose the subject and try and demonstrate the outcomes through that. Because every single one of them will be different in practice, we have to be …. There is no generic course because every practice will be expecting different skills from the nurses.'*

Mentoring

Each student must have an experienced Practice Nurse to act as their mentor and is encouraged to meet with them every couple of weeks to review progress on their competency portfolio. Some early students from the course are acting as mentors to current course participants.

Joan would like to work more closely with mentors and bring them in for training at the start of the course. Unfortunately, a trial of this on the same day as the course started was unsuccessful because no practice could spare 2 nurses on the same day. Joan then visited mentors, but the commitment was too time consuming.

No external mentoring is offered but Joan has strong relationships with practices and visits on occasion.

Relationships

Joan does link work with 7 practices and gains anecdotal feedback about the programme from her existing contacts still working across Primary Care. She works closely with Chloe Smith at HEE about developing General Practice Nurse Education and the workforce.

GP contribution

Students need to be released from work for one day per week to attend the course but student experience is highly variable and not all nurses are paid for their training time.

> *'That is entirely up to their employer. Some of them make them come in on their day off, some of them will pay them if they are generous.'*

There are two self-funded students on the current course who may have paid themselves, had their course cost paid by their practice, or been part funded.

> *'It does go up and down depending, but it is a big outlay. Some of the GP's will pay half and they will have to pay the other half. Yes, we have got quite a few of those and some of them are just paying for the whole course because they are so keen to get into practice nursing. Even if they are not paid for the day they are here, it is a loss of the day's work.'*

Some GPs prefer to pay simply for training courses, but since they are so expensive, Joan feels the additional education offered by the course represents value for money and additional support.

> *'It could also be a selling point to the GP's as although you don't want to fund this course, in there is the cervical smear course which costs you so much money, the vaccination course which costs you so much money, the ear irrigation course which will cost you extra money. They get so much more as well, they get networking, interaction, this is going on in my practice, also I try and encourage them to do WhatsApp™ groups. So that afterwards they can WhatsApp™ each other'*

Joan feels that Primary Care is a demanding work environment and the course provides an opportunity for an additional support system and community for training General Practice Practice Nurses.

> *'Yes, I have had 2-3 nurses who when they have had problems in their practices, they have emailed 'I have had a terrible day, this has happened'. Somebody may say that there has been a bit of bullying in my practice, it's the GP's being a bit horrible about this and that, then they will sit down and chat about it and they will ask our advice.'*

Joan is concerned that GP practices and in particular practice managers, hold significant power over nurse education but do not recognise the true benefits of the education on offer

> *'Funding, they don't want to pay out, they are worried about them going off and paying for the day, paying for the course. They don't understand they need to be upskilled for them to be really effective. I think they are worried about skilling them and then them going off because they are valuable property. What they should be looking at is how they can retain them, how they can make their life better, but I can't quite get that across.'*

Cohort

The cohort size is currently 10-12 with the potential to offer significantly more places if funding were available. There are 10 funded students and 2 self-funded students on the current cohort. Some students have previous experience in some areas and have already been on some training. Retention is 100% although completion rates are lower.

> *'I either get people who don't start at all, who want to come on the course and then don't show up. Or I usually have the whole cohort, I haven't, touch wood, lost anybody. I have had a couple who have come to the presentation and thought I can't cope with that. They have actually gone to the course for cervical smear, and ear irrigation, so they have still got the skills element of it and a little bit of the network, but they just feel that they can't take the assessment there.'*

The cohort takes newly qualified nurses as soon as they have their PIN number. Joan suggests some employers have been pushing for General Practice Nursing training to be introduced in the third year of the degree. Joan feels that student nurses need to have their PIN before starting the course.

> *'I am holding the line because I do feel we need a PIN number to do cervical smears and everything else, I think they have got to be qualified otherwise why aren't I taking health care assistants on the course? There have been practice managers who want me to take health care assistants and I have said no they need to be trained nurses. They need some nursing background.'*

Joan feels it is useful for nurses to have some experience in General Practice prior to the course and the opportunity to develop over time

> *'I would like to see them bed down 3-6 months. Ideally, I would like the Practice Nurses to have at least 3 months in practice just to get the feel of the practice. Because I think you need about 18 months to really get all the skills and the basics of practice nursing. So, although we give them the skills, they have then got to develop those skills.'*

Case Study - University of Wolverhampton (UoW)

Course Delivery Team

Zoe has been the course lead for the last 2 years and her post is full-time. Zoe is an experienced nurse who worked in General Practice since 1996. Directly before this post Zoe worked for Walsall CCG in a role where she delivered practice education and supported General Practice Nursing. For the first year in post she shared both roles working for the University 0.6 and CCG 0.4. Zoe was one of the originators of the West Midlands Practice Forum. Zoe is the course lead for the *Fundamentals*, and also for Specialist practice degree, she also teaches on other specialist practice routes, health assessment and supervises masters level students. Zoe's role also involves supporting public health leadership, research and supporting her team.

Fran supports Zoe and has worked for the University for 18 months. Fran was a school nurse who funded her own training to become a General Practice Nurse. She then spent 21 years as a General Practice Nurse with a role as lead nurse in her practice. Fran works for the University for three days per week and also acts as Practice Nurse lead for the CCG and a learning facilitator. As well as teaching across *Fundamentals*, Fran leads on V300 prescribing and health assessment modules for the University.

Zoe was invited by the University to consult on the development of the course in response to the HEE development of *Fundamentals* in 2016.

Course Delivery

The course is delivered over 3 modules of 20 credits and Zoe is the lead for each module with Fran delivering on each. The in-house 'community nursing' team (including 2 health visitors, school nurse, and 2 community nursing district nurses) also contribute to delivery across the modules.

The course is delivered once per year starting in January running over 12 months and ending in December. The decision to run the course at this time of year was specifically to offer variety to meet student needs in the local market, as well as being practical for newly qualified students.

> *'Zoe: It was thought to do January because a lot of universities were starting their programmes in September which will have your newly qualified from September and then there would be a big gap then for students. So those who were qualifying in January had got to wait until the following September to get on to the programme. So, we thought a January intake would be suitable and quite timely for those students who have just recently qualified.*
>
> *Fran: Stafford tends to do March and BCU have been running twice a year, certainly September sometimes April.'*

The course is delivered over 18 days with 6 days of delivery per module. The course started recruiting in 2016 and ran for the first time from January 2017.

There is no established pathway for GPN at UoW and this is something the team would be keen to develop.

Zoe: 'it would be nice to see a bit more push on these specialist programme for practices'

Fran: 'it is that sort of career framework really because some nurses are coming as Fundamentals and thinking where do I go now?'

Zoe: 'One year or 2 part time, nurses come on it first and they think I am going to get a degree. Because there is still a lot of nurses out there that haven't got a degree, they are still at that diploma level so they can do the BSc with all sorts of specialist practice. The development for that is quite emotional I feel, sometimes to see the development of the students. It is about them moving their evidence, their base line, so come out of the treatment room and start looking more holistic and wider. So, they develop skills and knowledge. In public health we have a research focus, we have a leadership focus, so we ask them to start undertaking leadership and management roles within Primary Care. We give them the tools that they need for that voice, to move forward, to go out and challenge and to look at the evidence based and challenge it, not just accept it. Again, it is a similar programme that they have 50% theory, 50% practice. They have the support of an assessor out in practice as well. We engage and encourage that collaborative working...'

Course Content

The course was designed to meet the HEE specification from 2016 and is based largely around the RCGP competencies.

The first module delivers an introduction and key skills including childhood immunisations and cervical cytology. The second module covers long term conditions, wound care, minor illness and mental health. The third module considers items such as travel health and contraception as well as developing further in long term conditions. The course offers education around resilience and working in the Primary Care environment.

Zoe: 'Some of mine have recently said just that, they do feel isolated. They go into the room and it is almost like the world outside has forgotten where they are. So, you can see your patients in, the patient goes, and they don't have contact with any of the other staff until they finish seeing those patients.'

Fran: 'Even if they go out and seek some guidance about that particular patient, they have got with them, it very much depends what you manage to get over in your presentation to the Doctor about that person. You might forget that you didn't mention something that is actually really quite relevant and then the decision is made based on that, so it is quite a big responsibility. So, I think that autonomy and responsibility are major concepts.'

Zoe: 'I would say that is threaded throughout the programme really because, say we were talking about immunisations for instance, once they have gained their competence they are very much on their own. So, in everything that we deliver we are talking around what happens in practice and you apply that theory into practice and where is your support network? So, when they come in next week,

> *our first theoretical talk sessions are public health and profiling. So, understanding what services are out there, understanding who the contacts are, understanding the referral pathways and that just gives them some confidence in that they are not on their own, so we sort of thread that throughout the programme. So, it's the same for family planning, travel health, we ask them to identify who are the people that they need to have on board with them.'*

> *Fran: 'Yes, the decision making is difficult especially for those that are coming into it straight from training because they have not got any experience to draw on if you like, sometimes it is really quite complex decision making to. I do feel for the newbies which is why the facilitator role has been good because you can plan to go and sit and have a session with them and sometimes you pick up things that you hadn't even realised they had been doing, that is actually perhaps the best practice. But you are behind closed doors and who is going to know?'*

Course feedback is collected from students and mentors by email template after each module and this feedback is used to report on the course. Response rate is good for students and around 50% for mentors. Students feel that all aspects of the course are useful in practice.

Competencies

The course is based on and mapped directly to the 2012 RCGP competencies.

Assessment

The first module is assessed by a case study from the students' own practice. Peers also watch the presentations and offer ungraded constructive feedback to each other. External assessors visit on assessment days.

The second module is assessed by a 3000-word essay, also about a localised case study.

> *Zoe: 'They have got to do a 3000-word written assignment for the 2nd module. Again, that is on a case study, obviously it can be on something they are dealing with, but this time we want them to have a look at resource management and collaborative working. So how they actually utilise that within practice. Again, it helps, when we do the public health profiling, they can bring some of that in, keep contacts particularly who they would use for that. And it is evidence based so they have got to look at what is current, has it changed in any way, why has it changed, what impact has that had? Those are the sort of things we are looking for.*

The third module is assessed by a piece of reflective practice drawing on the students' own clinical practice and experience.

> *Fran: 'It is about them not saying I have been and done the cytology training, but we ask them to write in the 3rd person. So that again, it is academic, but we ask them to reflect on their development, the good and bad sides of it. Ask them to sort of end point where they are, what is going to happen? It's lovely, very*

> *personalised obviously to each student. You can hear them through what they have written.'*

The pass mark for each module is 40% for level 6. Clinical practice is assessed by a mentor marked portfolio (clinical practice document) which has a pass/refer outcome. All students complete a training needs analysis at the start of the course so that the training can be personalised according to need.

> *Zoe: 'So, in the pack, when they first come in, because there is such a variance of students, I ask them to do a couple of papers for me. So where are they with their mandatory training first of all and also what skills have they already got, and competencies already achieved? So, I have got an idea then, I can sort of change the content slightly. So, if I have got everybody who is already competent in venepuncture, I can say to them ok you can all take blood from the arm? can you take blood from the back of the hand the metacarpal? If not, then we will focus on that. Like it is for them and their needs. They all do that, and I ask them to just keep that record in their portfolio and update it as they have gone through. So, when the portfolios come in for me to …, I do a formative review at the end of each module and then summatively at the end. So, I can see how they have progressed.'*

Where practice mentoring is problematic the facilitator role (held by Fran) helps with supporting students and helping to develop mentors.

Mentoring

Zoe is keen to build a network of practice mentors. Mentors attend on the afternoon of the GPN induction day.

> *Zoe: 'I go through what their responsibilities are. Talk them through the programme, talk them through the fact that I am going to contact them and ask them for evaluation. They are also invited to quarterly meetings and I then invite the specialist practice to come in at the same time.'*

Relationships

The team has strong relationships with their training hubs where they share expertise and give each other advice. At the Black Country training hub Zoe is a member of the Black Country Steering Group which has bi-monthly meetings. Fran works for Staffordshire training hub which covers a much larger area.

Staffordshire has one self-employed facilitator for General Practice Nurses provided by the CCG for each area (East Staffs, South Staffs, Staffs and North Staffs) and Fran holds one of these roles. The facilitators have bi-monthly network meetings with each other and the lead nurse for the training hub.

Fran's experience as a facilitator gives her useful insight into the other courses on offer in the region

> *Fran: 'I have been lucky because I have had students that have done the course at each of the universities, so I have seen all the paperwork from Stafford, BCU and Keele and Wolverhampton so that has been interesting.'*

The team works closely with other geographically close universities offering the Fundamentals course including BCU, Stafford and Keele. The universities share best practice and planning ideas

> *Zoe: 'We want to focus on the changes from the NMC with the standards for assessment in practice. Obviously, we want to do a standardised approach, so we share ideas and thoughts about when that is going to happen. We know it has got to happen by September but just getting some ideas of how we are each going to do it really.'*

Fran feels the training hubs play an important role in helping with course standardisation

> *Fran: 'that is certainly something the training hubs do, one of the meetings we have is we get together with the university, the next meeting is in Stafford, and that is pretty much to make sure everyone is doing the same thing'*

Zoe believes relationships and networks are crucial to the success of the programme. She suggests recruitment was difficult in year 1 when networks were under development but has been easier now that relationships are established.

The team links with Charlotte Smith, who is responsible for general nurse practice development nationally. Charlotte runs a network for GPN students and several of the cohort from UoW participate in this. Students are also encouraged to become Queen's Nurses with QNI.

GP contribution

Students need to be released from work for one day per week to attend the course. Student experience is variable and not all nurses are paid for their training time.

> *'There is a small number of them who are not being paid to attend, they are having to do it in their own time.'*

There are two self-funded students on the current course who may have paid themselves, had their course cost paid by their practice, or been part funded.

The team feels that Primary Care is a demanding work environment and the course provides an opportunity for an additional support system and community for training general Practice Nurses.

> *'Zoe: 'Well it is professionalism throughout isn't it?'*
>
> *Fran: 'It is. At least at the university we are giving them some clinical governance if you like, we are giving them some clinical supervision too really but they are not necessarily getting that, certainly in the single handed practices where they are the only nurse on duty.'*
>
> *Zoe: 'And they are on their own'*
>
> *Fran: 'It is giving them another avenue to culminate support from'*
>
> *Zoe: 'Definitely I think that the 3 groups, all of them have said that they have set up a WhatsApp™ group to share thoughts and ideas and support. We very much promote twitter so do GPM's so we promote that and advise them that there is a*

> *lot of health information and resource that they can access and where they can access things from.'*

Cohort

In January 2017 the course recruited 6 students and 4 completed.

In January 2018 the course recruited 11 students and 10 completed.

In January 2019 the course recruited 17 and 16 students remain on course to date.

The number of funded places on the *Fundamentals* course (and also Advanced Clinical Practice) is determined by the training hubs.

> *Zoe: 'So, secondments will go out for each of the training hubs to say you have so many places on ACP specialist practice and Fundamentals so the communication then is between the secondment, HEE and the training hub. Those commissions are just coming out now ready for September and onwards.' (July)*

The cohort comprises a large number of newly qualified nurses

> *Zoe: 'Newly qualified who had a General Practice placement in their final year, or they have had one in the 2nd year and want to go back in their 3rd year so they are pro-active and wanting to come into primary care '*

Recruitment is busy from September and is helped by the facilitator roles and awareness of existing vacancies in primary care.

> *Zoe: 'Come September or October the flood gates start to open; they came tumbling in last time and I was like oh my goodness where have all these come from!*
>
> *Fran: 'I think that is where the facilitator role comes in there, because the facilitators know where they have got a new Practice Nurse in place and they will be saying to them get yourself onto Fundamentals programme, there is funding available.'*

The team are unable to help with placements and jobs and only recruit nurses already in post. They require nurses to have an employment reference to demonstrate commitment from the practice to the GPN education and mentoring required. Fran feels that the cost of mentoring to the practice is the reason that some GPs send their nurses on training days instead of providing support and education.

There is often at least one student per cohort who changes practices during the training, or at the end of it. Of the 4 students who completed in 2017 all are still working in Primary Care and in contact with the team, one went on to do Advanced Clinical Practice and has just completed the V300 prescribing and now acts as a mentor to new GPN *Fundamentals* students. One of the 2018 students is now a student ambassador working to promote entry into General Practice at a national level. The team maintains contact with previous students through the facilitator roles and through students returning for further courses. Each cohort of students maintains contact through a WhatsApp™ group set up during their course.

Case Study – University of Hertfordshire

Course Delivery Team

Ruth Farrowly has worked for the University since 2000 initially teaching on pre-registration nursing before moving to Primary Care in 2010 and she has been the course lead for *Fundamentals* for the last 7 years.

Ruth began as a Mental Health Nurse in the 1980s and progressed to a role as a Community Psychiatric Nurse (CPN) before spending the majority of her career as a Health Visitor. Directly before this post Ruth worked directly for Trusts as a training officer supporting the development of community nurses (District Nurses and Health Visitors)

Ruth works in a small team with shared responsibility for several courses.

Lisa Otter works for the University (0.4 FTE) delivering the 'Fundamental Skills' module. She is also an Advanced Nurse Practitioner (0.6 FTE) delivering minor illness clinics in General Practice.

The Head of Primary Care is Denise Knight who runs the prescribing programme. The prescribing course is a 30 credit interdisciplinary module over 6 months with a cohort size of approximately 150.

Course Delivery

The course ran as '*Fundamentals*' for the first time 4-5 years ago. The first year it ran as a 60 credit module, but this was soon reduced.

> *Ruth: 'We only did it once, we changed it after we had run it the first time. It was too long for what they really wanted but not long enough. There were 60 credits needed, you can't do anything with 60 credits really… They weren't inclined to fund for 60 credits, because the GPs felt it wasn't specific enough so we had to re-look at it in terms of what skills we wanted the nurses to have, and we didn't think that actually that met what they required. So, we had to do a bit of a re-think. When we first did it, we tried to fit it in to what we were already doing.'*

In its second year the course was renamed 'foundation' and reduced to 30 (2x15) credits. The course is delivered twice per year starting in September and January with attendance for one day a week every week. Half of the day is spent on the 'Fundamental skills' module and the other half on the long-term conditions module with other students. All earning materials are held online on a VLE and online support is offered

> *Ruth: 'The students like it because they get information quite quickly and we try to get a little bit more creative in terms of Adobe Connect and we run evenings because they can't all get here for face to face tutorials and we will run Adobe Connect virtual tutorials with them.'*
>
> ***Researcher: 'Has that been popular?'***
>
> *Ruth: 'Yes funnily enough. If they can't get in, and they can't get release if they want tutorial, it is quite difficult to get time off in practice, so we put on something in the evening.'*

Course Content

The 30 credits are split into 2 x 15 credit modules. The first of these is called 'Fundamental skills' (delivered by Lisa) and includes travel health, childhood immunisations, cervical cytology and wound care which are delivered as two-day courses in line with the standards demanded. The course runs over a single semester, but students are allowed a full year to complete the portfolio for smears. The second module is 'Long Term Conditions'.

The course offers education around resilience and working in the Primary Care environment.

> *Ruth: 'Lisa does because they come in one day a week for managing long term conditions, fundamental she sees them every week and talks through some of those issues. She talks about negotiating skills, contracts, working within a business which is different from the NHS, those sorts of things she covers… we sort of box it all together into Fundamentals about you are new into General Practice, this is what you are going to experience, some of the challenges that you have.'*

The students are offered progression onto the specialist community programme degree or masters but very few do (4-5 in total from c100) as there is limited funding available. This would include interprofessional modules in minor illness and prescribing, leadership and research. Some CCGs (Barnett and Enfield) have previously funded the whole programme (up to 20 students per cohort). The funding is now no longer available.

> *Ruth: 'Yes, and I know Anita and Paula, they have put a lot through the full programme, I think they must have had about 40 that have done the specialist community award in General Practice. So, they have either come out with a degree or a post grad diploma which was funded by HEE. To me, the education of the workforce is more important than doing 2 skills and modules basically. You are giving them 30 credits but what are they going to do with 30 credits. If they are going to another university, they may or may not take those credits.'*

The specialist community nursing (full year) is a validated programme with NMC, and within that it has been validated for district nursing, community children's nursing and general practice nursing. It includes modules in minor illness and prescribing as well as research and leadership. Whilst Ruth feels this is a natural progression route for GPN students she encourages them to consolidate their learning in practice before returning to the pathway. She suggests that the reason for so many students not coming back to the pathway is because some modules are less attractive to GPs and therefore attract less support and funding.

> *Ruth: 'This is what we say to them, practice work, do that for maybe a year or two, then come back. But that is where the problem is, they haven't completed. They might get funding for minor illness or prescribing, but part of the NMC requirement is they have to do research and they have to do leadership.'*

Ruth feels that the full programme is more suited to general Practice Nurses than the *Fundamentals* programme and has parallels with the training offered to General Practice doctors.

> *Ruth: 'I think the full programme we have got running and the flexibility they have within it I think is a good one. I would design that and not do the Fundamentals. They would have to do the whole thing and come out with some academic qualification and a practice qualification. So, it is a recognised thing*

> *with the NMC, it is recorded on the NMC website and then they have got an academic qualification as well.'*

Ruth also has a colleague who has recently validated an Advanced Clinical Practitioner pathway which Ruth feels offers an interesting alternative pathway for GP nurses.

Course feedback is collected from students and mentors twice per year in committee meetings.

> *Ruth: 'We invite people from practice so we would invite Anita and Paula and that would include people from district nursing, health visiting, and school nursing, so everybody is there including students. From that we have a discussion, whether the students want to change anything, what the practice feel isn't working from their point of view.'*

Course feedback for the Foundation scheme specifically is also collected through module evaluation.

> *Ruth: 'The feedback is very good, they seem to get a lot out of it, nobody has complained about anything. Each module is evaluated, we have a mid-point evaluation and it is evaluated at the end of the module. Then have them all in at the end of the credits and say how did it go? So, there is lots of time for them to evaluate and give feedback. I think the only negative might be is if they don't have such a good experience in practice.'*

Competencies

The Foundation course is linked to the 2012 RCGP competencies. The Specialist Community Programme is linked directly to criteria for NMC validation as Specialty training.

Assessment

The first module 'Fundamental skills' is assessed by an essay based on a client that the nurse has seen in their own practice. Students also receive their cervical cytology training within this module and are expected to begin collected samples from smear tests to submit within one year.

The second module 'Long Term conditions' is assessed by a health information poster which nurses are encouraged to display in their own practices.

> *Ruth: 'So, it is education everybody and it is letting the surgery know what they have done.'*

Mentoring

The primary responsibility of practice mentors is to sign off the portfolio for smear tests and other clinical skills. There is a network of support for mentors (who are often also mentors on the specialist community year training scheme and pre-registration placements), and they regularly attend meetings at the University and with general Practice Nurse leads. Some areas have additional support

Ruth: 'Also, within Barnet they have also identified a more experienced general Practice Nurse that mentors can go to for additional support if they need to.'

Researcher: 'Wow so there is a mentor for the mentor?'

Ruth: 'There is... Anita and Paula have done a lot of work in terms of developing General Practice in both Barnett and Enfield, they have both done a lot. Anita has been around from the beginning.'

Ruth believes mentors are motivated to be in the role for altruistic and intrinsic reasons

'That's a good question, I suppose it is their own development, developing the workforce of the future. They all recognise that they can't recruit to General Practice, so I think that is what they are getting at, any extra money and time, it is about investing it in themselves.'

Some of the original *Fundamentals* students are now acting as mentors to current students.

Relationships

Ruth has strong links with the local CCGs (North Herts, Herts Valley, London, and Enfield) and feels this benefits the course development

'With those nurse education leads within the CCG and actually that has been a great benefit to nurses within each practice. Because they have driven the agenda in terms of what is required in General Practice.'

Ruth meets with local General Practice nursing leads on a regular but ad-hoc basis. Ruth does not have a relationship with training hubs but is concerned that they might be more concerned with training than education.

The team is linking with James Kellam at BLMK to deliver the scheme and conversations started in summer 19 to develop an implementation plan.

GP contribution

Students need to be released from work for one day per week to attend the course but student experience is highly variable and not all nurses are paid for their training time.

Ruth: 'It varies. There is a lot of talk at CCG about how they are going to support students to do it. Some students do it on their days off.'

There are no students funded for the 30 credit module, but some students are funded by the GP to do the 'Fundamental skills' module

Ruth: 'I might have had one or two from a GP that will fund them just to do one fundamental skills module. Actually, it is quite a good deal because they are only paying for one module rather than all the study days which would be more expensive. I think if we look at the cost, it is cheaper for them to go and do that one module rather than use their study days.'

There are variable funding models depending on area

> *'They allow them to do that 15 credits, GPs, but I think the rest is funded by the CCGs. But then if you look at Barnett and Enfield that is funded through Health Education England.'*

Ruth feels that the main obstacle to developing GPNE is funding and support. Ruth feels that GPs often prefer training over education for nurses.

> *'Ruth: here was quite a lot of input in to General Practice Nurse training but we are finding now, the interest is going down because it is not…..GP's don't want the nurses educated, they want them to be able to go out and do a skill or a minor illness, they don't care if they have got a research module or a leadership module, they want to be able to run a clinic. That is probably the crux. They will throw money at it but if the GP's say what do they want research for, we don't want leaders, we want somebody who can run a clinic.'*
>
> *Researcher: 'Is that what you hear directly from the GP's?'*
>
> *Ruth: 'Yes'*

Ruth feels it is key that the model of management of GPNs changes

> *Ruth: 'So, you won't ever change it until you get general Practice Nurses under one umbrella, managed by one organisation, and not managed by independent GP's. Nothing is going to change…. because like terms and conditions of employment are different in every GP. Some get maternity leave, some don't. You could have 2 nurses in the same GP practice, doing the same job, but getting different salaries. Based on what they can negotiate.'*

Ruth believes changes would only be accepted by GPs if mandated by a higher force such as government. Ruth suggests that about 15 years ago there was a recognised need for training for general Practice Nurses but no appetite from General Practice to take pre-registration or newly qualified nurses, but she can see a climate of change and development opportunities.

Cohort

The cohort size for the 'foundation' course is 10-12 nurses, all fully funded by HEE. Student achievement is 100% and anyone who is not likely to achieve the required standard is offered additional support until they do. The University does not maintain contact with students on completion of the course but are updated on their progress occasionally via the network of general Practice Nurse leads. About half of the cohort are newly qualified nurses.

> *'newly qualified who had a General Practice placement in their final year, or they have had one in the 2nd year and want to go back in their 3rd year so they are pro-active and wanting to come into primary care '*

Ruth has limited involvement in recruitment beyond promotion to pre-registration nurses.

> *Ruth: 'I do talk to the pre-reg students about careers within General Practice, I then put them in touch with the nurse leads because then they would need to*

> *identify a General Practice for them to sit in. I don't liaise with the general surgeries at all. Because I think they get to build the relationships, better to have one person identified.'*

Nurse leads also advertise and promote the course and most recruitment comers via this route, although a small number come directly from practices to the University.

Students already travel in for the course from a disparate geographical spread including Cambridge and London and so although BMLK students will probably travel 40+ miles for their course Ruth does not feel this will deter them from participation.

Case Study - Keele University

Course Delivery Team

Edward Dutton is the course lead (0.4 FTE) and also works as a researcher (0.6 FTE). Edward qualified as a nurse in 2000 and worked for 6 years as a staff nurse and senior staff nurse in rheumatology. Edward has worked for the University since 2006 firstly as a Clinical Skills Lecturer for 4.5 years when he won a pre-Doctoral fellowship followed by NIHR clinical Doctorate funding. Edward gained his PhD in 2014 which included designing a Practice Nurse consultation for musculoskeletal problems in Primary Care and evaluating it using a randomised control trial. During his PhD and teaching Edward set a network for GPNs to share evidence-based practice. In completion of his PhD Edward stayed working as a researcher (0.6) and returned to a teaching role (0.4). His current research is a small qualitative study on group consultations in Primary Care. Due to his existing work and links to GPNs Edward was approached by his Head of School to design and run the course when the University decided to bid for HEE funding. He was interviewed by Georgina Smith in 2014 and has been the Course Lead since it ran for the first time in 2015. Although Edward is the Programme Lead, each of the modules has its own module leader.

Olivia is the full-time GPN lecturer who started with the University in January 2019. Prior to this Olivia worked as GPN and prescriber for approximately 12 years. Originally Olivia worked as an HCA in Primary Care and when qualified as a nurse returned to the same practice. Olivia delivers teaching sessions across all modules.

Susan is the course administrator. Her involvement in the course is largely in recruitment and assessment administration. She has worked for the University for 30 years and for the course since it started.

With course timings tight and a small delivery team Edward finds the course has all year round demands

> *Edward: 'Their final assignment is in August so I am marking that in August, they are starting in September, Susan Floyd would tell you she rings me whilst I am on my summer holiday every year. "Edward, I have 3 students can I read you out the details, can we accept them and tell them they have got a place?"'*

Course Delivery

The course is delivered by Keele University at its only annex campus based at Stoke Hospital (3 miles from main campus). It is delivered for one day per week for 45 weeks usually on a Thursday.

While Edward co-designs and leads on the course, much of the delivery uses external experts. Keele has a relationship with Stafford University and some of the accredited training (cytology, immunisations, travel vaccines) on the course is delivered at Stafford University campus by their staff on behalf of Keele. Ear irrigation training is provided by the Rotherham course. Previously spirometry training was bought in but the registration for this has changed and so instead this year the course is buying in sexual health and frailty training. Keele has in-house expertise in mental health and runs dementia friends training. Close links to secondary care also benefits students.

> *Edward: 'We have respiratory nurse specialists come in, we do asthma and COPD, a diabetic specialist nurse, we have them on site you see. Because we are a partnership, so we bring them in from secondary care. We even had CKD specialists last week and she took them over to the unit to see the patients. One of the nurses knew one of the patients from her practice, he was an inpatient at that time. So, they were seeing the full trajectory. Complete fluke! But seeing a patient that she had dealt with renal problems in her practice who was currently over there.'*

Edward feels that the course could not be delivered online since the students gain so much from sharing experiences with each other face to face.

> *Edward: 'This is why I stopped doing a lot of distant learning, the first cohort I did but I started to draw it back which I know is not the way education is going, but they need each other. They don't have any peer group at all so there is 12 of them sits in a room and they absolutely need each other. I say ok we are done, I am packing up, they are still sat here saying this happened to me, my manager said this etc. so they need each other. What they really miss about the course and they always say this after, I miss the group, I miss what we had on a weekly basis. It is a little bit of a safety net for them. Once it has gone and it is 5 days in practice, you don't get that back again.'*

The students maintain contact with one another using a WhatsApp™ group.

Course Content

The course is 60 credits over 3 modules at level 6 and 7 and runs one day per week usually on a Thursday for 45 weeks.

The first module '*Fundamentals'* is a 30 credit module, the second module 'evidence based practice' (EBP) is 15 credits, and the third module 'clinical practice' is 15 credits. *Fundamentals* in General Practice Nursing runs for 45 weeks parallel to EBP for 15 weeks and clinical practice for 30 weeks.

The first two modules run parallel, half a day each – *Fundamentals* and Evidence Based Practice.

> *Edward: 'So, we do an evidence-based practice which I teach on, so I wanted to make that the first component of the programme. It would be half a day for 15 weeks. They all wonder why they are doing it at first, but the second half of the Thursday is Fundamentals, so it is all practice nursing. That Thursday morning, they don't get at first, Thursday afternoon they get because that is something to take back to the practice. They don't get the evidence-based practice because my practice manager wanted to know what I had done today. They are on their backs all the time about what they have done and how they are bringing the quality back. But the evidence-based practice module was my way of saying what is the evidence base for what you do, and do you understand it?'*

The EBP module is an interdisciplinary module (which also contributes to the degree in specialist practice – check) and runs for 15 weeks over the first semester. Edward acknowledges that students may struggle to understand the relevance of the EBP module the earliest part of the course but develop this understanding over time.

> *Edward: 'Evidence based practice feels like it is a bit standalone to them, but now, later in the programme, they get it. Because now they are coming to me and saying I am having to do this for asthma but there is no evidence for it. And you think yes, they are using the language. It is linked to the rest of the programme their assignment is their own, there will be people from renal, people from coronary care, Practice Nurses, District Nurses, all on that module, it is a shared module.'*

Edward had one student who completed the EBP module and her work was good enough to submit for journal publication.

> *Edward: 'I will call the patient Steve. We had a patient who used to come in with his mum, had type 2 diabetes but was majorly overweight. Mum wouldn't make him to any exercise because she thought he wouldn't like the environment, didn't understand his diabetes but complained that the nurse hadn't explained it well enough to him. So, I said let's write that up. So, we wrote that up as a case study and published it in 'Practice Nurse'.*

Sadly, the same student experienced issues in her workplace and decided to leave primary care altogether (she now works in Marketing for the University!)

The third module is the non-taught clinical skills modules which is PAD portfolio assessed by mentors.

Edward feels it is important that the course offers education around resilience and working in the Primary Care environment and develops resilience and leaderships skills.

> *Edward: 'I feel that they need to be consumers of research, not researchers but consumers of it because they are very often asked questions on the spot, not working in a team, having to feed answers back. They need extreme resilience. We talk about it, what I try to do is I try to build the programme a little bit not so much around resilience but in recognising their weaknesses. So, I do a lot with them that other programmes perhaps don't do. So, they have an oral presentation, they hate it. What I try to say to them is if you want to be a nurse lead, which is part of the Ten Point Plan, you have got to have confidence to stand up in a practice and speak in front of GPs and put your point across. So, the assessment you will do here will be why you do this skill this way. A Practice Nurse skill, how you deliver it, what's the evidence base for it and how do you work on that and take it beyond the evidence based. They are nervous wrecks about doing it, but it gives them that ability to stand and talk. So, I think resilience, the ability to work autonomously, they need strength of character, they need a good understanding of the evidence based for what they do. Unlike secondary care, it is a big responsibility to give somebody mismanagement of their asthma, or type 2 diabetic medication. Next person in is with a baby who needs immunisation might end up with cellulitis because you have done it a little bit wrong, then the next is a smear test, there is resilience for you. This could all be in the space of 2 hours, none of us have got a job like that.'*

Olivia had no input into the course design but feels it clearly meets the needs of GPNs.

> *Olivia: 'I think the positive, it is very clinically based, lots of guest speakers so they do get a good clinical input. They also get the more formal, like the vacs and imms side, the certified training if you like which just makes them ready made really. I like it, I wish it was around when I came out. I felt quite isolated at the beginning, I was entirely on my own. Just doing a course and then I would be off and up and running. You do feel quite vulnerable because you desperately want to protect your Pin, you also want to do your job, so you do feel a little bit vulnerable. I think also having other people do the course, so you have a bit of a buddy system. I do tend to find with these students they have quite a nice bond actually. I know the guy I work with in practice, he was in touch with a lot of people he did his course with. I think having that support at the beginning is so important and I wish I had had it.'*

The University offers a BSc Clinical Practice designed specifically as a top up for students who have a diploma to gain the 120 credits required for a degree. If students only complete 60 credits they can achieve a graduate certificate. The Certificate in GPN is one pathway into the programme.

The *Fundamentals* and clinical skills modules are unique to GPNs but EPB is taken by clinical students from a range of pathways. On completion of the Certificate in GPN students can continue to achieve a further 60 credits for the total award. 2/33 GPN students so far have completed the full degree.

> *Edward: 'Course feedback is collected from students during, and after, the course. The students do a RAG rating and course evaluation at the very end. I have to generate the RAG rating at the end, so it is red amber green, and if there are any comments.'*

Previously the course feedback has been sought after students have left the University and so completion rates are only around 50% for previous cohorts. For the current cohort Edward plans to hold a face to face evaluation event on the students' last day and collect feedback directly.

Feedback has led to course development and improvement.

> *Edward: 'Well it was last years' students that decided I shouldn't have spirometry this year. Everybody said you wasted your time doing spirometry, we didn't get to use it and when you bought in spirometry day 2, we couldn't work with the trainer. We hadn't done what she asked us to do on day 1 because we weren't doing it in practice. They told me at the time when I was saying what could I replace. One of the things they said was they wanted more sexual health.'*

Informal formative feedback is also sought, especially where using external training providers.

> *Edward: 'I will normally say frailty last week, first time you have done this, how did it go, and they are very positive. The frailty team this year was 2 GPs and they run a company, they bring in virtual reality headsets so basically, the phone rings, they are frail, they can't get to the phone, they do this virtual reality and the theory in the morning. The students said I felt they dragged out the theory. I don't know if it needed to be a full day, but I recognise the company needed paying for a full day, but they could do a half day training. I appreciate them saying that. They have had their own evaluations where the students tell them it was brilliant. What I am going to ask is could you do a half day if we wanted that? So, we do that informally a lot.'*

Course feedback for the Foundation scheme specifically is also collected through module evaluation.

> *Edward: 'The feedback is very good, they seem to get a lot out of it, nobody has complained about anything. Each module is evaluated, we have a mid-point evaluation and it is evaluated at the end of the module. Then have them all in at the end of the credits and say how did it go? So, there is lots of time for them to evaluate and give feedback. I think the only negative might be is if they don't have such a good experience in practice.'*

Edward is happy with the development of the course content at the 5 year stage.

> *Edward: 'The best thing is probably the content now, it has got better each year, and I think it is quite polished now. It is getting to the stage where I will probably be told that I am no longer leading it, you know when you get something good?'*

Competencies

The clinical skills module assessment is directly mapped to the 2012 RCGP competencies.

Olivia has been in the unique position of working with nurses new to General Practice when she was a Practice Nurse. Olivia feels that the competency level of those from the *Fundamentals* course is much higher than those who have not.

> *Olivia: 'One of my colleagues in practice before I left, came to start with us, I think he had maybe 3-4 months left of the course. He went on to top ups to do a degree and he loved it because he came in from district nursing to practice nursing. He hit the ground running with us because he had done vacs and imms and diabetes and all his respiratory stuff. Working with him, it did show it helped. At a similar time, we had another nurse start who was fabulous, but the skills difference was unreal because they both were from other areas. The training and support that was involved and the nurse who hadn't done the course, was significantly more…. She had worked in occupational health previously so again, some transferable skills but it was all the additional cytology, vacs and imms, etc. where the other nurse had covered.'*

Assessment

The first *Fundamentals* module is assessed with an oral presentation and oral exam. The oral presentation is related to a patient in their own practice.

> *Edward: 'The assignment is on multi-morbidity. So we have done all the long term condition stuff, evidence based practice, clinical practice, we have talked about conditions in isolation but what I want at the end of the course is, the patient doesn't present with one problem, the patient presents with multi-morbidity, several long term conditions, therefore the assignment is a case report about a patient in their care, how they dealt with secondary care, primary care, and dealt across the interface to manage that condition.'*

The oral exam is also related to a real-life scenario.

> *Edward: 'That is a series of consultation questions. Patient arrives for their asthma review. Yes, they have been overusing their inhaler etc. how would you start the review for 5 marks. How would you assess asthma control? What would be the management plan you would devise for this patient? It is me and a girl called Marie who is a health visitor. We get an ANP who helps me on the course, sits behind them and if we miss anything, she normally adds the marks. So, if we say they got 15, she will say no because they said this, worth another mark, so she supports them a little bit.'*

Each student receives a single side of A4 feedback, and an overall mark agreed by 3 markers. Olivia feels that this is a strong assessment with real benefits for practice.

> *Olivia: 'The oral questions do give people the chance to verbalise which often people don't put down very well on paper. I think the presentations are really good because it shows the students' knowledge and actually the students came up with other stuff that were really insightful and stuff we didn't think about in practice.'*

The second EBP module is assessed by an assignment based on the nurses' own practice where they are encouraged to find an area of suboptimal practice where they work and find evidence to fill the gap.

> *Edward: 'Evidence based practice is a 3000 word assignment about suboptimal practice and it is a literature review, I think it is a good skill to be taught. Especially it they were older nurses and perhaps didn't do it in their pre-registration training.'*

Edward suggests that one person on the course each year fails to pass this module but is always supported and encouraged to achieve on resubmission.

The clinical skills module is assessed by a private assessment document (PAD) mapped from the RCG competencies for General Practice Nurses and an assignment.

> *Edward: 'A 3000 word assignment to talk about the theories you have used to achieve all the skills. So, they will say the RCGP competencies were this, this reflects on the competencies and the challenges I had to deal with to achieve those skills, they usually talk about child vacs and smears because those are the hard ones.'*

Edward feels that while students don't like the assignments, he is clear that they drive learning and he organises them, as far as he can, to appropriately fit the student nurse experience.

Mentoring

Mentors are responsible for signing off the PAD assessment for the third clinical module. Edward is clear that students have variable experiences of practice mentoring which is the most difficult component of the course to manage.

> *Edward: 'I think what they find difficult is to get the mentorship support out there. When I say right now follow it up with your mentor, they say Edward, you*

> *are being idealistic. I can't get time with them; I can't get them to shadow me or me shadow them. That is hard sometimes. When they stay behind, can I have a word, it is never about the course, it is about practice.'*

Based on their experiences both Edward and Olivia feel that supportive mentoring is crucial to student success

> *Olivia: 'They need support, absolutely, they need to be not left alone. They need a mentor in practice when they are starting off, they need a supportive team around them. Otherwise, unfortunately, General Practice can break people.'*

Students from the first, third and fourth cohorts are acting as practice mentors for the most recent cohort. One practice has two students, and another has had students from several cohorts.

> *Olivia: 'They have changed the model of how they work, they were a single-handed practice and you know when they go to 2 practices, they did that. So, the nurse from cohort 1 of Fundamentals mentored the nurse from cohort 3 and cohort 4.'*

In planning the course alongside Practice Nurse leads an additional layer of mentoring was planned and funded.

> *Edward: 'We think we can get some funding together, get a clinical mentor that could support them from a more external point of view. So, if they struggle in their own practice, this person that we employ will go in on your behalf and work with you. So, I do clinical practice visits as part of the clinical practice module to check they are working with the PAD and I take the ANP with me. So, I will talk about the assignments and assessment and meeting the hours, but if the nurse says we are struggling with this skill, by ANP will say well the best thing you can do is this.'*

Relationships

Edward has consciously built on strong relationships with the local CCG Nurses leads in relation to the programme.

> *Edward: 'When I took on the course, I said I was only going to take it on if I could have some sort of working partnership with the CCG. I am not doing this as a standalone. Because it has to work across the two. There is no use in me deciding what is right for a Practice Nurse programme I want Practice Nurse leads to decide what is right.'*

Edward recognises the limitations in his experience and uses partnerships to mitigate this. Edward feels that not being a Practice Nurse himself has had some advantages for the course.

> *Edward: 'I think that is a downside of being a former Practice Nurse or ANP that has gone in to a university and 'I am going to do it all' because you are no longer a clinician, you can't do it all. I am not a clinician, I am the educator, I can design the programme, write the programme, assess, mark, teach but I have got the*

> *clinical team with me, (CCG Nurse Lead), (the ANP), (Clinical Practice Nurse Lecturer), I don't do anything without saying let us get our heads together.'*

Course materials and assessments are co-designed.

> *Edward: 'I used 3 APNs had a small focus group with them to write the questions for the oral exam. So, I didn't devise it.'*

Through his Doctoral research work and experience of training General Practice Nurses in Clinical Skills, Edward became aware of an identified need in evidence based practice.

> *Edward: 'I found that through the PhD and generally through other training that I had done with Practice Nurses. That they were all told different things, none of them were singing from the same hymn sheet and every General Practice was different. So, I thought what if I can do, there is something called a CAT process, critically appraised topic, what if I can devise a CAT group for Practice Nurses. They can bring their problems to the table and as a group, we would create a research question. I would set up the search, we would get the evidence back and we would go this is the clinical bottom line to your issue, this is what the answer would be, this is what you could do. They snapped it up.'*

In response to this and in partnership with and with funding from the local CCG Edward set up an EBP network of GPNs meeting regularly. Edward has had input to all aspects of the course from Practice Nurse Leads

> *Edward: 'So, before we started cohort 1, I had about 4 meetings with them of about a couple of hours. Said how involved can you be, if I do the programme I want you to say yes now whether that will or won't work, what do you think will work for a time period, what will be the best day of the week, what do you think the delivery retention rate will be, what do you think recruitment would be to the programme, do you think there is any scope for it in the area? And it snowballed.'*

Nurse Leads suggested additional input to the course and their involvement led to additional funding and the involvement of external mentors. The involvement of (CCG Nurse) in the course, and workforce development, also led to developing support for newly qualified nurses to participate in the course

> *Edward: 'We kept talking about 'could we have newly qualified'. So in year 2 we went to an open day in Keele Hall and put a stand up for Primary Care nurses, CCG etc. a lot of nurses came and said I have always wanted to work in General Practice, but there has never been a placement. That didn't tie up, there is a lot of placements. So, we said we will take your names and we will get back to you when you are qualified. So when I met with the CCG last year, they said how can we incentivise for General Practices to take new students and Georgina worked miracles, got to the point where the CCG was willing to pay £10,000 to a practice for half the salary pretty much for the first 10 months of the student as long as they were on the Fundamentals course.'*

Edward was involved with the HEE West Midlands network that Georgina Smith led before taking up her national role for NHSE/I. He is now part of the national network of Academic Assessors of General Practice Nurse Education (AAGPNE) and takes his CCG lead nurse to network meetings.

> *Edward: 'Because I am long since removed from being a clinician. I have Georgina as my clinical ears, Georgina wants to hear it because she has got an investment in Fundamentals and so have I.'*

Edward agrees that networks and discussions are beneficial but there needs to be a concrete output from the networks to take the agenda of GPNE forward.

GP contribution

Students need to be released from work for one day per week to attend the course, but Edward is clear that this causes tensions with General Practice.

> *Edward: 'Because General Practices don't want to let them out, they would rather do their own training, go on this and then start it tomorrow. They don't want to release them a day a week. In their minds they haven't got the capacity. They don't invest in the time for the education of the Practice Nurses. They want them to come in and run with our systems and how quickly can you do this. They don't invest in it and they don't get it. They will say to me can't you bring all the skills up front very quickly. Well if I do do that, one they might pull them because they have got what they wanted, two, where is the sort of retention of learning. If you do vacs and imms, we want you to do this, read a little bit more about that, have a bit of a practice, start to watch someone doing it. So, it is building on the learning a little bit. If we suddenly bring in smears next week, you have not really had the chance to take in that vacs and imms. So, space out the practical skills. But the practices are like what are they doing next week then if they are not doing something that is useful to me? Well they are doing something that is theoretical, I am sorry, but this is an academic course.'*

Edward feels that Practice Managers in particular struggle to understand the long-term benefits of the course.

> *'Edward: A couple of nurses have said to me my practice manager thinks your course is too academic. What they would want would be something like a 12-week short course which is the old model. You whack all your skills in very quickly, do a little portfolio and bang you are ready and equipped to do everything. It doesn't work that way.*
>
> ***Researcher: What is wrong with that model?***
>
> *Edward: It is for the practice, not for the nurse. The nurse can't retain it all, they can't take it all in, it is overwhelming, it is too much. The first thing Olivia (Clinical Practice Nurse Lecturer) said to me when she was here was, I wish I had been on a course like Fundamentals.'*

Susan is aware of the potential impact of the practice view on nurse education.

> *Susan: 'I think the course itself works, I think the difficulty that we face is more from the perception of practices that they don't necessarily realise or appreciate that it is a course that is run from September to June and attendance is required. And the students need to be given that time to simulate that knowledge and work on their skills. We have had students who have left the course because of lack of support.'*

Edward feels that the most demanding part of the course is helping to support students to resolve issues in their first employment in Primary Care.

> *Edward: 'The most difficult thing about it is the students' feedback of what is going on in practice, when you are helpless for them. On one occasion I had to ring Georgina and we had to get the CQC involved in cohort 1.'*

Cohort

In 2015 the cohort started with 9 students and retained 8; In 2016 the cohort started with 9 students and retained 8; In 2017 the cohort started with 7 students and retained 6; In 2018 the cohort started with 13 students and retained 12. Retention rate is 90-100%. Completion rate of those retained on the course is 100%.

The cohort comprises of local HEE/CCG funded places and some students who are CCG or privately directly funded from other areas.

> *Edward: 'We get a few outsources as well, we have had a couple of Cheshire students coming down every year, because I know the nurse lead at Cheshire. They pay their way on the course, they are not funded, she pays for them out of her training budget, the normal course price. We have got somebody from Derbyshire who enquired for September 2019 and will self-fund.'*

Edward feels that losing one student from the course each year is a natural process as some people will realise that General Practice is not where they want to work.

> *Edward: 'It has been people not realising what the requirement is. They have got a job, the practice have said yes you can have the job, but you have got to do this course to do the job and they have said ok then. Halfway through, this is what has happened with all of them, I don't like being a Practice Nurse anymore, so they leave General Practice. Ultimately, they leave the course. But it is a lot of pressure to ask them to do a new role, and a course at the same time. It takes a lot of character.'*

Case Study - Birmingham City University (BCU)

Course Delivery Team

Jackie Owen's is the course lead. She initially worked in hospital and as a midwife before gaining 30 years' experience as a Practice Nurse and ANP. Her first experience working for the University was in 2002 running a triage course for practice nursing in primary care then in 2008 she joined to run the Masters in Advanced Nursing Practice, initially as a lecturer practitioner then joining the University full-time from 2009.

Kim Daniels joined the team in 2018. Kim qualified in 1997 and spent 3 years in secondary care including A&E before moving into primary care in a part-time role. Kim works part-time (15 hours per week) delivering the *Fundamentals* course but also still works clinically for 3 days a week as a Practice Nurse. Kim also has roles as a cervical cytology teacher and CQC specialist advisor.

Jackie and Kim both suggest that their own previous lack of training was a real motivation for wanting to work in GPNE.

> *Kim: 'Non-existent. I remember being shown how by a nurse, yes, and I can remember ringing the other Practice Nurse every time I had to do a childhood injection because the primary then was just one injection and polio drops and it used to scare the living life out of me. After that, I started to do training a bit. It was never safe.' (Kim began as a Practice Nurse in 2000)*

Jackie suggests that a GP assumed she could do smear tests because she was a midwife despite never having been trained.

Kim's role is funded outside of the University and is primarily as a link between the course and current practice

> *Jackie: 'Kim was employed, well funded through the CPEN, community education network, purely to support mentors. There wasn't specifically the role to deliver the course, it was for her to support the practice element because we recognised that as a need. However, you have been involved in the delivery of the course as well. You see the students when they are in university and then you go out and visit them which is great, I would like more time if I could.'*

> *Kim: 'it is about holistic care because actually there is no way we should all actually try to be delivering a course that churns out practices nurses who have the piece of paper but don't work. What we need is our nurses to be really well qualified and competent, but among that we have a professional responsibility to strive for high standards. The only way you can get that is if you marry all of that up. So, in my opinion, the model that we have, works so well, we have really academic expertise, backed up with a Practice Nurse, then we have me with my proper up to date current clinical stuff. That is why it works really well because you are marrying up those 2 things and it has allowed me professionally, development but has actually allowed me to share what is right in the front on working in these places, that is how you are supposed to do things.'*

Jackie recognises that her academic commitment distances her from practice, as many other academics, and there was a commitment in co-design to a model which kept delivery close to current practice

> *Jackie: 'the other thing that was agreed with the universities when we first got together, was we would involve current people working in practice because I had worked in practice up to 4-5 years ago. Sadly, it was my intent to go back but I was only doing, you know when you are a full time academic, so nothing like Kim's up to date knowledge. So, we bring a lot of very experienced Practice Nurses in to deliver on the course.'*

The course has input from a range of experienced Practice Nurses and Kim suggests this model of cascading learning is beneficial for workforce development

> *Kim: 'We have done a lot of work with that haven't we, we have a really good set of specialists now haven't we? It helps them in their retention as well. If you were in a practice and were a specialist, one of our lecturers does a lot of sexual health and contraception, we have enabled her to pass on her skills to the next generation. Whereas just being in one practice she can only pass it on to one person. That is not good enough. We have got to be in a position where we are properly passing these skills on, we have got these nurses with the expertise, and this allows us to do it.'*

Jackie feels that the GPNE network exists beyond the University.

> *Jackie: 'they could probably do with a deputy course director, more of a team within the university. There are very few Practice Nurses, one or two Practice Nurses in school. But that is supplemented by the people that we bring in, I think of our team as the wider network. That is something we want to develop as well, that is more support for them, so they feel more part of the teaching team rather than just coming to their lecture and then never hearing from us again until next year.'*

Course Delivery

The course is 60 credits and runs once a week over a year with breaks for school holidays, for a total of 24 days starting in September.

The course was co-designed with a group of Universities under Charlotte Smith and BCU alongside UoW ran the first two cohorts as a pilot in April 2015. While the course core competencies and curriculum were agreed, Universities were free to personalise delivery of the course.

> *Jackie: 'It wasn't too difficult for us to agree on the general competencies, the core competencies. How each university then interpreted that and delivered it and exactly how the assessments were run was left to each individual HEI. So, you couldn't dictate how it was delivered, what the structure was. There was an agreement that is was level 6, 60 credits'*

Jackie suggests that the number of days the course should be delivered for was co-constructed.

> *Jackie: 'Basically this came from the collaborative university work, you were allowed 24 days contract time for the whole course. So, 12 days for each module. Don't know if it ever manifested as that. But that is certainly what I stuck to and that is what was agreed. The reason behind that was that obviously we were trying to sell this to the GP employers to get students to come and if we asked for too much, it wasn't going to happen. So that was the consensus, it was based a lot on the course down in Plymouth which had been running for a long time.'*
>
> *Kim: 'I don't know how you could do it in less than those 24 days because we are constantly trying to pack in every academic day, every minute of every day.'*

When the course first started Jackie was running 3 cohorts per year but while this helped the scheme to gain momentum and become established it was difficult to run with a small team. Due to demand from partners and availability of funding the team runs one full year course for *Fundamentals*.

There is a second course being delivered by the team running from April which runs on a different model to the *Fundamentals* course. The team were approached by a CCG with a set amount of funding to provide an intensive short skills course for nurses in General Practice and this runs in 4-day blocks over 6 weeks.

> *Jackie: 'So it was a bit last minute and they wanted it delivered in a shorter…, I am always getting feedback from the practices, particularly the GPs saying we just want them in and out, we want the immunisations and front loaded with all the key skills and we have always known, because of feedback from the students, it is too much. That is why we do the alternate days, they learn something and then go away, have time to practice and consolidate and that is ongoing. But they kept on, so we thought ok let's give it a go. So, we have done this cohort in chunks of 4 days at a time. So, for example, when they came in, in 4 days they had 2 days cytology training and 2 days immunisation. Two huge subjects in 4 days. We thought they might have that time over a year or 6 months to consolidate, in practice we are finding the practices are saying right you are trained up now, off you go.'*

The team has become directly aware of the weakness of this short 'training' model as it does not allow for consolidation of learning or confidence building.

> *Jackie: 'We thought they might have that time over a year or 6 months to consolidate, in practice we are finding the practices are saying right you are trained up now, off you go.'*
>
> *Kim: 'Then I am picking up people who are saying I don't know what to do, I am not signed off to do this, I am not competent, but my manager is saying I have got to do it.'*
>
> *Jackie: 'We have had more problems and in different local areas, where there is possibly practices that aren't quite as set up to support. But I do think it is proof that and I am hoping they will go back to the alternate days. It is already set out for September so we will have to try again give it a 2nd go but then I am planning on going back because I have got evaluations to say it would just be too much to*

have it done over a shorter time. It is about confidence levels and I have got a load of data around their confidence levels. The first 2 cohorts, that gradually improved over the course of a year, but it is only over the course year, not 6 weeks.'

The team felt that commissioning the short programme was an opportunity to demonstrate the benefits of the *Fundamentals* scheme

Jackie: 'We just kept getting asked about it. We thought the only way you can demonstrate is to try it out, I might be wrong.'

The team has been funded to run the short course again from September 2019 but will use comparative evaluations of the models to evidence the reason for education over training.

Jackie thinks the timing of the course prevents some nurses from accessing the training due to the ongoing need of the practice and is trying to be flexible to employer needs within the University system.

Jackie: 'Well that does come back to an operational issues that I have been trying to tackle ever since this started really. If we were only running September or even September and April, a Practice Nurse starts in October they have still got to wait. The GP thinks well we need you to be doing cytology and imms, and they send them off on the day courses. It is trying to get the GPs to understand the added value of the course. So I have been trying to get around to having a way of having a rolling programme so as soon as people are employed, they can step on the next time cytology runs, whatever, and then join the course at the appropriate time. That is very difficult so we haven't worked that one through, but I think that is how it should work.'

Jackie: 'so you are not leaving someone for 6 months in employment without any input.'

Kim: 'and that is a vulnerable time as well'

Jackie: 'but how to manage that within the university is difficult.'

Jackie: 'they would be, it is more the financial element. We have put CPD on, say we had travel health next week, so we will offer that out to existing practices who want a top up'

'As well as your cohort?'

Jackie: 'yes, we only get the odd one or two, we haven't had time to market it. But we have had one in particular this cohort, joined immunisation and contraception and said I would really have liked to have been on this course. I have had one before that has come on the immunisation over summer and then joined the course in September.'

Course Content

The course is 60 credits at level 6 and when first delivered ran as 2 x 30 credit modules but due to University transformational changes was restructured to 3 x 20 credit modules. Originally the course ran as 'core skills' and 'long term conditions' but now comprises 3 modules and so an additional 'professional skills' module was added from material moved out of other modules and additional academic skills.

'Core skills' is delivered first

> *Jackie: 'So, cytology, travel health, wound care, all the essential things you do as a Practice Nurse.'*

The core module is delivered alongside professional skills

> *Jackie: 'The autonomy, the legal issuess documentation, professional issuess, that sort of theory stuff ... We also slotted in their academic skills'*

The final module is an 'Introduction to Long Term conditions'

The team suggests that newly qualified nurse settle more easily into academic work and self-supported learning.

> *Jackie: 'In fact, the newly qualified tend to be quite switched on so they are used to the system, they know how all our systems work, and they know how to get the support so the newly qualified are great. Some of the other nurses, excellent, real high quality but we get some that really struggle. Why I have trouble with the 12 days of the 1st module, is that within that we have to get in academic writing, literature searching, evidence based appraisal skills. We don't get enough of that in as much as we would like to and it ends up down to the individual nurses, as to how motivated they are to support themselves. There is loads of support here, come to tutorials, meet with librarians, loads of support but they have got to do that outside of the 12 days'*

The team acknowledges that GPNs struggle to access central University support available to standard students and as a results online learning results are important. This is an area the team is working to develop

> *Jackie: 'We have tried, we are doing a Padlet at the moment, we are just starting to do u-screen cast-o-matics, what we are hoping to do is some of these classroom ideas. Because we have such little time with them, they watch a pod cast of the lecture then they come in for activity discussion, that would be to me what I would like to strive towards. In reality, we have the problem with those that can't access it, haven't time to watch it, so I am sure that is going to be a real learning curve for us but we are going to give it a go. I think it has got to be the way forward. We don't get enough time to give them the content face to face.*
>
> *Kim: 'let's look at them for example, CPR is a really good example, the way you teach CPR to a pre-registered nurse, who is going to be in a ward environment where there will be lots of people within one minute, is really different to the way you want a Practice Nurse who is going to be on her own or with one other who*

> *also hasn't done CPR for a long time, you would want that assessment, that identification, that plan of action to be more robust and it takes longer. So, we are trying to fit a variation on that set of skills so that we know they are safe and are confident in what they are doing. But everything takes so much time and that is the one thing we haven't got. So, to put some stuff onto those kind of formats is maybe going to help us. Or does that mean they don't engage too much, we don't know.'*

The course offers education around resilience and working in the Primary Care environment

> *Jackie: 'The one thing they have that they really value and is more for them, is a session on emotional intelligence and self-care, stress management and all of that. We have a lecturer here who is a trained phycologist and she was also a Practice Nurse beforehand. She is doing a PhD on emotional intelligence. She does a fantastic session with them and they love it. It gives them skills to help manage the course.'*

Kim explains the value of resilience not just for individuals but for the GPN role.

> *Kim: 'If you look at our current cohorts we have got nurses who have come from every specialty, for example, some of them come out from A&E. so they are used to that assessment, they are used to that crisis and they are part of a huge big team. When it goes wrong, we just bang on the wall and people come running from everywhere. In primary care we haven't got that. They really struggle with the kind of concept of actually I don't know what to do with you, but I could have you back tomorrow to have another look. So, starting at those basic changes in consultation skills and clinical decision making, that is so important. Then they are on to tasks that they have never done before like babies' injections. All of a sudden you get this 8 week old, tiny stick little leg and you have got to stick a whacking great needle in it 3 times, it is really difficult. A lot of people who come to those places they are ill, so if looking at A&E and carrying on that example, if you have got to stick a needle in somebody because they are ill or injured or in pain and you have got to resolve it. Most of the stuff we do you are not in that situation. So we are looking at prevention stuff where actually, they have got to do something that hurts the baby, and they have got to gain consent from the mum fully and totally before they do that and the positions are really really different. The dynamic is totally different. That ongoing relationship is different. Every skill is different, so cytology is another good example. The vast vast majority of cytology is done by Practice Nurses, it is not done in any other specialty. In fact, we have gynaecology nurses never use the speculum until they come into primary care. All of a sudden, we want them to get that lady on the couch and do that. So those skills, you haven't just got the learning of the practical skill because you could teach a monkey to put a speculum in an example, it is all the stuff around it. That is so multi-faceted. You have got everything from the employers expectations of a nurse, right down to how am I going to gain consent, what information do I need to say to this person to gain proper consent, how do I document it, what's the clinical system like? All the different things that they have never ever done before, we just expect them to do.'*

Jackie sees the course a solid pathway to further education and development for GPNs

> *Jackie: 'I see this course as a step forward for their ongoing career, not all of them but some of them that want to do advanced practice or whatever, this gives them a real solid foundation. It takes them longer to get there if they don't have this.'*

Jackie feels that the course and further pathway opportunities should be matched to the developing role for GPNs

> *Jackie: 'Tell you what I would like to get in and another reason for the 24 days, in all of the stuff, because they are band 5 essentially, there is this assumption that they are not assessing or diagnosing or doing minor illness or triage, but they are. The patients come to them for a smear and say I have got this rash on my leg or whatever, and they have to deal with it. So hence why we do the minor illness, but I would really like to get more health assessment in and that would set them up for their prescribing. We run a health assessment course here. I have at times when I have been able to fit it in, I have done it with the coronary heart disease, we did a bit of health assessment for cardiac conditions and looking at that.'*
>
> *Kim: 'it is just so difficult to fit it in'*
>
> *Jackie: 'but it is no good saying that they are not going to be making decisions about somebody with a sore throat because they are. They are making decisions whether to call the GP or not, whether to send the patient off, they are making these clinical decisions.'*

The team feels that the course offers education over training which has significant advantages not just for individual nurses but for workforce development in General Practice

> *Jackie: 'I think the fact that we are actually getting Practice Nurses together and they are getting a rounded education rather than just skill based, I think it is the difference between training and education, they are now getting the education rather than just being trained to do a task.'*
>
> *Kim: 'the best thing about it is that we are building local long term, highly educated, highly knowledgeable workforce that we really need and every single one is vital.'*
>
> *Jackie: 'we do stress to them, it is about confidence leadership, the assertiveness, being able to challenge practice even though they are employed by the person they might be challenging. That is a real part that is probably not even articulated anywhere.'*

Progression rates from the course are positive. A large proportion of GPNs go on to mentor training and other advanced levels training

Jackie collects feedback and conducted a large-scale evaluation of the first two cohorts which was sent to HEE and Charlotte Smith. The recommendations of the evaluation suggested that students need time to consolidate their learning.

> *Jackie: 'The big focus was about the confidence levels and how they needed time to develop and not just getting out, how we had to do.'*

There is some debate as to whether the course should be offered at level 7.

> *Jackie: 'the other thing that keeps coming out is why don't we run it at level 7? We had this discussion when we first set it up, I think I might be slightly changing my thoughts on this now. How can you be a master of something on your first day into the specialty, even though some of them have done a degree, they still struggle with the academic work. Yes, we encourage them to develop the academic side so they can go on to masters.'*
>
> *'It is a pathway towards that isn't it?'*
>
> *Jackie: 'but there are still some of them that are saying why am I getting level 6 credits when I don't need them? So, we may re-think that. It is not really going to help in the long run. Hence, I was thinking about the health assessment, if we could add that on.'*

Competencies

The course curriculum was co-designed with a group of Universities in 2015 and is linked to the 2012 RCGP competencies.

The team feels it is important that competencies are not just measuring skill development but providing an opportunity to link theory to practice

> *Kim: 'The portfolios are really good. One of the things about me going out was to try and encourage more robustness around that portfolio so rather than just ticking the box, we encourage them to write actual information about actual things that have been seen and the actual things they are competent in, in that moment. So obviously competency assessment is an at that moment thing but actually, if you have got that evidence, this and this has been covered, they are developing this this and this, that gives that document real robustness and evidence. We encourage them to put in other bits and bobs so one of them I have just had in was 91 pages long. That person had taken it to heart and there was all sorts of really interesting, she had articles that she had written about, obviously read them and linked them to practice, quizzes, loads of stuff and that was such a robust document, you looked at that and you thought reading this I know what you know. If called to account for that, it is such robust evidence, so I really like the portfolio document, I think it is good. I think it links the theory to the practice really well.'*

The team acknowledges that it is important, yet problematic, to link the competencies and assessments to the requirements of the role in practice.

> *Jackie: 'Just on that we had quite a lot of discussion around the content recently, because a lot of practices weren't doing ear irrigating, went through a phase of not doing ear irrigation, like the assistants are often the ones that do that anyway. We have had, just this cohort, putting "not applicable." What we say is ok, you may not run an INR clinic in practice, but you need to know about warfarin. We want everyone to have the same base line even if they are not actually going to be doing it. Same with contraception, some of them have*

services in, but that is constantly changing. So, we are having a bit of a challenge with that at the moment. We ae going to re-vamp it for September, it has not happened before apart from ear irrigation.'

Kim: 'but everything is so interlinked. Yesterday we were having a conversation at the diabetes meeting about younger females on some of the diabetic drugs, that are teratogenic, so contraception, we really need them to know about. Saying not applicable isn't going to work.'

Jackie: 'the other big issues I have is initially they say my practice manager said I can't see anyone with asthma, until I have done the 6 month asthma diploma. They get 2 days asthma and COPD now instead of 1. Whilst they have to be safe, I think unless they are starting to see patients under supervision, you can't say I am not going to see anyone with asthma when you are seeing patients in General Practice.'

Assessment

The first module 'Core skills' is assessed in multiple ways by both course staff and practice mentors. Students keep a competency booklet where they conduct a SWOT analysis at the start, track their competency against 16 core skills, have initial, interim and end reviews with their mentor alongside 15 hours of learning logged. Students write a 1000 word reflective essay based on communication and consultation skills as well as three reflective pieces and a competency review.

The middle module 'Professional Skills' meet a further 16 competencies for the portfolio and is assessed by a 3000 word academic essay on a service change based around one of the competencies.

'So, a lot of them do things like improving cytology, they might do immunisation and parental education, some have done sexual health or contraception. So, the leadership comes into that, they do theories of change, management, and we hope that they will actually implement it, but they don't have to.'

The third modules 'Long Term conditions' is assessed by the continued portfolio development and a 1000 word essay around behavioural change in patients in a long term condition.

The course competencies are assessed and graded

Jackie: 'Initially when it was 30 credit modules and they had the essay and portfolio; it was pass/fail then. But what I found with other courses, you get some students that put so much effort in and they produce such fantastic work, it is a shame then to just get a pass whereas there are ones who have just done the bare minimum.'

The team feels that academic writing is an important skill for nurses which justifies their use as a main assessment method

Jackie: 'Do think it is important for them to actually get a grasp of academic writing in this course because if they want to go on and to their advanced practice or prescribing, this will help them. Although some of them do say "Why essays,

> *why all this focus on referencing, academic work and literature searching." Because I see this as a springboard for career development up to nurse consultant level within General Practice. I feel it would be important for them to write academically and we also would like them to be able to publish, do research, we have done a lot of work around clinical academic careers, I have just recently done a research study on it which hopefully will be published, it is just being reported on. I think it is really important to get some Practice Nurses with the skills to be able to do it, I know it is not going to be many but that is why I think the essay is important.'*

Jackie suggests that the course is preparing GPNs with skills in EBP and leadership.

Mentoring

Jackie suggests that as part of the course there should be a minimum commitment of 30 hours mentoring from the practice but while Kim agrees she can understand this is a tension for the practice

> *Jackie: 'We also stipulated that all of the universities, the amount of contact supervision time in practice. So, it was determined at 30 hours over the full year. No way is that enough. All of the nurses do more but to pass the course they have to log that evidence. So we ask for a range of experience, I would love to be able to change that and get more officially but that is where we are at, that is what we say, employers have to allow them these 30 hours supervised practice but they do more. And it is not enough but you have to stipulate a minimum.'*

> *Kim: 'the trouble is you are trying to balance the opinion and the needs of the employer of the service of the cost of all the rest of the things, patients care and let's not forget there is a patient on the end of every single one of those first few injections and that kind of stuff. One of the challenges we have had is people developing competence of their own and that can be challenging. If you have got 3 hours of 10-minute baby immunisations booked in… these are the challenges that we have got. What we would like would never marry up with the employer's expectation because the employers need their patients seeing and there is that constant challenge between looking at every single aspect of it and being in a position where they can offer service.'*

The primary responsibility of practice mentors is to sign off the portfolio but also to provide opportunities for learning. Mentors are usually experienced nurses

> *Jackie: 'Whilst we do ask for the qualifications of the mentor, say I think 2 years' experience, most of them have got a lot more than that. Because we now have got Kim who can go out and support them, we know our mentors that are well established that we know we can trust just to get on with it. The ones that we don't, Kim is there to go and support them.'*

Kim explains the variations in mentoring experience

> *Kim: 'But we have got super practices where they have now got 2 on 1 cohort and that makes it easy because you are only talking to one person. Some of the super*

> *practices, maybe this is number 5 or 6 that they have put through. Those people really know about this already and the mentors appear to have done the course so it is those kind of people you worry less about, and worry more about mentors who only work 15 hours a week and they never cross over.'*

Where practice mentoring is problematic. Kim's role is instrumental in providing a bridge between the student needs and practice needs.

> *Kim: 'we have a student who at the moment has failed her smear course and actually some of that is about the workload, a smear in 10-minute appointment and already got 3 people waiting. These are the kind of things from our perspective we can stand back and say no, that is not right. We go out to the mentors; we will put a plan in place. Because we are that one step removed but because we are really credible.'*

Kim visits each student, in their practice, usually at least once during the course.

> *Kim: 'It is difficult because I don't have enough time, primary care is really insular, so you are in a situation where actually they don't really want to let you in is the first thing. However, because I am a Practice Nurse, I tend to be more persistent, 'I need to come out, I have got to come out'. The last cohort I went out to the vast majority of them once, I spoke to the mentors and I pick up the problems. I pick up the problems from every level so the practical stuff around cytology or immunisation, pick that up and deal with it. Speak to mentors, struggling students, from a practical perspective that comes my way and I will then go out or speak to the mentor. We have had one at the moment who has some struggles and we talked about it and worked out what that was going to look like in the next few weeks. We have resolved that with a bit of input, that is ok now. So, it is literally problem solving a lot of it. But it is also about that network, I am always on the end of my email, we are always answering our emails. The way we run it is we tend to copy both of us in so whoever is most appropriate will pick it up.'*

Kim feels that additional support for students alongside practice mentors is important, even post-qualifying

> *Kim: 'Yes yesterday somebody rang me really, really upset, newly qualified, been qualified 6 months, working in primary care, she had taken a dressing off and she wanted to put one type of dressing on it and the patient wasn't happy and said no, I want the other nurse. She went and got the other nurse and the other nurse said to put a different dressing on it. She was really upset about that; she knew what she wanted to do. I was like that is ok, this is all a learning curve. If they haven't got us, where are they getting that support? Where is that coming from? It impacts on their attendance and we need them working. So, the newly qualified have a really new set of challenges and they need really intensive support.'*

Jackie feels Kim's role is vital to provide genuine support to the workforce development

> *Jackie: 'I think actually we are the only, from my perspective when I was delivering the course before I had Kim's here, there was always the odd one that I became aware of that was not really being treated fairly and there were*

difficulties, and I helped supporting those. But there was no-one like Kim going out. I think actually we are seeing the true extent of the problem because Kim has been able to go out and find out.'

Jackie and Kim are keen to emphasise that many practices offer a very supportive environment and structure mentoring

Jackie: 'I must say some practices are excellent'

Kim: 'Yes and it is really easy to talk about the bad surgeries but actually we have some surgeries that provide an absolutely outstanding mentoring procedure, their feedback, all their stuff comes in, they really care for their students.'

Jackie: 'The mentors are developing as well'

Kim: 'Exactly. It is really easy to slip into the 'oh this is still happening' but in a lot of the cases they are well supported. They do have decent mentorship and you are confident that the sign off is good and they are not just left on their own. We have got that full balance.'

Jackie is keen that the GPNs follow a pathway to include mentoring to build the workforce

Jackie: 'At the end of the course we suggest they all do their mentor course because that is changing but a lot of my very first cohort, probably at least half, are now currently mentors.'

Relationships

Jackie knew Charlotte Smith through practice nursing and met with her when she was first seconded to HEE to discuss the need for a standardised GPNE course. She was then part of the original working group of Universities (along with Stafford, Worcester, Coventry, Wolverhampton and Birmingham) who co-constructed a basic curriculum for the course. Jackie feels that the nurse leadership West Midlands network which was previously strong lost some momentum when Charlotte Smith changed role and she has considered reconstructing the group because of the benefits of the network.

Jackie: 'We have thought about re-starting it, running it from here, it is one of those things that would be really nice to do.'

Kim: 'Out of that network we did lots of really good work, that was how we started the student project.'

Jackie: 'I used to go along as the HEI because it was really for the Practice Nurses in practice, but I used to go along because they are just around the corner so that really helped our working collaboratively with them. So, it is something we did think about.'

Kim: 'Everyone is just really tight on time, especially when you are looking at a network that has directive nursing and those kind of level of people in them. But I think we are fortunate in that we already had those relationships in place. So, when you are in that situation you can just send a quick email saying did you

know this was going on, had you heard this? You rub along on those relationships.'

The University team has strong links to the local CCGs. They work closely with Birmingham and Solihull (the second biggest CCG in England) which provides a main income in terms of amounts of students. They also work with Sandwell and West Birmingham (the smallest CCG) and take a few students from them but students in this area also go to Wolverhampton. The occasional student attends from out of the area (Wales, Shropshire, Staffs). The team's link to the lead nurse at the local CCG help them to facilitate newly qualified nurse recruitment.

Kim: 'I think that is another advantage, I suppose we have got such a huge network at reasonably high level.'

The team also works closely with the training hubs – one situated in Sandwell and West Birmingham CCG and the other within a care provider. The training hub helped to fund Kim's post in the first year.

The team feels it is important that the course development links into the national agenda for GPNE

GP contribution

Students need to be released from work for one day per week to attend the course but not all student experience is highlight variable and not all nurses are paid for their training time.

Jackie: 'They are agreeing to give them the time off to attend university, that doesn't always happen. They sometimes have to do it in their days off.

Kim: 'About a third of them will have a day off.

Jackie: 'That is where there is this mismatch. If you go for a job in an area you are not familiar with, and someone says these are the terms and conditions, and you have got to go to Uni on these days, but by the way we are busy this day and you can't go this day. You don't know about that agreement and you don't know what has been agreed behind that door, you are only having what you are being told. So, they may say well actually there is an agreement in place that you have got to attend. But there is that mismatch, it is not known, and the nurses are in a totally new environment, they don't know the staff, they don't know the leadership, they don't know the work office culture often.'

Kim 'It is very difficult to say if they say, oh by the way we need you, you can't go to university. It takes real leadership and real negotiations skills to say actually no, and they are not in that position. There might be agreements, how are they checked, how do we know the people receive what has been funded and agreed?'

Jackie suggests that some students are locked into paying the course fees back if they don't stay in their post

Jackie: 'The other thing we have is about employers wanting them to sign contracts about staying for so long after the course or pay back the money if they don't pass'

Kim: 'We have had up to 4 years '

Jackie: 'I think that is a fairly standard expectation, many employers outside of health, if you support training that you get something back. The point I want to make is that it is not always within the students control because if they haven't got the right mentorship, the right equipment, and the employers' expectations of what they do on the course and how quickly they…, it is unrealistic and it is not fair.'

Kim: 'I have a different take on that as if is it development, so if you are an experienced PN and you are going to do ANP, I can understand that tie-in because that is a development for you. However, to undertake a training course to fulfil your original job description to my mind should be funded. They don't just lose their skills when they walk away from the surgery, and they tend to move on to other sites. It is not the job that they tend to be moving away from. So, I have a different opinion about it. The employers aren't paying for the course.'

Kim suggests that variation in working conditions causing significant problems.

Kim: 'Massive inconsistencies in salaries, massive inconsistencies in annual leave, massive inconsistencies in expectations. As an example, if you are an employer who has no nurse on site at all, and you think that employing a newly qualified nurse would be more cost effective for you, you may choose that as an option. We have all sorts of issues around sickness… as in no sick pay, no ongoing support in terms of occupational health, and those kinds of issues. We have had issues around unsafe buildings. We have issues around equipment, no equipment at all, we have sites where there isn't the correct equipment, no risk assessments, no one going, and those are some of the challenges that we face.'

Kim points out that training for GP doctors and nurses is different despite working in similar environments.

Kim: 'You wouldn't just let a doctor have a day course on something and that is it, off you go. We are expecting a lot of our nurses, we are expecting them to work autonomously. We are expecting them to make clinical decisions, at high level, we have got to make sure they are trained and competent.'

Kim suggests that the primary care, and the role of GPN is significantly different now to 20 years ago when she first worked as a Practice Nurse.

Kim: 'Don't forget that is now 22 years ago for me and the roles were so different then. I used to spend my time doing new patient checks, the things that the health care assistants do now.'

Researcher: 'That's interesting, so you think it is a different role now?'

Kim: 'A massively different role now.'

Jackie: 'It was a lot of taking blood pressures. I can remember them trying to get me to give Kenalog™. I said I don't know anything about these drugs. It's ok you have just got to give it.'

Kim: 'There was a lot of sterilising to do and all that kind of stuff. That used to be our job, we used to do the sterilising.'

Jackie: 'I remember we had a thing you plugged in that boiled them.'

Interviewer: 'So nurses are doing a lot of things nowadays that presumably you wouldn't have been able to do then?'

Kim : 'Yes because you couldn't do your prescribing then either. There was no prescribing element.'

Jackie: 'I remember doing more focus on health promotion than they manage to get in now, smoking cessation etc.'

Kim suggests that a significant amount of her time on the course is supporting students in a difficult working climate

Kim: 'I certainly spend a lot of time dealing with problems within the environment. I know that has been a massive help to you hasn't it? When you look at some of these situations these nurses are in, even now in 2019. We have a responsibility to those students that we care for and I certainly spend a lot of time dealing with that, trying to find guidance and trying to support people who are working in very difficult work situations.'

Jackie and Kim understand the tension between the time allowed for training and mentoring and the needs of the business. They suggest a model which might successfully meet these conflicting needs

Kim: 'I would essentially employ them on an apprenticeship type contract for 18 months and put them in supernumerary, so you could develop those skills.'

Jackie: 'When you think a GP, it probably takes at least 4 years to train or more, and I know they are different roles, but a lot of these nurses are going to go on to be Advanced Nurse Practitioners, prescribing nurses, consultant nurses so the notion that we could do that in less than a year.'

Kim : 'And let's not forget they are isolated, it is not like they are going into big departments where there are 10 nurses, most of these guys, there are 1 or 2 of them. Sloppy practice breeds sloppy practice. I went out to an external event where someone did something and I was oh my goodness no you mustn't do that! And she said my mentor does it. Sloppy practice breeds sloppy practice and we have got to un-isolate them, the way to do that is to pull them together. So, things like the university days, it is never ever to the taught content, it is about the peer network, it is about the WhatsApp™ group. What shall I do about this? I have this patient with x or y, no-one knows what to do, what shall I do? It's that shared, that journey, walking that journey together and I think we are really involved in that. It is never us and them, we really feel like we are in it together.'

Cohort

The cohort size is growing and now the third cohort has a size of 20 HEE funded places (there are a similar number on the CCG funded April short course). Completion rates are 95% with 1-2 students leaving the course if they decide they do not wish to work in General Practice.

> *Jackie: 'We had one nurse from palliative care just decided practice nursing wasn't for her and she left. We have had some that haven't been in practices that have supported them, so they have struggled then left and moved to another practice. Often, we pick those up again because the funding stays with them. If somebody is interrupted through illness, have left their job because they are unwell, it happens. If they go and join another practice, within a year they can come back and join the next cohort and a lot of them have so they have eventually completed. We have just lost one who was interrupted for ill health, that is the other element we get, if we have people who want to get in to practice nursing, they want to come on the course, they haven't really got a job, and they persuade a practice to give them a day a week, we say you need 2 days. Then they are not really embedded in the practice, and if it is not going right, they give up.'*
>
> *Kim: 'it is easy to scuttle back to what you know.'*
>
> *Jackie: 'And they need to pay the mortgage'*
>
> *Kim: 'At the end of the day if you come out of something where you are an expert and you think it will all be fine, you have got a lot of transferable skills and then you get somewhere and hang on a minute, this is totally different to anything I have ever done. It is really easy to run back to what you know. '*
>
> *Jackie: 'I don't think we have ever lost anyone for any other reason, they have either decided practice nursing is not for them. On 2-3 occasions, the problem with them having to be less than a year in practice, often they come to us when they are still in their probationary period. So, for whatever reason, it might be the practice isn't happy with them, they don't want to keep them on, or the nurse isn't happy with the practice, we lose them. '*

The cohorts maintain contact with each other during the course, and after, using WhatsApp™ groups.

> *Jackie: 'My first cohort in April 2015 still keep in touch on WhatsApp™.'*

Whilst it is difficult to track students once they leave the University, Jackie is keen to grow an alumni CPD network.

The number of newly qualified nurses in each cohort has grown from 1-2 to 6 in the current cohort (25%). The team markets the course to pre-registration nurses but rely on the CCG to help them into placements which will secure their funding to attend the *Fundamentals* course.

> *Jackie: 'We are quite pro-active here, pre-reg students and developing the General Practice placements. I work closely with our pre-reg department, I go on*

> *careers days here, I am constantly getting our student nurses* emailing *me saying I would like to get into practice nursing, what do I do? We link them up with the CCG and they come back and they come up with the Fundamentals. We don't officially help them, but we do put them in touch with the CCG, they will know if any jobs are going.'*

The team's relationship with the lead nurse at the local CCG supports this initiative.

Jackie feels that the course supports students through an interesting change in professional identity.

> *Jackie: 'It is a bit like the novice to expert thing as well because the nurses that have been in A&E may have been really efficient and competent in their role, they come into General Practice and they feel like they know nothing. Then we have also got the newly qualified nurses which is a whole other challenge. Equally if not more challenges when they go to General Practice because however well supported, they are by their mentor, at some point, very early on, they are behind a closed door with a patient and think what do I do? Everyone else is behind closed doors, it is very difficult to ask for help in the same way.'*

Jackie is keen to point out that there are a range of routes into GPN not just though the degree but also through those with experience in Primary Care

> *'I think we have had 2-3 that were the receptionist in the practice, and they were supported to do their HCA training, and they stayed with the practice. Then the practice supported them while they did their RGN training. Then they came on the Fundamentals, we have had 3-4 of them, how great'*

There are several success stories from previous students working in Primary Care and branching out. Many *Fundamentals* GPNs act as mentors or took further specialist training courses. One has taken a teaching pathway and two others are in specialist roles. There are examples of the course learning having direct impact on nurse and practice development

> *'One nurse in particular, when they did the presentation and they did that on long term condition, they did a case study. They then became the dementia lead for the practice. There are quite a few examples I am sure we could put together of impact on practice.'*

Jackie believes capturing these types of impact are likely to be positive materials to persuade GPs of the benefits of the *Fundamentals* approach.

Competencies

The course portfolio is linked to the 2012 RCGP competencies as well as QNI and RCN standards.

Case Study - De Montfort University (DMU)

Course Delivery Team

Emily Stanton is the course lead. She initially worked for 2 years in hospital and then for five years in industry as a nurse advisor to the pharmaceuticals industry. This role involved working closely with General Practice around disease areas and service audit reviews. This sparked Emily's interest in working in General Practice and contact with a GP in her area led to her being approached when a vacancy arose. Emily's expertise in respiratory issues (asthma diploma and COPD diploma) meant that she was able to deliver services in the practice as soon as employed, whilst being upskilled.

> *'I started with the respiratory clinic, then I just started to gain other practice nursing skills, but it was very much see one, do one, teach one in those days. There wasn't a course you could go on that would look at it all, you had to do piecemeal training and most of it was supported by pharmaceutical companies. It was like one day on this, one day on that. So, I gradually built up my portfolio of skills and I worked full time, I think that makes a big difference. If you only work part time it takes you longer to get to that point of proficiency. Whereas when you work full time you get there much quicker because you see more patients.'*

Emily worked full-time as a general Practice Nurse then had a child and returned to practice part-time as a job-share Nurse Lead for 2 years. During this time, she further upskilled and topped up her diploma to a degree with specialty training in General Practice (ST). Emily also became a guest lecturer at De Montfort in respiratory from 2009. Emily was part of the steering group for the GPN programme when it went out to tender in 2012 alongside Teresa Stanley. Emily continued working in General Practice and contributing to the programme through teaching and as an external Practice Nurse trainer supporting students in practice. When Teresa left De Montfort to take central HEE role in 2015 Emily became employed directly by the University to deliver the course for 2 days per week whilst working 2 days per week clinically as an ANP in practice. Emily reports that it was difficult to manage the needs of the course and practice and she was relieved to move to a full-time role for the University in May 2016. Emily was supported by a part-time role, but the role-holder has recently moved on and the role is being recruited to in summer 2019.

Emily has recently gained a Masters in educational practice and is about to start her PhD which is likely to focus on the GPNE programme.

Course Delivery

The course is 60 credits and runs once a week (with one exception for cervical cytology 2-day course in one week). The *Fundamentals* programme is delivered over 9 months with a total of 17 taught days in 5 months and the remaining time to complete. The course runs twice per year starting in September and January with delivery of courses overlapping. The delivery of taught days on the first annual cohort completes at the end of January.

Students return to practice to work on their assessment (clinical audit) before returning in March for the presentation and May for the essay. Emily provides tutorials to students during this time. Due to the course being delivered across a wide geographical region Emily travels to meet students locally for tutorials where necessary.

Course Content

The course is 60 credits at level 6 or 7 delivered over 9 months.

- September delivers an induction to the course, library induction and immunisations and vaccinations training.
- October delivers venepuncture and cytology training
- November and December covers long term conditions including asthma, COPD, diabetes, and cardiovascular as well as mental health and learning disabilities.
- In January the focus is on travel health and contraception.

The course content is designed specifically so that core skills can be delivered early in the course.

> *Emily: 'We have imms and vacs front loaded. We do that because we are in September which is flu season. So, we purposely think about practice needs and we get the imms and vacs in quickly so that they can be delivering almost immediately. Obviously, they will need supervised practice and to be signed off competency in practice but one of the early things we like to get them doing is imms and vacs'*

Long term conditions are taught later in the course so that students are not expected to work above their level in practice.

> *Emily: 'We wanted to make sure that long term conditions were very much late on because we didn't want, and we were very careful to point this out, we didn't want practices thinking that after they have done one study day on asthma, they can go in on the asthma clinic. Because that is not what it is about? It is about a foundation to. So, every session is an introduction to, it's the basics. This is the basics of diabetes care in General Practice, so we have given you that foundation which you can now go away and build on. It doesn't mean you are now competent to go and run the diabetes clinic, you would need a lot more knowledge and experience to be able to do that.'*

Evidence based practice underpins all teaching.

> *Emily: 'What we also do, say we are doing asthma, we will talk about the kind of evidence which would be relevant for an audit in asthma if that is what they were going to audit. But everything is evidence, evidence, evidence. From start to finish.'*

Academic support is offered by a central department in the University which Emily acknowledges can be difficult for the student nurses to access as they are off campus most of the time. Acknowledging this limitation, and also the limitations of academic writing as an assessment tool, Emily discusses alterations planned to the assessment.

> *Emily: 'So, the idea is I am going with universal learning design and there will be a choice of how they submit their work… The idea now is I have flicked the assessments round, their first assessment is called a service improvement report. Instead of being an essay, it is a bit more business focused. They can either base it on an area of clinical practice or they could write a service improvement report*

> *about following a significant adverse event. Patient safety alert, some trigger that makes them think we need to improve the way we are working. All the evidence base will need to be there. Then they are going to come to a viva and defend it. Because that is what they would have to do in a clinical meeting. The doctor would be saying why should I do that? That is going to cost me £50 extra a week to put on an extra clinic for that. But the nice thing is the report can either be a written report of 4000 words or it can be a voiceover presentation, or it could be an infographic with 2000 word support in rationale. So, there is 3 choices of how the students submits the work. I got some feedback here saying you can't have a level 7 programme with no academic writing. I said why not? There is nothing in the QA standards that says that they have to write academically. As long as they meet the learning outcomes of the programme, who cares whether it is in a presentation or a written report. So, I am hoping Academic Committee agree with me because that will completely take away the need to write academically for those that are put off by that.'*

There is a strong element of co-design to the new assessment.

> *Emily: 'In order to do that we organised a co-creation event so in March, we called in our external trainers, the external examiner came in, myself and Shona. We invited students but they couldn't get out of practice. We all sat round a table and said let's pull all the learning outcomes to pieces and rebuild it. What do we actually want our students to know at the end and how are we going to assess that? So, it wasn't just me, it was a real collaborative with practice. I am really proud of that and I really hope it goes through.'*

Emily feels the course offers a network of learning to protect students from unsafe practice.

> *Emily: 'Prescribing is a big hot potato for us which has led to us providing some guidance on a university level on that. GPs asking nurses to add things to screens, I will come and sign it. That happens a lot. It happened all the time when I was a nurse in General Practice, but it was never on anybody's agenda, the CQC weren't around. Now the quality assurance in General Practice is tightening up and that means nurses are going to have to stop and think about their practices. There are some really unsafe practices out there. GPs need to re-learn that they can't just ask a Practice Nurse to add a prescription to a monitor when they are not a prescriber.'*

The course offers education around resilience and working in the Primary Care environment

> *Emily: 'Autonomous practice, getting to grips with that. Learning boundaries because you have lost your hierarchy so there is no Matron, no Chief of Nursing who is going to tell you what to do. General Practice is very much about finding your own feet in terms of what is safe practice. Students really struggle with that especially newly qualified. Because they are so used to being told this is what you do and don't do, when they get to General Practice, they have got to think for themselves. Can I or can't I do it?'*

Emily gives an example from her own practice of why confidence to challenge and protect safe practice is important

> *Emily: 'It is protecting yourself, safety ultimately. If I give you an example, when I was in (a practice in Nottingham) on Friday, one of the students was asking me for advice. A lady had taken the depo contraceptive injection which is usually given every 12 weeks. A GP had seen her and said you have got irregular bleeding, have your next depo earlier at 8 weeks. Booked her in with the Practice Nurse who is one of our students. She refused to give it, she said I can't give it because one I don't have any prescribing authority to give it because it is outside of the PGD, outside of any PSD I have got. It is outside of their guidance so I have got nothing here, there is nothing on the notes, that would constitute a PSD for me to give it, so I am not going to give it. The patient was really angry, I have had a day off work to come and get this. Went out to reception and reception said you have got to give it. So, there is a big issue with reception staff and non-clinical staff putting pressure on Practice Nurses to do things because they want to keep the patient happy. This is not an isolated experience; it happens all the time. My students are constantly saying reception have booked this in, I have told them I can't do it and they have told me I have got to do it.'*

Students on the course do not have to complete University module evaluation. Emily gains feedback directly from the students

> *Emily: 'I have got this little yellow box, this goes with me to teaching sessions, take a photo, take a slip if you like. Sometimes I don't take it to everyone because I see the students so often. If it is a session that I have changed I will take it for feedback, but otherwise I definitely take it at my last session. They just post it in there, all anonymous. What we have said to our hierarchy, the module level feedback on another module I ran, I had one student actually fill it in out of 25 students. Every single student will fill something in on that. That is so much better for feedback, so much more valuable. It is at the time, it is relevant, not relying on them logging in to complete something. I photocopy all of those and keep them in a file. I can send you the last cohorts.'*

Course feedback is also collected at University level and this has encouraged and stimulated programme growth

> *Emily: 'We have a programme appraisal evaluation. So, every year we have to fill out an analysis of our programme and we have to highlight areas of good practice for dissemination. We have action point areas for the programme which need improving. I don't know if that is something every university has but it is part of our academic quality and I think, although it is a pain in the neck to do, it is actually a really useful exercise. It keeps the momentum of improvement going. So, every year I have to plan improvements for the next year. It is live documents, so it is reviewed every time we have a programme management board which I think is quarterly. So, every quarter we have to go into our appraisals to update them, see how we are getting on with our direction points and we have to rag rate as to how the developments are going. So, my co-creation then came out of that programme enhancement appraisal.'*

Emily suggests this is a positive annual process.

Competencies

The course curriculum is linked to the 2012 RCGP competencies.

Assessment

Assessments are varied so that students can achieve level 6 or 7 depending on whether they have previously achieved a degree.

Clinical portfolios are developed throughout the course and assessed by external mentors.

> *Emily: 'The portfolio is pass/fail, that is assessed by our external Practice Nurse trainer and it is against the competencies based on the RCGP framework.'*

There is one academic assessment covering the 60 credits which takes place in March (for September start students). The assessment is a clinical audit and weighted 30% for a presentation and 70% for an essay.

> *Emily: 'So we ask them to go into their practice and find an area of service which they are not performing in very well, conduct an audit, find out what their performance is and then we get them to engage the change methodologies and leadership, to talk about how they would implement a change. I am just doing student tutorials at the moment for that. We have some presentations coming up in a couple of weeks. So, they go through an audit cycle, some of them use NICE 2002 audit cycle, they present their findings, what they are going to change, they conduct force field analysis, they really get into the change methodologies. Then they write it up as an essay.'*

The presentation acts as a formative assessment allowing the students the opportunity to access feedback on their work like an essay plan. The presentations are conducted in a small room with Emily in a scenario designed to mimic a clinical meeting. The presentations are video recorded for quality and external moderation.

Success rates are variable. Any students struggling with the portfolio are supported to complete so over multiple cohorts there has only been one person who did not complete (and they were referred to NM and struck off). The majority of students pass the presentation but some struggle with the written work, especially if they are not experienced at academic writing and do not access tutorial support. 4/20 students failed the essay on first attempt in the last cohort, but all were supported to pass on resit.

They work on this project largely after the taught course ends and when they are back in practice. Some students are given time by the practice to complete this and others are not.

The assessment has changed since Emily started working on the course and the University implemented Universal Design for Learning 'UDL'. Previously there were two heavily theoretical essays. Emily feels the new assessment has direct benefits for the nurses in practice.

> *Emily: 'A lot of them do actually make the changes in practice which is really lovely... they do implement changes, so I think quite a lot of good comes out of it at service delivery level.'*

Mentoring

Practice mentors must be a Registered Practice Nurse with 3 years' experience and who is in the building with the trainee nurse for at least one day per week. On a rare occasion in a single-handed practice with no nurse, the GP can act as a mentor. The mentoring commitment is a minimum of 30 hours over the course. Practice mentors sign off the clinical portfolio with the student.

External mentoring is also provided by a network of experienced Practice Nurses affiliated to the University. Each student is provided with an additional 15 hours of support from a mentor external to their own practice. External mentors meet with the student at the start of the course to help action planning, at interim points to support portfolio development, and towards the end of the course as they conduct the final assessment with the student on their portfolio. The practice pays a £500 charge for the student to attend the course which is paid directly to the external mentor for their costs.

Emily believes the external mentoring role has benefits for both the student and the mentor.

> *Emily: 'It works so well because that person is objective. They are not working for the surgery, so they don't have all that objectivity. If the student is not getting on very well with their internal team, that external person offers an objective view and also support. The students thrive with that external support. They learn from each other which is brilliant. It is like a big community. The externals will go and say love the way you are doing that; I could do that in my practice.'*

The course currently employs 50 external mentors across the East Midlands. Some work part-time in practice and take up to 2 students. Their commitment is 15 hours to each student over 9 months. Usually the mentor has 5 visits of 3 hours, although this is flexible.

> *Emily: 'What we say is split the 15 hours as you need but most will split it into 5 x 3 hours. They will do initial interview, mid-point interview and end interview then they will go in in-between. They will sit and do clinics with them. Another thing that is useful, one of the competencies is ear irrigation, there is currently nobody in their practice who does it, the external can actually supervise that. We have had occasions where a surgery doesn't provide service and our student has gone to the externals surgery and done it there.'*

Mentors are invited to the University before the course begins for a 'train the trainer' event. It is a 2 day event for new trainers and a 1 day event for those who have held the role before.

> *Emily: 'Yes, so we have a train the trainer event, twice a year. One in September before September cohort and same in January. New trainers can come on that, they do 2 days where they will learn about education theory assessment, basics of assessment, not being prejudiced being objective, how to support the students. They learn about the programme, how it all works. Then on the 2nd day we invite current trainers back in. So, they come and share their knowledge and experience with the new trainer. We then give course updates and say this has been updated, changed etc., you need to sign here now so that our externals are constantly engaged. They love it because they can use that towards their CPD.'*

The programme has been running in this way since 2012 and has gained momentum in the General Practice nursing community.

> *Emily: 'I think because we have been running since 2012, they have got to know the programme. We have got so much returned business from certain places, because they have got trust in the programme and they know it works. People have got to know me; I am the Practice Nurse person, so I get the queries about practice nursing. But that is fine, it is just linking it all up.'*

Some students who were early completers of the *Fundamentals* course are now working as external mentors to new students.

Relationships

Emily has strong links across the east midlands with her network of general Practice Nurse trainers. Emily also works closely with training hubs and CCGs.

> *Emily: 'I have got 3 main offices, Leicester West, East and Central, they have nurses who are GPN or not sure of the title, GPN educators maybe, they have got some hours from the training hubs. They are all our external trainers as well. So, they work for us on our practice nursing programme… Our training hubs are key contacts for student undergrad placements and also they support our students by being external trainers.'*

Emily works closely with a Practice Nurse lead at Leicester CCG who meets with all practice educators regularly ensuring she maintains contact with the wider network.

GP contribution

Students need to be released from work for one day per week to attend the course but not all student experience is highlight variable and not all nurses are paid for their training time. There is variation in the time allowed for assignment preparation (clinical audit) and study days.

> *Emily: 'Because this is Thursdays, some surgeries will continue to give them a Thursday to do their project and that is brilliant. A lot of surgeries wont and they say right now you have finished your Thursdays we want you back in practice. For those that are only working part time it is really important they do that to get their competencies. If they are working 30 hours and they can afford to give them the Thursdays, we do find we get better projects. They have actually got the time to invest in it'*

Emily suggests that the course length is driven by the demands of General Practice

> *Emily: 'We have thought about how we can increase engagement, but the problem is practice are driving this, it is a vocational programme and they want them out in practice with the skill sets early on. So, we could lengthen these dates over the course of the programme but that wouldn't suit what practice want.'*

Emily suggests that retaining students for tutorials after the taught elements of the course has ended can also be problematic

> *Emily: 'The biggest pressure is time to attend for tutorials once the taught days are finished.'*

Emily suggests that GPs are not as supportive of education as they could be.

> *Emily: 'GPs are not very supportive in terms of nurse training on the whole. They just want the nurse up and running as quickly as possible to do the job.'*

She also suggests that Practice Managers expectations can be problematic.

> *Emily: 'Practice managers mostly rather than GPs, which is really where we have the issues because they are not clinical, they don't get it. You usually find when it is a GP you get a more sensible email. When it is from a practice manager it is 'I need this person trained in this' without a real understanding of what that means. It is not fair to the nurse to put that kind of pressure on them.'*

She understands that Practice Managers focus on the needs of the business over the needs of the student and their development which is a tension for the course.

> *Emily: 'I have had some quite interesting emails from practice where one practice manager was complaining that the cytology was too hard, and it was taking to long for the student to pass. We need to make it easier. I was like this is national guidance from Public Health England and actually as a woman, having the smear test done myself, I want to know the person doing it has been really well trained. I don't make any apologies for robust training and competency frameworks at all because I just think it gives us quality.'*

GPs do contribute financially to the course, each student attracting a charge of £500 for their practice. This money directly funds the external training role. However, on occasion they have been known to use this to penalise a student who leaves

> *Emily: 'My biggest bugbear is practices who make the student pay the £500 back if they leave. I have even now heard about a practice that took money off for all the days they had attended.'*

Emily says that at least one student leaves their practice each cohort due to an unsupportive working and learning environment in General Practice.

> *Emily: 'Lack of support at the practice. So, we have at least 1 every cohort who actually moves job within the course. Doesn't make any difference to us as long as the new practice are willing to support their studies. It is always lack of support in practice, being asked to do things that they don't feel competent to do. Yes, and the terms and conditions of pay as well, that upsets them as well. Bearing in mind these are all new to General Practice but there will be a student in the room on £20 an hour and one on £12 an hour.'*

Emily says that General Practice needs to learn to be supportive if they want to retain quality staff.

> *Emily: 'Some GPs are horrible employers. We find that those students leave. But a lot of them will say to me I just want this course and as soon as I have done it, I am off because this course is a passport to walk into any Practice Nurse job. Once you have got it and that is unfortunate. I did have an email from a practice manager saying they were losing faith in De Montfort's course; they have sent 3 nurses through it now and all 3 have left. But it was my fault. I sent back an email saying perhaps they should consider incentivising the staff to stay.'*

Cohort

The cohort size is 20 HEE funded places in both September and January totalling 40 per year. Students come from all across the East Midlands (Nottingham, Derby, Lincoln, Northants, and Leicester)

The course has no problem in recruiting and in July 2019 have 12 people registered for the course starting in September.

> *Emily: 'I can see the momentum really growing. In the early days people didn't know about the programme, sometimes we would struggle for numbers. Now, I am overwhelmed with people contacting me, saying they have heard about the programme, I want to come on it. I have also had a lot of interest from people who want to do the programme to get a job in practice nursing.'*

Retention is high with 1-2 people leaving the course deciding that they did not want to work in primary care.

> *Emily: 'We have had 1-2 students halfway through said practice nursing isn't for me and they have gone back to their previous employment which is usually secondary care. They didn't like the role. It is usually that autonomy that puts them off, they prefer to work with a much more structured environment.'*

Several students have completed further training including ANP or mentoring.

There are a large number of newly qualified nurses on the course and Emily feels there is an appetite for this development at a political and practice level.

> *Emily: 'There is quite a lot of work streams going on so we have got the 10 point plan which is trying to encourage more newly qualified nurses into General Practice as a 1st point destination career and I think lots of practices are now getting that message. That unless they start training up a new generation of Practice Nurses, something like 30% are going to retire in the next 5 years. So, they have realised, and they are starting to pull newly qualified nurses and they will put them on our programme.'*

Emily encourages any newly qualified nurses in General Practice to take the programme.

> *Emily: 'I say any newly qualified nurse who wants to do practice nursing, all of my colleagues now send them to me. I do my best to organise them a placement. I say go and apply for the jobs, even if the jobs are asking for experienced nurses, go and say I am willing to undertake the programme and within 9 months I will have a base line of skills and be able to do the role.'*

One of Emily's undergraduate student that she was a personal tutor for came straight onto the scheme after qualifying. While there was usually only 1 newly qualified nurse in the cohort in 2014 this has risen to 4-5 by 2019 (25% of cohort).

Emily feels that primary care is disadvantaged against secondary care in recruitment of nurses. There are 480 nurses qualifying pre-registration each year at De Montfort and 95% work in secondary care.

Emily suggests this is largely due to timescales, but this could be countered with earlier commissioning procedures.

> *Emily: 'I would like to see CCGs and Primary Care Networks as they are going to be, taking on recruitment responsibilities for newly qualified nurses. What frustrates me more than anything is that the big trusts recruit all of our newly qualified nurses a year before they even qualify. They are out there, doing recruitment fares, offering them all jobs, and they all have jobs to go to but General Practice is not there. So I would like to see the primary care networks coming in to the university and speaking to our undergraduates, saying we will commission 20 places each year for newly qualified nurses to come and do the programme and become a Practice Nurse in Nottingham and support the salary for the 1st nine months of the programme.'*

Emily suggests that nurses take roles in secondary care despite potentially being interested in worked in primary care.

> *Emily: 'A colleague friend from Market Harborough rang me to say they had decided to employ a newly qualified nurse into a Practice Nurse post and they had targeted the advert specifically at newly qualified nurse who wants to do practice nursing who is coming on the programme in September. She had 40 applicants and every applicant had already got a job with UHL, the Trust, but none of them wanted the job. They all wanted work in General Practice. Isn't that amazing? The sign is there, the opportunity isn't there. They can't get a foot in the door which has always been a problem. She said to me the calibre of students was amazing, if I had 10 jobs, I would have given 10 of them a job. It has been such a positive experience we will definitely do that again. It was the first time they had done it.'*

Emily suggests that collecting case studies and testimonies like the one above are likely to help to persuade other practices to employ newly qualified nurses. Emily feels the network created by the cohort is invaluable. They keep in touch during and after the course using a WhatsApp™ group.

Case Study - Bishop Grosseteste University (BGU)

Course Delivery Team

Denise Corn is the *Fundamentals* course lead and has worked as a nurse educator for the last 14 years. Denise had a career as a Registered Nurse, General Practice Nurse, District Nursing Specialty Trained and Diabetes Specialist Nurse. Denise is also the programme lead for the BA Health and Social care (full-time) undergraduate course and lead on the MA in Social Care Leadership and MSc in Primary Care as well as the PG Certificate in General Practice (*Fundamentals* course). Denise is currently writing up her doctoral thesis about General Practice nursing networks.

Dr. William Brown is the Head of School (Social Sciences) and has a background in health as a Biomedical Scientist. William's specialism is in blood test results and he has published academically in this field. William was previously Head of Department (Allied Health) at De Montfort University. His remit for BGU includes expanding their health provision. William has an interest in both interprofessional learning and remote and rural practice.

The Health and Social Care portfolio is new and developing within the new school of social sciences

> *William: 'It is probably worth putting health and social care in context of a new school that was specifically created 4 years ago. To bring together the exiting education part so we have got early childhood studies, the education and so on, but then to also link that into counselling, sport, psychology, health and social care with a view to doing that as the next suite of health care. Not in the semantic sense but in the cognate sense of it and then to develop that into further strands… Cradle to grave stuff, thinking about unpicking social determines of health and saying ok, on that scale, education is one of those, we have got an education bit on that scale is health, we have got a health bit so we are kind of looking across how we can have a faculty.'*

Course Delivery

The team won the tender to deliver the course in January 2019 and began to run from March 2019. The '*Fundamentals'* course fits with the MSc in Primary and Community Care which BGU had ready (already validated but not running).

The course is delivered over 9 months for one day per week on Wednesdays between March-and November (with a 6 week summer holiday). The 30 credit *Fundamentals* module runs throughout the 9 months, the blood module runs parallel first with long term conditions running September – November.

The current mode of delivery has been ad-hoc as the course is still under development and pilot. For example, the 'childhood immunisations' training that might otherwise appear early in the course, was unable to be delivered until towards the end of the month.

> *Denise: 'It hasn't been early loaded only because what you identified earlier, the fact that we were asked to put it on rather quickly, and the external provider that I preferred, that was the creditable one, couldn't do it until September time so we front loaded that before the flu season to make sure we get that done. The focus for front loading the priority is around cytology because of the duration of the*

> *programme and the fact that they need to be doing their smears and things. That actually became the most priority. Ideally when we look at the programme for next year and I know I have got people who are already interested, the Imms and Vacs will come earlier.'*

Lessons from the first year of delivery are planned to be implemented in the second round of delivering the programme

The course uses external trainers and where possible invites them in early to deliver training and at a later date to top-up student learning.

> *Denise: 'So, the people that have been involved, some of the guest speakers have come back to do some top ups. So, for example the respiratory nurse is coming back, she has done a bit with them so they are going to go back into practice and then bring that in so there is that connectivity. Really important to do that because one of the things that the girls have said is that they need to bridge that gap between theory and practice. The only way to do that is to keep coming back into the classroom to talk about that.'*

Practice mentors support portfolio development and students are visited for an intermediate tripartite Interview with Denise and their practice mentor. Denise visits most students in practice 3 times during the course, and also acts as their personal tutor which means any arising issues can be resolved quickly and confidentially.

> *Denise: 'So, I have got a connectivity so if there are any issues in practice that they don't want to evidence they can come and talk to me. I am aware there are a number of things going on with some students. Sometimes some of the things they don't want to broach in front of their employers. So, it is about having that personal tutorial support as well.'*

Course Content

The course is 60 credits at level 7 over 9 months and called the 'Postgraduate Certificate in General Practice Nursing. It comprises of 3 modules. The first 30 credit module is called '*Fundamentals'* and a further 2 x 15 credit modules are delivered in 'blood interpretation' and 'long term conditions.

The credits can directly link to the MSC in General Practice and students are encouraged to continue on this pathway which includes a module in minor illness. The MSc begins in February and already one *Fundamentals* student has registered to continue on this pathway. The MSc GP is an interdisciplinary scheme taking on a range of health professionals. Although BGU does not offer prescriber training, there is the opportunity to APL this into the course if taken elsewhere (for example Lincoln which is the nearest provider).

'*Fundamentals'* is a 30 credit module delivered throughout the 9 months course.

The second module relates to 'Blood test results' and runs from the start of the course until the summer break ending with an examination in July.

The final module is an 'Introduction to Long Term Conditions' which runs September – November.

Students complete the full mental health first aid (MHFA) training with the LPFT (Lincolnshire Partnership NHS Trust (LPFT Mental health service). This is also linked to the MSc in Mental Health.

The team feels it is important that the course offers education around resilience and working in the Primary Care environment and develops resilience and leaderships skills.

> *William – 'That is a key role of the university, is for students to go out and challenge stuff, talk about customer practice, evidence based. But I think in order to do that, you have to have the underpinning knowledge and the language used to be able to have that conversation with GPs and other people. To say why are we doing that? Not from a deficit position but from a position of I already know the answer, I want you to talk me through it again because I don't thinks it is right so that kind of nuance language of communication which some of these students, they have been on a journey as well around communication and their own confidence.'*
>
> *Denise- 'that is why communication is the first core competency.'*

The team feels that the course offers education over training which has significant advantage snot just for individual nurses but for workforce development in General Practice.

Assessment

The first module '*Fundamentals*' is assessed by portfolio with 2 elements – the first is a portfolio of competencies to be achieved in practice and the second is a written case study reflection.

The practice portfolio encourages student nurses to achieve 19 core competencies which are mapped to the RCGP competencies as well as QNI voluntary standards and RCN standards where possible. The practice mentor assesses the portfolio.

The case study reflection based on one patient is directly related to their practice

> *Denise: 'The case study is based on something, a patient, and that allows them to explore critically their own learning but also around evidence based practice, about impact in terms of patient care and how to effectively manage a patient.'*

Although the assessments are yet to take place, Denise is pleased with the work students are putting in to preparing for the *Fundamentals* case study assessment and its relevance for their practice.

> *Denise: 'I have done a lot of tutorials and tutorials for the case study; I have been really impressed with what people have done so far. In terms of the knowledge and the reading they have done, and their enthusiasm, looking at how from that knowledge base they can then influence practice. So, for me it is all about the patient at the end of the day.'*

The second module relating to blood tests is assessed by an exam. (The students are preparing to take the exam at the time of the visit July 2019)

The third modules about long term condition management is assessed by an academic poster.

Mentoring

Students are supported by a practice mentor who helps them to develop competencies and signs off the practice portfolio.

Students are also supported by an external academic mentor (Denise).

> *Denise: 'Partly it was to do with the fact that we were all quite quickly coming on board. But also, about having that external objectivity around the academic side of things. Because the students are in training practices, all the mentors that are assigned to them, they are mentors, they have gone through additional training for the NMC. They are obviously part of a training practice; they are enthusiastic so there is a lot of connectivity. I have been in and talked to the supervisors about their role, and they see that as being really beneficial because that is part and parcel of their revalidation, supporting the students within their own practice.'*

Relationships

Through Denise's work at the University she maintains contacts in Primary Care.

> *Denise: 'I have a lot of connectivity with the local environment, so I sit on the Practice Nurse Reference Group with Peter Edwards, I sit on the local LWAB, and I sit on the National Educator's Forum for General Practices.'*

Denise feels that BGU has strong links to practice

> *Denise: 'The USPs around our health and social care programme is that practice element and bridging that practice theory gap.'*

Through relationships with the LPFT the students are able to access full MHFA training

> *Denise: 'I work with LPFT so I just said, can you? They said bring it on so yes'*

Denise feels that partnerships and networks for GP nurses is vital to the growth of the workforce and had undertaken her own research in this field.

> *Denise: 'Talking about that peer support network and for me, that is something that is really important. My own research points that being a real deficit in practice. We started the Practice Nurse forums Peter and I and I think that has enhanced practice locally, spread the message out there, it is not just turn up, have your lunch and have a training session. There is that conversation about innovation, about leadership, about making practice better. I see this programme as being fundamental to that, improving the network and community of practice.'*

William suggests that the network should also include interdisciplinary contacts to benefit the wider General Practice workforce

> *William: I think that kind of network within general Practice Nurses is important and also the integration. Looking into the future of extended physiotherapy, pharmacy practitioners, medic practitioners, GPs with special interests so the whole sector, the whole environment is changing dramatically. It isn't going to be reversed… Physician's associates across the board. We have talked about integration and how they work with somebody from a pharmacy background, somebody from a physio background.*

GP contribution

Students need to be released from work for one day per week to attend the course but not all student experience is highlight variable and not all nurses are paid for their training time.

Cohort

There are 11 students on the course, 9 funded through the HEE scheme, one trainee also funded by HEE and a self-funded student. This has worked well as a pilot cohort size. William has a business case with the University to develop 30-50 places on the course, with the potential for multiple entry points.

> *William: 'So, in order to get approval, the university has a programme management group where viability documents have to go to it. So that is how many students are going to be on the course, what the staff capacity is, and how many extra staff we need. So that is fine. We have also spoken to HEE around if they want multiple entry points, and they want to send 30-50 students then the university would look to support that. So, we think 10 is a viable number as a pilot but should it be more than 10, then we feel we have got the infrastructure to deliver that. We would just need extra staff.'*

Since running the course, the team has seen an interest in future demand from nurses who want to move from secondary care.

> Denise: *'So, I have had a number that have actually said it is what I want to do, how do I get into it, I am at the hospital at the moment? Some of the advice I have given them is getting some bank work in General Practice so you have the connectivity but yes please do look at coming onto the programme because we need more general Practice Nurses because of the recruitment and retention issue.'*

Denise feels confident that a PGCert in GP offers a portable education and qualification which benefits workforce development.

> Denise: *'I am confident with these skills that they have got on this programme that they are going to be portable. That they can work within any General Practice and if you turn up with our PG cert in General Practice nursing, a practice is going to say yes. You are going to hit the ground running. You know you have got a credible high level of education and you can do that role.'*

Denise is keen once the course has run for the first time, to build a community from the course alumni

> *'Another thing I am going to do when they have finished the programme is to do some top up days, bring them in for peer review days and they can talk to each other as part of their alumni activity. So, we have some continuity because I am aware having taught the non-medical prescribing that there is a disconnect once people leave university and I would like to nurture that environment, in terms of having a Practice Nurse academic environment. Hopefully they will do MSc and maybe PhD who knows!'*

Conclusion

This section has showed some commonality amongst programmes but also levels of 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 PG Certificate equivalent. Each course runs for one day per week however there is huge variance in student experience as some students are paid by practice for this time, and others are not.

There is a generically agreed model of a minimum 9 months (although 12 months is generally agreed as required time to complete a portfolio of smear test, and this only if training in this area is front loaded to allow time for samples to be collected and processed by the lab.) There is agreement that core skills training (cervical cytology, immunisations and vacs, ear irrigation) need to be front loaded into programme delivery.

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 RCGP 2012 competencies, 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. 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 confidentially 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.

Competitor analysis – *Fundamentals*

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 using selective sampling and is limited to East Midlands areas not included in this study (Nottingham, Derby) and those appearing in a Google Search for '*Fundamentals* in General Practice'. The search gives the following top 16 results (first 2 pages)

The findings presented outlines advertised course provision by area in order to locate the *Fundamentals* course within the market for GPNE regionally and wider.

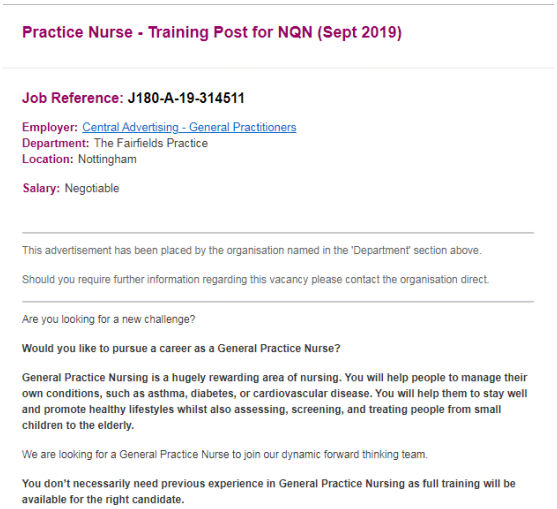
Nottingham

Nottinghamshire LMC advertises DMU course. There is evidence of engagement in this area through a job advertised in Nottingham 2019 which includes training on the DMU Course for September 2019.

https://www.jobs.nhs.uk/showvac/1/2/915664842

Historic provision in Nottingham includes a 2015 course (HEEM funded) offered by Education for Health.

https://www.educationforhealth.org/news/learners-bask-in-a-job-well-done-nottingham-city-ccg-practice-nurses/



Practice Nurse - Training Post for NQN (Sept 2019)

Job Reference: J180-A-19-314511

Employer: Central Advertising - General Practitioners
Department: The Fairfields Practice
Location: Nottingham

Salary: Negotiable

This advertisement has been placed by the organisation named in the 'Department' section above.

Should you require further information regarding this vacancy please contact the organisation direct.

Are you looking for a new challenge?

Would you like to pursue a career as a General Practice Nurse?

General Practice Nursing is a hugely rewarding area of nursing. You will help people to manage their own conditions, such as asthma, diabetes, or cardiovascular disease. You will help them to stay well and promote healthy lifestyles whilst also assessing, screening, and treating people from small children to the elderly.

We are looking for a General Practice Nurse to join our dynamic forward thinking team.

You don't necessarily need previous experience in General Practice Nursing as full training will be available for the right candidate.

https://www.educationforhealth.org/news/heem-funding/

https://www.magonlinelibrary.com/doi/abs/10.12968/pnur.2014.25.5.258

Education for Health link with University of Herts to offer a range of programmes including Postgraduate level courses. EFH also runs the JPN (Journal of Practice Nursing) https://www.journalofpracticenursing.co.uk/

PCDC (Primary Care Development Centre) based in Notts is a private broker of training courses provided by a range of training suppliers including:

- Access Apprenticeships
- Compact Learning
- Education for Health
- Healthcare Training Services
- Kraft HR
- M&K Update
- PCIG Consulting
- QACTI
- Sadlergate
- Vision Primary Care Training

Access Apprenticeships (Notts) – Level 3 Clinical Healthcare training (includes overlap with GPNE skills) https://www.atem.co.uk/uploads/3/0/8/7/30876269/clinical_healthcare_l3_pro.pdf

Compact Learning (Derby) - Rural training (NOT education) including workforce development for practices http://ruralpride.net/rural-pride-training/

Education for Health (as above) National clinical training e.g. 2 day spirometry to be added to the register, 3 study days, assessment to be organised independently £590. Most courses delivered out of Warwickshire https://store.educationforhealth.org/product?catalog=SPROME1912WA

Offers up to MSc/L7 level training (MSC Long Term conditions) including dissertation, research etc. accredited by University of Herts e.g. Frailty level 7 £625 single study day 15 credits https://store.educationforhealth.org/product?catalog=frailtyregint

Historically EFH was 'National Asthma Training Centre' now a private provider limited by shares based in Warwick. In 2019/20 delivered 291 courses to 3694 HCPs https://tinyurl.com/y2vsfs2b

Healthcare Training Services offers basic training courses including '2 hr Doctors surgery emergency procedures'' £220 or 1 day appointed person training for £360 https://www.firstaidhcts.co.uk/prices

Kraft HR – Personal training and consultancy in HR for General Practice http://www.khrconsulting.co.uk/managing-HR-in-general-practice.php

M&K Update (based in Keswick CA12) National or in-house clinical training e.g. Imms training 2 day course £290 https://www.mkupdate.co.uk/courses/immunisation_training/immunisation_training_for_nurses_and_ahps

PCIG Consulting – (based DY5) GDPR and Data collection training including support for mandatory NHS DS&P Toolkit submission - https://www.pcigconsulting.com/

QACTI – (Newark) Emergency and clinical training including 1 day ear irrigation http://www.qacti.co.uk/about/

Vision Primary Care Training (Based in S Derby delivering nationally) Provides practice training including GPNE Imms and Vacs 2 day course £420 https://www.visionpct.co.uk/courses.html

Derby

Fundamentals Course represented by Derby LMC https://www.derbyshirelmc.org.uk/generalpracticenursingprogrammeatdemontfortuniversity

University of Derby has a range of progression pathways for *Fundamentals* but no equivalent provision

https://www.derby.ac.uk/postgraduate/nursing-health-care-practice-courses/

MSc Community Practice includes General Practice and District Nursing (includes V100 and leadership. Targeting those 1-2 years post qualifying with work experience. £9250 per year

MSc Advanced Clinical Practice (Or various PGDips) 2 – 5 years 180 credits, £1000 per 20 credits

Derbyshire are active in Practice Nurse development, the LMC conducted a Practice Nurse project in 2017 and arising from this was the PNCF which is used nationally to identify Practice Nurse skills training needs.

https://www.derbyshirelmc.org.uk/thepracticenurseprojectcompetencyframeworkandcompetencydevelopmentplan

Worcestershire

Fundamentals at University of Worcester on offer in 2015 (no longer offered)

https://www2.worc.ac.uk/aqu/documents/BSc*Fundamentals*GeneralPracticeNursing.pdf

18 months 3 x 40 credits

Now offering MSC Advanced Clinical Practice or Public Health

'Introduction to General Practice Nursing' 3 day course on offer www.practicenursetraining.co.uk

Run by Jane Brown & Lisa Gardener GP Nurses (ex and current) frustrated that courses did not meet GP demand). Offers 2 day course £500 and 1 day's skills lab £250 RCN accredited as into to General Practice. Found through Google promoted Ads

Staffordshire University

Fundamentals https://www.shropshireccg.nhs.uk/media/2340/flyer-for-september-2019.pdf

1 year 1 day per week 60 credits uses PCNF Assessment is ONLY portfolio assessed

Private course cost is £3400, fully funded by HEWM (unless fail to meet conditions then charged)

https://www.staffs.ac.uk/assets/Fundamental%20of%20GPN%20April%20cohort%20Flyer%20new%20document%20for%20linking_tcm44-86642.pdf

Uses a contract

https://www.staffs.ac.uk/assets/V001%20Conditions%20of%20FGPN%20funded%20places_tcm44-86643.pdf

LJMU

Fundamentals level 6 20credits 1 semester £800 runs twice per year

1 weeks attendance then distance learning

Plymouth

3 modules x 20 credits = RCGP competencies

https://www.plymouth.ac.uk/about-us/university-structure/faculties/health-medicine-dentistry-human-sciences/cpd/clinical-skills-in-community-and-primary-care-degree-and-masters-level

Clinical skills in primary and community care

Integrated PC care in context

Integrated PC practice

Bournemouth

Full funded by Health education Wessex

Called Foundation not *Fundamentals*

9 months 40 credits

(Sept / Jan / May) (Portsmouth / Bournemouth / Winchester)

https://www.bournemouth.ac.uk/study/courses/foundations-general-practice-nursing-level-6-or-7-credits

BHIC Foundation (London)

https://bhcic.co.uk/wp-content/uploads/2018/09/HEE-London_GPN-Foundation-Programme-Guide-2018-19-_v18-300718.pdf

Calls *Fundamentals* equivalent courses 'Foundation'

'Foundation programmes are available from all seven Higher Education Institutes (HEIs) serving London. The programmes vary from HEI to HEI (Level 6/7, 20-60 credits) and last around 6 months. Foundation programmes broadly offer 'start up' skills based training for newly qualified nurses (NQNs) and/or new to employment in General Practice. At the end of the programme the nurse meets Level 5/6 competencies (HEE GPN framework) including cervical sampling, childhood immunisations and travel vaccinations and will be ready to work autonomously as part of the General Practice team.

Academic programmes (Level 6/7, 120 credits) are available from three HEIs in London and offer an academic GPN qualification in Primary Care. The programmes can be undertaken either part-time over 2 years or full-time in 1 year. The latter offers a 'fast track' progression in General Practice Nursing suited to newly qualified nurses looking to establish a career in General Practice. At the end of the programme the nurse will have achieved a Primary Care (Practice Nursing) BSc/ PgDip, meet Level 6/7 competencies (HEE GPN framework) and be working autonomously as part of the General Practice team.'

HEE funds the Foundations as follows:

HEE Activity and funding Costs of foundation programme/ GPN Administered by Community Education Provider Networks (CEPNs)

Tuition fees £2,000

Training grant £1,500

Mentoring cost £1,500

Total **£5,000**

The institutions offering 'Foundations' courses are:

- Buckinghamshire New University (Bucks)
- City University (City)
- Kingston University and St. George's, University of London (KSGuL)
- London South Bank University (LBSU) • University of Greenwich (UoG)
- University of Hertfordshire (Herts)
- University of West London (UWL) Buckinghamshire New University (Bucks)
- City University (City)
- Kingston University and St. George's, University of London (KSGuL)
- London South Bank University (LBSU)
- University of Greenwich (UoG) • University of Hertfordshire (Herts)
- University of West London (UWL)

Summary of providers and courses under this network is as follows

Education provider details	Course name	Course cost total/ per student	Course credit	Course start dates
Buckinghamshire New University (Bucks) **Course leader** Sian Hayes **Administrator** Wendy Diplock	Graduate Certificate GPN	£2,750	60 credits (Level 6)	September 2018 (High Wycombe) *and* February 2019 (High Wycombe/ Uxbridge)
City University (City) **Programme director** Marie C. Hill **Course officer** Carolina Melendez	Foundation Programme	£1,500	30 credits (Level 6/7)	10 September 2018
Kingston University and St. George's, University of London (KSGuL) **Module Leader** Joanne Powell	GPN Initial Preparation: Introduction to excellence	£1,600	30 credits (Level 6)	22 January 2019
London South Bank University (LBSU) **Senior Lecturer/ Course Director** Angie Hack/ Maxine Jameson	Introduction to GPN Programme	*£2,370	60 credits (Level 6/7)	**Induction:** 22 January 2019 **Course start:** 28 January 2019
University of Greenwich (UoG) **Course leader** Alice Neave	Fundamentals of General Practice Nursing	£1,185	30 credits (Level 6)	3 October 2018 (Cohort 1) 6 February 2019 (Cohort 2)
St. George's, University of London (KSGuL) **Module Leader** Joanne Powell	Preparation: Introduction to excellence		(Level 6)	
London South Bank University (LBSU) **Senior Lecturer/ Course Director** Angie Hack/ Maxine Jameson	Introduction to GPN Programme	*£2,370	60 credits (Level 6/7)	**Induction:** 22 January 2019 **Course start:** 28 January 2019
University of Greenwich (UoG) **Course leader** Alice Neave	Fundamentals of General Practice Nursing	£1,185	30 credits (Level 6)	3 October 2018 (Cohort 1) 6 February 2019 (Cohort 2)
University of Hertfordshire (Herts) **Programme Leader** Theresa Titchener	Nursing in general practice: foundation programme	£2,310 £1,360	30 credits (Level 6) 30 credits (Level 7)	October 2018 (Hatfield)
University of West London (UWL) **Further details** GPNursing@uwl.ac.uk	GPN Foundation Programme	£2,592	**20 credits (Level 6)	November 2018 March 2019

Within this model there is no expectation for GPNs to be paid for their working day whilst training. The funding grant is administered through a training grant from CEPN

Alternative post-registration training models

It is important to note that the above is a review of GPN training without localising the offer within the wider Primary Care training landscape. There are different models of training for the various clinical professionals within Primary Care and it may be useful to contextualise the provision for GPNs within the training provision for their colleagues.

Prior to qualification a Nurse studies a 3 year undergraduate degree, a Pharmacist studies a 4 or 5 year undergraduate degree and a Medical trainee studies a 5+ year clinical masters level degree.

Upon qualifying Doctors enter a period of 'Foundation' Doctor status where they undertake a further 2-3 years of specialty training in a chosen area where they are mentored and pass further exams before taking independent responsibility. For a Doctor training to work in General Practice the training is a 3 year specialty pathway which includes 18 months' work experience in a hospital or mental health setting followed by 18 months in General Practice supported by a mentor. GP mentors have to be qualified and experienced and often work in training practices. The qualification for GP specialty status on the RCGP register is a portfolio of achievement and competency achieved during training as well as a knowledge and clinical skills exam. Pay scales for foundation posts are fixed across the NHS in both primary and Secondary Care, and in some cases enhanced bursaries are available for GP training due to lack of entrants to this specialty.

Upon qualifying pharmacists enter a period of 'Pre-registration' pharmacist status where they undertake a further 1 year of training under supervisions where they are mentored in their chosen area – usually either hospital or community. Pharmacists in General Practice are a new role piloted in 2017 and new pathways for pre-registration training for GP Pharmacists is under development. In the meantime, the training pathway for conversion to a GP Pharmacist is administered by CPPE. It includes a range of training courses delivered both face to face and online over a period of one year and often includes the V300 prescribing provided by local Universities. In their first year GP Pharmacists have a mentor who helps them to achieve a portfolio of competency to achieve the CPPE course requirements. The achievement of GP Pharmacist status is not a registered specialty however the V300 confers qualified prescribing status. Pay scales for Pharmacists are not uniform and although there are recommended bands, there is huge variety in practice depending on the employing GP Practice.

Nurses complete 3 year undergraduate degree, however prior to the last decade nursing was a diploma level qualification and therefore the majority of experienced current nurses will have a diploma level qualification. Upon qualifying there are a wide variety of pathways for nurses to grow in specialist areas, but these are largely focused on Secondary Care.

There are a range of alternative clinical and allied health roles working in Primary Care. One example of this is paramedics working in Primary Care https://www.hee.nhs.uk/sites/default/files/documents/Paramedic%20Specialist%20in%20Primary%20and%20Urgent%20Care%20Core%20Capabilities%20Framework.pdf. It may be worth considering the wide range of work done by HEE and others around ways of training professionals in Primary Care roles in order to share learning.

Competitor analysis summary

There is evidence of a wide range of General Practice Nurse training offerings, some clearly targeting those new to practice.

The '*Fundamentals*' broad model is replicated across the country. Evidence from the London 'foundation' model shows both a national support for this type of pathway, but also that other areas similar struggle with standardisation and variation.

There is evidence of much shorter historic skills focused courses such as those in Worcester which make big claims about meeting the needs of practice whilst clearly being a profit making enterprise.

These models demonstrate the risk to the *Fundamentals* course from competitors who have much more piece meal offerings which exist as competitors in the same marketplace.

A brief economic analysis shows that the 'cost' to Primary Care of initial GPN training can be as a little as £800 with a claim to give the nurse enough knowledge to be 'up and running' in 3 days.

Some course staff claim benefits from evidencing the alternative cost of sourcing private training in all areas covered by the *Fundamentals* education.

Course provider	Content	Delivery	Other	Cost
Education for health (Herts/National)	Spirometry	3 days	Component of most *Fundamentals*	£590
Healthcare training services (Nottingham)	Emergency procedures in GP	2 hours	Included in many *Fundamentals* (not core)	£220
M&K Update (Nottingham)	Imms and Vacs	2 days	Core *Fundamentals*	£290
Vision Primary Care training (Nottingham)	Imms and Vacs	2 days	Core *Fundamentals*	£420
Practicenursetraining.co.uk (Worcester)	Intro to General Practice	3 days	Rival to *Fundamentals*	£750
Equip (Essex)	Practice Nurse Essential Skills	8 days	Rival to *Fundamentals*	£1500

Figure 6. Economic summary of GPN training courses sample table

However, this directly contradicts evidence from this work (and others) which suggests that trainees need a combination of support over time and a trajectory of learning in order to be able to practice independently safely. There is evidence that the investment of time to a HEE funded *Fundamentals* programme has more return than a financial investment on a shorter course which does not help the trainee to grow in skills and confidence or to develop a sense of worth.

There is also evidence of a range of alternative education pathways for other healthcare professionals including GPs and pharmacists which can be drawn on as examples of ways to train Primary Care professionals.

It is therefore evident that the benefits of education over training must be sold as part of a large scale culture change in Primary Care.

Conclusion

This section has shown that *Fundamentals* is one offering in 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.

The evidence from this research suggests that stakeholders uniformly agree the content and delivery structure of *Fundamentals*, as outlined by the working group and delivered by the majority of providers. UoH does not deliver this model.

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. Further all sites agree the course delivers learning beyond skills 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 best.

The evidence suggests variance from this model whilst appearing responsive 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.

Objective 2 – Course outcomes

Introduction

The Kirkpatrick (2006) 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.

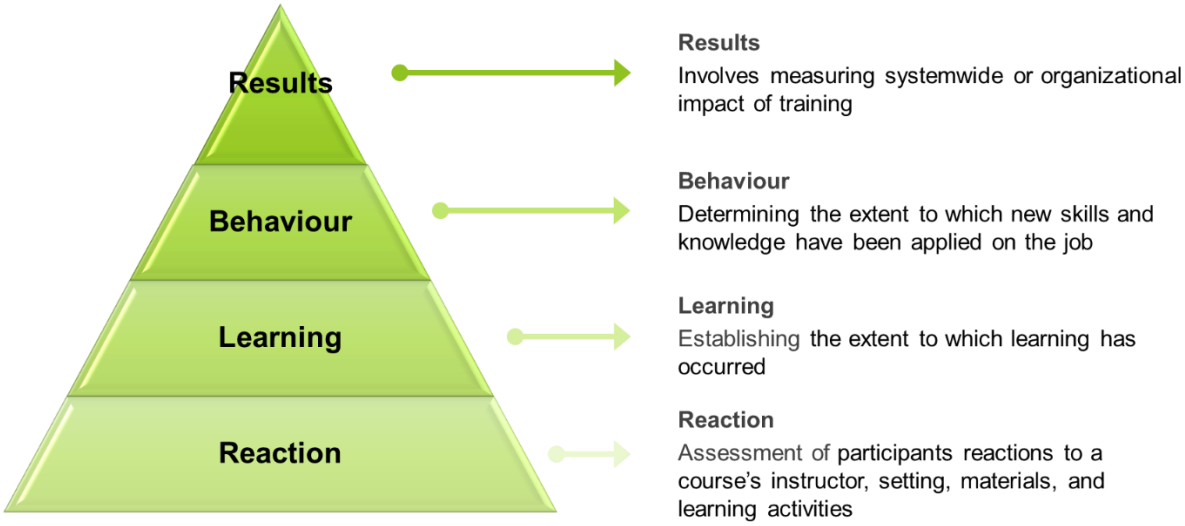


Figure 7. Kirkpatrick model of course evaluation taken from Rouse (2011)

Data collected for the evaluation was coded against this outcomes framework at one of the 4 levels. This section examines 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. Course leaders are all confident that student reaction to the course is positive.

> *'Students enjoy it! Students feedback really well about it, we work hard with the students in terms of, and our colleagues in practice, to try and have a programme that meets everybody's needs.'*

UoH Course Leader

This is further evidenced through in-house documentation provided as part of the course evaluation**.**

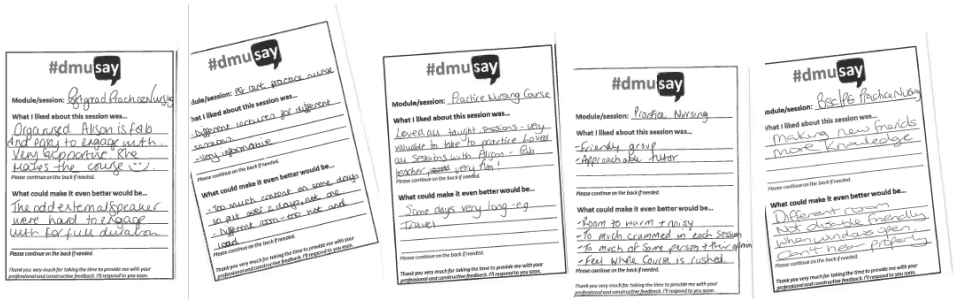


Figure 8 Sample data from DMU GPN Fundamentals student course evaluations

Most course leaders report specific issues with their course that students react negatively to and the way they try to resolve these issues.

> *'The only negative feedback I got from this session was about the critical analysis, they felt that they needed to be spoon fed about the critical analysis. Which is something I am going to be thinking about for Tri 1 because every time they say something to me, I do alter it for the next trimester.'*

ARU Course Leader

This 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.

> *'It is a bit standalone to them, but now, later in the programme, they get it.'*

Keele University Course Leader

Figure 9 summarises the differences between deep, surface and strategic learning strategies. Surface learning is short term and narrow and involves memorising information whereas by contrast deeper learning seeks to critically understand the subject. Strategic learning is where a student focuses only on the learning required to achieve course success and shows the importance of linking assessment to deep learning including evidence-based approaches. Deeper learning has longer term impacts and builds tacit skills such as confidence and leadership.

Type of Learning		
Deep Learning	**Surface learning**	**Strategic learning**
Actively seek to understand the subject	Try to learn in order to repeat what they have learnt	Intend to obtain high grades
Interact vigorously content	Memorise information needed for assessment	Organise their time and distribute their effort to maximise effect

Make use of evidence, inquiry and evaluation	Take a narrow view concentrating on detail	Ensure that the conditions and materials for studying are appropriate
Relate new ideas to previous knowledge	Fail to distinguish principles form examples	Use previous exam papers and assessments to predict questions
Tend to read around, going beyond the course requirements	Tend to stick closely to course requirements	Use marking criteria carefully
Motivated by interest	Are motivated by fear of failure	Motivated by grades

Figure 9: Summary of deep, surface and strategic learning strategies

Evidence from educational research suggests this is likely to be because critical thinking is evidence of deep learning which takes time to consolidate and understand.(Entwhistle 2000)

At DMU and BGU students reported the negative impact of any lateness to the key skills training offered since this did not allow them enough time to gain practice experience in skills, to a high enough level to complete the portfolio, and more importantly to work safely and independently in practice upon completion of the course. In this way, students' reactions to the course are closely linked to their perception of their changed behaviours (level 3) since they are so aware of the day to day demands of the job and the investment of their employer in their development.

Recruitment and retention can be considered a measure of reaction to a course. Recruitment to all courses is steady and all courses fully recruit despite a short period in which to do so. 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.

Whilst retention is steady at 90% across courses, a 10% loss is financially significant, especially in the event of upscaling course cohort size or intakes. It is therefore worth understanding causes of attrition in order to potentially consider measures to increase retention. The majority of course leads suggest that students leave the course not down to reasons related to the course, but those related to working in primary care. Negative reactions by students are largely related to practice issues, these are explored further in response to the next objective.

Building a network shows positive ongoing reaction to the institutions delivering the courses. At many sites positive reaction can be evidenced by ongoing involvement with the course by alumni

> *Researcher: 'Do students like this course?'*
>
> *ARU Course Leader: 'Yes I would say so. We actually have former students coming back to talk to the current cohort.'*

Level 2 Learning

This level of evaluation relates to knowledge and skills gain in students and how these map to the programme or 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. For example, the extent to which portfolios are used varies between as a record of observations, through to a fully reflective document. BCU encourages and rewards depth in their portfolio assessments

> *BCU Course lead: 'The portfolios are really good. One of the things about me going out was to try and encourage more robustness around that portfolio so rather than just ticking the box, we encourage them to write actual information about actual things that have been seen and the actual things they are competent in, in that moment. So obviously competency assessment is an at that moment thing but actually, if you have got that evidence, this and this has been covered, they are developing this this and this, that gives that document real robustness and evidence. We encourage them to put in other bits and bobs so one of them I have just had in was 91 pages long. That person had taken it to heart and there was all sorts of really interesting things. She had articles that she had written about, obviously read them and linked them to practice, quizzes, loads of stuff and that was such a robust document, you looked at that and you thought reading this I know what you know. If called to account for that, it is such robust evidence, so I really like the portfolio document, I think it is good. I think it links the theory to the practice really well.'*

	Portfolio as % of overall assessment	Portfolio marking	Portfolio depth
Anglia Ruskin	1 assessment + portfolio 50%	Practice mentors sign off competencies	Link to 2012 competencies
UoW	3 assessments + portfolio 25%	Practice mentors sign off competencies	Link to 2012 competencies
UoH (BLMK)	2 assessments + portfolio 33%	Practice mentors sign off competencies	Link to 2012 competencies
Keele	3 assessments + portfolio 25%	Practice mentors sign off competencies	Link to 2012 competencies
Birmingham City	3 assessments + portfolio 25%	Practice mentors sign off competencies Regular review meetings with mentors	Link to 2012 competencies
DMU	1 assessment + portfolio 50%	Practice mentors sign off competencies	Link to 2012 competencies
BGU	3 assessments + portfolio 25%	Practice mentors sign off competencies	19 core competencies Link to 2012 competencies and QNI

Table 3 Summary of portfolio assessment information

In some course's portfolios are signed off solely by a practice mentor who notes dates of observations. Students are expected to present reflective additional in-depth reflective evidence against competency criteria. In some courses all assessments are clearly linked to course competencies. Therefore, whilst there is a standardised skill level set by the competencies, the depth to which these competencies are achieved varies by course. Some course leaders feel that the course should offer a level of education beyond simple skills acquisition.

> *BCU Course Leader: 'I think the fact that we are actually getting Practice Nurses together and they are getting a rounded education rather than just skill based, I think it is the difference between training and education, they are now getting the education rather than just being trained to do a task.'*

	Assessments	Module 1	Module 2	Module 3
Anglia Ruskin	1 x 30 credit (30) 1 module 1 assessment + portfolio	Presentation (to lecturer) Linked to their role Relevant to practice		
UoW	3 x 20 credit (60) 3 modules 3 assessments + portfolio	Presentation (to Group) Linked to their role Relevant to practice	3000 word case study essay Linked to their role Relevant to practice & evidence based	Reflective writing based on personal clinical practice
UoH (BLMK)	2 x 15 credit (30) 2 modules 2 assessments + portfolio	Case study essay Linked to their role Relevant to practice	Health information poster students encouraged to display in practice	N/A
Keele	3 x 20 credit (60) 3 modules 3(4) assessment/s + portfolio	Oral presentation Oral exam (scenario: consultation questions) 50/50 split	3000 word essay (sub-optimal practice) Linked to their role Relevant to practice & evidence based	3000 word essay Reflective writing based on personal clinical practice
Birmingham City	3 x 20 credit (60) 3 modules 3 assessments + portfolio	Core skills Part portfolio 1000 word reflective essay based on consultation skills as well as three reflective pieces and a competency review	Part portfolio 3000 word essay on service change (based on one competency)	Long term conditions Portfolio 1000 word essay behavioural change in patients with a long term condition
UoW	3 x 20 credit (60) 3 modules 3 assessments + portfolio	Presentation (to Group) Linked to their role Relevant to practice	3000 word case study essay Linked to their role Relevant to practice & evidence based	Reflective writing based on personal clinical practice
DMU	1 x 60 credit (60) 1(2) assessment/s + portfolio	One academic assessment in March Clinical audit – 30% presentation (formative) + 70% essay (summative)		
BGU	1 x 30 credit 2 x 15 credit (60) 3(4) assessment/s + portfolio	Portfolio + case study reflection Linked to their role Relevant to practice	Blood results Exam	Long term conditions Poster

Table 4. Summary of full course assessment information

To measure knowledge, Universities use a range of assessment methods. Students are assessed in a range of ways across the course with wide variance and little commonality. For example, one course requires detailed academic essays, whilst another requires students to pass exams in blood results. Oral presentations are used at multiple sites, ranging from peer group presentations, individual one-to-one presentations and OSCE-style mini-group consultations. Each of these is defended by the institution as an appropriate method of measuring their learning objectives. At Keele an oral exam considers both communication, knowledge and confidence skills.

> *Keele Course Lead: 'That is a series of consultation questions. Patient arrives for their asthma review; they have been overusing their inhaler etc. how would you start the review for 5 marks? How would you assess asthma control? What would be the management plan you would devise for this patient?'*
>
> *Keele lecturer: 'I think they are very good. The oral questions do give people the chance to verbalise which often people don't put down very well on paper. I think the presentations are really good because it shows the students' knowledge and actually the students came up with other stuff that were really insightful and stuff we didn't think about in practice.'*
>
> *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.*
>
> *Learning is an ongoing journey and the Fundamentals course represents the initial step on a pathway. There is evidence on every course of students progressing into further learning pathways.*
>
> *'UoW Course Lead: One of them is actually going on to do advanced clinical practice, she has just passed her V300. They keep coming back to the Universities for courses'*

There are examples of standardisation in learning content across skills and measurement of these by portfolio. A variety of approaches measure knowledge in different ways, the most successful of these relating learning to localised current practice and using skills that nurses will need such as communication and confidence.

Level 3 Behaviour

Learning and behaviour are inextricably linked – there is little value of the new knowledge and skills attained if they do not result in a change in behaviour. Evaluation evidence at level 3 is therefore closely linked to level 2.

The learning of skills of the course 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.

> *UoW Lecturer: 'At least at the university we are giving them some clinical governance if you like, we are giving them some clinical supervision too really, but they are not necessarily getting that, certainly in the single handed practices where they are the only nurse on duty….. it is giving them another avenue to culminate support from''*

There is evidence from most courses that they teach student nurse's practical evidence-based practice approaches they can use in future practice

> *UoW course lead: 'We show them those shortcuts for them, don't we? We often signpost them to public health England's vaccine update for instance, and we ask them, part of your homework today is we've done theoretical underpinning for immunisation, one of your pieces of homework, is you register for public health England's vaccine update. So that comes into your inbox. It is as you are going along, and it is the same for us though.*

These basic changed behaviours encourage long-term attitudes towards evidence-based practice.

There is a close link between learning and behaviour as in this context students are aware that their behaviours have to change and are keen (and to a certain extent under pressure) to demonstrate increased abilities in practice. There is evidence that *Fundamentals* courses which clearly align learning objectives and assessments meet this need and there is evidence of speedy changes in behaviour which benefit practice

> *UoW Student: 'This brings it all together rather than going on a course 6 months ago then going on another course so many months after, I think it helps you progress and be able to be a Practice Nurse as fast as you can really.'*

There is evidence that changes in behaviour extend beyond changes in skills ability and into the domain of changes in values and attitudes. Students gain more form 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.

> *BCU Course Lead: 'For all its flaws and how it is developing, I think the fact that we are actually getting Practice Nurses together and they are getting a rounded education rather than just skill based, I think it is the difference between training*

and education, they are now getting the education rather than just being trained to do a task.'

BCU Lecturer: 'The best thing about it is that we are building local long term, highly educated, highly knowledgeable workforce that we really need and every single one is vital.'

BCU Course Lead: 'We do stress to them, it is about confidence leadership, the assertiveness, being able to challenge practice even though they are employed by the person they might be challenging. That is a real part that is probably not even articulated anywhere. You wouldn't know that unless you sat in on the course really.'

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.

Level 4 Results

Results of the *Fundamentals* course impact on patients, practices and workforce development.

It would be difficult to measure the impact of the *Fundamentals* scheme on patients directly, due to the myriad of other factors that impact on patient care and satisfaction. However, it is fair to assume that the benefit of additional staff working in the practice, will improve access to clinical care and therefore have an indirect benefit for patients. Further quantitative research would be required to evaluate the direct economic impact of the role – for example the number of additional patient appointments available in practices.

Benefits for practices relate to the return on investment they achieve from the course as an intervention. There is wide variation in the levels of mentoring, financial and time support offered by practices to nurses and wide variance in workforce attrition. Further evidence would be required to validate the hypothesis that those who invest in their workforce retain skilled workers longer.

The impact of the *Fundamentals* course on workforce development can be clearly identified. In the last 5 years over 250 skilled and trained work ready nurses have been trained to join Primary Care who otherwise might not have had an opportunity to do so.

It is interesting to note that in educational literature, an outcomes-based approach would begin to plan the outcomes required at level 4 and works backwards from the required outcomes to plan the learning that needs to take place. In this model of planning course aims and objectives arise from outcomes. There is evidence of an outcomes-based approach by the network of Universities in the North and East that originally formed the network and discussed a standardised approach

Data collected from practice and shared with the evaluation 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. There is however a clear tension between providing best education for the role and most cost-effective methods of developing the workforce and it is this tension that drives difference in experience for student nurses. It is therefore vital to acknowledge the role of the practice in contributing to the outcomes from the *Fundamentals* courses. Some practices who

maximise the investment in their *Fundamentals* nurse reap longer-term benefits, however this is always weighed against the risk to the business of investing in staff who may move on.

We have one of these GPN-ST trainee nurses going through the programme at the moment. The standards she has achieved through the GPN course have enabled us to now offer her permanent employment at the end of the course. In the past nurses coming into primary care for the first time have come at a significant training cost to Practices and this has perhaps been a major contributory reason as to why many Practices have been reluctant in the past to recruit anyone other than a nurse already trained as a Practice Nurse. 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 in Lincolnshire 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 yrs. 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.

Figure 10. Lincolnshire Practice Manager Testimonial

There is a clear need to develop the GP culture towards an investment in education model, especially since this is already in place for GPs and in many cases can be extended to include GPNs.

Conclusion

In conclusion, there is evidence that all courses contribute to learning at all levels of Kirkpatrick's' (2006) evaluation models.

There is variance in levels of learning from surface to deep across the courses. Strategic learning is where a student focuses only on the learning required to achieve course success and shows the importance of linking assessment to deep learning including evidence-based approaches. Deeper learning has longer term impacts and builds tacit skills such as confidence and leadership. Reaction to content is generally positive and where it is less so, this tends to be in areas that students appreciate the benefit of later – especially evidence-based practice. High levels of recruitment demonstrate a positive reaction to the course. While retention is 90% across most courses, this represents a financial loss that might warrant further investigation into methods to mitigate attrition. There is evidence of changes in behaviour across all learning domains including skills, values and attitudes. Some courses however focus on skills development whereas others focus on longer-term changes to develop confidence and leadership skills. There is variance in the learning by institution for example changes in behaviour are focused on surface level learning, change in skills behaviours and short-term development in shorter courses (such as UoH) whereas the longer courses (such as UoW, Keele and DMU) focus on deeper learning, changes in skills values and attitudes and longer term development. All sites have further courses for nurses to continue their learning and development and *Fundamentals* courses fit into a range of pathways, most of which include a route to Masters of Advanced Practice including prescribing, long term conditions or specialist disease pathways.

The *Fundamentals* course does link to results which positively impact on individuals, practices and patients.

An outcomes-based approach can facilitate standardisation. Where this approach is taken it is successful but requires the ongoing commitment of key individuals to sustain momentum. It is also requiring the buy-in of practices, as well as Universities, and this requires both strong relationships and cultural change.

Objective 3 – Link between Fundamentals as GPNE and outcomes

Outcomes Analysis

The outcome is learning as per the Kirkpatrick (2006) evaluation, initial positive reactions, changes in values, attitudes and behaviours and workforce development.

Data has been collected that can identify some specific ways in which impact is achieved through these learning outcomes.

There is evidence of the benefits of the educational experience afforded the *Fundamentals* courses that extends beyond the learning that can be categorised by Kirkpatrick's (2006) course evaluation framework and it is vital that these elements are not lost in a framework evaluation. This section of the report therefore details some of the key additional benefits of the education offered by the *Fundamentals* programme that extend beyond the learning that might be gained from training.

Community of Practice

The General Practice Nursing community can be considered a community of practice as a group who share cultural experiences and a shared aim. There is evidence across all courses that students gain significant benefits from being part of a learning community who benefit from the opportunity to discuss and consolidate learning and share learning experience with peers at the same stage of development.

Students benefit from learning from each other's shared experiences

> *Keele Lecturer: 'One of the first teaching sessions I did was with them on diabetes. I had prepared and prepared. But actually, it turned out to be a discussion. It was lovely because they had got the experience. Although they are very new to General Practice, they knew a bit about diabetes so it was more, what would you do.'*
>
> *Keele Admin: 'I think it is good that they are from different practices and they bring different perspectives in. '*

This is important to ensure that the learning is contextualised in the broader area of primary care than simply the local practice where the student nurse works.

> *UoW Course Lead 'The benefit of having a course, they have got one another to bounce ideas from and also hear what is being done in other practices'*
>
> *UoW Student 'We all talk, and we all say about our experiences, what we have done each week, what changes we have come across really.'*
>
> *ARU Course Lead: 'They get so much more as well, they get networking, interaction, this is going on in my practice'*
>
> *Keele Lecturer: 'I felt quite isolated at the beginning, I was entirely on my own. Just doing a course and then I would be off and up and running. You do feel quite vulnerable because you desperately want to protect your Pin, you also want to do*

> *your job, so you do feel a little bit vulnerable. I think also having other people do the course, so you have a bit of a buddy system. I do tend to find with these students they have quite a nice bond actually. I know the guy I work with in practice, he was in touch with a lot of people he did his course with.' Keele Lecturer*
>
> *BCU Course Lead: 'So things like the university days, it is never ever to the taught content, it is about the peer network, it is about the WhatsApp™ group. What shall I do about this? I have this patient with x or y, no-one knows what to do, what shall I do? It's that shared, that journey, walking that journey together and I think we are really involved in that. It is never us and them, we really feel like we are in it together.'*
>
> *DMU Course Lead: 'They get a comradeship; they get to network which is really important.'*

Entry to a community of practice is at the 'legitimate periphery of participation' and supported by both a range of more experienced peers. All courses recognise the benefits of the community of practice to the student nurses and actively facilitate opportunities for broad sharing of knowledge and experiences.

> *Keele Lecturer: 'They need support, absolutely, they need to be not left alone. They need a mentor in practice when they are starting off, they need a supportive team around them. Otherwise, unfortunately, General Practice can break people.'*

The community of practice and especially the support provided by the course enables students to navigate the complex employment system operated in primary care.

> *ARU Course Lead: 'If we do have somebody who comes along who say I have had a really awful time, my practice manager is going to re-write my contract, what should I do? We sit down, we discuss it, I wouldn't put up with that. Contact this person, and that gives them confidence.'*
>
> *UoH course lead: 'We sort of box it all together into Fundamentals about you are new into General Practice, this is what you are going to experience, some of the challenges that you have.'*
>
> *Keele CCG Nurse: 'the benefit of coming into a structured programme where they have got a) benefits of academics and that experience but also getting that peer network because that gives them real strength. Connecting with each other and realising that they are not on their own and actually they are experiencing the same things so what do they do about it as a group'*

Courses recognise the depth of support networks required by student nurses in General Practice.

> *Keele Lecturer: 'They need support, absolutely, they need to be not left alone. They need a mentor in practice when they are starting off, they need a supportive team around them. Otherwise, unfortunately, General Practice can break people.'*
>
> *Keele Course Lead: What the course is, this is why I stopped doing a lot of distant learning, the first cohort I did but I started to draw it back which I know is not the*

> *way education is going, but they need each other. They don't have any peer group at all so there is 12 of them sits in a room and they absolutely need each other. I say ok we are done, I am packing up, they are still sat here saying this happened to me, my manager said this etc. so they need each other. What they really miss about the course and they always say this after, I miss the group, I miss what we had on a weekly basis. It is a little bit of a safety net for them. Once it has gone and it is 5 days in practice, you don't get that back again.'*
>
> *BCU Lecturer: ''It isn't* just about the academic, it's about the support. I certainly spend a lot of time dealing with pr*oblems within the environment. I know that has been a massive help to you hasn't it? When you look at some of these situations these nurses are in, even now in 2019. We have a responsibility to those students that we care for and I certainly spend a lot of time dealing with that, trying to find guidance and trying to support people who are working in very difficult work situations.'*

The community of practice in local areas is actively growing as nurses pursue a pathway through general Practice Nurse education.

> *UoW Course Lead: 'From our first one, she was a previously qualified nurse when she came in, so she seems to have sped through. She is the one who has gone on to do the advanced clinical practice. She is a mentor at the moment for one of the Fundamentals I have got.'*

There is evidence that student need and benefit from the community of practice beyond the timing of the *Fundamentals* course.

All courses have a WhatsApp™ group which remains in use as a network after the course.

> *BCU Course Lead: 'my first cohort in April 2015 still keep in touch on WhatsApp™.'*
>
> *DMU Couse Lead: 'The first thing I do on day 1 is encourage them to set up a WhatsApp™ group. So that they have got peer support.'*

There is evidence that experienced nurses add value to the newly recruited nurses and there is a benefit to mixed cohorts

> ***Researcher: 'So is there a lot of peer discussion that goes on?'***
>
> *UoW Student: 'Yes there is and there is a lot of people who have got a lot of different experience really. There is a lot of people who have gone into practice that have only been qualified a couple of years and there are people who have been nursing for a little while, so it is quite a variety really.'*
>
> *Keele Course Lead: 'It works in here because there are a couple of mother hens and they are older nurses and there are a couple of newly qualified who are frightened to death of practice but have just finished their dissertation. Mother hen is helping them with the clinical work, they are helping mother hen with the assignment, the mix of demographic is ideal.'*

There is also evidence that students benefit from engaging with the wider community of GPNs.

> *Keele CCG Nurse: 'One of the really good elements in this course is there is a couple of lead GPNs that come in and do sessions with them. So, they get a real opportunity to talk about those things and recognise that that is part of, is cultural.'*

DMU suggests external mentors contribute to the growth of the community of practice and support network.

Interprofessional learning can also benefit the wider development of nurses beyond General Practice into the wider primary care domain

> *Keele Course Lead: 'When I booked frailty training, I booked it for the District Nurses and there are Practice Nurses on it together. I said to the frailty group separate Practice Nurse, District Nurse, Practice Nurse, District Nurse. So, they can talk about frailty together rather than in their own little cliques.'*

At several courses a final day acts as a 'transition' day using the benefits of the wider community of practice to support students into their new role

> *Keele Course Lead: 'I had a lady called J, she works with another university with Fundamentals, she is coming in and Georgina [CCG Nurse], a lady from Cheshire called T and we are doing a morning masterclass. So the final morning is you are done with me, you are finished, you have done everything you are meant to do, we have covered the fundamental skills but you are not going to get the opportunity again to be able to just ask anything you want of Practice Nurses. All these 3 are experts in the field, you have the morning.'*

Safety

There is evidence that the education afforded benefits over training in terms of practising safely.

Kim, course lecturer at BCU suggests that education provides a safety net for practice that training cannot offer.

Emily feel the course offers a network of learning to protect students from unsafe practice.

The course offers education around resilience and working in the Primary Care environment

> *BCU lecturer: 'Autonomous practice, getting to grips with that. Learning boundaries because you have lost your hierarchy so there is no matron, no chief of nursing who is going to tell you what to do. General Practice is very much about finding your own feet in terms of what is safe practice. Students really struggle with that especially newly qualified. Because they are so used to being told this is what you do and don't do, when they get to General Practice, they have got to think for themselves. Can I or can't I do it?'*

The course offers a safety net that students require in Primary Care.

> *Keele course lead: 'What they really miss about the course and they always say this after, I miss the group, I miss what we had on a weekly basis. It is a little bit of a safety net for them. Once it has gone and it is 5 days in practice, you don't get that back again.'*

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 since the course educators were qualified, however recently.

> *BCU Course Lead: 'There is definitely a different level of acceptance. Some of it is probably rooted in the sort of social history where nursing came from, traditionally they were hand maidens, they had to support the Doctors and I don't think you are going to lose that. I think until you start to see the newer Doctors coming through who have worked in very different relationships in hospitals, very much multi-disciplinary team relationships, where there seems to be far greater equality'*

General Practice in the UK is in a state of constant flux and understanding and adapting to this new cultural environment is a vital function of the *Fundamentals* course.

> *Keele CCG Nurse: 'I am doing a nursing workforce session and that is one of the things that is going to be on there. The Fundamentals programme is going to be on there as well. The Nursing Associate, things about that. Apprenticeships. Also, the changes about NMC standards, what is going on in terms of supervising then also linking in with the graduate training apprenticeship scheme that is happening in our STP area through one of the local colleges. So, it is all about trying to recognise this new workforce that we need to be supporting and growing our own'*

Universities use a range of approaches within *Fundamentals* courses to actively promote the growth of the community.

> *'Keele CCG Nurse: We have also put in the schedule this time in, we have called it a masterclass, but basically it is an opportunity for myself, lead nurses from Cheshire who has had students on the Fundamentals programme, the training hub Nurse Facilitator and a Lead Nurse who also supports some of the course delivery, an opportunity for them to ask us questions and us to ask them questions.'*

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 staff involved with delivering the *Fundamentals* course recognise the benefits of the course on workforce development.

DMU Course Lead suggests that primary and secondary care compete for staff.

> *DMU Course Lead: 'I think GPs have got to get more newly qualified nurses up and ready with the foundational skills as quick as possible and get them out there to replenish the workforce. Because otherwise there won't be a workforce'*

The *Fundamentals* course offers a new alternative to the standard entry from qualification into secondary care.

The *Fundamentals* course offer encourages new nurses into Primary Care which has benefits for availability of staff.

> *DMU Course Lead: 'I think it is having a big impact, I think it is giving practices the confidence to train nurses who have not done practice nursing before rather than just poach off each other.'*

UoW staff suggest that the gap in workforce development which *Fundamentals* seeks to fill is impossible to measure due to constant change in the workforce.

> *UoW Course Lead 'it is a leaky bucket because when you do talk to the nurses, we have had nurses on the programme who have said my mentor is retiring at the end of year, what do I do then?'*

> *UoW Lecturer: 'Within my CCG role I am trying to persuade the CCG to look at a retire and return scheme, specifically really for those mentors that are going to retire to help them to perhaps stay and do maybe a day or two a week or even just a session or two a week. Just to support the newbies.'*

A student on the UoW course is mindful of changes in her own practice and the need for development to fill workforce gaps.

> *UoW Student: 'The nurse practitioner is going to retire shortly which then obviously leaves an open space. Is somebody new going to come in or is it going to be one of us? I think you need your prescribing really before you start doing that.'*

Mentors benefit from their role in the community of practice and that has a positive impact on developing the community of practice.

> *UoH Course Lead: 'I suppose it is their own development, developing the workforce of the future. They all recognise that they can't recruit to General Practice, so I think that is what they are getting at, any extra money and time, it is about investing it in themselves.'*

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.

> *UoH Course Lead: 'There is definitely a shortage. I know some surgeries struggle to recruit which is what we say if they could even work as a collaborative workforce, if you got more nurses in, those that are doing well, you train them and they stay and then you have got a workforce. But because they work in silos, if they are ok, they are ok, they have got their nurse, they are not interested.'*

> *Keele CCG Nurse: 'We have seen the nurses who have done the Fundamentals, who then straight away want to step on to masters, they want to extend this that and the other so I think that in whole the education in general just brings out so much more in terms of confidence etc. But there is a real lack of appreciation for*

> *that from GPs. Because the GPs still, a lot of them, think very much just in terms of the skills that they need their nurses to do within practice.'*

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.

> *Keele CCG Nurse: 'They have got to be in it for the long-term gain and we know from all the surveys, whether it be QNI, whether it be……that nurses feel better valued if they know they have been supported in terms of their education and training and ultimately they can deliver it as well. And that is what they all want to do, and they are far more likely to stay in practice if that is the way they are treated and that is the way they are viewed. If the practice actually thinks of it as a long term career pathway, the nurses that we have seen, because each cohort we have had nurses move practice.'*

Slow rate of adapting to change in the Primary Care workforce and narrow locally focused strategies are represent some of the initial practice barriers evidence in the project.

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

Lack of financial / time support from practice for education

On every course there is evidence of variation in the financial and / or time support given by practices to student nurses.

> *DMU Lecturer: 'Bearing in mind these are all new to General Practice but there will be a student in the room on £20 an hour and one on £12 an hour.'*

Some students are given paid time off work to attend University and others are expected to attend in their own time.

> *UoW Course Lead: 'certainly the students on this course, there is a small number of them who are not being paid to attend, they are having to do it in their own time'*

> *ARU Course Lead: 'Some of them make them come in on their day off, some of them will pay them if they are generous'*

There is evidence that some GPs are so reluctant to give additional time for education over training that they buy in skills training

UoW Lecturer: 'That is why some of the practices, from a facilitator role, they won't send their nurses and that has been a problem. They have funded them to just do the cervical cytology training and the Imms training and they have said that is fine thank you.

UoW Course Lead: 'Because they feel it is too big a cost for them to send them on this.'

There is evidence of nurses self-funding part or all of the course costs and time in order to break into Primary Care.

There is evidence of wide variation in GP response to the initiative.

UoW Lecturer: 'When I was in the Nurse Facilitator role I went to the LMC, the Local Medical Council, and did a presentation on what the Fundamentals would offer and about how they could employ newly qualified nurses and how they could educate and train them. There was a lot of GP's sat there, arms folded trying to really not engage and really seem disinterested and then you would get some on the other side who were younger, more motivated, could see the benefit of having a newly qualified nurse and moulding them and helping with their development. So, there is still a lot of variation out there really.'

'Keele course admin: I think there are some practices that are just not as supportive as others.'

Variation in salary, reward and support between practices

The course offers an opportunity for students to contextualise their own employment experience in the broader context of primary care.

UoW student: 'It is quite interesting how different GPs treat different nurses.'

UoH Course Lead: 'Terms and conditions of employment are different in every GP. Some get maternity leave, some don't. You could have 2 nurses in the same GP practice, doing the same job, but getting different salaries.'

BCU Course Lead: 'They are agreeing to give them the time off to attend university, that doesn't always happen. They sometimes have to do it in their days off…. about a third of them will have a day off.'

BCU Course Lecturer: 'We have all sorts of issues around sickness, as in no sick pay, no ongoing support in terms of occupational health, those kinds of issues.'

BCU Course Lead: 'The other thing we have is about employers wanting them to sign contracts about staying for so long after the course or pay back the money if they don't pass.'

DMU Course lead: 'It can be negative sometimes as in when they start to talk about pay, that can be quite morally destructive for some of them. Hopefully it empowers some to go back and say why I am only getting £10 an hour when my colleague is getting £15 an hour.'

The impact of this can be movement in the workforce during, as well as immediately after, the course and there is evidence of students moving their practice mid-course at several sites.

There is evidence that moving practice can be both disruptive but beneficial for the student, however the variation in experience can also support the argument foe 'training practice' initiative.

> *'Keele CCG Nurse: I think the ones that we have supported to move, have then stayed in their practices and some of them have really gone on to thrive in the right setting but, that is why I can see the argument for having these advanced training practices where they receive all that training and the safe environment where you know everybody wants to work in that way and they are all buying in to the concept. '*

Lack of understanding of or support for training role

There is evidence on all courses that staff in the practice do not always understand the role and abilities or need for support for general Practice Nurses

> *Keele admin: 'I think the course itself works, I think the difficulty that we face is more from the perception of practices that they don't necessarily realise or appreciate that it is a course that is run from September to June and attendance is required. And the students need to be given that time to simulate that knowledge and work on their skills. We have had students who have left the course because of lack of support.'*

> *DMU Course Lead: 'GPs are not very supportive in terms of nurse training on the whole. They just want the nurse up and running as quickly as possible to do the job.'*

Keele CCG nurse worked actively with practices in order for them to understand the role and their commitment to it

> *Keele CCG Nurse: 'It was very much around getting practices to understand this is a commitment, so if you find the person you think that would be somebody who would fit within your team, you know that they will have had the training over the 12 months and at the end of 12 months, you think yes we want to keep this person, you can. But if you don't want to, there isn't an obligation that you have got to. But they did have to be in a position to support newly qualified, that they had got a mentor. Then we have also linked them in because they are on the Fundamentals programme, we have the support of the nurses facilitated through the training hub, you also have the support of me if things aren't going particularly well within practice.'*

It is suggested the student success can be completely dependent on their practice site

> *BCU Course Lead: 'It is not always within the students control because if they haven't got the right mentorship, the right equipment, and the employers' expectations of what they do on the course and how quickly they…, it is unrealistic and it is not fair.'*

There is evidence from all course staff that GPs are committed to skills over education because of the tension between development and practice needs.

> *Keele Course Lead: 'General Practices don't want to let them out, they would rather do their own training, go on this and then start it tomorrow. They don't want to release them a day a week. In their minds they haven't got the capacity. They don't invest in the time for the education of the Practice Nurses. They want them to come in and run with our systems and how quickly can you do this. They don't invest in it and they don't get it. They will say to me can't you bring all the skills up front very quickly. Well if I do do that, one they might pull them because they have got what they wanted, two, where is the sort of retention of learning. If you do vacs and imms, we want you to do this, read a little bit more about that, have a bit of a practice, start to watch someone doing it. So, it is building on the learning a little bit. If we suddenly bring in smears next week, you have not really had the chance to take in that vacs and imms. So, space out the practical skills. But the practices are like what are they doing next week then if they are not doing something that is useful to me? Well they are doing something that is theoretical, I am sorry, but this is an academic course.'*

Lack of time for mentoring

There is significant evidence of students being prevented from having timely access to mentoring in order to link their theoretical learning in practice.

> *Keele CCG Nurse: 'Sometimes you can be supported to go and do the education but you are not being supported in terms of putting it into practice and having opportunities to use that learning for the benefit of patients and that is quite challenging.'*

Course leads are mindful of the need for the opportunity for the University theoretical learning to link with practice learning opportunities.

> *Keele CCG Nurse: 'I think sometimes it has been very much around the actual access to the clinical role itself. So for example, on the programme they will get vaccination and immunisation training, they get all the theory, then the way it should work they go back into practice and have supervised time with the mentor or somebody else within the practice who is equipped if their mentor is unavailable. So that they can build up that confidence and then get signed off. But the reality sometimes of accessing time to do that can be really difficult for some of them. Sometimes it can be sickness or nothing you could have foreseen, so in some of those occasions when I was doing the post I would go in and I would do some of those supervised clinics with them and that is really helpful. But you can imagine if you ended up with 10 on the programme who all ended up with mentors that weren't that sort of great, then a day a week, you would have much support to do that.'*

There is evidenced that some practices do not recognise or plan for supervised practice time.

> *Keele CCG Nurse: 'I think there is a lot in that supervised practical education time and I think that practices just don't acknowledge what their commitment is because they are being gifted funding for the training which they will snap your hand off for.'*

> *Keele course lead: 'I think what they find difficult is to get the mentorship support out there. When I say right now follow it up with your mentor, they say [A], you are being idealistic. I can't get time with them; I can't get them to shadow me or me shadow them. That is hard sometimes. When they stay behind, can I have a word, it is never about the course, it is about practice.'*

There is a suggestion that training practices recognise the development of other professionals in General Practice above the needs of nurses.

> *Keele CCG Nurse: 'We have got training practices as such which makes me laugh because training practice means everybody other than nurses, so the Medics, GP Registrars, Physician Associates and Clinical Pharmacists, but then don't necessarily take student nurses or Fundamentals.'*

A lack of mentoring opportunity limits the amount of learning that the student can potentially achieve. This fits with long standing models of pedagogy including Vygotsky's zone of proximal development which suggests that students achieve more of their potential when their learning is scaffolded.

> *DMU Course Lead: 'The worst things for me are the lack of practice support. So, it is the student who is all enthusiastic, wants to learn, and you see them actually get knocked down in practice. I see them get disheartened, they cry, they come to tutorials in tears, they are having an awful time in practice and it is all around lack of support. Practice just wanting them to work rather than seeing the educational needs of the student. That is the worst thing about this programme.'*

The need for resilience

A key difference between nursing in Primary and Secondary Care is working alone and needing to be resilient.

> *BCU Course Lead: 'Let's not forget they are isolated, it is not like they are going into big departments where there are 10 nurses, most of these guys, there are 1 or 2 of them.'*

> *BCU Lecturer: 'I have had 2-3 nurses who when they have had problems in their practices, they have emailed 'I have had a terrible day, this has happened. Yes, somebody may say that there has been a bit of bullying in my practice, it's the GP's being a bit horrible about this and that, then they will sit down and chat about it and they will ask our advice.'*

Localised needs over workforce needs

There is a need to sell the benefits of the course to General Practice.

> *Keele CCG Nurse: What I found with GP's is that you have pretty much got to go with that business case, you have got to go in with that idea that it will work for you'*

Practice Managers in particular focus on localised needs and in doing so can overlook the benefits of education over training

> *ARU Course Leader: 'Funding, they don't want to pay out, they are worried about them going off and paying for the day, paying for the course. They don't understand they need to be upskilled for them to be really effective. I think they are worried about skilling them and then them going off because they are valuable property. What they should be looking at is how they can retain them, how they can make their life better, but I can't quite get that across.'*
>
> *ARU Course Lead: 'Here have been Practice Managers who want me to take health care assistants and I have said no they need to be trained nurses. They need some nursing background.'*
>
> *Keele Course Lead: 'A couple of nurses have said to me my Practice Manager thinks your course is too academic.'*
>
> *Keele Lecturer: 'The trouble is you are trying to balance the opinion and the needs of the employer of the service of the cost of all the rest of the things, patients care and let's not forget there is a patient on the end of every single one of those first few injections and that kind of stuff.'*

UoH concedes to acting under pressure from GPs to limit the amount of education delivered for *Fundamentals*

> *UoH Course Lead: 'It is driven by the GP's rather than what we think the education should be... Because each one has their own needs to be met, that is what we are finding. There was quite a lot of input in to General Practice Nurse training but we are finding now, the interest is going down because it is not…..GP's don't want the nurses educated, they want them to be able to go out and do a skill or a minor illness, they don't care if they have got a research module or a leadership module, they want to be able to run a clinic. That is probably the crux. They will throw money at it but if the GP's say what do they want research for, we don't want leaders, we want somebody who can run a clinic.'*

It is suggested that while the General Practice business model remains intrinsically-focused the benefits of any initiative will be limited

> *UoH Course Lead: 'So, you won't ever change it until you get General Practice Nurses under one umbrella, managed by one organisation, and not managed by independent GP's. Nothing is going to change.'*

UoW Lecturer: 'We need to get a bigger nursing voice in the Primary Care world and that is not easy because they do seem to be very dominated at the moment by the Medics. But you see that is General Practice isn't it?'

Conclusion

The results show there is a clear link between commitment and outcomes. The key to delivering quality outcomes is developing relationships and ensuring you engage with general practice to understand the outcomes they need and share the benefits of the education that can be offered

Keele CCG Nurse: 'I think I would probably go out to have some sort of facilitated workshop with GPs and Practice Managers and the HEI's because I recognise now that if I was running a business, then obviously my views would be very different than just looking at it from a nursing and patient point of view. That there probably is still an element of compromise that can be reached. That doesn't mean that the content or the qualities has got to suffer as a result of it, but there is an element of better collaboration I think that could be made.

Keele CCG Nurse: 'But there is no contractual obligation that they have to sign to, and I think that is a bit of a loophole. I did flag that with HEE when I first started doing it because practices will take what is on offer, but they don't see that they have actually got any responsibility.'

Fundamentals Conclusion

This first half of the report has presented an in-depth examination of the HEE *Fundamentals* courses and outlined the important affordances, constraints and outcomes associated with the course.

We have presented a case study of each site and showed a wide range of GPNE models of delivery for the *Fundamentals* course. There are areas of commonality and agreement but also levels of variance largely attributed to the demands of General Practice and the competitive marketplace. 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 PG Certificate equivalent. Each course runs for one day per week however there is huge variance in student experience as some students are paid by practice for this time, and others are not.

There is a generally agreed model of a minimum 9 months (although 12 months is needed to complete a portfolio of smear tests, and only if training in this area is front loaded to allow time for samples to be collected and processed by the lab.) There is agreement that core skills training (cervical cytology, immunisations and vacs, ear irrigation) need to be front loaded into programmes.

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 RCGP 2012 competencies, 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. 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.

The second section of the *Fundamentals* evaluation considered the data mapped against the Kirkpatrick (2006) model of course evaluation to highlight the various levels of learning on the schemes. There is evidence that all courses contribute to learning at all levels of Kirkpatrick's' (2006) evaluation models.

Reaction to content is generally positive and where it is less so, this tends to be in areas that students appreciate the benefit of later – especially evidence-based practice. There is evidence of changes in behaviour across all learning domains including skills, values and attitudes. Some courses however focus on skills development whereas others focus on longer-term changes to develop confidence and leadership skills. There is variance in the learning by institution for example changes in behaviour are focused on surface level learning, change in skills behaviours and short-term development in shorter courses (such as UoH) whereas the longer courses (such as UoW, Keele and DMU) focus on deeper learning, changes in skills values and attitudes and longer term development. All sites have further courses for nurses to continue their learning and development and *Fundamentals* courses fit into a range of pathways, most of which include a route to Masters or Advanced Practice including prescribing, long term conditions or specialist disease pathways.

The *Fundamentals* course does link to results which positively impact on individuals, practices and patients.

An outcomes-based approach can facilitate standardisation. Where this approach is taken it is successful but requires the ongoing commitment of key individuals to sustain momentum. It is also requiring the buy-in of practices, as well as Universities, and this requires both strong relationships and cultural change.

The final section of these results evaluated the link between GPNE models and outcomes and show there is a clear link between commitment and outcomes. The key to delivering quality outcomes is developing relationships and ensuring you engage with General Practice to understand the outcomes they need and share the benefits of the education that can be offered

The findings lead to the following recommendations:

- A standardised model of *Fundamentals* course
- *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 cheaper alternatives
- Pathways should be developed and shared
- Partnerships with other key stakeholders are important and time should be allowed to nurture these and participate in important local networks as many already do
- Practice mentoring should be supported through pastoral care at university and any issues arising shared with project management
- External mentoring is important part of course, range of model may be implemented
- Universities can regulate and educate mentors to develop the broader community
- Shared commitment towards building a community of practice - *Fundamentals* should support trainees to engage with wider network of GPN

The following quotation summarises the importance of the *Fundamentals* course and the role it plays in General Practice Nurse education.

Course Lead BCU: 'I think the fact that we are actually getting Practice Nurses together and they are getting a rounded education rather than just skill based, I think it is the difference between training and education, they are now getting the education rather than just being trained to do a task.'

Course Lecturer BCU: 'The best thing about it is that we are building local long term, highly educated, highly knowledgeable workforce that we really need and every single one is vital.'

Course Lead BCU: 'We do stress to them, it is about confidence, leadership, the assertiveness, being able to challenge practice even though they are employed by the person they might be challenging. That is a real part that is probably not even articulated anywhere. You wouldn't know that unless you sat in on the course really.'

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. The following diagram represents the locations of hosting CCGs, Federation sites and Universities involved in the GPN-ST scheme.

Figure 11. Location of GPN-ST pilot delivery sites 1-3 (HEE Midlands and North)

The following data excerpt from evaluation documentation provides a useful introduction to the scheme from the perspectives of the programme managers.

The traditional model of nurse training resides with an individual employer and the responsibility for recruiting and establishing new GPNs rests with a relatively small practice team. Usually this team has limited infrastructure, staff and training expertise, hence General Practice vacancies are prioritised, by most practices, for nurses with GPN experience. Entry into General Practice is therefore limited to new nurses. The re-cycling and poaching of nurses from other practices is hindering the supply of new nurses. To compound this, experienced GPNs are in relative short supply and is being exacerbated by an ageing workforce (Queen's Nursing Institute, 2015). In comparison, the training capacity of large acute trusts offer nurse development opportunities, structured learning, clinical educator support, security and diverse career prospects.

Financial Primary Care pressures, increasing competition to recruit a reducing nurse supply and an ageing GPN workforce dictate that consideration needs to be paid to how GPN education is managed in the future. The expectation that all General Practices can support the training of their future GPNs whilst also expecting that GPN to immediately contribute to service delivery, with no capacity to 'overlap' between outgoing and incoming nurses, is an unrealistic future expectation but has previously been dismissed as "too difficult to tackle".

The purpose of the GPN Ten Point Plan is to ensure a reliable and sustainable supply of suitably trained GPNs but innovatively, it encourages non-reliance on traditional solutions and provides an opportunity to tackle a long-standing problem with relatively small amount of funding.

Without a pipeline of new GPNs, many of the actions within the Ten Point Plan will be redundant. 'GPN Specialty training' offers a 'way in' to General Practice nursing for both newly qualified nurses and those wanting to make the transition from other nursing fields.

Stakeholder Feedback

Results – GPN-ST

This second results chapter presents an introduction to the Specialty Training route. There is a case study of each site presented underpinned by thick descriptive qualitative data to illustrate how the course is operationalised at each site.

Background

The aims of the scheme are identified by project management stakeholder documentary data.

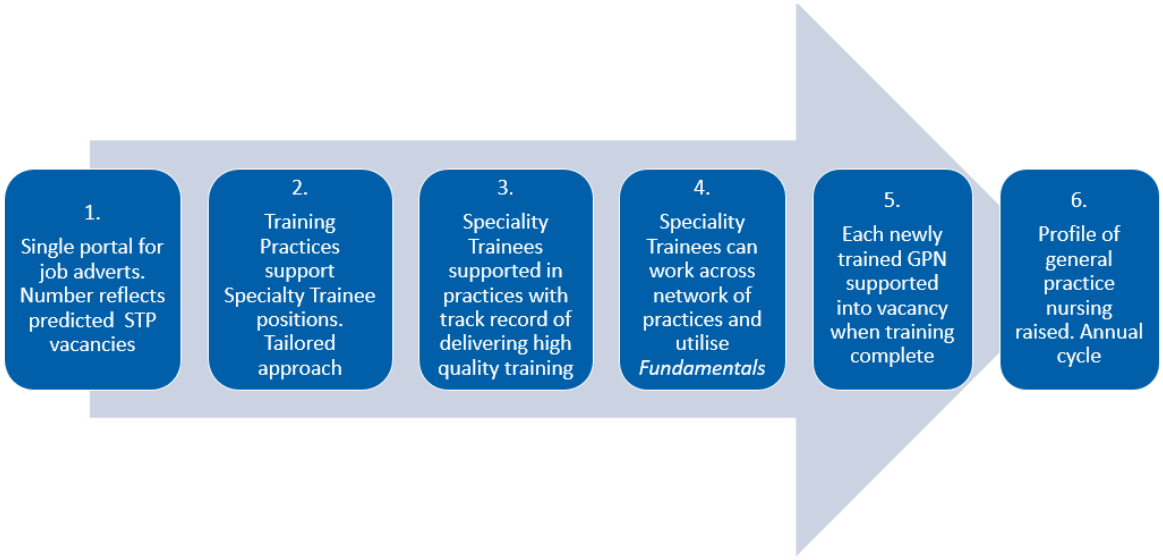


Figure 12. Aims from Stakeholder evaluation evidence

This data gives a useful introduction to the needs that specialty training offer seeks to meet.

> *'The traditional model of nurse training resides with an individual employer and the responsibility for recruiting and establishing new GPNs rests with a relatively small practice team. Usually this team has limited infrastructure, staff and training expertise, hence General Practice vacancies are prioritised, by most practices, for nurses with GPN experience. Entry into General Practice is therefore limited to new nurses. The recycling and poaching of nurses from other practices is hindering the supply of new nurses. To compound this, experienced GPNs are in relative short supply and is being exacerbated by an ageing workforce (Queen's Nursing Institute, 2015). In comparison, the training capacity of large Acute Trusts offer nurse development opportunities, structured learning, clinical educator support, security and diverse career prospects.'*

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The key difference between the traditional model of training (or lack of one) and the ST route is that the responsibility for moving forward the overall General Practice Nurse recruitment and training agenda is taken from individual practices with their individual motivations and over to the local CCGs and STPs who have broader responsibilities. This approach seeks to mitigate the power of individual GPs and afford cultural change in recognising the broad need to provide a development pathway for the General Practice Nursing workforce for the benefit of the overall Primary Care generally.

It is important to recognise that this pathway is a first step towards cultural change which is inherently a longitudinal process. This study is therefore at the 'innovators' end of the diffusion of innovation model.

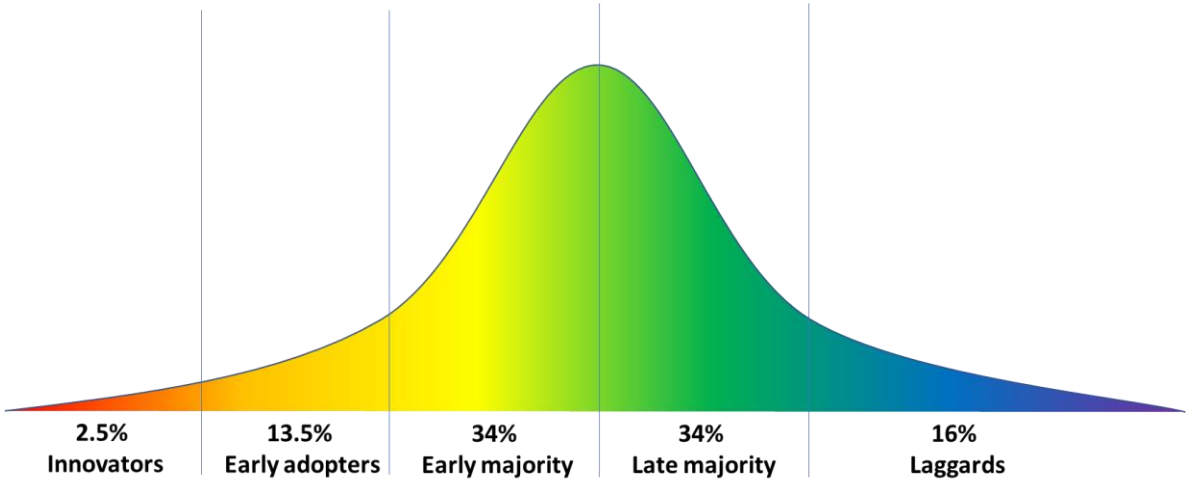


Figure 13. Diffusion of Innovation Model (Rogers 1995)

Evaluation of innovation is important to understand if a model can scale successfully. A proof of concept study can indicate how easy the model is to implement, identify and understand the processes involved and therefore demonstrate the potential likelihood of wider adoption of the innovation. This evaluation takes a 'proof of concept' approach seeking to establish a theory of change for the culture of General Practice Nurse education and identify processes and key areas of success and development from early empirical evidence of implementing the model in practice.

Case Study Data

The following case study data is presented as a brief insight into the structure and organisations of the sites. The three sites have similarities and differences, and these are explored briefly here.

Case Study A - De Montfort University / Northampton Healthy Care Partnership (STP)

Introduction

The most established partnership, this ST route was first piloted in 2018 and builds on successful models of GPNE. The project management for the scheme was with Nene CCG who engaged two GP Federation hosting organisations for the nurses. *(Lakeside and 3Sixty Care Partnership)* The education was provided by DMU who were also responsible for the external mentoring provision.

The following is the relationship map for this partnership site

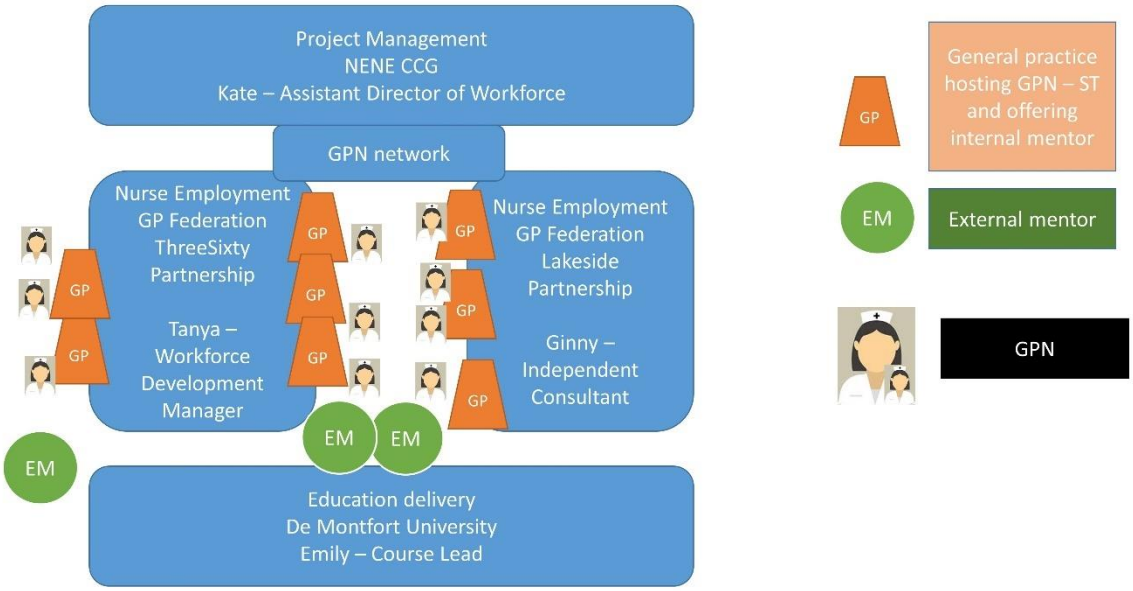


Figure 14. Relationship network map for DMU/Northants site

The overall management of the scheme falls within the CCG and Kate Wallace takes this responsibility. As Workforce Development lead her role includes monitoring workforce needs in Primary Care and within this fall's responsibility for the overall management of the scheme and the local networks.

The network brings together the nurses across the scheme to share learning.

The day to day management of the nurses and their education is devolved largely to practice level where it managed at Federation level. 3Sixty Care Partnership employs SR as a Project Manager,

and she has local responsibility for the scheme implementation at this site where 6 GPN-ST trainee nurses are placed. Lakeside is a Super Practice with a practice population of 165,000 and 150 nurses and is host to 3 GPN-ST trainees. At Lakeside the responsibility falls to the senior nurse who is supported by an external consultant Ginny Draycon who employs Holly Jones as a fulltime Project Manager.

The 3Sixty Care Partnership Federation has 26 practices over 5 CCG areas. They host 7 GPNs across 6 practices (with one large training practice acting as a host for 2 GPNs) in the Nairn CCG area where Kate Wallace works as Primary Care Workforce Lead for Nairn CCG. Lakeside hosts 3 GPNs across 3 practices which fall in the locality of Corby CCG. All the GPNs work in areas covered by the same STP 'Northamptonshire Health and Care Partnership.'

The University employs, trains, allocates and monitors the external mentor role. There is minimal engagement between the practice sites and the University, and this is identified as a weakness in this relationship network.

Planning

Aims

The key stakeholders across the project agree clear aims for the project.

The primary aim is workforce development with the primary objective to increase the number of GPNs in the local workforce.

> *'We know we are going to have some real big gaps over the next few years.'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

And

> *'We know, from a workforce point of view, we are struggling so we have got to make this happen.'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

This aim fits with the role of the key stakeholders

> *'We know one of our challenges and again Kate is doing quite a lot of work in terms of promoting, particularly Primary Care nursing'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

> *'What I am doing at Lakeside, I am directing a programme to set up an education centre. We are developing a primary skills academy across the whole of the Lakeside patch which runs from Corby right up to Lincolnshire. So, we are really well placed for the GPNs pilot because we have got both of them in our patch. So that is a link'*
>
> *Interview with SC, Lakeside Implementation Consultant, Data source 21*

A Practice Manager suggests that recruitment is a big issue

> *'I guess one of the biggest problems we have always had is recruiting to post with a fully qualified skill set'*

Interview with JR, Practice Manager, Data source 19

The Practice Nurse with several decades experience suggests the needs of General Practice have increased recently

> *'Probably within the last 6 years the team has really expanded as change in needs of GP practice have changed.'*

Joanne Stewart, Practice Nurse, Dryden surgery, 3Sixty Care Partnership Federation, Northants, Data source *18*

The Practice Nurse explains that turnover of staff in General Practice is high with significant numbers of retiring GPs. The practice recruited a newly qualified nurse but after one full year of training she moved into a Health Visiting role. The practice is willing to train another newly qualified nurse.

The STP is currently working on a detailed analysis of local primary care workforce needs and has employed someone specifically to look at workforce analytics.

Preparation for delivery

Federations were invited to bid, and that process was conducted by the CCG.

> *'Yes, that was done through the CCG to make it fair and open. That is how it all unfolded. There was a little bit of flex in that and I think in terms of the nurses that came forward, and how we recruited, and where they were able to get to but that is how we ended up with that 7-3 split o it was based on the bid to the CCG and then the recruitment process.'*

Interview with TE, Federation Programme Lead, Data source 17

The whole process was very speedy because existing partnerships were in place. Interviews took place on 12th December 2012 and offers were made and start dates confirmed before Christmas 2012.

> *'So, I was involved right from the pre-recruitment stage basically so initially it was my colleague, Kate Wallace, that was involved in securing the project, the bidding etc. So, we got the project, we need to go, we need to go quickly so she did the advert going out and I have worked alongside her from that. She actually works over at the CCG now whereas I work in 360 which is a GP federation. My colleague Kate, who you will meet later on today, she was the one who was working with NHS England. So, she had a split role as in she did work at 360 where I am now, but now she is working solely for the CCG.'*

Interview with TE, Federation Programme Lead, Data source 17

Key relationships and experience in delivery were significant in supporting the speedy turnaround of the scheme initially.

Planning education and support

A first conversation between the University and KW took place in late December/early January. The existing partnership and course meant that the course started at the end of Jan. The only negative was that some nurses started the course before being able to be in post. It was a hindrance, but all were in post by March.

Execution

This section highlights key points of learning throughout the delivery and execution of the scheme between December 2018 and September 2019.

Recruitment / HR

The CCG and Federations took responsibility for the initial recruitment, sifting and matching of candidates to vacancies with practices having the final approval of candidates recruited. This was a novel approach to recruitment that had not been used before and was beneficial as it saved practices all of the admin time associated with recruitment.

The Federation programme lead worked variable time according to the needs of the scheme. She worked full-time on the project for the period of recruitment of about one month during the recruitment phase.

> *'In terms of time, when this was at its peak, we were getting the nurses on board, I guess it was the main project. We were doing the recruitment, working with the practices to secure the placement, all of that, that was probably about a month.'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

KW put the advert together for ten posts and circulated it across the region. There were 40 applicants for the 10 posts from one single advert. The candidates were of mixed calibre and some were from outside the area; although they were invited to assessment some were not willing to relocate and so were not shortlisted further.

One GPN-ST trainee interviewed had moved from a non-clinical post as a disability assessor into the training post. She had wanted to get into GP nursing but found the entry criteria generally too high.

> *'It is really hard, whenever you see any job adverts it is always like at least 18 months experience in all different areas. Although I could probably blag asthma because of the emergency and all that, it's other things I wouldn't have like immunisation, cytology, I wouldn't be able to sell myself.'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

KW led the assessment day supported by SR (3Sixty Care Partnership), a colleague from Lakeside and a couple of clinical colleagues, a team of 5-6 in total. The candidates were involved in both group tasks and one-to-ones and were scored and shortlisted by the team. Since the vacancies had geographical spread, the location of nurses to practices was taken into account in the shortlisting process. The final candidates were shortlisted and paper-matched to practices. A further follow up session was held for practices to interview the candidates shortlisted.

There was some variation in offers between practices

> *'When we had our discussions with the practices it went out at the standard band 5 but again as they were local GP practices, the T&Cs are generally different. So what we have found, it depends from where those nurses have come from, the practice have been funding in line with what the project funding was but you will find there are some differences in the individual pay for the nurses. So, if a nurse is presented to a practice and they wanted them, there are some of them topping that salary up and things like that. But it was advertised as a standard band 5 position at that rate of pay but there are some differences because they all have individual contracts.'*

Interview with TE, Federation Programme Lead, Data source 17

The quick recruitment process was faster than many could serve a notice period and also did not coincide with an end of course period. Some GPNs had to take unpaid leave during their notice period and this had to be reimbursed so was an unforeseen additional cost of the speed of process. Due to the tight timescales, some nurses started the course before starting the post.

> *'Yes, so literally some came, some were still in their old jobs some of them on the De Montfort programme because we had to get them in.'*

Interview with TE, Federation Programme Lead, Data source 17

The project management team identified the risk that nurses started the course but were not yet in employment which may limit their ability to transfer learning into practice. This was monitored on a case by case basis as notice periods differ and by March was considered no longer a risk as all nurses are now in post. In May De Montfort were asked to check whether this has adversely impacted on the nurses who have had a delayed start and one nurse has reported they feel this might have had a minor impact alongside some other general concerns about learning and teaching in practice. These were escalated to the practice in question to address.

The diverse cohort of candidates included both newly qualified nurses and more experiences nurses.

> *'They are a real mix. We have got some that have qualified then taken a break from nursing and done very different roles, literally coming back into nursing. We have got another one that was a nurse over in Poland, hadn't been able to get a position here and was doing bank work. We have got a real mix.'*

Interview with TE, Federation Programme Lead, Data source 17

Trainee motivations

Trainees had a range of reasons for wanting to start or move into General Practice roles. A key theme was the desire for variety and building relationships with patients.

GPN-ST trainee Ch moved to the role from working on general medicines wards:

> *'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. Whereas when you are in hospital you have recurring patients and you want to*

do more for them to stop them coming back. And you can't in hospital whereas here you can help better support people be well at home.'

GPN-ST trainee RT moved to the role from a role of clinical research nurse before this role:

'So mainly in dementia, Alzheimer's, mental health. Practice Nursing, because you see a variety of ages, so from baby clinic and I had someone last week who was 96, so it is probably one of the only roles you get such a variety of people in. Like Ch said, you really get to know the people and it is really nice to have that contact with people.'

GPN-ST trainee MO moved to the role from District Nursing:

'Came into Practice Nursing, not something that I always wanted to do but it was very similar to the role of what I was doing anyway. Like K says, doing the extended clinics, seeing different things, different tasks, new things to learn'

GPN-ST trainee MO returned to practice in the GP role:

'I trained a long time ago and I didn't work as a nurse, I worked for a charity for a while. I never really started my nursing. Always wanted to do practice nursing, couldn't find a way in way back then, you just didn't do it. So, I did a return to practice course, before I started this course, and I did a placement in a hospital, but this is my first time as a newly qualified nurse on this course. I always knew that was what I wanted to do, and I was absolutely right because I am absolutely loving the job.'

GPN-ST trainee I came into the role newly qualified:

'I spent 4 years in a nursing course and I really felt I wanted to take it up clinically. I think I applied 10 times to be a Practice Nurse. This amazing opportunity came out and it is actually a really good appointment for everyone who is new to Practice Nurse and they really don't want someone who is new. They want someone who has experience. So, what I found with my practice, it is a completely new area, you get to learn so many things. But I am happy with what I am doing because I like learning lots of stuff and also, I can prevent sometimes to the hospitalisation by giving patients good advice if they have infections, how to prevent diabetes by doing health checks.'

GPN-ST trainee MO came from rehab in a Community Hospital and wanted to follow up patients she had to discharge.

'I was discharging people and one day I was discharging somebody, and he said what do I do now? So, I said you go to your Practice Nurse and they will do x y and z. Oh, will they be ok? And so, I kind of knew the hospital wasn't where I wanted to be, but it was a great experience. Then this came up and it was an opportunity I wanted for learning, and I thought I am going to try for this. This is where I am sending my patients to, what is the service like there? I came on the course, meet the patients, someone bought me tomatoes, (laughing). There is the wall you can build up and then you can start asking difficult questions, you give a

> *little bit of yourself and get something back and you see improvement in people. You refer people to activities at the gym, or they have got high blood pressure and they are frightened if their cholesterol goes up, they don't know about things like that, so you see them through that journey. It is a lovely thing. You can sometimes prevent things from going any further. The other part that I like is where do we sit within taking care of the population, to prevent the hospital admissions, I am a little bit on ground level and I love the fact that we could probably do more to work together and move it forward.'*

GPN-ST trainee MOT worked as a Disability Advisor and Analyst

> *'So, I would listen to patients' problems and I would send them on their way then I would get a report for the Government. I couldn't do anything about it, I wasn't allowed to give any advice or to help in any way and sometimes I could see they were on the wrong path, this is better for me. You can help patients.'*

GPN-ST trainee W worked as a hospital nurse. She aspires to specialise in Heart disease & sexual health with youngsters.

GPN-ST trainee H worked as a community nurse and holds an asthma diploma and is looking to become an asthma specialist

GPN-ST trainee B worked previously as a District Nurse and is interested in becoming diabetes nurse specialist.

Timelines

All sites reported timelines being tighter than they would have liked. DMU was able to facilitate a faster start to the other schemes as key relationships were already in place.

There were tight timelines reported both in working around the Christmas break, causing a rush to the recruitment process.

> *'The timescales weren't very feasible, they were really challenging, we were doing this leading up to Christmas. That came out in terms of feedback from the nurses. Once we actually got them in post, they were saying they felt they would have liked a month to get used to their practice before starting the programme, it was quite intense. Similarly, from a recruitment point of view, it was rushed. So, whilst that process worked really well, if we had had a slightly longer lead in time, it is not the best time of year to recruit people. There were all sorts of other things that you know but you run with it but in an ideal world….'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

It was suggested that it would be ideal to recruit to a course that started in January in the summer before, preferably in August, to enable recruitment from nurses finishing courses, and to allow for notice periods, and in order to allow nurses some time to work in practice before the start of the course.

In terms of a development and practice timeline, the trainee suggested she benefitted from an initial month of settling in which was in a largely observational role building to confidently working autonomously.

> *'At the very beginning I don't think I was alone with a patient for about the first month really. Which is good because it was me going back into it as well. as shadowing, I think for the first week I basically watched you, I did a bit with Kate, one of our ANPs, I watched people doing minor ops... then basically it developed, watching me with patients to make sure I was safe and didn't harm the patients as well. Doing blood pressures, injections, all those techniques I needed to come back. Obviously in hospitals we don't use manual blood pressures, I am used to getting the machine. Then started to have my own little clinics with no-one there, they were around but no-one there.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

Working with the HEI

There is some debate amongst key stakeholders about the components of the *Fundamentals* course. For example, one mentor feels that cervical cytology is not a key skill

> *'because most practices will already have a nurse doing cytology clinics. We have 5, we don't need extra, we can meet demand.'*

Cervical cytology training was raised as a problematic issue by several stakeholders. This was partly due to a delay between theory and practical training and also due to a delay in lab processing results Nationally.

There are inequalities reported in the amount of study leave that the trainees are given by their practices. SR suggests this could be resolved with clearer guidance from the HEI.

Trainees and mentors report an initially steep learning curve which takes time and support to develop into safe practice which then levels out as experience is gained.

> *'I think there is a lot to learn in a short space of time. Having that time to really develop and nurture the skills is quite tricky. We are all saying we enjoy learning, but we are having to learn so much very quickly. So, it is trying to balance that. We are quite lucky that although we have done a lot of the theory side of things at uni, we are not doing everything at the moment because we are becoming competent in a few areas, then running with that and the slowly adding to our load. I don't know if that is the same for everybody else but certainly for myself, that is the way we are doing it and trying to become competent and safe. That is the other thing, being safe, because we are not taking everything on board and thinking we know everything.'*

GPN-ST trainee MO, Trainee Focus Group, Data source 20

Some elements of the course, in particular those delivered by external trainers, felt rushed, in particular the travel training element

> *'I think one thing that frustrated us, I don't know other people felt, when we did the travel day, the woman stood up and said this is a 2 day course but I am going to try and teach you as much as I can in 6 hours. Ok, why couldn't we have done 2 days then? Then we could have gone back and disseminated it properly to people rather than sending us home with 9 hours of e-learning, which is great, but it is a lot to learn just looking at a screen. You really need to do the 2-day course. So, we went to practice and said we need to do the 2-day course. Trying to get two of us off together to a course and everyone else as well in the practice, it is just not feasible. But we were already there for a day, even though it should be 2 days.'*
>
> *GPN-ST trainee A, Trainee Focus Group, Data source 20*

Trainees and practices were wary of Universities providing access to e-learning materials and counting it as learning hours, requiring the trainees to find additional time for learning

> *'We still can't do it because we have to do 9 hours of e-learning.'*
>
> *GPN-ST trainee MO, Trainee Focus Group, Data source 20*

Trainees provided their federations with both positive and negative feedback on the course. There was a feeling that the demand of the course alongside practice were significant

> *'The course looked really interesting and comprehensive, but when students started it was overwhelming, with the three 10-hour days in practice, 1 day at university and 8+ hours on top for e-learning to be completed in their own time.'*
>
> *'Self-directed learning 8+ hours a week – this was not clearly explained by the course leaders at the outset. It was thought that students would get time in practice to complete this, but it actually had to be completed in their own time and this took a long time each week to complete.'*
>
> *Lakeside Interim evaluation, Data source E1*

There is evidence of an awareness amongst trainees and practices of variation in the training available to GPN nurses and in particular were aware of shorter and / or cheaper alternatives to their course.

> *'The course that we are doing seems to be very long and very much more detailed than some of my colleagues have done. They did it at the same time as me, she completed it within about 2 weeks, now she is doing smears. Whereas mine, I am still doing it, I started slightly before her, the process is just a lot longer. So why are we not doing the shorter version of it because then we could easily get it done within the time. (lot of talking about time scale)'*
>
> *GPN-ST trainee MO, Trainee Focus Group, Data source 20*

There is a suggestion that cytology could be an optional component of the course, as at other places.

> *'We have looked at Bournemouth and other places and cytology is actually a module; it is treated as an optional module that you can do rather than built into the course. You can do free standard ones and then there are options.'*
>
> *GPN-ST trainee T, Trainee Focus Group, Data source 20*

> *'We have 5 in our team that do the smears. You might go to a practice, well yes you have done that, but we don't actually need you to utilise that skill.'*
>
> *GPN-ST trainee MO, Trainee Focus Group, Data source 20*

> *'If we had a male in the room, we wouldn't necessarily be expecting them to do this would we?'*
>
> *GPN-ST trainee RT, Trainee Focus Group, Data source 20*

> *'T: think there needs to be some off the shelf module*
>
> *K – yes that are appropriate for what the practice needs. So, for example, we have a male in one of our practices and he doesn't go near smears, but that is fine. But it might be that they do want to do them. I think it would be helpful to have those options so they could choose, that is appropriate for the course, but also appropriate for what their practice needs. It might be 2 or 3 options.*
>
> *T – yes, I think that would be a much better idea.*
>
> *J – there are many components to being a Practice Nurse. Cervical cytology is one of those deliveries that we obviously need to meet demand. But you get very few 1 partner, 2 partner practices generally speaking. What I am saying is I don't think it should be the be all that you are doing cervical cytology.'*
>
> *GPN-ST trainees, Trainee Focus Group, Data source 20*

One trainee points out that a broad level of skills is a useful introduction to understanding the role.

> *'Lot of the things my role wouldn't be to do them anyway. Things like mental health reviews I wouldn't necessarily undertake that myself. However, I can use those skills with the patients that I have got. I don't think I would do travel health myself; I am aware of it and I know what needs to be done. I have sat in on a few clinics but a lot of it is just be aware of. So, we don't technically do renal puncture, but you can do it, it is trying to find that right skill for where you are.'*
>
> *GPN-ST trainee MO, Trainee Focus Group, Data source 20*

DMU provides practices with a how to guide full of supporting information about the course and the practice requirements and including checklist to use with external mentor *(Data Source D3)*

Despite significant efforts by DMU to reach out to practices there remains a disjoint which requires tighter relationships and better communication.

> *'Yes so I think there is a big learning for Lakeside in making sure that not only is there absolute clarity about what your student is doing when at university, but the Practice Mentor has a responsibility then to slot in to make sure that the rota slots in some practice that relates to the learning at the university. So, there is duties on both parts for sharing information and then trying to make the stuff match up. It must be possible, there are things happening in practice every day so they should be able to match it. But it is the pressure of work.'*
>
> *SC, Programme Consultant, Data source 21*

Overall all trainees were able to complete the full course with support but not all cervical cytology could be completed.

Mentoring

The mentoring model at this ST site is unique. Practices offer in-house mentoring of clinical skills. External mentoring is also provided by a network of experienced Practice Nurses affiliated to the University. Each student is provided with an additional 15 hours of support from a mentor external to their own practice. External mentors meet with the student at the start of the course to help action planning, at interim points to support portfolio development, and towards the end of the course as they conduct the final assessment with the student on their portfolio. The practice pays a £500 charge for the student to attend the course which is paid directly to the external mentor for their costs.

The course currently employs 50 external mentors across the East Midlands. Some work part-time in practice and take up to 2 students. Their commitment is 15 hours to each student over 9 months. Usually the mentor has 5 visits of 3 hours, although this is flexible.

The scheme has varying levels of success as outlined in the following sections.

Practice mentoring

Practice mentors must be a Registered Practice Nurse with 3 years' experience and who is in the building with the trainee nurse for at least one day per week. On a rare occasion in a single-handed practice with no nurse, the GP can act as a mentor. The mentoring commitment is a minimum of 30 hours over the course. Practice mentors sign off the clinical portfolio with the student.

The scaffolding method of learning enables trainees to learn a skill and the underpinning and practice that with support in a clinical context building towards confidence and autonomy.

A significant part of the practice mentoring role is dedicated to the scaffolding role to help GPN-ST trainees build confidence.

> *'Normally when you do the introduction without any immunisation, you take on the principles, you go to practice and then you are observed until competent or feel safe. That is where you learn a lot of your skills because you are actually with patients. If you have got a senior who is supporting you, they then add bits in, or you will take bits out and then you learn on the spot. It is only then you find you will become comfortable seeing patients.'*
>
> *GPN-ST trainee MO, Trainee Focus Group, Data source 20*

However, where mentoring time is not protected there is a risk to the scaffolding model as trainees may not be developed to practice new skills.

> *'The nurses have found that they have been required to work in their previous sphere of competence (i.e. wound care for both community nurses) and their clinics have been dominated almost totally by this which had a very detrimental effect on their capacity to develop competence in the clinical skills covered by the course.*

Lakeside internal feedback document E1

Managing the expectations of the practice are crucial to the scaffolding model

> *'I think where I work they are expecting me to go back and do asthma reviews and diabetic reviews. But it is an introduction, so I don't think they fully understood what the course was.'*

This view that confidence is vital is supported by a Practice Mentor and supports the requirement for practices to understand the role and mentors to support this.

> *'I don't want the girls that are doing this course to think that they come out and they can do an autonomous asthma review because there are 6-month courses to become a specialist within that, not a one-day course. It is giving you an introduction and a taster. It is where you are stepping off and going then to finesse your skills and your expertise by doing this more lengthier courses that allow you to make these autonomous decisions.'*

Practice Mentor M, Trainee Focus Group, Data source 20

Practice mentoring is vital to the success of learning in the workplace. Naturally standardisation is problematic, and variations arise.

> *'I think where it breaks down is in the grey area of what happens outside the classroom.'*

Interview with Sc, Lakeside Programme Lead, Data source 21

Nurses in the 3Sixty Care Partnership Federation had a range of mentors and largely reported positive experiences. However, at Lakeside one mentor was allocated to three GPN-TS trainees and the time load on this mentor was too great with little protected time

> *'The mentor works part time, is on a course herself and had her own workload plus 3 trainees.'*
>
> *'There were no protected blocks of time, where the Practice Mentor could sit in clinic observing and teaching the trainees.'*
>
> *'It would have been more useful to work with the mentor straight after relevant theory – but the practice mentor did not seem familiar with the course structure and content.'*

Lakeside internal feedback document E1

Interim feedback suggested that poor levels of support by the practice for the Practice Mentor meant in terms of time release meant that trainees were not achieving the levels of learning required for the course

> *'The course was to include 285 hours supervised training in practice which is equal time to the time spent at university plus self-directed learning– however, this did not happen for any of the trainees, it was an hour here and an hour there.'*

Lakeside internal feedback document E1

Trainees report feeling like a burden where their mentor is required to support multiple trainees.

> *'[My Practice Mentor] has got 2 or us, we are knocking on her door, she has got her own patients to see, but it is frustrating, she says it is fine, but because we feel like we don't want to be a burden. [My practice mentor] would never make us feel like that but we don't want to feel like that'*

GPN-ST Trainee J, Trainee Focus Group, Data source 20

One Practice Nurse suggests that she has mentored GP nurses both supernumerary and those who 'count towards the numbers' and prefers to mentor those with supernumerary status (which the GPN-ST scheme affords) as she feels they have a greater opportunity for supported development which the role requires in the early days.

> *'It has meant for me I would take time and there is supernumerary position and allow S to develop and it is pressure on the rest of the staff. Because I could still continue what I was doing with them. So, I didn't have to put everything else on hold which I did with [previous GP Nurse] because she was part of the numbers. I couldn't release other people but with S, S can still go on in the background.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

Protected time for both trainees and their Practice Mentor is vital to the success of the scheme

> *'I think there are real issues that Lakeside is going to have to follow up around protected time. Firstly, making the trainees feel that they are trainees, not a pair of hands and that the mentor has protected time and adequate capacity to be able to deal with supporting the trainees.'*

Interview with Sc, Lakeside Programme Lead, Data source 21

External mentoring

The programme has been running in this way since 2012 and has gained momentum in the General Practice Nursing community. Some students who were early completers of the *Fundamentals* course are now working as external mentors to new students.

There is a suggestion of variation in practice amongst the external mentors.

> *'The other thing that came out from the last meeting was something happened with the nurses and their managers, I forget what they call them, not mentors but the De Montfort mentors, I think there is quite a difference in their approaches as well. So, although we have got 7 nurses, what the De Montfort mentors sign off is very different as it is for another nurse. There is quite a wide range there. Again,*

> *they talk so one nurse in a practice can sign something off then another one, oh I am not allowed to do that.'*

Interview with TE, Federation Programme Lead, Data source 17

Interim feedback suggested that at Lakeside the allocated hours were not utilised effectively. It was suggested this may have been due to the allocation of one external mentor to three trainees in one location, despite not all trainees being available together on mentoring visits.

> *'University GPN trainer – to provide 1 hour every 2 weeks – WP provided 3 sessions'*

Lakeside internal feedback document E1

Overall there were reports of varying levels of satisfaction with external mentoring. External mentoring was beneficial where it met needs not able to be met within the practice. However, this was not always the case.

> *'Although the GPN trainer was good her visits didn't feel joined up with the programme – it was just slotted in where it could be. This wasn't planned well, for example the University Trainer watched Helen doing wound care, which she is highly proficient at rather than observing her doing new skills.'*
>
> *'There was no coordination with the theory, practice and then mentoring all linked in the same time period to enable the nurses to develop competence.'*
>
> *'Portfolio – The university mentor (Wendy) oversaw the portfolio, the hours log and the areas covered. This was well supported.'*

Lakeside internal feedback document E1

Where the external mentor replicated or challenged the work of the Practice Mentor this was problematic for the relationship.

Positive mentoring experiences reported include those where the Practice Mentor and external mentor build a relationship with the GPN-ST trainee over their training period and support their needs directly.

> *'[External mentor] sits in doesn't she and then she will say what went well, what could have been better, if she thinks there is something she needs to speak about whilst the patient is there, she will chip in and help us. So, we had an initial discussion about her role was, what she felt she would like to help [GPN-ST trainee] to do and anything I would need to help her with. [Other GPN-ST trainees] they tend to be the most communicative with her, it is their concerns. Then she comes to see them in house, we have a conversation at the end of the clinic and bring up anything that is a concern or just re-assure or reiterate they are doing really well.'*

Practice Mentor, Trainee Focus Group, Data source 20

If there is conflict between the internal and external mentor this can be an additional source of stress for the trainees

> *'I think that model is quite a good model where your internal and external mentor meet and manage expectations and have a plan together. When you get an internal and external mentor who don't see eye to eye, and you are caught in the middle, that is tricky.'*

GPN-ST trainee MO, Trainee Focus Group, Data source 20

There is variety in the experience of mentor relationships reported

> *GPN-ST Trainee A – 'because we are new to practice, we need structure. We need to know we are going to be able to use some of the skills, some of the stuff we have learnt at uni. We need to know what is expected of us. It needs to come from the same hymn sheet.'*
>
> *GPN-ST trainee MO – 'we need the internal and external to understand each other to be able to sign it all off. Because obviously one is never going to see everything that we do so she will rely on the other to say yes, I have seen this, I am happy, or no I have got a concern here. So, they need to have that relationship.'*
>
> *GPN-ST trainee RT – 'my internal and external mentor have one meeting, my internal mentor signs nothing, my external mentor does it. Which I think has sometimes happened before. They are really good professional people. So, they make it work for me.'*

Trainee Focus Group, Data source 20

The practice feels that since they are funding external mentoring, but it is managed by the University, it should be subject to quality assurance procedures by the University.

> *'I think the university has a duty because if they are awarding the qualification then they have a duty to make sure that the people who are being turned out from that programme, have achieved the outcomes that were stated in that programme. So, there should be a really clear overarching statement from the university, this is the outcome for the student at the end of this programme, and this is how we make it happen. I think the commissioners, or HEE, or whoever pays for the programme, should have a contract that says here are the responsibilities, you all need to fulfil this. It should be a sort of completion of the cycle at the end of the programme, or throughout the programme. There should be touch points through the programme where there are critical touch points where you say this is working, after 3 months, are things going well? Is there a good connection in what you are learning in university and what you are learning in practice, are you progressing as you hoped? Those are touch points that universities should be connecting with the practice and the nurse. '*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

One of the well supported trainees is encouraged already by the practice and her mentor to consider her future pathway to include mentoring, to utilise existing skills and help her continue to develop.

> *Practice mentor: 'That is something we are looking at, one of our health care assistants, his name is L, on the nurse associate apprenticeship, starting in January*

Researcher: So, S will be able to act as their mentor?

Practice mentor: Yes, S will play a big part

S: What I do miss about my old job is actually the training, I was a trainer and I quite like that

Practice mentor: That is such a good way for you to consolidate your skills as well. We identified that. We had a very informal interview, when you started, I made a note of this, I thought ok I know where I am going with this!'

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

In summary mentoring is vital to the learning of the GPN-ST trainees. The context for successful mentoring relationship is protected time offered by the practice to both trainees and mentors and enacted despite pressured of the job. One to one relationships are important for mentoring where possible and this may limit the number of trainees in one place if alternative capacity is not on offer. External mentors should communicate their approaches towards a consistent model and be regulated by the University. There should further facilitation of positive trilateral relationships for mentoring which lead to high levels of success and support. The pathway for trainee's development can and should include mentoring others in the future.

Support

The project management system identified the risk of attrition and took active steps to instigate wide support mechanisms.

'Attrition - there is a risk that nurses may leave the course/employment due to the demands of working and studying. UPDATE - May, as above one nurse has expressed concerns about juggling to work demands and learning whilst in practice. The practices have been asked to address to look into this (as they have a further two nurses for whom there are no recorded issues). UPDATE: Sept 2019 - we only lost one nurse on this programme due to personal circumstances - this nurse had through all the engagement cited how positive the experience had been therefore, this was beyond the control of the programme. Mitigating actions: Engagement and networking plan needs to be developed to ensure the nurses have avenues to escalate concerns and issues and feel supported.'

Task and Finish Group meeting notes Sept 2019

Internal evaluations are conducted throughout the programme to measure satisfaction on an ongoing basis. Nurses at Lakeside are co located therefore networking and providing opportunities to have informal action learning sets is readily available. 3Sixty Care Partnership developed informal meetings with all nurses in their practices to replicate this level of support. Nurses throughout 3Sixty Care Partnership have come together for networking opportunity in May and also all nurses have access to PLT in the county. Data was collected at a network meeting designed for nurses and mentors at 3Sixty Care Partnership to informally meet with programme leads in July and provide feedback on the scheme. This meeting was also an opportunity to support nurses with their scheme exit strategies.

Outcomes

This section reflects on both planned and unanticipated outcomes

The original aim of proof of concept was met and 9 new nurses were trained and employed in General Practice.

This section discussed the mechanisms and reflection on the model which supported the GPN-ST trainees' transition to work.

The trainees were well supported at a Federation level to transition into long term roles in General Practice.

> *'When we selected our practices, we did ask them to give assurance as much as possible that they could that they have got a position available at the end of the programme. Again, things change, we don't know. So, I do think my next key thing is because there are 10 fixed appointments for the period of the project, so I think my role will be making sure if that practice can't offer that position, that we don't lose them. I think then that transition from being on the programme to becoming, I am confident we will place them wherever, it might just need a bit of help and support.'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

> *'All the nurses are employed with Lakeside; they have all got a secure tenure within Lakeside. So, none of them are finishing the course and then looking for jobs, they are all currently employed.'*
>
> *Interview with SC, Lakeside Implementation Consultant, Data source 21*

3Sixty Care Partnership would be willing to host the pathway in the Federation and feels the programme would gain strength from experience and growth in the network.

> *'Obviously we had 7 this time because it was split, but I think we could probably get a cohort of 10. Because we have gone through that learning curve ourselves, we have got like here you go, these are the results, the network is obviously stronger, the world of PCNs has created more opportunity for us to yes definitely. Again it was a lot around where they could travel to, so we 7 practices that were willing and we hadn't got enough nurses, or nurses in the right place. Because we had this timeline, we had to make it, we had to get the best fit we could. But we could do more.'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

The Practice Manager interviewed would be involved again and has learned from each experience

> *'I would jump at the chance to be involved in the programme again. Maybe we were just very fortunate, we got [GPN-ST S] and she has been a totally invaluable member of the team since the day she started really. Maybe we wouldn't be so fortunate next time around. But we would want to work with whoever we got to make sure that they left us with all of the skills if they went elsewhere, even if they didn't fit for us. That is the thing we have to bear in mind.'*
>
> *Interview with JR, Practice Manager, Data source 19*

The CCG also offers support to the nurses to ensure they have employment at the end of the training period

> *'The other thing I wanted to mention is could I remind you all that you all have your individual contracts with practices, start and finish dates of those, they were all 9-month contracts. At the point we went out to practices where possible we tried to sign up practice leads that were hoping to have a position available at the end, obviously there was no guarantee of that. That is what we tried to do from the outset. But I am conscious that the clock is ticking and ticking quite fast now. I don't want to put people on the spot but I do want to make it clear, if there isn't going to be a permanent position at the practice that you are at, please, please, please let me know because I will support you individually to make sure we can place you somewhere else in the network. Because even if your practice doesn't have a vacancy for you, we will have lots of vacancies elsewhere. I just wanted to say you know, we don't want you to feel you are on your own with that, already I have got one practice saying to me I need somebody, any of your nurses haven't got anywhere please can you let me know'*
>
> *CCG Lead KW, Trainee Focus Group, Data source 20*

HR/Pay issues

There are key HR and pay issues which arose through the scheme. The first is the lack of standardised pay for the role, and no recognition for the training achieved or standardised pathway for development in the role.

> *C: 'If you are introducing this course you need to recognise that when they qualify, they should be recognised with the qualification and therefore I would start with these nurses and say, yes we recognise that you have done it, you have got the specific achievements in this course, we recognise it, we give a standard rate. That is where you could start from because unfortunately, historically as Practice Nurses evolve, we have evolved with different diplomas and different extras, and GPs randomly say I will give you this amount.*
>
> *SR: So when we started this programme, when we put the advert out, those of you that applied for it will know we advertised it as band 5. So again, they agreed the standard of it. I think you are right, once we get to that point where we are at a certain level, we can look at the job description, we can get it evaluated. Then we could say "This will be following National guidance" because there is quite a lot of National work around this.*
>
> *C: It is just I need to be able to say this is the guidelines, this is the standard and therefore I would like.'*
>
> *Trainee Focus Group, Data source 20*

There is recognition that terms and conditions are not standardised in Primary Care.

The trainees do compare themselves with others outside the industry.

'We are not on the same level of salaries as other graduates with degrees. My son graduated as the same time as me as a designer and he earns £10,000 more than I do.'

GPN-ST trainee MO, Trainee Focus Group, Data source 20

T: 'They don't recognise Agenda for Change, so you are employed by the GPs. There is no power on earth that can force them to say because you and I know full well that somebody down the road has a very similar job spec to me, who will be paid £4-5 an hour more. That's the reality and moving from the Acute Sector into Primary Care, that is the reality. We don't have Agenda for Change, there are very few practices in the UK that support that, because there is a cost implication. You can take advice from NHS scales but there is no parity.

C: If you have got a newly qualified Practice Nurse, it would be a good start for them

T: Small steps yes

L: I think if I had a magic wand, nurses would be on Agenda for Change and so would the Allied Health Professionals within the practices. But you have to be a bit careful about what you wish for because that could mean some nurses are disadvantaged. That happened when Agenda for Change was implemented, some people went up, some people went down, lost a lot of money. I think the ambition going forward is that agenda for change comes in through this process. So, in 5, 6, or 7 years' time, there will be a significant number of nurses on Agenda for Change terms and conditions in its entirety because it is more than just pay isn't it? Its annual leave, sickness and it's about making sure that those packages are there. So, I think our aspiration is as nurses go through this programme if it continues, that it absolutely is rooted in Agenda for Change.

S: So when you go for a job interview, the next thing that we are going for, where is the starting point around negotiations, how do we negotiate? Being realistic, knowing that there is no parity, what is our starting point? How do we know? I know it is a sensitive thing but where do we start? I don't want to devalue what we have done and make it worse for those coming afterwards?

T: Well the individual practice will have probably pitched it themselves. We have people on different paygrades. The AFC comes into, hopefully that does aid with your career progression. Again, it is very individual, I couldn't answer that question.

L: You bring other skills, your previous experience that you have, you can't just solely go on I am a new Practice Nurse, you have got other skills

T: But you don't get increments. What usually happens in most practices they will look at the job spec, evaluate it, look at your qualifications etc. take all those into account then they will look to see if it is a band 6 or will go somewhere in the middle. Because you don't get increments there. You get an annual pay rise hopefully, but you don't progress through the incremental route.

S: Unless you do an additional course which is recognised

T: But then it is incumbent on that practice to recognise it, but you won't get your increments. So, it is just pitched individually.

C: So saying for example you have got to have two years in Primary Care to get the next band, I think there does need to be flexibility because I think that would be quite constraining to get on without previous experience.

T: Because we all know if you get to the top of band 5 and go to the bottom of band 6, it is very individual to practice, no two practices are the same.

L: It is the same with non-medical prescribing, so in acute, if you are in non-medical prescribing and are band 7, and in other areas you are in 8a. I think there is a good argument for higher. But there is just no parity even in Agenda for Change.

CS: So we don't even go in as a band 6, it is equivalent to band 5

T: They can advise you from the band where the pitch is. You could be at the bottom of band 5 or 6 and stay on that.'

Trainee Focus Group, Data source 20

Workforce related outcomes

Eight of the nurses have secured permanent posts following this programme, one is actively looking with support from 3Sixty Care Partnership and the remaining nurse unfortunately resigned following a personal issue that was unforeseen. The partnership will now look to utilise the funding for fellowships within the CCG to support further posts each year (pending the outcome of the new to practice guidance at the end of September 2019 and recurrent money).

One practice mentor suggests the scheme meets workforce needs but needs to continue to be sustainable with development of GP and nursing generally

> *Practice Mentor: 'This is a great programme but actually we need all those other things, all those different steps along the way. S is a General Practice nurse now hopefully to go on to be an ANP so how are we going to have someone to do what S is doing now, here and across our network really. It is it is working with individual GP practices who perhaps in the past, have worked very much as a small business. It is getting everyone to look at this now, but that can't work anymore.*
>
> ***Researcher: The old model can't work?***
>
> *Practice Mentor: No we have got to do something; my generation are going. Most of my friends have retired.*
>
> ***Researcher: So, it is a new model for the new generation?***
>
> *Practice Mentor: But I think also appreciating young people now will not just have one career. I look at 20+ year olds and they are already thinking about what they are going to do next. They are not going to stay in health care for 20 years. I think they are used to progressing, they are used to achieving and they want to do that. I think we have got to allow for that.*
>
> *GPN-ST trainee MO: Like you say we know that is going to happen*
>
> *Practice Mentor: There is a small group of us here, a couple of nurses have been here longer than I have. But we are becoming the exception. I did move around, I was a hospital nurse, I had that planned. But I think it is accepting in General Practice that that happens.'*
>
> *Trainee Focus Group, Data source 20*

One Practice Mentor suggests that recognising that nurses will want to progress along a pathway might be at odds with the needs of the individual practices

> 'I think on the practice manager side, if you are not a nurse, that is quite difficult. You do want people to stay for 20 years, so you haven't got to do the recruitment and stuff. But I think it is accepting that this is a very different world. Not just for health care, I think it is a different world and health care *has got to move with it.'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

One practice mentor recognises the tension between the needs of individual practices and the needs of the sectors

> *'I think for me, they are those individual businesses and I respect that, but we have to work as a network. the GP recruitment for example, the practice here has become part of the International Recruitment Programme for this area and we have a GP coming from that programme starting in September. So, I think because of their involvement in this, I think it is changing'*
>
> *'Nursing recruitment is starting to change, which two years ago, there were things being talked about, now things are happening. The changes with the nursing recruitment, when we took [Previous GPN-ST trainee] on as a trainee nurse, that is the first time I think I was able to convince our practice manager and the practice that we could do it….prior to that we were looking for like ex district nurses and things, the skills that the came with and everything.'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

One Practice manager hosting a GPN-ST trainee would like to see the scheme rolled out more widely for broader benefit

> *'Having something like this that is rolled out Nationally and the impetus for it going forward to remain full on would benefit everybody in General Practice involved. Or not involved. I think some of the things I would like to see it expand upon are the numbers, definitely.'*
>
> *Interview with JR, Practice Manager, Data source 19*

There is recognition that GPNs will work in a diverse and developing MDT.

> *'We are definitely developing a broad workforce We've also got 4 HCAs who were receptionists.'*
>
> *GPN-ST trainee J, Trainee Focus Group, Data source 20*
>
> *'I think more broadly because we have seen Clinical Pharmacists in General Practice, we are going to have Social Prescribers, just thinking about all of those different alternatives, how we use this and what is best to support them. '*
>
> *Mentor M, Trainee Focus Group, Data source 20*

Feedback from trainees

Trainee satisfaction levels appear to be high at the mid-point and end point of the scheme. At the midpoint trainees report enjoy learning a variety of new skills and putting them into practice

> *S – 'right now I am just enjoying what I am doing and would just like to get more competent and do it better.'*
>
> *L – 'I can't believe that we all enjoy the same things'*

> *S – 'the huge variety, you have to know a little bit about everything. You just have to be aware of all these factors going on in the background and put it all together'*

Trainee Focus Group, Data source 20

One trainee reported a less positive experience overall.

> *'One of the students would not do the training post again and would not recommend this route.'*
>
> *'One student feels her confidence is knocked massively and the thought of doing clinics she is not trained in causes anxiety.'*

Lakeside Interim evaluation, Data source E1

Several trainees report enjoying the challenge of working autonomously and developing independent practice

> *K – 'you don't know what is walking through the door. You don't know what they are going to say as they walk out the door.'*
>
> *L – 'you have to be quite strong in saying that, imagine that conversation that you can't fix it there and then, and you have got to think on your feet. That's what I like about it.'*

Trainee Focus Group, Data source 20

There is evidence that trainees recognise their limitations and the need to build confidence eoi practice safely.

> *S – 'I think* there is a lot to learn in a short space of time. Having that time to really develop and nurture the skills is quite tricky. We are all saying we enjoy learning, but we are having to learn so much very quickly. So, it is trying to balance that. We are quite lucky that although we have done a lot of the theory side of things at uni, we are not doing everything at the moment because we are becoming competent in a few areas, then running with that and the slowly adding to our load. I don't know if that is the same for everybody else but certainly for myself, that is the way we are doing it and trying to become competent and safe. That is the other thing, being safe, because we are not taking everything on board and thinking we know everything.'

Trainee Focus Group, Data source 20

One trainee nurse feels that the main benefit of the course for her is the access to a network of peers.

> *'I think the best thing is I do meet other Practice Nurses; it is not isolated. This is great but I also meet other Practice Nurses to actually realise this is quite good because other people have different experiences. As it is Leicester, Nottingham, Northampton, Derby it is all different practices that I am meeting and our network area as well so that is good. Obviously, I have had excellent support here as well.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

Feedback from practices

Feedback from practices about the scheme is overwhelmingly positive.

> *'Practices love it, the nurses love it!'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

> *'I think practices were almost a bit, when you are trying to get them on board, it was almost a bit too good to be true. They say are you sure, what is the catch? But I think now that we have got that cohort through, I think we will be perfectly placed to do it again'*
>
> *Interview with TE, Federation Programme Lead, Data source 17*

Experienced Practice Nurse Mentor points to the benefits of supernumerary status comparing the current trainee GPN to a previous unfunded one

> *'Yes, so the difference I think between when we put C through and paid her salary, and with S, for me, I had been able to be more flexible and her learning needs. Because C, right from the start, was part of our numbers. I had to work very hard to create space for her to do her learning and because she was newly qualified as well, I was almost working on a different level. Whereas with S, we were able to do things slightly different'*
>
> *General Practice Nurse Mentor, Data source 18*

One Practice Manager sees the investment in the scheme as having high returns and would recommend it to others.

> *'What we are going to get with S is a massive benefit to us, she is going to be a qualified nurse with all of the Primary Care experience and skill set that we need. It is an opportunity for practices'*
>
> *'With some time and effort, we don't begrudge that in any way because we know at the end of it we are going to get a fully competent team member who we hope, we create an environment that she wants to stay in, will stay with us and we can then develop that further forward. It is our future. If we can't support that we are doing something wrong.'*
>
> *Interview with JR, Practice Manager, Data source 19*

There is feedback that there needs to be wider communication across practices to help all staff understand the role and desire its effective use

> *'Reception do not understand what they can put in with the trainee nurses or what is their level of competence, so when they are presented with a patient that is not within their scope of competence, they have to recognise this and then ask for help with the patient. It would have been useful if reception staff were made aware as each trainee became competent in a new skill, so they could book in appropriate patients and allow the nurses to continue developing the skill.'*
>
> *Lakeside Interim evaluation, Data source E1*

> *'The rota clerk should have been brought into the training from the beginning to understand the structure and content of the course, so that she could set rotas appropriately to align our clinics and her availability.'*

Interview with SC, Federation programme Consultant, Data source 21

For some practices, the layers of Federation, CCG and University represents a confusing number of project interfaces

> *'I don't know whether there are too many tiers. I don't quite know where to go to ask. Do I go to 360, to SR, to HEE? I know 360 is involved in the educational side somewhere along the line, SR I go to because I know SR, it is that kind of thing. So, I don't know whether, I fed back to KW, the NCCG Workforce Development Programme Lead, I don't know how all that fits together. I fed back on one of the forums I spoke to her on that there needs to be clearer lines of what funding and what education is coming online and where we need to go to access that. I have sent emails and to get funding, we have got a nurse that we are looking to put through her diabetes programme at Warwick University. Is there any education funding sitting in a pot somewhere that I can have? I got £500. It is all speculative. Rather than a strategic clear …. This is a pot of money that has come into private care education, this is going to be ring fenced, nobody else outside of Primary Care can get it. You have to be quick off the mark to know about the funding, to get access to it. So, it is a case of everything is done speculatively. So, having SR on board this programme and the next one we are getting involved in, has been great, I can't thank Sarah enough. But from a Primary Care's Manager point of view, to know that there is ring fenced monies for development within Primary Care, would be wonderful. But there is nowhere to go for it.'*

Interview with JR, Practice Manager, Data source 19

It is recognised by practices that it is important to be party to relevant networks

> *'I really feel fortunate in that I sat on another forum with the CCG, got involved, heard these names, and think well they can only say no. Send an email, what did they say, yes that is great.'*

> *'And down to the LMC, the Local Medical Committee, they sit with pots of educational funding so you end up going there for a little bit, and you think we will fund the rest of it which is fine. But you cannot plan that strategic bit, you cannot say for absolutely definite that in 18 months' time you will do x. because we have got to make sure that we as a business have that resource available. Whereas if there was a pot of money that was strategically managed purely for Primary Care which we know is for recurrent funding. Well to do a one off here is no good to anybody.'*

Interview with JR, Practice Manager, Data source 19

Shared learning is beneficial

> *'I would also say to those people to engage with the practices who have done it.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

One GP Nurse Mentor feels that the programme model represents a network which can and should be extended

> *'I think for me it would be like it is on the scale model. A similar thing but looking at it from up here if you like and we need to put ourselves in that position, we know we have got to grow, the proof is there that we can do it. So, it would economy to scale. Equally that whole kind of encouraging people to work as a network so rather than working as an individual practice, I think this shows, clearly the numbers benefit, but more than that it is about sharing those things.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

One Practice Manager recognises this scheme as education over training

> *'We have actually got a committed team of nurses; I can't emphasize how fortunate I have been having Sarah and some of the senior team here to develop what we have. But without that, you are going out and finding a little bit of training here and there, half day workshop here, then trying to put it all together. How much of what we need have we actually got to meet that requirement to be competent in the areas that we want. It is always very difficult and the longevity of it.'*

Interview with JR, Practice Manager, Data source 19

Pathways

GPN-ST is a first step on a career as a GPN and the stakeholders recognise the need for a standardised pathway of development.

> *'Yes, so my interest in the programme is how it fits within the overall GPN professional development and preparation because we are looking at all levels of nurses.'*

Interview with SC, Federation programme Consultant, Data source 21

Some suggested the course needs to be longer, or to form part of a longer pathway during which greater confidence is built

> *The course should be longer - a year or 2 years, 9 months is not enough to cover the theory, the eLearning and then the training and mentoring back in practice. It felt very rushed and students have not got to where they felt they should be by completion.*

Lakeside Interim evaluation, Data source E1

> *'It is a fantastic site to really develop a new concept and test it, which is basically what we are doing. We have had a little bit of funding from the GPN Ten Point Plan, so the pressure of time is on. So, we are developing an education framework but also a kind of online portal for the nurses so that we can have masses of data about what they need, what the qualifications are, what they are attending. Actually, build up their career larger in a really co-ordinated comprehensive way*

> *with all the information to hand. Because of course, it is chaotic for GPNs, it is just the luck of the draw.'*
>
> *Interview with SC, Federation Programme Consultant, Data source 21*

The GP Mentor would make small changes to the GPN course to make it more generic. She also feels it should be on a pathway with prescribing through to Advanced Practice

> *'Adding in prescribing as one of those optional branches. Because S is going to have to prescribe, S knows this and has kindly agreed that she will…. so, I think that needs to be added in to the 2nd tier of the education.'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

This fits with GPN-ST trainee MO's view of her development and she would like a pathway linked to advancing her clinical practice in the longer term.

> *'My plan is to become an ANP. I am not too sure it will happen within the 5 years. But even to have the prescribing would be massively beneficial for our treatment room. I can see most Practice Nurses, either being pushed or encourage to have prescribing.'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

GP Nurse Mentor suggests a need for an expended full entry development pathway

> *'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.'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

The GP Nurse mentor suggests that a development pathway is essential for the retention of staff

> *'People were staying for a couple of years and getting experience, not through anything that we were doing wrong, but it was this I have got one skill, I am going to move on. So, we thought ok we might as well gain the most benefit while we have got people and I think that is what the Practice Nurse and the assistant gives us if you like. It increases the benefit that we get in a shorter period of time potentially. And for the individual, the satisfaction, the qualification and the support that comes with it. If you develop people's confidence, and we are not the only people that are doing it, if we are doing it across the board, then we all have a pool of people,'*
>
> *Interview with GPN-ST trainee MO and GPN Mentor, Data source 18*

One of the Practice Managers agrees that a development pathway is essential for the sector

> *'But also, then have a clear developmental programme for going forward. We can offer all sorts, but we do it kind of piece meal. As and when our needs require and also as and when those programmes come online that are suitable. We can very quickly identify the gaps in what we need, that S will need upskilling on, straight away. So, to have a game extension to the core programme that says these are the other areas that post disqualification, a practice will need…. It is also about*

> *that retention of staff to feel like having done as much as S has done. Ok then you need a period of consolidation, of course you do, and we as a business need some requirement saying we need this for a period of time. To feel like you are going to stagnate having given such an effort into where she needs to be, would be awful and unprofessional. So, to know that there is a continuation extension project, that in 18 months' time or 2 years' time, that S can get on, that would be absolutely wonderful.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

Practice Manager suggests a need for a development pathway to meet business needs as well as those of the individual

> *'When I interviewed for nursing team members, one of the things I used to hate saying was if you didn't have a career development structure, you had to make it up as you went along. You have got this professional sitting in front of you and you are interviewing and hope they stay with you for a long time but you can say well I have got no clearly defined pathway of development that we can offer, what we can do in conjunction with that individual is meet your needs as and when they come up. Whereas to know that you can offer an individual something very clear and descriptive and say this will give you and me x at the end of y, what more can you ask for.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

One of the programme leads suggests that continuation pathway is essential to ensure the continued learning of the GPNs

> *'I think it is a strong model because it allows them more fluidity and flexibility around how the programme fits within their job. How the practice can respond to their needs and then do a longer plan beyond scope of say GPNSC. To highlight what further mentorship and clinical supervision would be helpful. How much more, what you need to be confident in? So, I think it would be really advantageous because what we are hearing from our cohort anyway, they got to the end of the programme and they don't feel ready.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

There are practical recommendations for methods to link the GPN-ST pathway to the future fellowships model.

> *'I think it would be far better if the GPNs sit within something like the Fellowship Programme, either within their preceptorship year as newly qualified, or it sits within a preparation for GPN if they are transitioning to somewhere else. It needs to be a longer supportive fellowship type structure.*
>
> *'The thematic analysis needs to include analysis of future options in terms of apprenticeships and fellowships and recommend a single but adaptable model for clarity in moving forwards'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

Learning

There is evidence about the types of learning that the GPN-ST scheme offers, and also about the learning from the scheme that can be shared with others.

The GP Nurse Mentor suggests that she has previously been a mentor to new nurses who have simply be sent for training courses rather than being an education pathway. She notes her personal perceptions of differences in learning outcomes

> *'Previously I have just mentored people internally and we have sent people out for courses …that was fine but the difference I have noticed with C and S is the broader knowledge they have of General Practice and the Health Service and the function of it. They engage much better with the workloads. They understand why we do things. That has been a huge bonus for me, and I think the practice because they have fed that back into the practice. Passed that to other people.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

One trainee suggests she learns skills with associated underpinning theory

> *'I think time management is an important part of learning to be a Practice Nurse. So, I could use that in previous ones before. I think you just have to be a sponge really, just soak in all these rules. You would in any new job, but I think it is nice to have the knowledge behind it as well.'*

One Mentor suggests working autonomously and being confident is important in the role.

> *'But I think one of the skills you have to learn is you are in a room on your own, with a patient. For those few minutes, it is you, you haven't got a Doctor immediately, you haven't got someone else who is the other side of the curtain. Usually we have someone very easily accessible, but there are occasions when you haven't. You have to make decisions yourself, instantly in the room on your own. I think that is very different.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

The Practice Manager recognises the value of developing theory alongside practice

> *'I can train anyone to do anything I want. I can learn a skill and I can pass it on, and I am confident in my abilities to do that. But it is the wider understanding, then getting people to commit to doing it because they understand why they are doing it. That is the extra that you get from something like this.'*

Interview with JR, Practice Manager, Data source 19

All stakeholders suggest the benefits of sharing learning both across partners in the scheme, and with others outside the scheme.

There is evidence from the practice perspective that time spent building relationships is crucial to the success of the scheme.

> *'Don't go into it cold because I think there is some misunderstanding about it. We gained hugely from being involved with the university before, I think it made it easier for us and the rest of our nursing colleagues.'*

Interview with JR, Practice Manager, Data source 19

Internal feedback from one practice site suggested that partners in the site should learn to work more closely together and communicate better.

> *'There should have been more Communication between De Montfort, Lakeside and 3Sixty, as to what the roles & responsibilities of each organisation is to support the trainees.'*

Lakeside Interim evaluation E1

Strong mechanisms for formative evaluation exist within the system internally. These include local forums, university feedback mechanism and regular update meetings. These provide a vital opportunity for support and iterative development of the scheme whilst in operation and have also provided vital data to the summative evaluation presented here.

> *'LHG have met regularly with our nurses on this programme and sought feedback on the course programme and the lived experience of the trainees. We have a formal evaluation session planned with our internal Nurse Education Programme leads and will formally share findings and learning. Both Lakeside and 3Sixty are also supporting the University of Nottingham who are conducting a full evaluation of the programme.*

Task and Finish Group Meeting Data

Development of Nursing

Multiple stakeholders report their commitment through the scheme to the development of General Practice Nursing on a broad scale.

The GPN Mentor suggests that historically there has been little support for GP nurses but that it is time for change.

> *'I have been nursing 43 years, 28 in General Practice and the career progression, the structure, the training, is not standardised. It is very individual to the practice. I just so happened to have worked for x number of practices, but you are a generalist with developing specialisms. So, I am a prescriber, I have a diploma in asthma, a diploma in diabetes 6 months, minor illness 6 months. You can do an MSc in travel. There are various pathways that you go on your journey in General Practice, but the structure is very individual. So, there isn't any standardisation within the UK. Also, there isn't the career progression that you get with our NHS colleagues, it is very flat line.'*

Interview with GPN-ST trainee MO and GPN Mentor, Data source 18

Evidence suggests that there needs to be a culture change in perceptions around the role of the GPN

> *'I do think General Practice has got that image of being an end of career type role and that is the bit we are trying to change.'*

Interview with TE, Federation Programme Lead, Data source 17

A Practice Manager concurs and feels the time is right for this change in culture.

> *'I have been in General Practice for too many years, but it really is the first time that we feel there has been an emphasis given on the development of this particular area of staffing. Everybody has always been looking at GP recruitment, GP training, ANP training, how that can support the team. But actually, we have got to look at every single tier of what the team is, that is from administration, all the way through to our GPs. This is the first time I have felt that we have given this particular area of staffing justice in terms of their development needs.'*

Interview with JR, Practice Manager, Data source 19

It is suggested by stakeholders that GPN training needs parity with GP training and this scheme offers the opportunity to develop this ongoing need.

> *'I think it needs building and I think it begins to bridge the gap between GPN training and GP training and I think that is a massive political leap that we have been trying to deal with for decades around the Deaneries look after GP trainees brilliantly. It is all funded and very well supervised and there is adequate time. GPN's are just thrown in at the deep end. So, establishing this GPN-ST programme is a huge leap forward in terms of equality of those two professional groups. Particularly as the GPNs now, a lot of the work they are doing, is really picking up some of the GP work. I think they really need to mirror each other those programmes and the fellowships. I think the reality of that is more complicated in terms of securing the funding and getting the infrastructure established and recognised. I think in having something like RCGP involvement, absolutely this needs to mirror the GPN-ST programme and strengthen it. So, I think it would be really important not to lose what you have gained, but to build on it and to secure the long-term funding stream. Building on the evidence of your evaluation about what needs to be improved.'*

Interview with SC, Federation Programme Consultant, Data source 21

Integration a key theme, and it is suggested that the work undertaken in this scheme must be translated to fit with the broad development of GP Nursing and be sustainable.

> *'Despite the assurances of the GPN Ten Point Plan team, from Charlotte Smith, it absolutely wasn't re-invent the wheel and they must embed stuff this time so there is a legacy, it is not happening! Because there are too many projects and they are too poorly co-ordinated, and we are just doing the same. So, I wanted Lakeside to do something actually practical to make it happen and make it last so that is kind of the purpose.'*

Interview with SC, Federation programme Consultant, Data source 21

One Federation Consultant suggest that the work must feed into the National work in the area to take it beyond pilot status into embedded practice

> *'I think the RCGP has got a very supportive approach to General Practice Nursing with Jenny Aston, again you have got somebody who has really been a great representative and an advocate of Practice Nursing, and very particularly Advanced Practice. So, she is very much…, one perspective is beating the drums*

> *for ACPs. Where I think the gap is, is around a really comprehensive powerful sort of movement that can actually influence long term change for the entire GPN workforce. Because it is now really grey, it is not Practice Nurses and Practice Nurse Practitioners. What we need is to build on the work that has been happening through the GPN Ten Point Plan, and HEE framework and everything and to stocktake where that actually has taken General Practice Nursing. Then have some involvement with the NMC because all the work they are doing about postgrad standards and recognising that the Community Specialist Practitioner staff has been really, it is so out of date and so irrelevant now. The programmes that General Practice Nursing needed was never actually fulfilled with a qualification, but we need, so that it actually gives professional recognition as well as an academic accreditation to something that is then respected. I think we have got all the elements we just haven't got…. What I would like to see from the GPN Ten Point Plan movement is they force the change that actually then creates a legacy that actually is made of concrete rather than just another wave of pilots.'*
>
> *Interview with SC, Federation programme Consultant, Data source 21*

Work at the Lakeside site will be important to monitor moving forward as they build in this area.

> *'We are building a Primary Care skills academy that is contentious throughout all the nursing grades, I think it offers an opportunity of doing some more prototyping or investigating because there are 150 nurses under one roof. Already involved in a very developing piece of work that encompasses a lot of what you are looking at.'*
>
> *Interview with SC, Federation programme Consultant, Data source 21*

It is crucial that there is National overarching work bringing together the excellent practice and developments occurring in the Midlands and North region.

Summary

The course was a successful leader in the field and provides excellent opportunity for learning to other sites. Project aims were met, and the scheme was a successful proof of concept. Contributing factors to success were strength of existing relationships and where successful tripartite mentoring relationships exist. Areas for development include working on the large number of mentors and continuing to facilitate their input over a distributed role. A significant amount of the learning from this site contributes to the how-to guide which is a key outcome from this work.

Case Study B - Bishop Grosseteste University / Lincolnshire STP

Introduction

This new partnership was formed in response to the call for tender.

Running for the first time this year, this GPN-ST route can be considered to be in their pilot year in respect of the University running the *Fundamentals* course. It is therefore vital that at this stage the course is evaluated as a 'work in progress' with lessons to be learned which can be identified to help further course developments.

The following is the relationship map for this partnership site

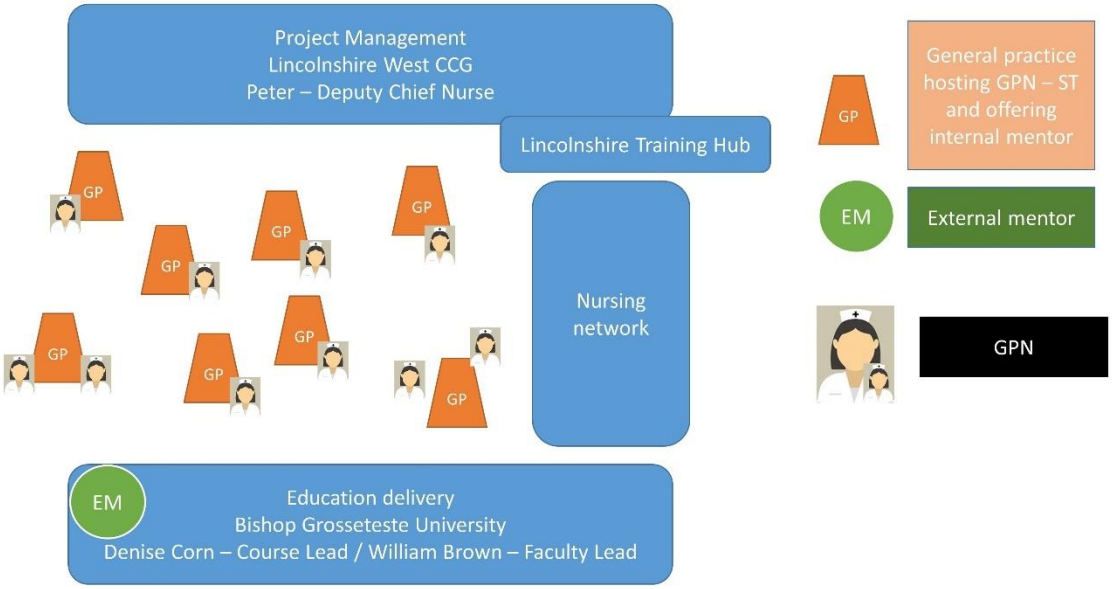


Figure 15. Relationship network map for BGU/Lincoln site

The overall management of the scheme falls within the Lincolnshire STP (on behalf of 4 CCG areas)

Peter Edwards was allocated project management responsibility as Deputy Chief Nurse in the CCG as his role has a wide range of responsibilities which can be seen to complement this scheme.

> *'The CCG acted as the Lead Project Manager for the 4 CCGs within Lincolnshire and utilised an experienced Project Manager to initiate the programme (highly labour intensive). This resource discontinued once the GPN-ST commenced their Fundamentals course. This did leave a void in terms of project management capacity from an STP perspective which did require escalation (from NHSE/I/I PMO) to the STP GPN Nurse lead (Director of Nursing for Lincolnshire South & South West CCGs). This led to a more formal arrangement with the Lincolnshire training hub who took on more responsibility for the GPN-STs in terms of responding to issues and identifying solutions.'*

Interview with PE, Lincs CCG DCN, Data source 15

Peter has a role with wide scope and as a result has limited time to offer to day to day project management

> *Yes, that is certainly one of the challenges that I have found is capacity. I am full time, but I do well over 50-60 hours a week. In terms of formal projects this is the only project, but I do a lot of firefighting, dealing with complaints, care homes, General Practice, hospitals, mental health.*

Interview with PE, Lincs CCG DCN, Data source 15

Additional support is offered by the Nurse Leads in the training hub covering the area.

> *'All 3 CCG areas which is what the training hub covers now. We used to be east and West Lincolnshire, now we are East, West, North and South so we cover the whole county.'*

STP Business Manager, STP Focus Group, Data source 14

Changes in responsibility left some gaps in monitoring and management of the scheme in its initial rollout. The local training hub has been increasingly involved in the day to day management of the scheme.

The day to day management of the nurses and their education is devolved largely to practice level and this means there is great variance in experience with little local overview. This devolution causes trainees to primarily approach the University for support.

The University is responsible for the external mentor role and this is provided by the course director. There is minimal engagement beyond the University and the practices, and this is identified as a weakness in this relationship network.

The local Primary Care Network is attended by all parties involved in project management. There is little evidence of a network which brings together the nurses across the scheme to share learning outside of the course.

Planning

Aims

The key stakeholders across the project agree clear aims for the project.

The primary aim is workforce development with the primary objective to increase the number of GPNs in the local workforce.

> *'The pilot will increase the provision of GPNs in Lincolnshire'*
>
> *'An increased GPN workforce will support targeted prevention and management of long-term conditions'*
>
> *'The coms and engagement team will be engaged in ensuring that practice nursing is seen as a first-choice career in Lincolnshire'*

Task and Finish Group data

STP Nurse Leads suggest that the project is timely and fits with the transformation work being undertaken in training hubs.

> *'It was kind of work we were already doing as a training hub. We were already looking at vacancies, approaching the practice with vacancies and offering them support. How to go on similar Practice Nurse courses.'*

CCG Nurse Lead, STP Focus Group, Data source 14

The STP staff suggest that the aims of the scheme are directly related to the workforce needs in the area.

> *'To fill in the gaps. We had looked at 10 practices that had experience or training experience to roll that out into the not so successful practices that struggled with recruitment. Like we know there is certain clusters within Lincolnshire that struggle with recruitment so we thought if we could have 10 highly skilled, highly trained GPNs then they could then be potentially employed across the whole of Lincolnshire.'*

KA Nurse Lead, STP Focus Group, Data source 14

The University suggests the demand for *Fundamentals* is driven by the needs of GPs and the desire of nurses for an opportunity for an entry into a career in the setting

> *'I had an email from admissions this morning saying somebody who was interested in the programme. So, I have had a number that have actually said it is what I want to do, how do I get into it, I am at the hospital at the moment? Some of the advice I have given them is getting some bank work in General Practice so you have the connectivity but yes please do look at coming onto the programme because we need more General Practice Nurses because of the recruitment and retention issue.'*

Interview with DC, BGU Course Staff, Data source 12

The project aims to develop the workforce and build a future model of leadership and mentoring

> *L: 'So, we know that in Lincolnshire there is a massive recruitment and retention issue.'*
>
> ***Interviewer: 'Do you have any stats on that?'***
>
> *KA: 'We do have stats yes'*
>
> *CA: 'I think it is 72 full time equivalent vacancies across the county*
>
> *KA: 'So, the first phase would be to fill with the 10, whether they are full time, part time equivalent. So that is a small portion. They can then be the sort of trainers of the future.'*

STP Focus Group, Data source 14

The employment model agreed at the GPN-ST is different to that in Case Study A.

CA: 'So there is a slight difference so the ones that went to De Montfort are actually employed by the surgeries whereas the ones that are on this course are employed by the CCG.'

SM: 'And that money was obtained to pay for the full wage of the GPN in training.'

STP Focus Group, Data source 14

Preparation for delivery

The setup of the scheme started in October 2018. The initial working group was established in mid-October 2018 and planning and partnership work took place throughout November 2018. This included the invitation to training practices to offer their expertise in training and working out employment models and criteria for selecting practices. Placements were due to be confirmed by the start of December, but this was realised at the start of January. Daily log shows that it was useful to have an admin contact, and this was TV's PA.

All sites reported timelines being tighter than they would have liked.

'The only thing I would do differently about having that lead in time, that is the only thing that has been an issue.'

Interview with PE, Lincs CCG DCN, Data source 15

Planning education and support

There was a short lead time for a new course with the provider commissioned in January for a course to start in March. DMU was able to facilitate a faster start to the other schemes as key relationships were already in place. At BGU the *Fundamentals* course ran for the first time which created a large workload at the University for tight turnaround.

Course Lead: 'We validated it in January. Won the tender in January to provide for the 10 places for the specialty training through HEE and we started in March.

Researcher: That is a pretty quick turnaround.

Course Lead: It has all been worth it hasn't it?'

Faculty Lead: 'Yes, I think it is important to say we do have an underpinning MSc in Primary Care and community care.'

Researcher: Ok was that in place in advance of this?

Faculty Lead: 'Yes it was validated before that as a new programme which we haven't recruited to yet in terms of time scales to when we saw the tender and were asked to provide. So, we have taken the modules from that.'

Interview with Course Leads, BGU, Data source 12

In the absence of development time, the University utilised their areas of existing expertise to develop and deliver the course. For example, one module of the course focuses on blood tests and results (unlike any of the other *Fundamentals* courses) due to this being an area of specialism for the Dean of the School of delivery.

> *G: 'So I am a Fellow of the Institute of Biomedical Science, trained as a Biomedical Scientist 20 years ago. Head of Allied Health at De Montfort, came here for remit for expanding the health provision, spend a lot of time training and teaching Nurses, Midwives, Allied Health Professionals. Really interested in blood test results and published books and papers on that. How blood test results are helpful to enhance practice but also in a kind of story telling way. I am also interested in distilling the interdisciplinary key themes but also in a remote and rural practice because quite a lot of the stuff is in an urban environment, so policy driven by urban environments. So, interested in where are the services going kind of help economics leadership.'*
>
> *Interview with Course Leads, BGU, Data source 12*

Timing, inexperience and speed of turnaround created issues for the University which can be resolved in future cohorts with longer lead times into the course and scheme.

> *'The fact that we were asked to put it on rather quickly, and the external provider that I preferred, that was the creditable one, couldn't do it until September time so we front loaded that before the flu season to make sure we get that done. The focus for front loading the priority is around cytology because of the duration of the programme and the fact that they need to be doing their smears and things. That actually became the most priority. Ideally when we look at the programme for next year and I know I have got people who are already interested, the Imms and Vacs will come earlier.'*
>
> *Interview with Course Leads, BGU, Data source 12*

Execution

This section highlights key points of learning throughout the delivery and execution of the scheme between Summer 2019 and September 2019.

Recruitment / HR

Project management first recruited trainees, then a course provider, and finally hosting practices

> *'Timeframe for engagement of Successful practices prior to commencement of trainees. Resource has been targeted on recruiting the trainees in the timeframe required and the provider of the course was unknown until this week. There is now a limited timeframe to communicate and engage with practices. CCG Leads are arranging an event before the end of February'*
>
> *Task and Finish February 2019*

Nurses

Job adverts were placed which generated national interest.

> *'We put it out on the NHS website, the LMC, all practices were emailed.'*
>
> *HO Nurse Lead, STP Focus Group, Data source 14*

Communication through flyers were shared with 'return to practice' and 'new to practice' courses at 5 local universities (Doncaster, ARU, Derby, SHU, Hull) and flyers at ARU 19/20th November.

The criteria for recruitment was in line with the aims of the scheme

> *'They couldn't have ever worked in General Practice, so they had to be new to General Practice or new Qualified Nurses that had just left university.'*
>
> *KA Nurse Lead, STP Focus Group, Data source 14*

The adverts generated 68 applications and 32 applicants were shortlisted for interview. All shortlisted trainees were contacted to see which of the 3 Lincoln areas they wanted to be interviewed for. Training Hub and project leads coordinated set up of seven panels and invited the candidates.

Interim interviews took place by 12th August. TV was constant on the interview panels along over 5 days with a rotation of available staff from Practice Management, Practice Nurses, the local LMC, university representatives, HEE. Each applicant was interviewed by the panel and scored. Scores were compared for validation.

> *'So, although there could have been potential for a lot of variation, but we were very consistent on our scoring.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 15*

Practices were invited to attend panels relevant to their CCG area. Notice was shorter than working group would have liked for all involved. Some candidates had to change timing of interview due to work commitments and therefore GP Practice staff interviewed on panels with some candidates who did not want to work in their CCG area.

> *The applicants represented a variety of ability*
> *'A wide range I would say. We probably had about 15 that were appointable, the other 15-16 candidates were not appointable.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 15*

By 31st August all interim interviews had taken place and 9/9 offers had been made. Successful candidates were informed by Project Lead and unsuccessful given feedback from interview panel lead.

Because of strict turnaround times and limitations with capacity in the team, a consultant was employed to help with recruitment. Whilst this meant targets were met, this short-term relationship did not feed into the long-term aims of the project

> *KA: 'There was lots of applicants so the shortlisting process, it wasn't done by us, it was somebody externally funded to initially start the programme but there were lots of applicants.*

> *HO: I think that was a tricky bit her coming in as well. We had the initial meeting to set it all up and then she came in to run it. [Consultant SR] like just comes in and sorts projects out like this. Self-employed. But when she left there wasn't really a handover and so everyone didn't know what was going on, where we were out, who had been told stuff, who hadn't, which was a big issue.*
>
> *N: Yes, there was no kind of work for us to pick up either, because it was confidential data like applicants, we didn't have access to any of that information.'*

Lincs STP Focus Group, Data source 14

The STP suggests they would have liked to have done a follow-up piece of work with unsuccessful candidates but had not enabled the GDPR permissions to enable this.

> *'There was more as well but the application was quite specific and there was a lot of exclusions. That is one of the reasons we wanted those other nurses that weren't successful. We wanted to follow them up to see whether we could support them in another role. GDPR wouldn't let us have names.'*
>
> *'That information would have been useful because we know that they would probably have been equally as good candidates.'*

CC Practice Nurse lead, STP Focus Group, Data source 14

It is therefore important to consider the benefits of short-term goal setting against longer term aims and recognising the GDPR limitations of any project. Furthermore, where consultants are used, there should be a clear handover to facilitate the ongoing development of the scheme.

Although 10 GPNs were recruited, only 9 of those started the scheme. Before the start of the scheme one offered GPN withdrew for 'personal reasons' which was the requirement for her to relocate. In view of the late withdrawal of a candidate, other applicants were reviewed. The first initial reserve had then secured a post in a General Practice and other candidates were deemed not to be appointable. Also, the timescales involved would not enable other candidates to complete pre-employment checks and give the 2 months' notice required and commence on the programme in a reasonable time. Therefore, following discussion with HEE and NHSE/I, the *Fundamentals* place was offered to a previous applicant who withdrew when securing a post in General Practice and had attempted to self-fund attendance on the *Fundamentals* programme, therefore she is now part of the learning cohort, but her salary is not funded.

The lead time for recruitment was anticipated to be one month but that did not allow for the typical notice period of 3 months that was often enforced. Primary Care induction that was envisaged to take place in January had to be postponed and took place in March. The rushed timeline was problematic and is a lesson to be learned for future iterations.

> *'But trying to interview in January February to start a programme in April, it just wasn't do-able. If I had the time over again, I would have just refused to have done it. We were directed to work within those timescales.'*

Interview with PE, Lincs CCG DCN, Data source 16

Several HR issues arose both at the start and throughout the scheme.

HR were unable to work to timescale required by the working group to set up interview panel and inform successful and unsuccessful candidates.

It was identified by project management that there was a risk of a fixed term 9-month contract being prejudicial towards pregnant women and advice was sought from HR.

Incorrect contracts were issued by HR that placed trainees on paypoint in line with their previous post. These were signed where correct but in 3 candidates' situation, the paypoint was calculated wrongly which is how it came to light. In discussion it was decided that the damage that this would do to morale of the group and possible late drop outs not to mention possible legal implications where contracts had already been signed, the Executive Lead Nurse took the decision to honour paypoint and fund the discrepancy.

Pre-employment checks delayed the start and took longer than anticipated.

Some candidates initial HR paperwork was not been completed by payroll deadline meaning they were not all paid as expected. In some cases, this led to financial hardship for GPN-ST trainees. Urgent payment requests had to be used to resolve the situation.

Practices

The planning to recruiting training practices started in November. A list of training practices was requested from the training hub and a list was provided by HEE and a list was also sourced from Lincoln University. There was a process to find out how to contact training practices through local Federations/networks. An expression of interest was sent out to practices and included in the LMC brief at same time. A first reminder was sent after one week and two weeks later any practices who hadn't replied were contacted personally.

> *'A small number of Practices identified to the training hub that they had not found communication around the pilot to be effective. It is not clear if these are training practices or other practices within the networks/federations. It is acknowledged that tight timescales have impacted on preparation time for this project and in the timescale for informing practices of the outcome of their expression of interest. However, all training practices received an initial contact requesting expressions of interest and two follow up contacts. The LMC highlighted the pilot in their newsletter and the CCG Leads/STP highlighted the pilot in various forums. In addition to this in the CCG areas where there were less expressions of interest a targeted communication took place. In instances where the dissatisfied party has been identified the audit trail indicates that the practice did not respond to communications. That said it would be helpful if this formed part of the evaluation.'*
>
> *Task and Finish February 2019*

STP Nurse suggests that the recruitment criteria for practices was appropriate but under serious time constraint.

> *'We decided early on that we would only use training practices, the reason for that was we knew they already had the infrastructure for having trainee GPs and*

> *registrars. So, we only approached training practices. We put out an advert for special interest for all those that were interested, not all came forward. Then we had a process in place which the hub led on, to evaluate each of the placements and decide on the number and criteria, whether they were suitable or not. They rang them and we actually came out with 4 practices in East Lincoln, 4 practices in the West CCG and then 2 practices in South/South West.'*
>
> *STP Business Manager, STP Focus Group, Data source 14*

> *'We had quite a strict criterion. They probably had medical students or student nurses. We kind of excluded people we knew were in special measures with CQC because we didn't think it was a fair time for students to go in. There were lots of practices that were desperate because they had vacancies, but they couldn't provide that support to a new nurse because there wasn't a big enough team. So, we talked about finding the good quality training practices. The turnaround was really tricky from like going out to going live. I think we had about 2 weeks to interview people.'*
>
> *CC Practice Nurse lead, STP Focus Group, Data source 14*

STP Nurse also suggests that recruiting practices required an understanding and commitment to innovation

> *'Sourcing practices that are willing to take on, in effect, a super newbie. Because it was like, it had not happened before, so it was convincing people that it was a good idea. That was the initial difficulty. Finding those practices that we could ensure would provide good quality training, support, education.'*
>
> *CC Practice Nurse lead, STP Focus Group, Data source 14*

Timelines for recruitment

The recruitment process was rushed.

> *'The project starting, or the anticipation of being told we had been awarded the pilot and then the expectation of the time to recruit. To get people started in post, to get the university programme started was just ridiculously too short. HR was just not equipped to deal with it, so we used our own HR team provided by commissioning support unit. It really threw them, unfortunately, a lot of the issues that we have had around HR and around processes'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*

Reflection suggests that the time of year plus time allowed for planning and recruiting needs to be changed.

> *'A lot of it has been down to the fact that we were interviewing January February time, that would have been an ideal time to be interviewed when to start in September. But trying to interview in January February to start a programme in April, it just wasn't do-able. If I had the time over again, I would have just refused to have done it. We were directed to work within those time scales.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*

Recruitment was planned with a tight turnaround which only allowed for 1 month from design of job description and advert to fully recruit. The job description and advert took 3 weeks to get to HR and from then it took a further 3 weeks to recruit, so total time was 6 weeks from confirmation of job description and advertisement to fully recruited.

Some of the process fell over the Christmas break which was problematic. The original idea was for big panel interviews, but no big enough meeting space could be sourced in timescale, so the process moved to smaller 3 person panels with GP engagement.

Trainee motivations

Trainees had a range of reasons for wanting to start or move into General Practice roles

> *S: 'I have been qualified approximately 4 years, went into A&E, so straight into the hospital. Which I hated. I don't know why actually. I love being busy, I think it was because being newly qualified, the thought of losing my pin after I had worked so hard for it, that was what was scaring me. I would have loved to have come into Practice Nursing but found it very difficult to get in without any experience. However, I was very lucky in getting somebody to take me on. So, I have been practising for about 2 years.'*
>
> *CS: 'I am different to the other people on the course. I qualified nearly 2 years ago, went to the hospital, worked in cardiology and diabetes. Did my final year as a student in a GP surgery and went back to do my management there. But there was no job at the time, so I thought go to hospital, get a bit of knowledge under my belt. The surgery that I did my placements at, a job went on NHS jobs, so I applied for that in November, then got the job and started in January. So, I was in GP practice before this course started so the GPs are funding me to be on this course. So, I am different because it is not funded by the CCG for me.'*
>
> *Student Focus Group, Data source 13*

Timelines

All sites reported timelines being tighter than they would have liked. At this site one key learning theme from the evidence is having realistic timelines.

> *'They wanted to get the programme up and running in that time. It just wasn't realistic.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*
>
> *'The project starting, or the anticipation of being told we had been awarded the pilot and then the expectation of the time to recruit. To get people started in post, to get the university programme started was just ridiculously too short.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*

> *'Ok so the biggest issue for me and what has caused the team most problems, was the lead in time.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*

The tight deadlines caused the need for consultancy

> *'Because we got the bid and results through. Was it middle of November we got the results, and then we had a deadline? On the sheets that they gave us they wanted applicants to be recruited within 2 weeks. That is really not going to happen. So, at that point nobody really had the capacity. I think if we were 12 months on in the training and in the situation, we are in now, we would have done the whole thing. But Lesley and I had only just come into post, there just wasn't the capacity for us to do it. So, it had to go somewhere, someone had to do it. That is why it went out.'*
>
> *HO Nurse Lead, STP Focus Group, Data source 14*

In future the team would prefer longer term collaborations to enable relationship building within the team and continuity of support and project management

> *'To have a team that was going to manage it from the start all the way through to the end and they finished with their contracts. The communication issues I think would have marginally been resolved with that. If we had longer time to sort it all out and then also not have to swap over halfway through.'*
>
> *HO Nurse Lead, STP Focus Group, Data source 14*

Peter recognises the need for the scheme to have clear project management responsibility with a time commitment which can vary according to the needs of the project.

> *Peter: 'I think you have to have clear programme management support. I think we had that at the start, we don't have that now.*
>
> ***Researcher: What changed?***
>
> *Peter: The programme manager that was supporting us has actually secured different employment, she was no longer available to help.*
>
> ***Researcher: So, somebody in post as the manager of this scheme?***
>
> *Peter: We bought them in, 1 or 2 days a week, I think 2.*
>
> ***Researcher: On a short-term contract?***
>
> *Peter: It was a bank contract. So, we did that, and they served notice to us at the start of the programme and we didn't replace them.*
>
> ***Researcher: Had you in mind keeping that person on?***
>
> *Peter: We would have kept them on longer definitely. Probably would have kept them on for the duration of the programme.*
>
> ***Researcher: Why didn't you replace them then?***

> *Peter: Initially I thought through the oversight, because we had done all the recruitment, the oversight of the programme is going to be the easy bit and it doesn't need as much maintenance. But actually, in hindsight, realise it probably did.'*

Interview with PE, Lincs CCG DCN, Data source 16

Working with HEI

The scheme brought together new relationships with varying responsibilities.

The University course was commissioned with tight turnaround. HEE commissioned the University course and feedback from the CCG and STP suggested they had not been involved in the early relationship with the University.

> *'I think it is important to say that the CCG didn't commission, it is not us that has commissioned the course, it has been Health Education England. They led the process, it has been down to them, we weren't involved in that.'*

Interview with PE, Lincs CCG DCN, Data source 16

Evidence suggests a need to develop stronger relationships and communication channels between the HEI and other key stakeholders

> *'I think the biggest improvement that we can make is communication between practice, student and university. Because this is the first time it has happened, and we are still waiting on the detail of the course to regards what is happening and when? So, we don't have a schedule from September yet and the practices need to know what the student is doing so that they can facilitate the learning and the experience together.'*

LT Nurse Lead, STP Focus Group, Data source 14

There is evidence of overlap between ownership of the course content.

> *SM: 'So that comes from the University. The university decide what the skills will be involved. We know, and we have given feedback.*
>
> *KA: But we have collated a Fundamentals skill, that was one of our actions from the last meeting, from General Practice employers' point of view, what would they expect Fundamentals skills of General Practice Nurses to be? So, we collated that information.*
>
> ***Researcher: And is that practice managers, GPs, both?***
>
> *KA: This is kind of the Royal College of GPs, their competencies, which is all sort of set out in stone. Like what we used to use with De Montfort, like similar Fundamentals, the key skills that if you were taking on a Practice Nurse with experience, what you would expect those skills to be.*
>
> ***Researcher: So, what are they?***

KA: We have got cytology, immunisations, travel health, ear care, phlebotomy, wound care, contraception.

CA: We can send you a list'

STP Focus Group, Data source 14

The STP discuss undertaking work independently of the University to consider appropriate content for a *Fundamentals* course.

The model of mentoring is different at this site and practice mentoring is supplemented by external mentoring provided by the course leader. This is considered in detail in the next section on mentoring.

Trainee feedback on the course is broadly positive. Areas for improvement include mentoring and external training provision and timing of come aspects of the course.

S: 'I think maybe the external training, surely it should be provided by them? The ear care, we provide it through them. The cervical cytology it was provided through them. A competency pack for bloods isn't exactly unheard of is it? (lots of chatter)

N : I think that is probably because comparative wise, …like L?

L: I did phlebotomy at [private company], they have a full information pack.

J: I didn't realise you didn't have one. At your own practices.

S: Our practice doesn't have them because they get them from their training providers. We get them on external training if we don't get one on our external training with the university, we don't get one elsewhere which is a bit of a problem for us.

J: You do need a competency pack definitely in my opinion anyway.

N: It is something to take forward isn't it?

S: I don't want to dampen it, or she said this or whatever

N: No it is completely anonymous and moving forward….

S: Yes, we are just feeding back, we think it is a great course, the feedback is because we want it to continue and be better

J: That is something to consider, it is the first, it will have teething problems. Whereas the De Montfort course we attended had been going for a few years. So as long as we are feeding that back and it is improved.

Network Focus Group, Data source 22

'This is a big issue as we have things we are doing after the portfolio is due in. we have our vaccination course over the first two weeks back then we have only got a couple of weeks before we have to hand it in. So how can we be competent? I

> *have backtracked to get in on those clinics and become more confident and be asked to lead the clinic with somebody there so that I have got that experience.'*
>
> *Trainee Focus Group, Data source 13*

The STP suggests that feedback from the practices suggest that key skills need to be frontloaded in the course.

> *'We have approached Practice Managers for feedback at this stage, that it is a fundamental course and to this point, halfway through, there is only two fundamental skills that they have had the opportunity to do in university. So, it leaves all the rest of the Fundamentals to learn very late on in the course to then expect them to be competent to go out into practice after December.'*
>
> *KA Nurse Lead, STP Focus Group, Data source 14*

Some trainees suggested the University were not responsive to their feedback. Others disagreed.

The University suggested that their own internal procedures find it difficult to align to the short turnaround times and planning needed by HEE. However, at an early stage the University feels positive about moving forward with developing the programme and implementing it widely

> *'is it ok me talking about the business case to the university then? So, in order to get approval, the university has a programme management group where viability documents have to go to it. So that is how many students are going to be on the course, what the staff capacity is, and how many extra staff we need. So that is fine. We have also spoken to HEE around if they want multiple entry points, and they want to send 30-50 students then the university would look to support that. So, we think 10 is a viable number as a pilot but should it be more than 10, then we feel we have got the infrastructure to deliver that.'*
>
> *Interview with WB, BGU Course Staff, Data source 12*

At the midpoint of the scheme there was some confusion about the future of the BGU *Fundamentals* course and the relationship with the local STP.

> *CA: 'I guess the other option is if we do get more people coming to the De Montfort course, so they then are employed by the GP practice and go through it another way rather than through CCG that they are doing now.*
>
> ***Researcher: Could that model not work with BGU?***
>
> *HO: We don't know if the BGU course is going to get commissioned or not. I believe it is going through different evaluations and some pieces for feedback. Interview with DC, [BGU Course Staff, Data source 12] was saying something about it changing a bit, but we haven't got anything concrete, so we don't know what is happening. So, if somebody is coming to us now the only thing, we can offer them is the De Montfort course.*
>
> *KA: When it was initially set up the plan was that De Montfort were going to provide the education portion, that was always the assumption.'*
>
> *STP Focus Group, Data source 14*

The University suggests that there is likely to be demand for the course by practices and CCGs beyond the GPN-ST scheme.

> *'The programme we are going to set up anyway, whether we get the tender from HEE I don't know, but there might be enough people privately but at the moment I don't know. I know there has been 5-6 enquiries outside of the HEE contract.'*
>
> *Interview with DC, BGU Course Staff, Data source 12*

Mentoring

The model of mentoring is different at this site and practice mentoring is supplemented by external mentoring provided by the course academics.

Practice Mentoring

The scaffolding method of learning enables trainees to learn a skill and the underpinning and practice that with support in a clinical context building towards confidence and autonomy.

The STP recognises this as a key objective for the scheme.

> *'The ability to be autonomous. Obviously better supported autonomous. There is being autonomous and being a bit scary. Knowing if you are stuck you can go somewhere. For example, travel health, you probably only get one day, two days on that, you wouldn't want them to…., you always need supervised competency building to your consolidation prior to them being let loose and doing it themselves. So, ability to get support when you need it.'*
>
> *KA Nurse Lead, STP Focus Group, Data source 14*

Most trainees report a positive experience of practice mentoring.

> *S: 'I have got a lovely mentor in practice.*
>
> *N: Mine is really lovely, cannot do enough for me. Messages me, if I am working on my own and she is in a different room doing a different clinic, she is like are you alright?'*

External mentoring

Practice mentoring is supplemented by external mentoring

> *CS: 'We have academics that go in and do the initial and intermediate interviews. They are clinical supervisors. They are from the academic team.'*

This model was raised as problematic by trainees, especially where practice mentoring was not strong.

> *'You aren't confident, and you don't feel that you are supervised sufficiently, and you are not able to evidence that competency then you need to go back to the drawing board. Where are the gaps, what do I need to do? Is it the supervision that is lacking, is it the fact that I need to evidence what I am doing? There might not be any particular package to say somebody comes and watches you but if that is what you need that is what you have to evidence. Somebody else might need to do 20 samples before they are confident. But there is a practicality to this that I think with anything that is new, we are learning all the time.'*
>
> *Trainee Focus Group, Data source 14*

The model was also raised as problematic by the STP.

> *'The training hub have identified that an element of oversight is absent from the procured training package. There is usually within the training model an element of clinical supervision independent of the practices to ensure that aspects of the course assessed in practice are moderated independently to ensure consistency of course application. Mitigating actions: A lead Practice Nurse role is being developed. This role will work closely with the training hub and LMC on leadership for Practice Nursing and will support supervision in practice and CPD. There will be a gap before the role is appointed to and during this period the CCG Leads, training hub and University will ensure that GPN-ST trainees suitably supported in practice.'*
>
> *Task and Finish group data April*

It is suggested that since the hosting sites are training practices, the expectation of Practice Mentoring quality is high and mitigates a need for regulation by external mentoring.

> *CS: 'We have a different system to other universities and that is purposely adopted for this because these guys are in training practices.*
>
> ***Researcher: Are they all in training practices?***
>
> *CS: Yes so it makes a big difference in terms of the skill set of the mentors that are out there.'*

The University agrees and considers this model an opportunity to create a link with Practice Mentors.

> *'Because the students are in training practices, all the mentors that are assigned to them, they are mentors, they have gone through additional training for the NMC. They are obviously part of a training practice; they are enthusiastic so there is a lot of connectivity. I have been in and talked to the supervisors about their role, and they see that as being really beneficial because that is part and parcel of their revalidation, supporting the students within their own practice.'*
>
> *Interview with DC, BGU Course Staff, Data source 12*

BGU sees the external mentor role overlapping the personal tutor role offering pastoral support.

> *'I also have a personal tutor responsibility as well. So, I have got a connectivity so if there are any issues in practice that they don't want to talk about there they*

> *can come and talk to me. I am aware there are a number of things going on with some students. Sometimes some of the things they don't want to broach in front of their employers. So, it is about having that personal tutorial support as well.'*
>
> *Interview with DC, BGU Course Staff, Data source 12*

Students acknowledged the knowledge and support provided by academic mentors

> *'Every question you sort of query, they know the answer whereas the other training programme I went on they would say if you send me an email I will get back to you on that one. Because they were unaware of what you were asking.'*
>
> *GPN-ST trainee MO, Network Focus Group, Data source 22*

There is evidence of practice mentors learning from academic mentors and benefitting from the learning undertaken by the trainees.

> *CS: 'And the mentors like it as well. The two nurses we have got in my practice, they have been there for about nine years, so quite often we will be doing something, and they will say what did they tell you on your course. They told me this…….*
>
> *S: Yes, we are most updated. I said there are things that I have learnt because I have not read any more research in something so this way you are learning what is best practice now. Not four years ago when I was training. So, you can pass it on, you can say did you know you don't do that anymore? And they say where did you find that out? At uni. Oh, that's ok then. You do get into sort of habits don't you, you get stuck in your ways.'*
>
> *Network Focus Group, Data source 22*

Support

The training hub linked to the CCG through the GPN networks provides important support to the locality

> *'We think it is important to have a nurse on the ground, active in that patch, to make sure that we are reaching all the practices basically very rural, very spread and very diverse medically. Across the county as well, different sizes of practice, different requirements from localities. We all attend a GPN meeting, we are quite active our GPN group. usually the first Wednesday in the month. We learnt there that we were putting a bid in led by Peter Edwards at CCG for money to be available to pilot this GPN course.'*
>
> *Business Manager, Lincs STP Focus Group, Data source 14*

At the end of the scheme the STP feels it has been able to offer support to the GPNs to facilitate a community.

> *I think there has been quite a lot of interaction and support. You know when you are a student your kind of are in that group, but we all know Practice Nurses you*

are very much out there on your own, so I think they have got that sort of community. They have got support from CCG, the practices, we have supported. We are taking them out for breakfast in September for a kind of get together.

KA Nurse Lead, STP Focus Group, Data source 14

Outcomes

This section reflects on both planned and unanticipated outcomes.

The original aim of proof of concept was met and 9 new nurses were trained and employed in General Practice.

This section discussed the mechanisms and reflection on the model which supported the GPN-ST trainees' transition to work.

The trainees had varying levels of support from a range of places but in particular were supported by the CCG and STP to transition from the CCG roles into employed long term posts in General Practice.

'What we are planning to do is match them up to wherever the vacancies are. So obviously if those training practices do have vacancies, or they find they want to take this person on, they can do so.'

Interview with PE, Lincs CCG DCN, Data source 16

N: 'I think from our point of view we are able to help with covering letters and applications and CVs so always get in touch with us to help apply for jobs, if you see anything that you are interested in. don't leave it until the last few weeks, it is always good to plan ahead, there are quite a lot of vacancies about and it is always worth approaching to say I am coming up to the end of my training, would they consider you for the post? Because with all the qualifications that everyone is going to have, people are going to snap your hands off.'

Network Focus Group, Data source 22

N: 'Also use the conference in a couple of weeks' times to network, speak to people, speak to nurses because they are going to be the ears on the ground knowing what is coming up and whether they are retiring. Advertising, that is the other issue, it is costly, it is time consuming, so some are quite tunnel-visioned that somebody is going to knock at their door. So even if there aren't vacancies advertised, it is always worth sending covering letters and approach practices in your patch that you may want to work at.

S: That is how [this GP practice] works, they very rarely advertise. The practice manager said I would rather a nurse come knock on the door and come and have a conversation.

R: I approached when I was qualified, and they didn't have a vacancy at the time but said they would take my details.

B: Practices, they tend to advertise on various different sites, NHS jobs, Indeed, etc.

N: We track that quite closely so hopefully we have most bases covered so we usually know where the vacancies are.'

Network Focus Group, Data source 22

The STP is satisfied towards the end of the course that it meets its original aim.

'So, we are going to have these qualified nurses at the end of December that are going to be a massive asset to Lincolnshire because they will have had good quality training and they will all hopefully be staying in General Practice.'

KA Nurse Lead, STP Focus Group, Data source 14

Trainees are made aware by the STP of their position within the regional workforce

S: 'Are the practices in Lincolnshire aware of us and what we have done, all of them?'

BM: Every single practice in Lincolnshire was initially invited to apply for posting advertising at the beginning, we had a huge response. But periodically throughout your time we have done a few promotional things where an account has been published, gone out in the newsletter to all the practices, then shared across each of the CCGs. The good practices that keep up to date with everything, that you want to go to, they are the ones that will know more about you. Then it is making them aware basically as well, you have this full package of skills and if they don't know about it make them aware of it, talk to them about it.'

Network Focus Group, Data source 22

HR / pay issues

There are key HR and pay issues which arose through the scheme. The first is the lack of standardised pay for the role, and no recognition for the training achieved or standardised pathway for development in the role.

Initial pay rates matching pre-scheme roles caused a later problem as trainees transitioned into the GP workforce. This was raised as a risk through the project management.

New risCS: Concern raised that due to being employed on A4C T&C, trainees would be reluctant to take practice T&C if they were perceived as being less advantageous and they would therefore not fulfil a GPN role at the end of the programme.

Task and finish meeting notes

Trainees are aware at the end of the course that the role can hold variable pay levels and benefits.

> *B: 'It does vary widely; I was looking for a job last year and I went more towards the East Coast. They were looking at £16 an hour and they wanted an experienced nurse for that. Whereas go somewhere else you would be looking at £8…. so, like the prison service they were more similar to NHS so that was slightly less than that, I think around the £12.50 mark.*
>
> *N: Look at with a view to saying this isn't forever, I might have to accept this for a while. I know it is difficult if you have got mortgages and things. As long as it is written in to say yes, we will review it. Usually they work on an hourly rate as opposed to this will be your salary. I don't know many people who are on a set salary. You have just got to go in, and it is going to be a good practice, you do have a bit of leeway to go ok, a good practice, I will gain this experience, and if the pay rise they have discussed doesn't work out then you could say well actually I will go somewhere else where I would get that.'*
>
> *Network Focus Group, Data source 22*

Trainees are supported by STP staff to negotiate beneficial contracts.

> *S: 'Having that conversation can be tricky though. What I found really useful is HEE have already printed a guide as to what a Practice Nurse does, what an Advanced Practice Nurse does, and it is banded, this is what they are. You can then say this is coming in at? and I can get, you have got something to look at and it helps broach that conversation.*
>
> *N: Other things that you can negotiate at interview is whether they pay your RCN fees or your annual registration.'*
>
> *Network Focus Group, Data source 22*

STP representatives are keen to highlight the benefits of the potential for development in the role, that may not exist in other domains.

> *N: 'Even though there was doom and gloom about pay and terms and conditions, there is the beginnings of career progression through General Practice now which is new in the last few years. Even though you think the pay is rubbish, that is not going to be for ever. You could move up the career path in the future.'*
>
> *Network Focus Group, Data source 22*

Trainees raise concern at moving between posts and in having a pathway of further development.

> *L: 'I know you can't offer a preceptorship, but that concept I think would be really good. Just having that external help, I think that would make me feel more secure going into a practice. It is just an unknown territory isn't it? I think that is the scary thing.*
>
> *S: Like we started 9 months ago at a new job, 9 months down the line we are doing it all over again, starting a new job is daunting isn't it?'*
>
> *Network Focus Group, Data source 22*

Trainees were reassured by the training hub that their role in supporting them would continue into their new posts

> *BM: 'And if it was a requirement moving forwards, to your first year, if you felt that you required support from the training hub, it is something that could continue to track you with your progress, support you, and supporting you in that new role. We deal with all of the practices in Lincolnshire and have good relationships with all of them so maybe that is something else that could maybe help you to feel that you are not out there on your own when you go into new practice.'*

Network Focus Group, Data source 22

There is a recognition that negotiating salary and terms and conditions in General Practice can be competitive and as a result, secretive.

> *BM: 'The issue is you are dealing with separate practices who have different terms and conditions, so from practice to practice it is very different. I think it is generally discussed at interview stage. Because likewise, the practices do not want their neighbours to know what their terms and conditions are.'*

Network Focus Group, Data source 22

Trainees recognise the alternative benefits General Practice context can offer

> *'I love the social aspect, I love getting home for 5.15 every day, love not having to work weekends, nights, early, bank holidays etc that is fantastic so it is just knowing actually what I am worth to General Practice. It is knowing what is on offer.'*

GPN-ST Trainee B, Trainee Focus Group, Data source 13

The trainees acknowledge this is unusual to them with experience from alternative settings and something they require support with,

> *'I think that is quite alien as well because as far as I am aware, all of us have come from a hospital NHS background, where you get this band and that pay etc, it is all set out for you. It is quite alien for us to have to go in and be like I want x amount a week and I want x amount of annual leave. We have never had to do that before.'*

GPN-ST trainee MO, Network Focus Group, Data source 2

Workforce related outcomes

All nine of the nurses who started the training scheme completed it and were available for work in General Practice. Eight of the original nine secured permanent posts following this programme, six being employed by their training host site, two by new sites and one working elsewhere.

The partnership will now look to utilise the funding for Fellowships within the CCG to support further posts each year.

The training hub accepts responsibility for retention and employment of the GPN-ST trainees at the end of the scheme.

> *'I will just re-iterate our role with the training hub, we are primarily in charge of recruitment and retention of you in Primary Care so although we have been involved in the course, what we want to do is make sure your employment continues on this first year so we are looking beyond December and what your options are. We collectively look at the options and vacancies that are there and try and facilitate and help you with your next step!*
>
> *Focus Group BM*

Feedback from local practices suggest the course has achieved its aim of producing a qualified and trained GPN employed in the local workforce

> *'We have one of these GPN-ST trainee nurses going through the programme at the moment. 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 testimonial source, Data source R2*

The course develops a broad range of transferable skills for trainees that has not existed previously

> *CS: 'Because we can do everything because some of the nurses that have been there years don't do everything. They picked what they wanted to do, what they liked or knew the most about. We have got a nurse that does smears but she will not do baby imms, so she has never gone on the training to do it. Whereas now they want everybody to do a bit of everything then if somebody leaves, or goes off sick, you have got that cover.*
>
> *N: You are portable then aren't you, so if you decide to change practices you have got all the skills.*
>
> *CS: Yes you have got everything. Which will put you at an advantage in an interview'*
>
> *Network Focus Group, Data source 22*

The training hub's original aim was for trainees to move beyond the training host practices and into alternative sites plugging workforce gaps

> *HO: 'So it looks at the GP Ten Point Plan with the recruitment and retention. Because they are going to be trained in training practice sort of highly skilled practices, then they can be rolled out into practices that probably don't have the capacity to train a new Practice Nurse, or new student, or somebody who has never worked in Primary Care. So, they are like a pre-made General Practice Nurse into that post.*

> *SM: We see that as the training hubs role, that has always been our role, recruitment retention, keeping these into General Practice and continuing the up-skilling, that is what we do.'*

STP Focus Group, Data source 14

Six of the original nine nurses remained in employment at their training practice and only two moved to alternative sites in the local areas. Therefore, the aim was only met in a minority of cases.

BGU is confident the scheme meets its aims of producing work ready GP nurses

> *'I am confident with these skills that they have got on this programme that they are going to be portable. That they can work within any General Practice and if you turn up with our PG Cert in General Practice Nursing, a practice is going to say yes. You are going to hit the ground running. You know you have got a credible high level of education and you can do that role.'*

Interview with DC, BGU Course Staff, Data source 12

The scheme meets the aim as a proof of concept that General Practice is a suitable first career for newly qualified nurses

> *'I think it is opening up General Practice to newly qualified nurses so I think there is still a belief from nurses, if you had asked me 3 years ago as a Secondary Care Nurse, there is all this belief that you have to go through Secondary Care, you have to consolidate your training. Even though there are more services obviously being delivered in Community now, it is still that belief that you have to do time before you can go into these roles. I think this programme is showing very much that actually you don't. The wide depth and breadth of role within General Practice makes it an excellent first destination for newly qualified nurses. I think that is something that I have learnt, and I think the programme helps support that.'*

Interview with PE, Deputy Chief Nurse, Data source 16

Feedback from trainees

Trainee satisfaction levels appear to be high at the mid end point of the scheme when trainees report continued enjoyment in the role.

> *D: 'I love my job, I tell everybody at work I love my job, and they say we know you love your job Diana because you come in every morning and you are full of beans*
>
> *S: I never go home and think oh I can't go to work tomorrow, where in hospital, I would not sleep at night knowing what shift I had had and what could come tomorrow. Whereas I don't go home stressed, I am not moody, I don't think I am not going in tomorrow, I look forward to going to work.'*

Trainee Focus Group, Data source 13

Feedback from practices

CCG suggests that Practice involvement in the scheme is indicative of their support towards changing models for Nurse training

> *'I think the fact that the practices have been so signed up to it and been so positive about it, it demonstrates that it has very much been the way forward. I think General Practices are starting to realise that they have got to, if they want to recruit, they can no longer find people that are on the shelf or ready to come and work in General Practice. They now need to realise they have got to start investing and that might mean taking on newly qualified nurses and giving them that additional support.'*

Interview with PE, Deputy Chief Nurse, Data source 16

The scheme collected positive testimonials from many practice staff.

Pathways

Trainees feel disappointed that there isn't wider recognition for the course or pathway

> *'I think all practices have been like that, I think it is the concern of going into a new practice who* hasn't understood the course we have been on.'

GPN-ST trainee MO, Network Focus Group, Data source 22

BGU sees the GPN-ST trainee role as transitional and recognises the importance of sustaining the learning network

> *'Another thing I am going to do when they have finished the programme is to do some top up days, bring them in for peer review days and they can talk to each other as part of their alumni activity. So, we have some continuity because I am aware having taught the non-medical prescribing that there is a disconnect once people leave university and I would like to nurture that environment, in terms of having a Practice Nurse academic environment. Hopefully they will do MSc and maybe PhD who knows!'*

Interview with DC, BGU Course Staff, Data source 12

BGU has a pathway for trainees who wish to return for further education

> *'No, we have got 1 x 30 credit module which is the Fundamentals element, then we have 2 x 15 credit modules which are the blood interpretation and long-term condition management. That one is a PG cert at level 7, 9-month programme, and trainees will be encouraged to go on if they want to do the MSc because they can hop on hop off the MSc as well.'*

Interview with DC, BGU Course Staff, Data source 12

One of the trainees has enrolled onto the MSc intake in February 2020 (in July 2019)

Trainee express a wish to continue their learning

> *'I am going to work towards Nurse Practitioner and prescribing after this.'*

GPN-ST trainee RT, Network Focus Group, Data source 22

Leadership

The University feels that leadership is a key skill to empower trainees

> *'That is a key role of the university, is for students to go out and challenge stuff, talk about customer practise, evidence based. But I think in order to do that, you have to have the underpinning knowledge and the language used to be able to have that conversation with GPs and other people. To say why are we doing that? Not from a deficit position but from a position of I already know the answer, I want you to talk me through it again because I don't thinks it is right so that kind of nuance language of communication which some of these students, they have been on a journey as well around communication and their own confidence.'*

Interview with WB, BGU Course Staff, Data source 12

The University feels that they have an important role in developing a new type of nurse

> *'It is about innovation and leadership which we try to install in them in the programme. If I can comment as programme leader, I think there is something there about being gatekeeper's quality for education, because I designed the programme and there is a lot of variance out there in terms of teaching. That was coming from the practice because it relates to research. Practices were saying if you could get me a gold standard in terms of cervical smears, in terms of imms and vacs, then it is actually well worth to General Practice coming through the programme because it is a one stop shop.'*

Interview with DC, BGU Course Staff, Data source 12

The STP is keen to emphasise leadership opportunities to new GPN

> *'I think the opportunities that we have got facing us now, it is not just clinical opportunities, we have probably got more opportunities than ever before in terms of Nurse Leadership in Primary Care. Educational opportunities to equip nurses to be able to be the voice out in the community. We all know about the shift that services are moving out of hospitals, into Primary Care, that is the focus, that is a long-term plan. So, there are so many opportunities, if you want diversity, and you want to grow and develop, I can absolutely guarantee that that will be the way going forward.'*

STP Focus Group, Data source 14

The scheme is part of a movement around leadership

> *'It was an NHSI programme. So, did that and I had to write about an area within my sphere where I recognised leadership challenges. And I had already started to recognise there were leadership issues with General Practice Nurses. So, part of that assignment, I had to do a lot of reading and just around that time, General Practice Nurses came out and I became very passionate about it. So, when I came*

> *back to base, I had to write, and I was looking to take a lead on it for my CCG but then said it makes sense if I take a lead on it. I said I might as well do it for the area.'*

Interview with PE, Lincs CCG DCN, Data source 16

Learning

There is evidence about the types of learning that the GPN-ST scheme offers, and also about the learning from the scheme that can be shared with others.

Trainees all believe they have gained skills and confidence through the scheme

> *S: 'Definitely, just the way I speak to my patients now, I feel if they ask me a question, 9 out of 10 times I can give them the answer. If I don't know the answer there and then, I know where to go and find it.*
>
> *CS: Yes so, I do a lot of wound care and a couple of weeks ago we had a wound care session didn't we and I learnt so much, I was probably putting half the dressings on wrong. The things I was doing previously, they weren't necessarily wrong, they weren't just the best option.*
>
> *J: When I went to General Practice and I was fairly experienced, it felt like everything had gone out the window. Because it is such a different way of working. That autonomous, in your own room, nobody looking over your shoulder, all that way of working is completely different. It is not unusual at all, even for fairly experienced nurses, to feel like they are right back at the beginning again. It is confidence, competence as well. That can't be got from reading a book or being in practice for a couple of months, that will only come with time.'*

Trainee Focus Group, Data source 13

The STP suggests that the best learning is localised in context

> *KA: 'What about the consultation skill? Because obviously communication is different, the tempo is sometimes quite brisk to be fair, but the tempo will be different to Secondary Care as well. So, it is figuring how to maximise the best value out of the consultation you have.*
>
> *CA: You are making 'every contact count', that is absolutely critical in General Practice because say someone comes in for a blood test, you have got the opportunity to provide something else, that is really important. If you have not had the opportunity to work in that environment, that is something that needs to be looked at.'*

STP Focus Group, Data source 14

Trainees acknowledge that working in different setting require a different set of skills

> *CS: 'And compliance. Like in the hospital I am in charge. You are in my bay of patients, I am in charge of you whereas in Primary Care I can tell you until I am blue in the face but it is actually you that is in the driving seat.*
>
> *S: I think the patient also expects you to know an awful lot in Primary Care as well. So, you need to know a little bit of everything. I think they see you as like little GPs at times.*
>
> *CS: In the hospital you are treating that one specialty whereas in Primary Care they have probably got 3 long term conditions and they expect you to know about them all even if you only specialise in one.'*
>
> *Trainee Focus Group, Data source 13*

The scheme provides specific wraparound learning that the STP recognises GPNs require in the context where they work

> *'Your legal and ethical is quite different in General Practice, how you manage that. People that have never worked in Primary Care, Secondary Care is completely different. You get to know people differently. General Practice is completely different.'*
>
> *KA Nurse Lead, STP Focus Group, Data source 14*

The STP invoked mechanisms for formative evaluation

> *SM: 'We have been involved all along so involved in the interview stages, we did a little bit of our own evaluation. Just so this half way point, the plan was to improve anything that we could put in place before the end of the course that would help to better the quality of what was coming out from all proportions, be it if they needed extra support at practice, extra support in university. So, we see ourselves as quite independent, given that we are not the employer, we are not the education provider and we are not the practice. So, we are quite well placed to offer that evaluation which worked well with [BGU] and [Trainees] and [CCG DCN]. We did that as a bit of a stop gap and some action points, anything we can do before the start of the 2nd semester in September. So, we got some really good feedback. Lots of positives and lots to work on as well.*
>
> *SM: Yes, I think the biggest improvement that we can make is communication between practice, student and university. Because this is the first time it has happened, and we are still waiting on the detail of the course to regards what is happening and when? So, we don't have a schedule from September yet and the practices need to know what the student is doing so that they can facilitate the learning and the experience together.'*
>
> *STP Focus Group, Data source 14*

There was less formative evaluation or network meetings at this site than case study A. (These may represent missed opportunities for support and iterative development of the scheme whilst in operation and have also provided vital data to the summative evaluation presented here.)

The scheme learned that clear project management with protected time is required for scheme success.

> *'It doesn't necessarily need to be somebody dedicated but it needs to have somebody that has the capacity to oversee it a good couple of days a week I would think. Getting out to the practice, visiting students, working more closely with the university, more closely with the training hub. Which is the bit I have not been able to do, and I have felt frustrated that I have not been able to do that.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*

It is acknowledged by all stakeholders that in piloting the *Fundamentals* scheme for the first time and having responsibility for external mentoring, the University would undertake learning

> *'I guess with any course there is on-going niggles and I believe De Montfort are in exactly the same position for the first three years, you learn by what has happened previously.'*
>
> *KA Nurse Lead, STP Focus Group, Data source 14*

Development of Nursing

The peer support network created by the scheme is highlighted as a key benefit by the University to drive forward the community of GP nurses.

> *NW: 'They were talking about that peer support network and for me, that is something that is really important. My own research points that being a real deficit in practice. We started the Practice Nurse Forums Peter and I and I think that has enhanced practice locally, spread the message out there, it is not just turn up, have your lunch and have a training session. There is that conversation about innovation, about leadership, about making practice better. I see this programme as being fundamental to that, improving the network and community of practice.'*
>
> *GB: I think that kind of network within General Practice Nurses is important and also the integration into the future of extended Physiotherapy, Pharmacy Practitioners, Medical Practitioners, GPs with special interests so the whole sector, the whole environment is changing dramatically'*
>
> *Interview with Course Leads, BGU, Data source 12*

In the absence of a formal preceptorships scheme the STP suggests the network of support acts as an alternative

> *CA: 'It provides a preceptorship as well for those ones that are complete newbies.'*
>
> *STP Focus Group, Data source 14*

The STP believes that partnerships PCNs will play a key role in the future development of GPNs.

> *BM: 'The other thing is Primary Care Networks are new everywhere, they cover the locality of practices so we are establishing good relationships with the Primary Care Network and that might be a better way to approach because it is the locality. If we looked at everybody individually and said you were suited to that network, then we can approach the networks to say this person will be qualified to do x y z as of this date and see if we get any response or feedback that way.'*
>
> *STP Focus Group, Data source 14*

This is agreed by the CCG

> *'Well that is where I wanted to start looking about how we engage with Primary Care Networks. Because I think recruitment in the future would be through Primary Care Networks. It will be having that infrastructure in place rather than necessarily training practices that would then be able to support the training programme in the future.'*
>
> *Interview with PE, Lincs CCG DCN, Data source 16*

Summary

The scheme was a successful proof of concept and had workforce related outcomes.

To some extent original aims were met, and key learning was recorded to benefit future schemes.

It is acknowledged at this case study site relationships are new and evolving. The piloting of the *Fundamentals* scheme and the tight turnaround demands led to some clearly identified and mitigated shortcomings.

The role of the STP in supporting and transitioning trainees is acknowledged within the context of specific workforce aims.

The alternative model of employment and mentoring offers additional learning points.

One trainee did not take up post and one chose not to stay in General Practice due to unfavourable terms and conditions, in particular relating to maternity pay by comparison with a Secondary Care AfC post.

The scheme was successfully closed in January 2020.

Case Study C - University of Hertfordshire / Bedford, Luton and Milton Keynes STP

Introduction

This partnership is set to commence operating the GPN-ST route from October 2019 for the first time. The project was designed to meet locally identified workforce needs. This site followed a different funding model – no HEE funding was provided, two thirds of funding was provided by NHSE/I and one third was match funding by the local system.

This STP has a dedicated Project Manager who was responsible for reporting, internal governance, risks and issues. The overall management of the scheme falls within the CCG and James Kellam takes this responsibility. James is supported by Sharon GPN Lead who is employed for ten hours per week on a self-employed basis by the CCG and provides the role of external mentor to the group. The day to day management of the nurses and their education is devolved to individual practice level.

The education was provided by University of Hertfordshire who were running *Fundamentals* for GPN-ST for the first time. There is minimal engagement between the STP or practice sites and the University, and this is identified as a weakness in this relationship network.

The overall management of the scheme falls within the CCG and James Kellam takes this responsibility. As Workforce Development lead his role includes monitoring workforce needs in Primary Care and within this fall's responsibility for the overall management of the scheme and the local networks.

The scheme completed its first successful rollout in Spring 2020.

Planning

Aims

The key stakeholders across the project agree clear aims for the project.

The primary aim is workforce development with the primary objective to increase the number of GPNs in the local workforce.

> *'We know we will have gaps over the next few years.'*
>
> *Interview with JK, STP Programme Lead, Data source 25*

While it is acknowledged there is a need to increase GPNs in the workforce, there is limited existing data in this area and work is being undertaken locally to develop mechanisms to track workforce statistics.

Preparation for delivery

Federations were invited to bid, and that process was conducted by the CCG.

> *'So how this came about in BLMK, Northants and Lincolnshire are part of the programmes and Miriam approached Susie Clarke who is our Workforce Manager in BLMK, and said are you interested? She said yes, it is an interesting idea. So, they signed up.'*
>
> *Interview with JK, STP Programme Lead, Data source 25*

This site had a longer lead in time to the scheme than other projects. Upon realisation of learning from other schemes and in light of emerging issues the decision was taken to request a delay for 3 months to ensure that the scheme was able to meet all major requirements.

Unlike alternative schemes there were limited existing relationships and networks to build the scheme upon.

There were a range of factors which caused various delays including recruitment, employment and training issues.

Planning education and support

The lack of existing relationships with a HE partner and the lack of relationships between HEE and STP suggests that successful schemes build on existing relationships.

BLMK started early discussions with the University of Hertfordshire (UoH). Despite these early discussions, the disparity in content between the UoH and other *Fundamentals* courses was not identified, and this was agreed as the foundation programme not *Fundamentals*. The LTC conditions module had to be added later to bridge the gap between the foundation and *Fundamentals* provision. This was attempted in November but wasn't started until March and caused disruption to the continuity of the scheme.

There was discrepancy about the content and cost of *Fundamentals* Programme between the STP and HEI which was only identified when invoice was due to be processed. This issue was escalated to project team and NHSE/I for resolution. It was recommended as a learning outcome that course content and cost is formally agreed and signed off as part of the project plan. Multiple meetings were arranged with the UoH and HEE to discuss course outline and finalise schedule of training days,

RT suggests that he was not given enough guidance about the appropriateness of the Higher Education courses and this is a significant learning point. There seems a disjoint between knowledge, expectation and understanding shared between HEE, STP and University at this site.

This example highlights the importance of ensuring that the course outline for the *Fundamentals* Module is standardised and mapped to meet the needs of patient is General Practice.

Execution

This section highlights key points of learning throughout the delivery and execution of the scheme between November 2018 and September 2019.

Recruitment / HR

This covers issues which arose with recruitment of practices, trainees and creation of an employment model.

Recruiting practices

Recruitment of practices took place between November 2018 and March 2019.

Practices were sent Expressions of interests (EOI) requests in November. Initially an EOI invited practices to apply either as a group of practices or cluster to host. This was based on feedback from other STPs was not to be too stringent in criteria and individual practices could also apply providing they met criteria. After initial EOI was cascaded a number of potential candidates contacted CCG asking for further details. Details of interested practices were held on file and to contacted once the formal recruitment campaign was been launched.

Practices were invited to apply until early March and successful practices confirmed and informed by the end March, so this part of recruitment had a quick turnaround. HR processes were delayed and not confirmed until 1st April 2019.

Jacky suggests that with hindsight she would recommend spending less time advertising and generating interest with practices, and more time focusing on selecting appropriate hosting sites.

> *'I do think more attention needs to be given to selecting practices, to see all those details and see if they are suitable.'*

Interview with JM, CCG GPN Nurse Lead, Data source 23

Recruiting Trainees

Recruitment of trainees at this site was time and cost intensive.

A public relations (PR) company (Alta Dicta) was hired for interim media support (and significant amount of time were spent discussing media and recruitment than how to address the needs analysis). There is evidence that this approach generated widespread publicity and awareness raising coupled with significant interest (over 80 applications). (However, there is no evidence that this approach generated any better quality of applicants than at other sites.) This approach generated greater workload in recruitment for all parties and more delays than the standard recruitment approaches taken at other sites. There was also an issue of timing which arose where potential candidates expressed interested in course but were not eligible to apply due to their degree/PIN number being released after the start of the Foundation programme.

There was significant time slippage to the recruitment phase of the project from the original plan. The PR company was due to be engaged in January, but this took place in February. The advert which was due to be circulated at the end of January was not launched on NHS jobs until 1st April.

A two-stage interview process was undertaken. Trainees were interviewed twice, firstly by CGC/STP staff and then by practices. Interview with practices was 'rubber-stamping' provisional appointments and acted as a getting to know your opportunity for the nurses and sites.

Offer letters were sent out in June and July, with two months factored for notice period, planning for a provisional start date of GPN-ST trainees working at practices in mid-September and being able to commence the University course at the start of October. Despite this planning the notice period was again problematic as although two months had been allowed for, some sites needed more. It also emerged that potential applicants may be Band 6 nurses who would need a longer notice period.

The project timeline was adjusted to factor in recruitment changes and longer minimum notice periods than anticipated. Issues were escalated to T&F Group and the scheme was delayed due to being flexible and adaptive to emerging issues.

The site learned from previous sites about drop out and had a contingency plan.

> *'The concern is that they could find work elsewhere and we don't have time to find someone else, there are risks'*

Interview with JK, STP Programme Lead, Data source 23

10 offers were made 9 were accepted. The contingency plan was useful when one offer was turned down. An offer was made to the first reserve interviewee who also turned down the offer. The funding was used to train another nurse who was already in a GPN post.

One of the nurses had a background as a Children's nurse. The practice raised concern about her skills and the match to their demographic of elderly and frail. They had initial reservations, but the candidate interviewed brilliantly and was selected by the panel as Trainee to take part in the programme. The Practice concerns were escalated to HEE who liaised with NMC confirming that

there are no restrictions for a Children's Nurse to work with adults and hence be part for the Programme. This represents learning for other sites who can be assured that if the programme has Nurses from other disciplines e.g. Children's, Learning Disability, Mental Health who are successful to get on programme they are unrestricted and the sites may wish to consider matching up with GP Practices where their training/skills could be utilised but equally can be assured their skills are transferable to new contexts.

Employment Model

The employment model at this site differed from previous models. BLMK opted for an employment model where the practices directly employ the GPN-ST Trainees, which means that employment contract sits with the host practice. This caused some complications over other modes identified as follows.

At other sites the HR processes were managed at CCG/STP level and/or devolved to a Federation level. Although practices were direct employers it was not feasible or practice to expect ten individual practices to tackle key central issues such as recruitment, negotiating terms and conditions, performing DBS and occupations health and safety checks. HR at CCG level were initially unwilling to manage these processes for non-employees. Negotiation with parties resulted in a central recruitment process later individualised, with practices processing checks locally. Practices raised concerns about employing GPN-ST trainees on Agenda for Change Terms and Conditions due to potential conflict with their substantive staff but NHSE/I and project team stakeholders agreed that contracts must be aligned to AfC. This was deemed a significant point to attract candidates from Secondary Care

> *'If you want to attract good calibre of staff from other areas, how are you going to attract someone from the acute centre who have got really favourable terms and conditions for interchange between practices?'*
>
> *Task and Finish Group Meeting Notes*

Central HR support was offered for arising issues during the contract e.g. increment points and transferring NHS pensions to local schemes.

Feedback from this site suggested that a preferable model would be to devolve processes to a central source, for example at Federation level.

> *'They should be employed centrally. All of it, if it was done centrally'*
>
> *Interview with JK, STP Programme Lead, Data source 23*

Trainee motivations

Trainees had a range of reasons for wanting to start or move into General Practice roles and came from a wide range of backgrounds. This site had the highest proportion of newly qualified nurses at 30% of the funded cohort (3/9) A key theme in trainee motivation, as per other sites, was the desire

for variety and building relationships with patients. At this site trainees also raised the potential for progression available in General Practice and not perceived as available in some other areas.

GPN-ST trainee MO came in as newly qualified from Northampton University having known she wanted to work in General Practice.

> *L: 'I came in as newly qualified.*
>
> ***Researcher: Did you know during the main nursing course that you wanted to do General Practice?***
>
> *L: Yes, I did two placements in General Practice, six months in total.*
>
> *Network Focus Group, Data source 24*

GPN-ST trainee A and GPN-ST trainee MO were also newly qualified nurses.

GPN-ST trainee E came directly from working in Occupational health, but had a broad range of previous experience.

> ***Researcher: 'Interesting, what made you think you would like General Practice?***
>
> *E: I had done it before that, I have been around a bit.'*
>
> *Network Focus Group, Data source 24*

GPN-ST trainee V was a Prison Nurse and felt General Practice would be a safer and more varied working environment with progression opportunities.

> *'I really enjoyed Prison Nursing, but it was a volatile area for me to work in and there was nowhere for me to go for progression. I knew I could become a Practice Nurse in prison but it would be predominantly male health where I wanted a bit more variety and the Practice Nurses that were there have been there for a very long time and will be until they retire so I would have had a long time to wait. It would have been ideal because it would have been NHS Practice Nurse jobs, I would have had maternity pay, sick pay, all annual leave things like that. But I am happy in the community now, I get a variety of people, children, babies, ex-prisoners (laughing). They get discharged summaries from prison from the health care department when they are released so I think if they ever thought I would have to see one they make sure I am happy with it first.'*
>
> *Network Focus Group, Data source 24*

GPN-ST trainee I transferred from Secondary Care and took a pay cut.

GPN-ST trainee RT transferred from cardiology and took a massive pay cut but sees this sector as offering him better opportunities.

GPN-ST trainee MO had a bad experience, was placed alongside another but has a post in a new place.

GPN-ST trainee D had a good experience and will stay with her host site

D: 'They always have a positive outlook, they said they would like to keep me if they could.'

Network Focus Group, Data source 24

Timelines

All sites reported timelines being tighter than they would have liked. This site took longer than others to achieve aims due to new partnerships and new practices which took time to develop. Action plans were amended accordingly, and contingency plans invoked where required.

Most trainees started in post and on the course in September or October. This was later than originally planned but allowed for delays in recruitment of trainees and mentors.

Researcher: 'Was that because they were serving notice from previous hosts?

James: Yes, holidays, a number of factors. We had to accommodate student trainees during that time as we had people on leave or whatever, you had to make sure you had sufficient mentors around.'

Interview with JK, Programme Lead, BLMK, Data source 23

Working with the HEI

The relationship between the STP and the University was a new one, and there is evidence of some initial misaligned expectations.

'So then we signed up for Fundamentals but what happened when we found out is later on to our detriment, that the foundation programme, we thought we were signing up for the foundation programme, didn't realise we were only signing up to the Fundamentals modules with only 15 credits. The foundation programme contains the long-term conditions and obviously we didn't factor that in.'

'We don't commission that, HEE do. I think it is quite a new thing and I have no idea about asking different credits. De Montford university is different, the course is different.'

Interview with JK, Programme Lead, BLMK, Data source 23

The GPN external mentor working at the CCG had not been involved with the University and had been unaware of the problems caused by the course

'I don't think I was aware that it was such a problem. If we had known, we could have contacted…. So, looking forward we will try and be a bit more specific about what is in the university module. '

JM, CCG GPN Nurse Lead, Network Focus Group, Data source 24

A key problem arose to the scheme due to inconsistencies between the *Fundamentals* provision (identified in the previous interim report). In alignment with the recommendations of the interim report, and the findings of this report, it is suggested that there is a need for the *Fundamentals* course to be standardised.

> *'One of my key feedback for this evaluation is the actual foundation should be equitable, the same across the board. There needs to be a consistent framework and the content which we deliver.'*
>
> *'I think in Lincolnshire which has got a university, I think it is a year course. How can you say, 'Fundamentals' when some are totally different?'*
>
> *Interview with JK, Programme Lead, BLMK, Data source 23*

The University was originally contracted to provide only one module and had to be later commissioned for further training as the components of another single module were not considered to be enough.

> *'I think the way the course came about was wrong because we thought the students would get Fundamentals and long-term conditions but when it came out……this is terrible…. there is no clarity in it…. so, we scrambled around for long term conditions…. and funding….in hindsight it should have been more than one.'*
>
> *Interview with JK, Programme Lead, BLMK, Data source 23*

The content of the course was questioned as significant components seemed to be missing, compared with other courses.

> *'I couldn't believe that there wasn't even a mention about contraception, a really basic thing that all Practice Nurses are expected to do fairly quickly is pill checks, repeat pills. When I questioned it at the university at Hertfordshire, why there wasn't anything about that, they said we deliberately don't say anything because if we mention it, then they go back into practice and the practice thinks, the Doctors think they have been trained in contraception so they don't mention it. That is really bad, because it is a really fundamental part of their job.'*
>
> *Interview with JK, Programme Lead, BLMK, Data source 23*

While feedback was broadly positive, the missing of contraception was a concern for the GPN-ST trainees.

> *'Fundamentals was mostly good; I gained a lot of skills. But I do think one of the things that should have been covered was contraception.'*
>
> *GPN-ST Trainee N, Network Focus Group, Data source 24*

It was also a concern for the GPN Mentor who seeks to resolve with further training

> *'I am interested in the sexual health thing, when I ask the university why that is not included in the Fundamentals module, they said they didn't want you to go back into practice and think you were fully trained in sexual health. I don't think that is good enough. I think you need some element of it so you can have that conversation. You need some knowledge. I know this hasn't been included this time but going forward if we can get some funding, we are looking at a course for you.'*
>
> *JM, CCG GPN Nurse Lead, Network Focus Group, Data source 24*

The timing of the learning in the course was raised by stakeholders who suggested that immunisation and vaccination training had to be front loaded in the scheme

LEARNING: if course starts in September ensure that that the immunisation and vaccination training is completed early on allowing the Trainees to participate in season flu vaccinations.

Task and Finish meeting notes, Feb 2020

The delivery of the first 'Foundation' module was for one day per week and solely for the small cohort of GPNs.

The delivery of the second 'Long Term Conditions' module was also specified for one day per week and was delivered to a large cohort of around 40 Allied Health Professionals.

> *'Some were on the Community Nurse Specialist Programme. Like us from the CCGs and Primary Care Networks but different areas in London.'*
>
> *GPN-ST Trainee N, Network Focus Group, Data source 24*

The module was often reduced to 2 hours of face to face delivery supported by e-learning. This approach was not favoured by trainees or project management.

The scheme paid the same amount for both modules.

> *'The course is quite expensive. I don't see the parity of 2 hours'*
>
> *Interview with JK, STP Programme Lead, Data source 23*

> *Nurse: 'With the long-term conditions I do think they are covering a vast amount of things, but I don't think a 2-hour session is long enough to cover everything for each topic. When you go back into practice, they think you suddenly know everything about everything. My practice is quite good, I am shadowing the nurse, but other people maybe expected to do them.'*
>
> *GPN-ST trainee MO, Network Focus Group, Data source 24*

> *N: 'The first course we did was really good, covered everything, full on days but so much content. Really easy to access the lecturers by email. The second one so far has been a lot in just 2 hours.'*
>
> *GPN-ST Trainee N, Network Focus Group, Data source 24*

> *Nurse: 'They try to cram too much into a short gap, and they are just talking at us, unless we go home and go over it ourselves…there wasn't time, it is like teaching yourself really.*
>
> ***Researcher: Was that delivered by the university or an external company?***
>
> *N: University lecturers but they use specialists from one of the courses in health and social care team. The diabetic one, she was a Diabetic Nurse Specialist. What*

she was doing probably wasn't relevant to just coming into practice, meeting people with diabetes for the first time.'

GPN-ST trainee I, Network Focus Group, Data source 24

Trainees rated the first module more highly than the second

'The Fundamentals was brilliant because it was more practical. I think I went into long term conditions thinking it would be more practical whereas it is just two hours of someone talking at you. I haven't got anything out of it.'

GPN-ST trainee MO, Network Focus Group, Data source 24

Trainees suggest that their travel for a short face to face session did not feel worth it.

'It is quite a long way to go for just two hour sessions.'

'The only other thing is the journey; you are exhausted before you start. I think a day would be better because it is two hours for ten weeks.'

'Maybe a different location.'

GPN-ST Trainees, Network Focus Group, Data source 24

Trainees only opportunity for formative review was with JM in action learning sets, as the University only collected summative evaluation.

Researcher: 'Have you had the opportunity to feed that back into the university at all, do they ask for your feedback?

Trainee: There is a final review at the end.'

GPN-ST Trainee, Network Focus Group, Data source 24

In October, CCG GPN Nurse lead JM set up action learning sets as a peer networking opportunity for trainees to support their university and practice learning. The first event was held in January 2020 which was a useful opportunity to update on issues and begin a formative evaluation dialogue.

Mentoring

The trainees are supported by practice mentors. The CCG employs JM to provide external mentoring, on a contract of ten hours per week.

Practice mentoring

The scaffolding method of learning enables trainees to learn a skill and the underpinning and practice that with support in a clinical context building towards confidence and autonomy.

'the things we have covered at uni, I am gradually doing under supervision then on my own, so it has been great'

GPN-ST trainee MO, Network Focus Group, Data source 24

The scaffolding is reduced when the trainee becomes more confident in her skills. However, it is important that the needs of the practice do not overwhelm the needs of the trainees to develop broad skills and this is a risk.

> *'I was supernumerary until about the end of November, then I did my own clinics. The only thing that has been a bit of a downer, was the phlebotomy. I suddenly became the phlebotomist …. so, then I had to negotiate that role saying I would do it in the mornings, but you have to give me other things in the afternoon which they did.'*
>
> *GPN-ST Trainee V, Network Focus Group, Data source 24*

All the newly qualified nurses report positive experiences

> *'The practice has been amazing; they have retained me as supernumerary status whilst being able to have my own clinics. I have worked with the nurses, blocked out time so I can go in if I want to, they have given me extra days alongside Uni for studying.'*
>
> *GPN-ST Trainee A, Network Focus Group, Data source 24*

> *'I love the clinical stuff; the course has been fantastic. When I tell my friends, who have newly qualified what I am doing, they ask for email addresses.'*
>
> *GPN-ST trainee MO, Network Focus Group, Data source 24*

Some trainees are well supported in a supernumerary role

> *'It has been really good from the start. They are really supportive, I have been supernumerary all along, I have had my own clinics, they have given me extra time when I have had uni, extra tutorials etc so they have been really good.'*
>
> *GPN-ST trainee MO, Network Focus Group, Data source 24*

> *'They have let me do what I want, and I feel really really lucky. So, anything I wanted to go on they have been quite happy to support me through it.'*
>
> *GPN-ST Trainee V, Network Focus Group, Data source 24*

There is some evidence of a mismatch in expectation. Some trainees do not feel scaffolded with their learning in practice.

> *'In my practice I feel quite comfortable to say I need a bit more experience, a bit more training.'*
>
> *GPN-ST Trainee, Network Focus Group, Data source 24*

Experiences were variable and some trainees suggest their supernumerary status was not appreciated by all staff.

> *'Clinical staff were amazing they kept me going. It was just the lack of understanding from the manager. She didn't know that I was supernumerary. The person who did the rota didn't quite understand either. So, the first couple of months were slightly more challenging.'*
>
> *GPN-ST trainee MOh, Network Focus Group, Data source 24*

Practice mentor feedback is positive

> *'I thought it was fantastic actually to have her on board. She is a brilliant nurse anyway but the way she has picked everything up is amazing, really quick learner.'*
>
> *Mentor M, Network Focus Group, Data source 24*

Feedback from the CCG suggested that it might be better to just use training practices which have the in-house expertise to support trainees to reduce variability in support.

> *'I think possibly it would be better to have what we call GP Training Surgery where you have got all the resources. I think with the long term conditions we were complaining about too much information, if you were in the surgery where you get all the support that you need because I think we are all coming from different backgrounds. Some people got a lot of support, some people didn't get anything. At the end of the day the training that we get is different so if there is a surgery that has got all the resources for training us, I think it may work very well.'*
>
> *Interview with JK, STP Programme Lead, Data source 23*

External mentoring

It had been envisaged in project planning that external mentoring would be provided by CCG GPN Lead Nurses. Unfortunately, there were difficulties and delays in recruiting 2 GPN Lead Nurse vacancies in Bedfordshire and Milton Keynes CCG resulting in capacity issues to support GPN-ST trainees. Whilst there is evidence of JM having a positive impact on the scheme, this was mitigating work and one post was not enough support for the GPN-ST trainees. There remained one vacant post in Milton Keynes CCG throughout the scheme. James admitted in Feb/March meeting that they are short of GPN leads in the CCG they have been hard posts to recruit to and they would have been great to support but it's too late now they are due to finish mid to end March.

Jacky is the external mentor for all of them on ten hours per week self-employed and she is paid by the CCG. Feedback about JMs impact on the scheme since joining is very positive

> *'Jackie has been fundamental in my growth in the first 6 months as a Practice Nurse. As a newly qualified nurse, at times I have felt overwhelmed stepping into my new role by the challenges that occur in Primary Care, not only the challenges of caring for patients with complex needs but also working within a new large team. Jackie has not only supported me in assuring I am well supported within my role, but she has also given me advice in how to further my confidence as an individual. She has always been extremely prompt in in replying and also given other contacts to approach if needed if she is unavailable. I have found the clinical supervision sessions that Jackie and her colleagues have ran extremely helpful and will miss them greatly when my course comes to an end. I have also felt very encouraged by the emails that I receive from Jackie with a variety of different training opportunities that are available to myself and colleagues. I have greatly valued the Nurse Lead role and believe it has greatly benefitted me within my new role as a Practice Nurse.'*
>
> *E10 Site C Iterative internal trainee evaluation form*

One newly qualified nurse suggests that JMs role will have a positive impact on trainee nurses as the role develops

> *'It would have been even better if I had known Jackie as a student nurse! I believe student nurses across Luton and Bedfordshire would greatly appreciate and value knowing the Nurse Lead for networking, support, training and job vacancies in their local area.'*

E10 Site C Iterative internal trainee evaluation form

CCG GPN Nurse Lead JM has organised access to further coaching through an external company (https://www.shinymind.co.uk/) to support her role. Funding was used to enable the GPN-ST trainees to access six hours of coaching each.

The company offers a 2-day coaching and training course which enables participants to join a bank of coaches. CCGs buy in coaches from this bank to provide personalised coaching to nurses in practice. This approach is utilised by other CCGs (Claire Ward, Milton Keynes)

> *'It is all part of…. It is not just for these ten but it would be very much built into their experience …and it would be good when they first go into practice'*

Interview with JM, CCG GPN Nurse Lead, Data source 23

JM suggests that coaching links to resilience training. She gives an example of how the coaching might help a learner with workplace issues.

> *'I said how are you doing, she said they just keep giving me all these extras …. the receptionists have gone home, and I am still in here seeing patients …. I can't cope with that I might just give it up. She is not retirement age though. So, I said come and have a chat and she actually came and saw me for about 2 hours. I said what can we actually do. She said, I didn't want to say no, I tried to be helpful. If you are stressed…. so, it is a massive problem. So, we ended up talking about how she might do things differently, practising phrases and how she can say no. Identifying other nurses have accountability and all this sort of thing. It was good. Afterwards I checked in with her and she is staying put'*

Interview with JM, CCG GPN Nurse Lead, Data source 23

This seems to mirror the support offered by external mentors in other sites using a model bought in expertise.

Support

Delays meant that trainees were not as well supported in their roles at the start as toward the middle and end.

There was one negative mentoring experience reported where scaffolding was not provided.

> *'I have never had a review about my patients, I have never had a one to one or feedback about what I am doing. So, I kind of have to work extra hard.'*

This was resolved with support from CCG Lead Nurse.

> *'I had a meeting with the Doctors and a lot of support from Jacky as well. Since then I have had a really lovely three months. As soon as I had those discussions it has been really good.'*

GPN-ST Trainee Ab, Network Focus Group, Data source 24

GPN-ST trainees were encouraged to approach for support where necessary, but it was not always proactively offered. Trainees were encouraged to take responsibility for asking for support

> *Trainee: 'I think she was told I was doing well so she didn't support me the way I was supposed to be.*
>
> *R: We also wanted you and stated quite clearly let us know because we can't fix anything if we don't know. So, we did try to intervene. There is only so much you can do.'*

Network Focus Group, Data source 24

Trainees benefitted from coming together as a network with support

> *'Yes, and when people come and say whatever it is, you just don't feel so alone and that you are doing a rubbish job. But if there are issues, they get a perspective of your issues compared to others, we can have the same or others can be different. Jacky is really supportive and helpful.'*

GPN-ST trainee MO, Network Focus Group, Data source 24

Outcomes

The original aim of proof of concept was met and 10 (9) new nurses were trained and employed. 80% of trainees were employed at their host practices and the others remained in the STP footprint. The site also proved the concept that there are no issues in employing newly qualified nurses into General Practice roles.

This section discussed the mechanisms and reflection on the model which supported the GPN-ST trainees' transition to work.

The trainees were well supported at a CCG level to transition into long term roles in General Practice.

> *'At the beginning we did say that the practice is not obliged to offer a contract and you are not obliged to accept one either. But we did say if you were in a position where your host practice wasn't able to employ you, we would then do whatever we could to secure you a post somewhere because there are so many vacancies around. So, you would have hopefully ended up with something that has got a job at the end of it.'*

Interview with JM, CCG GPN Nurse Lead, Data source 23

HR/Pay issues

HR at the start of the scheme was inconsistent with many trainees not having the correct elements in place for starting the training and also to be paid. All trainees appear to have varied contracts with different pay, leave entitlement and a lack of pro-rata written in for the nine month contract.

The key HR issue which arose through the scheme was pay and the fact that trainees were brought in on parallel salaries to the ones they left, which in many cases were more advantageous than GP usual scale and which resulted in some trainees experiencing a reduction in salary at the end of the course.

> *U: 'There was nothing really that I didn't feel happy with. Obviously, everyone wants more money, but it is difficult. You look at the hospital pay and what I would be on now… it is a bit painful about pay'*

One GPN-ST trainee was made an offer she was not happy with and had to negotiate her offer with the practice whilst retaining alternative options.

> *'The terms and conditions are what I expect they are ok. It is just the hourly rate. I don't know how much a nurse should get but I feel it should be a bit more. I feel the job I left to do this, I was financially a lot better off. I understand this course leads to a job anyway, fair enough. I know 2 different jobs, the one I am doing now is so much more than what I was doing before. It is a lot more direct, a lot more patient involvement, the Doctors require you to do a lot for them, as well as what you are doing as well. I feel it should be looked upon a bit more generously.'*
>
> *GPN-ST Trainee D, Network Focus Group, Data source 24*

Sick pay and maternity pay options were recognised as often not as favourable as AfC.

> *'I did talk about terms of pay in my meeting I had with the partners. They said at this point in time, maternity is not included in the GPN contract, they said if it was brought in across the board for all nurses then they would. I kind of new this but I am currently the only person in the company that is young enough to have a child. (laughing) but they said they will support me, and they were very good.'*
>
> *GPN-ST Trainee V, Network Focus Group, Data source 24*

Trainees recognised wide disparity in terms and conditions across the sector

> *'She said I would be paid sick so that was something. She said I was not to say that out loud because some staff members just get the SSP, everybody's contracts are so different. I noticed nothing is the same for 2 people there. I can only talk about my practice. Everything is like negotiable I think, your terms and conditions to an extent.'*
>
> *GPN-ST Trainee D, Network Focus Group, Data source 24*

One Nurse Mentor suggests that standardisation of terms and conditions in Primary Care is, and needs to be, a priority area for development

> *'In an employment seminar recently, the practices the PCN and Primary Networks, they are looking at standardising the contract and the terms and conditions and contracts and things. So, we had a seminar by a barrister who specialises in General Practices, who said quite often a lot of practice work is illegal. They could take things to a tribunal, so I suspect some point in time that is formerly going to change.'*

Mentor M, Network Focus Group, Data source 24

GPN-ST trainees accept there are alternative benefits to pay

> *'It feels like I am back from where I was, but I know it is going to progress.'*

GPN-ST trainee I, Network Focus Group, Data source 24

> *'Like we said to James earlier, the only chance of promotion I had was if I wanted to be a Ward Sister and I never had that inclination. So, a Practice Nurse was something I fancied doing so when I got the opportunity…so I am always appreciative of that. So, I keep telling myself it is not exactly what I wanted but it is what I expected. The Nurse Manager she said to me once you get on long term conditions, it will go up a bit more, she explained it quite well.'*

GPN-ST Trainee, Network Focus Group, Data source 24

Workforce related outcomes

All nine of the GPN-ST trainees have secured permanent posts following this programme.

The scheme was successful in bringing 3 newly qualified nurses to General Practice.

GPN Lead is confident that the scheme has proved the concept that the GPN-ST can be a pathway to being 'GPN ready'

> *'We use the term GPN ready. Because you can come in and do the basics. That is different to how you were 6 months ago.'*
>
> *Interview with JM, CCG GPN Nurse Lead, Data source 23*

GPN Lead Nurse is working to develop the Fellowship scheme locally and align the GPN-ST trainees to an ongoing learning network and pathway.

Feedback from GPN-ST trainees

GPN-ST trainee MOatisfaction levels appear to be variable, but largely positive towards the end of the scheme. Most trainees report enjoy learning a variety of new skills and putting them into practice

Most trainees had positive experiences:

> *'I love the clinical stuff; the course has been fantastic.'*
>
> *GPN-ST Trainee A, Network Focus Group, Data source 24*

> *'It has been a great journey.'*
>
> *GPN-ST Trainee D, Network Focus Group, Data source 24*

> *'I know I have been lucky'*
>
> *GPN-ST trainee I, Network Focus Group, Data source 24*

> *'I had a really similar experience; it has been really good from the start. They are really supportive'*
>
> *GPN-ST trainee MO, Network Focus Group, Data source 24*

> *'have had a fairly positive experience.'*
>
> *GPN-ST Trainee M, Network Focus Group, Data source 24*

> *'They have let me do what I want, and I feel really really lucky'*
>
> *GPN-ST Trainee V, Network Focus Group, Data source 24*

'I have had a really positive experience. The practice has been amazing'

GPN-ST Trainee Ab, Network Focus Group, Data source 24

One trainee described her journey as 'rocky' and another trainee had an overall negative experience

'My last day is next Tuesday and I can't wait (laughing) I have had a very bad experience, but I persevered and got there in the end.'

GPN-ST trainee MO, Network Focus Group, Data source 24

However, this trainee remained as a General Practice Nurse securing employment at an alternative site to her host.

Trainees suggest they would like their status at the end to be defined or clarified

N: 'Would you say we apply for experienced nurse jobs or like new trainee?

J: I wouldn't say you are a trainee; you will obviously be learning as you go, but you are all qualified nurses. If you apply for a job then you have some experience, you are very valuable commodities now.'

Network Focus Group, Data source 24

'I think it would be nice to have some sort of accreditation.'

GPN-ST Trainee, Network Focus Group, Data source 24

Feedback from practices

There was evidence of some misconception between the practices, the CCG and the University about the level of training and support that the *Fundamentals* course would deliver,

'The other thing as well, if you call it Fundamentals, that is what the perception is. They expect somebody to be fundamentally equipped and be doing that.'

Interview with JK, STP Programme Lead, Data source 23

'It is not fair to them. It is almost like, if you have got this and got that at the end of it, they are qualified and able to do this.'

Interview with JM, CCG GPN Nurse Lead, Data source 23

There is evidence that practices do not understand the training that the course affords the trainees.

'My practice doesn't seem to care that I have got the course for long term conditions. It's do you want to be a Practice Nurse here or not? You will get ongoing training, but the courses weren't taken into consideration. I mentioned that they were kind of ignored.'

GPN-ST trainee MO, Network Focus Group, Data source 24

There is evidence of the need to manage expectations of the trainee's ability and supernumerary status to the practices, and to clarify the relationships and strengthen communication with the University.

There is evidence that strong two-way communication does benefit both the trainee and the practice.

> *'When I sat down and spoke to the manager, she did say you have taught me a lot about being a newly qualified nurse and that felt really good. It is hard and we need a lot of support. But equally we will really try when given that support.'*
>
> *GPN-ST trainee MO, Network Focus Group, Data source 24*

Pathways

The trainees described a desire to continue their clinical learning. Two in the focus group want to be ANPs and one would like to focus on LTCs and develop as a prescriber.

The GPN mentor outlined a future alignment with the fellowship scheme and support in the longer-term along a pathway of support.

> *'It is very different. But you are all at the point now that you can. We have got this thing called the Fellowship. There is a pot of money to support you. It is about looking at the next steps, we are going to look at the contraception bit. I am quite happy to deliver additional bits and pieces if you want to do that. We will be in contact with you all shortly and see what you need next. Do you want to do any more training? What is going to fit in for you and for the practice? Some of you might want to do the leadership route. Things still need to be put in place on agenda for change but eventually things will change for you and raise your profile. So, started having a think about how you next want supporting.'*
>
> *Interview with JM, CCG GPN Nurse Lead, Data source 23*

Learning

There is evidence about the types of learning that the GPN-ST scheme offers, and also about the learning from the scheme that can be shared with others.

Several trainees gave examples of having opportunities to apply theory to practice in scaffolded clinical learning in context.

Alongside the clinical skills developed, GPN Lead is convinced that the scheme encourages the development of Nurse Leaders

> *'[GPN-ST trainee RTr) is very articulate, very vocal and is already wanting to go on leadership roles and that is what we need. '*
>
> *Interview with JM, CCG GPN Nurse Lead, Data source 23*

The Project Management Team implemented iterative development, engaging delays to the scheme timetable where necessary to re-work plans in response to emerging learning. There is significant evidence of learning about new models and new partnerships which are relevant for other parties. These are discussed further in the thematic analysis and noted within the recommendations.

Development of Nursing

The stakeholders recognise the scheme as an opportunity to contribute to the development of General Practice Nursing on a broad scale.

The GPN Lead suggests that to contribute to changing culture, nurses need to participate in local networks.

> *'Currently at the Primary Care PCN meetings you have a Doctor, a Pharmacist, Practice Manager but where are the Nurses? I asked a GP where are the Nurses in your network? He asked what have they got to offer? So, I took quite a bit of time explaining this. He said ok we will pay for one then. But then nobody wanted to do it. They can't get out of their practice to do it. So, we have got work to do to try and sort this and raise the level of empowerment. So, in these sessions, it is kind of like a network of support rather than clinical supervision. Maybe you could feedback if you would like it to run in different ways?'*
>
> *Interview with JM, CCG GPN Nurse Lead, Data source 23*

Parity with GP training is raised as query by the programme leads

> *'I couldn't understand why we weren't modelling the GP registrars. They have got an instruction programme, they have got a debrief at the end of each session, they have got their own trainer, they go to the hospital for their VTS or whatever they call it now, they are training on a Tuesday afternoon, they have competencies to achieve, and by the end of that they are a qualified GP. Why don't nurses have that?'*
>
> *Interview with JM, CCG GPN Nurse Lead, Data source 23*

Standardisation is raised as a significant and minimum part of the requirement for parity with GP training.

> *'If you are going to be a Doctor, your degree is going to be the same isn't it?'*
>
> *Interview with JK, STP Programme Lead, Data source 23*

It is suggested that the culture change required will be led by innovative practices, and these should be the focus of initial development work

> *'I think we have to focus our energy on those that are wanting to do it and encourage them, then eventually the culture will change.'*
>
> *Interview with JM, CCG GPN Nurse Lead, Data source 23*

The GPN Lead recognises the limitations afforded by some GPs

> *'We had like a work force get together, and there was a GP, a fantastic GP who is very high level in leading in training and education, and he actually said to me like on the side, not out in the main group, I must tell you it is really frustrating, we have got these three nurses who will not do anything unless they have been trained. And I said, 'and you think that is a problem?' He is a trainer. He said they want to do this course and that course, and they won't do it because they are not allowed to do it until they have been trained. I said do you not think that is an appropriate thing. Why would you want the nurse doing something they are not trained to do? How does that impact on the quality of care for your patients? He said well it is just so frustrating, they won't budge. I said you had better change your attitude (laughing).'*

Interview with JM, CCG GPN Nurse Lead, Data source 23

The GPN Lead is married to a GP, and as such in a strong position to comment on culture change.

> *'Why aren't they having their own practice, why aren't they? A group of nurses being partners in a practice, why are they not running it themselves? And actually, pay for the Doctors to come and do whatever the Doctor needs to do. Why is there this "yes here is the Doctor, here is the Nurse?" It has been for many years and there is still a lot of learning. I hear a lot, someone, my husband, said to me a few years ago, a GP, I said why don't you get a Nurse Practitioner in? He said well nurses do what nurses do. I said what do nurses do then? He knows that I have worked at …. Well they do dressings and that sort of thing. I said hang on a minute, that is what the nurses have always done that, and baby vaccines and travel vaccines. He had another concept of what an ANP role would be. They have actually realised since that actually that is a lot cheaper and effective, so they are doing that now. But it is that mind set. He is not a stupid person.'*

Interview with JM, CCG GPN Nurse Lead, Data source 23

Summary

The scheme was successful, met all key aims, especially leading on NQN recruitment. The case studies provide excellent opportunities for learning for other sites. Project aims were met, and the scheme was a successful proof of concept.

The course offered and relationship between course staff and other key stakeholders required iterative development and will require continued development. This site can recommend the importance of clarification and standardisation of the components and delivery time for the *Fundamentals* course. Relationships were directly between practices and trainees with limited, remote and slightly late support from the CCG.

A significant amount of the learning from these sites contributes to the how-to guide which is a key outcome from this work.

Benefits and Challenges

Introduction

This section will present the findings of a cross-case analysis of the GPN-ST case studies. They expand in depth on the preliminary findings in the earlier interim report. The findings presented in this section highlight the key benefits and challenges identified which inform the development of the recommendations and 'how to' guide for stakeholders.

The evidence collected shows proof of concept – the 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. The following list of challenges and benefits provides 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. The scheme is summarised with a theory of change model and a summary of process outline and recommendations.

Planning

Aims

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

> *'It has always been the case that GPN has been ad-hoc and peace meal and that wasn't attracting new nurses into GP, no professional development wasn't attractive for a transition. For employers they had to attract them but had nothing to offer in terms of a progression development package. What the needed was to have new nurses to hit the ground running with the skills and expertise to deliver from day one. That was the problem we started with in 2012'*
>
> *Interview with GF, HEE, Data source F2*

This was the specific focus, especially with stakeholders at workforce development level. Multiple stakeholders across all sites suggest that the project is timely and fits with the transformation work being undertaken in training hubs and STPs.

> *'General Practices need GPNs with experience in order to maintain delivery of essential patient, but many practices have neither the capability nor capacity to train. As the focus on keeping people out of hospital increases, there's an urgent need to create a pipeline of GPNs. This is the context against which GPN-ST was designed.'*
>
> *HSJ awards entry, HEE, Data source D8*

Most sites key aim is to breach gaps in the workforce and obstacles to entering General Practice as demands increase and supply decreases trough increasing attrition and retirement levels.

> *'Without General Practice experience there's no job and without a job, no experience. Experienced GPNs are in short supply – it was estimated across England around one third will be due to retire by 2020'*

HSJ awards entry, HEE, Data source D8

Whilst there are developments at each site to monitor and analyse workforce statistics, there is limited capacity at the existing time to have accurate reporting on numbers of live vacancies and therefore impact of the scheme at a broad level. Therefore, the aim of each site to contribute to increasing numbers of available nurses in the region broadly cannot be accurately measured at the present time. It is likely that mechanisms for this level of tracking will develop over time and should be shared between sites in order that the broader impact of workforce development can be measured. This would also enable further longitudinal development.

It is recognised that the training and employment of GP nurses is a complex dynamic and this scheme contributes to a wider dynamic in the context

> *'… resolves the endless inter-practice poaching and recycling from the diminishing pool of experienced GPNs.'*

HSJ awards entry, HEE, Data source D8

The primary aim for evaluation therefore is to measure the number of new entrants to the market based on the assumption that these roles would not otherwise have been filled. Furthermore, adding to the number of experienced nurses is likely to reduce turnover rates. Further long-term tracking would be required to evidence this assumption.

Stakeholders shared further tacit aims to upskill the GPN workforce with leadership skills and lifelong learning habits; this in a concerted effort to support the culture change in General Practice required to move forward the Nursing workforce.

> *'GPN-ST raises the profile of the specialty as an exciting and dynamic first destination career and is a forerunner of the [NHS] Long-Term Plan's 'GPN Fellowships'. Showcased nationally as a model of good practice, GPN-ST offers a viable solution to the GPN workforce crisis.'*

HSJ awards entry, HEE, Data source D8

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.

Preparation for delivery

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.

The time for sites to prepare to deliver from the announcement of the tender until the course had to be recruited and delivered was very tight and as such caused some challenges for planning.

Where established *Fundamentals* courses were utilised in the partnerships (DMU/Northants and UoH/BLMK and later BCU) this enabled courses which met the needs of the scheme to be 'up and running' quickly. Differences between the *Fundamentals* courses between these sites may impact on the outcomes of the course and this will be considered within the full report. By contrast, a new *Fundamentals* course ran alongside the pilot at BGU/Lincoln and the tight timelines to implement both new ventures caused some challenges which were not experienced in partnerships with established courses. These challenges are likely to be mitigated over time, however they point to the benefit of partnerships linking to existing *Fundamentals* courses at the pilot stage to minimise the challenges encountered.

The complexity of funding the scheme also impacted on its delivery. There is evidence of late payments and sites chasing payments at each case study site. Funding for the STP programmes was delayed for some time, partly due to organisational processes and to the complexity of differing funding pots. The GPN Regional Delivery Board also had a paucity of regional financial support which meant queries and challenges were not followed up in a very responsive manner. Funding was released in tranches to the STP which could have created ambiguity within the STPs. However, this was overcome by the use of memorandum of understandings and the effective partnership working of the GPN-ST Task & finish group.

A key recommendation in planning for delivery is for the maximum lead time to be allowed by commissioners in order for as many sites to participate in innovative development as possible. As schemes are rolled out more widely (along the curve of innovation) longer lead times may be required to facilitate the involvement of further removed sites. Project Managers also need to account for realistic timescales in order to facilitate implementation without barriers.

There is evidence from those on the front line in site delivery (practices and nurses) of barriers experienced as a result of short timescales. To mitigate this risk, there is evidence of strong existing links between workforce development at CCG/STP level, and practices, in particular those represented by Federations, and these partnerships are primed to respond to arising funding bid and innovation delivery opportunities. This evidence emphasises the importance of networking and relationship building between CCG/STP staff and Federation/practice staff.

Furthermore, in the rollout of the scheme there is ongoing opportunity for flexible and responsive iterative development. The work of Federation level links (SR and LS at case study A for example) can be crucial to ensuring successful delivery of a scheme. One of the Federation sites in case study A is in a key position to develop this work alongside their development of a Primary Skills Academy in the region.

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.

Evaluation was planned from an early stage and built into the ongoing scheme as a significant part of development.

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

Planning education and support

In case study A, the HEI provider was experienced in delivery of *Fundamentals* (and external networking) and existing partnerships were in place between the HEI and local networks.

In case study B, the HEI provider was providing *Fundamentals* for the first time and building new relationships directly with practices. There was limited planning or development engagement between the HEI and the CCG/STP.

In case study C, the HEI provider was experienced in providing a wide range of CPD modules to a wide range of professionals and had run a 'foundation' course before but this was a scaled down version of the *Fundamentals* course. A second module in long term conditions supplemented the initial module.

Courses were commissioned directly by HEE with no direct input from workforce development. Often courses were run with little or no meaningful 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.

DMU was able to facilitate a faster start relative to the other schemes as key relationships were already in place. At BGU, the *Fundamentals* course ran for the first time which created a large workload at the University for tight turnaround. BLMK started early discussions with the University of Hertfordshire but there were ongoing miscommunications. Despite these early discussions, the disparity in content between the Herts course and other *Fundamentals* courses was not identified until the completion of the commissioned module.

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.

At case study site A, despite significant efforts by the HEI to inform practices about the course, this information did not always filter through.

> *'Yes so I think there is a big learning for Lakeside in making sure that not only is there absolute clarity about what your student is doing when at university, but the Practice Mentor has a responsibility then to slot in to make sure that the rota slots in some practice that relates to the learning at the university. So, there is duties on both parts for sharing information and then trying to make the stuff match up. It must be possible, there are things happening in practice every day so they should be able to match it. But it is the pressure of work.'*
>
> *Interview with LS, Lakeside Implementation Consultant, Data source 21*

At case study site B, the course running for the first time suffered some inevitable teething problems such as the inability to source external trainers for the preferred time in the timetable. Lessons learned from this course pilot are likely to improve further iterations of the scheme.

At case study site C RT suggests that he was not given enough guidance about the appropriateness of the Higher Education courses and this is a significant learning point. There seems a disconnect between knowledge, expectation and understanding shared between HEE, the STP and University at site C which leads to confusion about the course and problems with delivery. This example highlights the importance of ensuring that the course outline for the *Fundamentals* Module is standardised and mapped to meet the needs of patient is General Practice.

The misunderstanding about the *Fundamentals* course is further compounded by a lack of standardisation of the course content and outcomes. This is discussed further in the section about working with the HEI and leads to recommendations about standardization and dissemination of the '*Fundamentals'* course.

Planning education and support shows that relationships are important to build them and share awareness about the content of *Fundamentals*.

> *'Relationships matter'*
>
> *Fieldnotes from HEE launch meeting, 2018, Data source F1*

Execution

Each scheme took a different approach to recruitment and employment of GPN-ST trainees. It is recognised that schemes need to be localised according to local supply and demand.

> 'The STPs were encouraged to manage their projects based on local needs and variations.'
>
> *Stakeholder reflection MC, Data source R1*

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. This is supported by a comparative timeline to aid future project planning.

Recruitment / HR

SWOT analysis

	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

Recruitment / HR SWOT analysis commentary

Each scheme took a different approach to recruitment and employment of GPN-ST trainees. There are a complex list of challenges arising from the different models which are summarised in the table above and discussed briefly below:

Differing employment models were used across the 3 areas. This has posed some challenges but also identified many positive outcomes.

There were a range of strengths of the schemes. Firstly, all sites successfully recruited the planned number of GPNs and practice sites within the allotted timescale. A PR company used for recruitment generated positive press. NHS jobs was successfully used by all sites to reach the desired audience. The ratio of applicants to posts varied from 1:2 to 1:4. Practice sites were often involved efficiently at the interview stage of recruitment.

Weaknesses identified, causing delays and problems, included a lack of preparation for the intensive time support required at CCG/STP and federation levels depending where HR project support is provided. Delays to organising contracts, checks and payroll issues caused problems. Use of short term contracted staff led to disjointed practises and caused a lack of follow up to potential candidates and practices. Applications from GPNs outside the local area were problematic. Existing partnerships with Federations and training practices facilitated easier recruitment than new partnerships being formed, especially with individual practices.

Opportunities were created by the development of partnerships and networks between key stakeholders. The good quality honest recording of learning points provides an opportunity for development

Threats to recruitment included the discontinuity of short-term staff and high turnover and the lack of existing data on workforce to support evaluation. Ensuring nurses could serve their notice periods has been an issue for all STPs. Depending upon employment contracts, nurses in current employment were required to give 4-8 weeks' notice. This particularly affected Northants STP but mitigations were put in place such as requesting nurses take annual leave for mandatory days required by the university and then recompensing them later in the programme.' There was an issue of timing which arose where potential candidates expressed interested in the course but were not eligible to apply due to their degree/PIN number being released after the start of the Foundation programme.

Timelines

There were some key similarities and differences in timing between the case study sites. Each site identified time pressure as a key barrier to implementation.

Case study site A met together and started recruiting practices and trainees simultaneously. By contract Case study site B recruited trainees, then a course provider, and finally hosting practices Case study site C experienced a 3 month delay to their scheme but had the opportunity to advertise to NQNs. All sites had trainees who started their job after the course due to insufficient lead time to give full notice in an existing role.

The time for sites to prepare to deliver from the announcement of the tender until the course recruited and was delivered was very tight and as such caused some challenges for planning.

> 'Timelines from the announcement of the second proof of concept to the initiation of the programme were extremely tight. Having to wait for the 2nd STP meant that Northamptonshire needed to work extremely quickly to establish the programme delivery. The fixed deliverable for this STP was the absolute need to commence the *Fundamentals* programme in January 2019 (already a well-established programme with participants signed up). This meant the STP had to utilise their own resource to help support recruitment of the GPN-ST.'

Stakeholder reflection MC, Data source R1

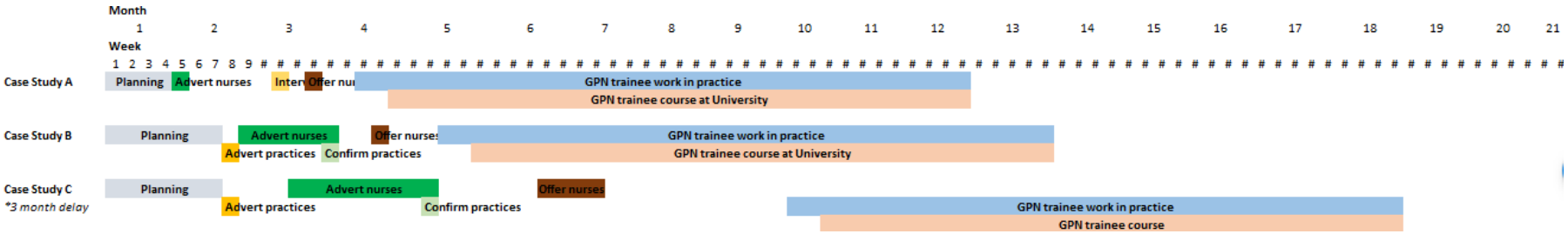
Commissioners can only offer a fixed gap between the announcement of funding and the start of courses for recruitment to take place. As aforementioned, whilst accepting the NHS is familiar with working to tight turnarounds, any effort to lengthen the time between the announcement of funding and the start of a course would benefit the project management in terms of the balance of workload. All sites reported an increased workload for Project Managers at CCG/STP or Federation level during the recruitment period which should be acknowledge and planned for. For example, at case study site B the HR function at the CCG did not have the capacity to recruit and organise contracts in the timescale required. Some sites used temporary consultants in this capacity, however since these are short term roles there was some loss of continuity in handover.

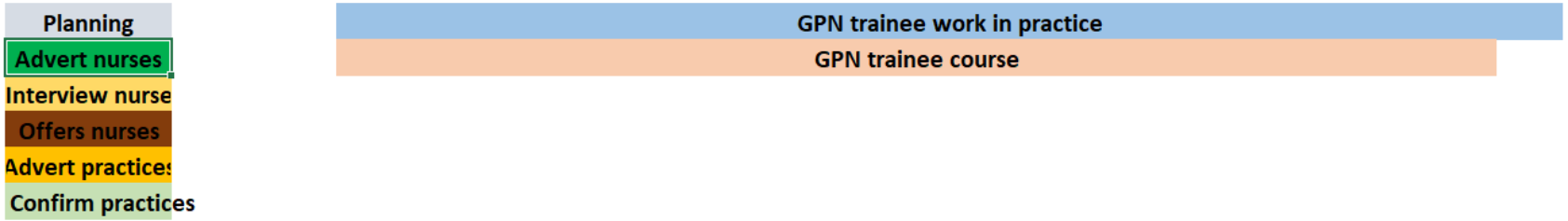
Most schemes allowed one month from recruitment to the start which is not acceptable since many nurses have three-month notice periods. The impact of this was that some trainees had to use annual leave and others had to start the role after the course, which had a negative impact on their learning. It is recommended that where possible 3-4 months is allowed between offers made and courses starting to allow notice periods to be served and people to undertake an initial induction period into the role.

A one-year lead in time is recommended to establish a recruitment procedure allowing to recruit from a broad area and allow for notice periods and a brief time in post before the course begins. Where schemes begin to run annually this cycle will benefit from establishment. For example, future cohorts could consider aligning promotion of the role to Foundation Programme when trainees finish course locally and also consider aligning to the end date of Return to Practice programme. These steps could maximise potential NQ applicants.

It is important to note the key critical events, or drivers, of the timeline schedule.

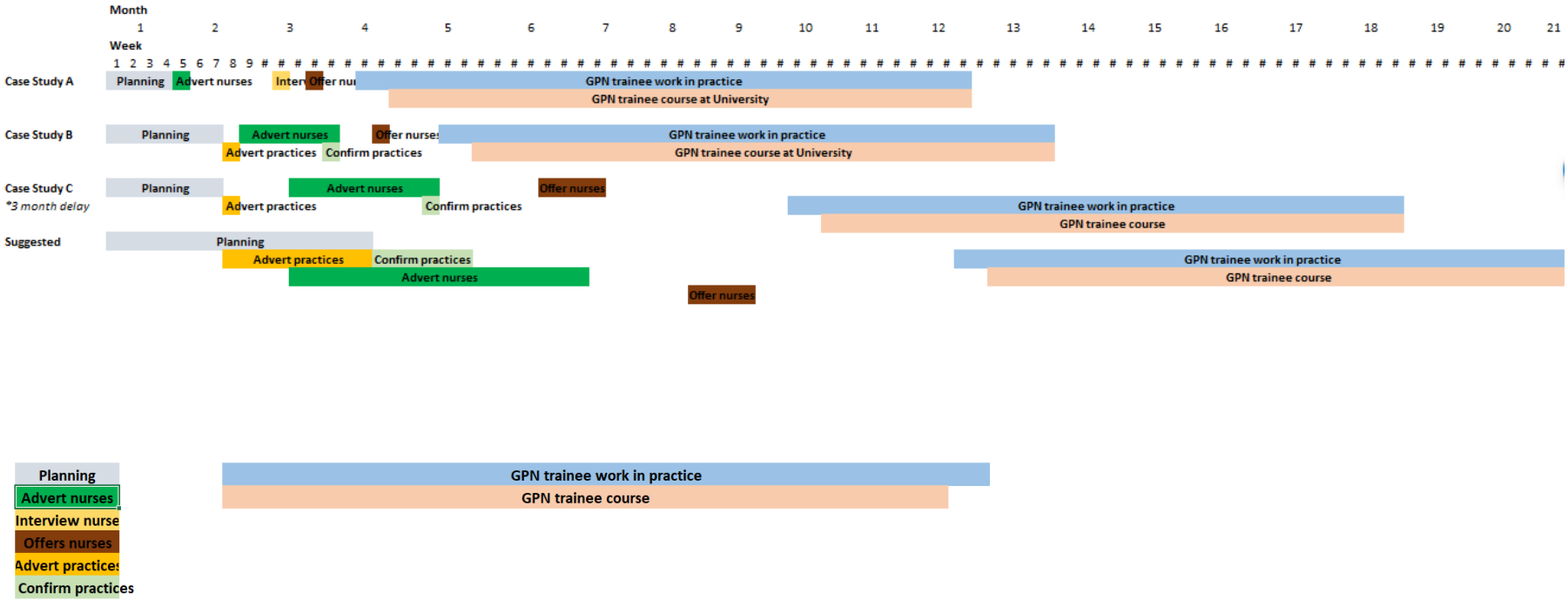
Primarily the HEI uses fixed dates with advanced planning and these are usually non-negotiable. Course start dates in September, January and March depending on the site. The following GANTT chart demonstrates a visual overview of the timelines of case study A, B and C.





The comparison of timelines in early iterations show that the third site had a longer lead time to allow for lessons learned in the earlier case studies.

It is recognised that in the diffusion of innovation model, initial pilot schemes usually roll out at faster rates than those in later stages of the model and this is evidenced by the above. It is likely therefore to expect that at the mainstream adoption level, as the widest range of providers become involved, the speed of rollout is likely to slow. The following diagram replicates the timelines alongside a proposed best practice timeline that may be useful to consider moving forward in later stages of diffusion. As a result of these factors the proposed ideal timeline (as shown above) extends beyond the original 12-18 month plan to an 18-24 month period.



It is acknowledged that this model may require different levels of involvement by different stakeholders at different stages. Evidence shows a need for increased programme support at the start and end phases of the scheme with the need for nurse mentor support at the middle phase of the scheme.

Employment models

The following table outlines the employment models 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.

Similar issues were experienced all sites. Most experienced trainees take a pay cut to work in General Practice which may be at the commencement of employment or when they complete the *Fundamentals* course and move into a substantive post. Trainees are aware of alternative benefits afforded by their appointment which should be emphasised in marketing the role. Threats to the employment models include variability in terms and conditions across the sector and a lack of an established pathway for development. Whilst both of these are currently areas being developed, this research can evidence the need for this to support the growth of the GPN role.

Working with HEIs

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.

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. By contrast, a new *Fundamentals* course ran alongside the pilot at BGU/Lincoln and the tight timelines to implement both new ventures caused some challenges which were not experienced in partnerships with established courses.

> 'There were additional concerns regarding delivery of a course fit for purpose within Lincolnshire. Although the STP had identified the use of the De Montford University programme (course start date of January 2019), their preferred option was the new commissioning of a bespoke programme for the Lincolnshire based HEI- Bishop Grosseteste. This presented a variety of challenges for HEE in terms of developing an amended service specification and the procurement of the new course. Confirmation of a new course was only announced in February 2019 and the course was able to commence in March 2019.'
>
> *Stakeholder reflection MC, Data source R1*

These challenges were mitigated over time; however, they point to the benefit of partnerships linking to existing *Fundamentals* courses at the pilot stage to minimise the challenges encountered.

However, there were also considerable issues arising from misunderstanding between UoH and BLMK due to the lack of standardisation of *Fundamentals* courses, identified in the earlier sections.

It is useful to note that while HEE commissions courses, they do not QA and this process is devolved. There is evidence of HEIs attempting to share data with practices and finding it difficult to devolve information to the relevant levels. There is frustration at Federation level where roles are not clear.

> *I also think that the university has a duty to say that is not the model, we do need your assurance that you are going to have one mentor per student and that they have protected time to sit in on clinics and watch.*
>
> *Interview with GD, Data source 21*

Stakeholders seem unclear about who has responsibility for quality assuring the process in particular that for mentoring and support of trainees. This highlights the importance of strong relationships between the HEI and STP and clearly understand of responsibility. It also emphasises the importance of a clear and shared understanding by all stakeholders at HEI, HEE STP level of the *Fundamentals* programme which would be facilitated by a standardised course.

Universities undertake formative evaluations, and at several sites this is duplicated by formative evaluation at STP level and these are often not shared.

As the previous sections suggested there is no broad understanding of the *Fundamentals* course, high levels of variances and needs to be a big change awareness alongside standardisation.

> *'Well I am not absolutely clear about the differences between the programmes at De Montford and BGU. So, whether the GPNs is an absolutely cast in stone programme or whether it is using the Fundamentals programme is running at both universities and they are slightly different.'*

Interview with GD, Data source 21

It is recognised that this is part of national ongoing work and it is important that the findings of this evaluation link to work being undertaken across the country in this area.

> ***'**But I am involved in a national piece of work looking at standardising those programmes. It is actually in London at the moment but standardising what elements must be within the Fundamentals programme. No, it is not. It draws on the Q & I template, but it is actually capital nurse which is London based. It could be funded through GPN Ten Point Plan as well, but it is looking at London. Yes, I think we are heading towards trying to have a kite mark so that all HEI's that are providing Fundamentals programmes, will have a minimum of them, all the elements that have got to be contained within it.'*
>
> *'Yes, I think we are heading towards trying to have a kite mark so that all HEI's that are providing Fundamentals programmes, will have a minimum of them, all the elements that have got to be contained within it.'*
>
> *'Then obviously flexibility according to the actual institutional requirements but that nurses know that if they go to a kite marked Fundamentals programme, then they get something that is uniform.'*

Interview with GD, Data source 21

It is however acknowledged that through the course of this evaluation it became apparent that the *Fundamentals* programme sits within a wide range of training on offer to GPNs. As such a brief competitor analysis was undertaken and is presented earlier in the report to contextualise *Fundamentals* within the broader marketplace. It is clear from this analysis that *Fundamentals* is located in a competitive market and culture change is essential to underpin *Fundamentals* as the established route for GPNE.

Mentoring

At each site trainees 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-ST trainee learning. Where problems were experienced with practice mentors, they were resolved with support from STP/CCG/Federation leads or university mentors.

Each scheme took a different approach to mentoring GPN-ST trainees. It is recognised that schemes need to be localised according to local supply and demand. Each trainee was allocated 15 hours of external support and this was distributed as follows.

At site A mentoring is coordinated by the University. Practices are charged £500 each and this payment is used to pay a network of experienced practice mentors working in the sector.

> The external trainers are GP nurses recruited and trained by DMU for 2 days in supervision and assessment (usually NMC mentors) arrange to go into the practices of the nurse 5 times over the 40 weeks usually for 3 hours (15 hours external trainer can offer the student)

Interview with GF, HEE, Data source F2

The advantages of this scheme are that trainees have access to experienced mentors working in the field and when a tripartite relationship is built between the trainee, practice mentor and external mentor there is evidence of high levels of successful learning and growth and relationship building. However, the risk of this model is that sometimes there is disagreement between internal and external mentors which becomes a source of conflict. There is some evidence that the network of external mentors requires higher levels of regulation and training but there are the obvious limitations of working in the sectors.

At site B external mentoring is provided through visits from academic nurse mentors. Whilst this provides an objective third party, there are some disadvantages to this model. Trainees do not experience access to a wide range of support from the field and there are limited opportunities to build relationships and networks.

At site C external mentoring was due to be provided by CCG nurses but was delayed to late appointments leading to limited early external mentoring for trainees. When one CCG lead nurse was appointed, she quickly provided support to each nurse in practice as an external mentor. She also arranged for 6 hours of personalised 1-21 - coaching through an external company funded by the CCG. Further evidence is required to evaluate the benefit of this approach.

Mentoring is vital to the scaffolded learning undertaken by GPNs and should be considered an integral part of executing the scheme successfully. External mentoring models should be defined in the planning of the scheme and feed into wider opportunities for networking and development across the profession.

Support

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.

At case study A the project management system identified the risk of attrition and took active steps to instigate wide support mechanisms. Formative evaluations were undertaken throughout programme to measure satisfaction on an ongoing basis. Nurses at Lakeside were co located therefore networking and informal action learning sets were readily available. 3Sixty developed informal meetings with all nurses in their practices to replicate this level of support. Nurses throughout 3sixty have come together for networking opportunity in May and also all nurses have access to PLT in the county. Data was collected at a network meeting designed for 3sixty nurses and mentors to informally meet with programme leads in July and provide feedback on the scheme. This meeting was also an opportunity to support nurses with their scheme exit strategies.

At case study B&C the STP/CCG organised networking support events and formative evaluation.

At site C support was delayed due to vacant posts which meant that trainees were not as well supported in their roles at the start as toward the middle and end. Trainees were encouraged to approach for support where necessary, but it was not always proactively offered. Trainees were encouraged to take responsibility for asking for support.

At the end of the scheme there is evidence that sites have been able to offer support to the GPNs to facilitate a community and transition into employment with ongoing support networks.

Management and Relationships

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.

There is evidence that localised project management ensured the trainees felt supported on the ground, such as in the Federation model at DMU/Northants. This meant that any arising challenges could be dealt with quickly. However, a disadvantage of this additional layer of management meant that reporting and networking of the overall scheme was further removed and caused delays.

Having less project management support, such as in the model at BGU/Lincs, resulted in delays to respond to arising challenges. This caused some issues which the project steering group identified and resulted in additional project management support being provided from within the local STP.

Relationships between Universities and their external mentors was strong but there was limited contact between this side of relationships and those in practices which caused a sense of disconnect and on occasion limited rather than facilitated the linking of theory to practice.

It takes time to establish relationships and therefore naturally those sites linking to existing *Fundamentals* courses and other pilot schemes for Primary Care staff had easier access to resources to support trainees which minimised challenges in operationalisation.

Relationships take time to develop and therefore those programmes built on existing relationships were successful more quickly where others may need longer to develop.

Task and Finish group

The task and finish group have the overall project management responsibility. The group meets bi-monthly and consists of core staff from the NHS along with opted-in staff from local project delivery usually employed by STP or CCG but occasionally at a lower level in the management chain such as project management by federations. This is a rolling scheme with different members each time from local programme teams managed by a core team. For each task and finish group each local manager was required to update their action log and a corresponding action log was kept for the project overall.

> *'What we have asked both sites is to be absolutely focused on capturing as much as they can of the day to day experience.'*
>
> *Interview with GF, HEE, Data source F2*

The action log was updated at site level and reported on at each bi-monthly meeting by each live site and actions transferred to the overall programme action log for the wider team to track and support any outstanding issues. Project plan and daily log were the main useful tracking sheets. Data collected across site in these sections is reported throughout the thematic analysis.

Responsibility for the timely completion and return of the logs and attendance at the meetings was allocated to the local project lead for each site. On occasion it was reported that completion of paperwork was time consuming for project leads and on multiple occasions the senior team had to chase project leads for timely completion of the logs. The logs were useful in identifying and resolving local issues at a broader level and for project learning. This documentary data is a vital source of information for the evaluation.

The task and finish group were the leading source of guidance and regulation to the scheme and this approach should be utilised in other schemes.

Outcomes

Evaluation

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.

However, it is important to note the limitations of the commissioned work. Firstly, the timing, duration and tight turnaround of the evaluation is not a good fit with the desired outcomes for the work. Originally commissioned in January 2019 the work commenced in April 2019 but is a short piece of work which has been extended due to the delay in the BLMK course rollout. The research will consider the pilot rollout of the scheme but will be limited in its ability to measure the outcomes and impact of this scheme due to the evaluation ending at the same time as the first course. The benefits of the scheme are likely to be realised longitudinally and it would be prudent to commission a longer and more extensive piece of evaluation to consider the long-term impact of the changes in GPNE.

Furthermore, there is an element of interview saturation which has limited the engagement of trainees with the research. A request for trainee interviews and a link for online questionnaires administered via the University contacts elicited NO responses from trainees. At each site, there is local evaluation work being undertaken and therefore no value to duplicate such work. This includes university evaluations, practice site evaluations, and at some areas locally commission evaluations including surveys and focus groups. While this evidence is included in the evaluation, its quality as evidence is less valid than that directly collected for this research as its hidden bias cannot be established. It would be useful to follow up trainees after the course but there is no mechanism to do so (unless informally through CCG/STP/University networks).

There has been limited opportunity for engagement with patients and GPs as the evaluation is many layers removed from practice. Further ethnographic work involving patients who have experienced the GPN-ST trainee MOervices would be beneficial. There is significant evidence from practice managers and senior nurses that the scheme has positive outcomes.

Further areas for evaluation are identified throughout the report.

HR / Pay issues

In the transition to the GPN role and later transitions between training and substantive roles HR and pay issues consistently arose.

Where trainees are employed by the CCG and have to transition to new roles with new contracts this is time intensive and stressful. In other schemes over 50% of trainees are retained by the hosting practice on a similar contract to their traineeship.

The lack of standardised pay for the role is raised as a concern at each site. There is recognition that the sector does not operate in the same ways as AfC and trainees need to be made aware of this and

how to negotiate. Sick pay and maternity pay options were recognised as often not as favourable as AfC.

Initial pay rates matching pre-scheme roles caused a later problem as trainees transitioned into the GP workforce and this reduction in salary at the end of the traineeship rather than the start is a risk to retention. One trainee at the end of training decided not to accept a post in General Practice as she could not afford the pay cut.

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 trainees to negotiate beneficial contracts.

Most GPN-ST 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.

Trainees raise concern at a lack of recognition or standardised pathway for development in the role.

Workforce related outcomes

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 trainee 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 trainees 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.

Pathways

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.

The impending fellowship seems the route for development favoured by most sites. There are practical recommendations for methods to link the GPN-ST pathway to the future fellowships model.

> *'I think it would be far better if the GPNS sits within something like the fellowship programme, it is within their preceptorship year as newly qualified, or it sits within a preparation for GPN if they are transitioning to somewhere else. It needs to be a longer supportive fellowship type structure.*
>
> *The thematic analysis needs to include analysis of future options in terms of apprenticeships and fellowships and recommend a single but adaptable model for clarity in moving forwards'*

Leadership amongst GPNs is a key emergent theme of the research. There is evidence of the early start of a culture change. STPs are keen to emphasise leadership opportunities to new GPN and GPNs seem keen to forge into new territories for GPNs. Trainees at all sites seem keen to commit to a development pathway. The networks facilitated by the scheme are vital to the growth of leadership across the profession.

Communications & engagement

The steering group believe that more could be done to share the benefits of the scheme. Regional support for communications and engagement for the programme was lacking due to lack of resource and therefore this role was subsumed by project leads. All communications and engagement assets were created by the HEE operation lead and NHSE/I. This included:

- Articles written for the national trade press
- Support for articles written by the STPs to promote the programme
- Fliers advertising the programme
- Support for TV filming within Northants
- Support for STPs to design internal marketing such as videos

This has been particularly time consuming and completed in most instances without the expertise of a Communications resource. The programme funding made no allowance for this either regionally or locally to STPs.

The evaluation team found significant evidence of communication around the scheme in local areas and national press as above. This finding extended to *Fundamentals* courses, as well as to ST training route. This evidence, alongside the high applicant numbers for the scheme, suggest that no further investment in local communication is required. Support should be given to sites about successful ways to promote their scheme.

Areas for development were identified. As the GPNE and ST pathways are new and developing, more information is required about GPNE route on mainstream NHS websites relating to Nursing. There is evidence that students within Universities offering *Fundamentals* courses are targeted for GPN and this could be extended to a wider region. There is some evidence of this, for example DMU courses are advertised through Local Medical Committees in Derby and Nottingham as well as through Leicester. Simple local networks are effective tools for communication and engagement.

Communications can be improved using direct evidence from this evaluation. It is suggested that future strategies are multi-layered and include promotion at policy through to practice levels. Towards this aim, this evaluation presents outcomes from this research in the form of a policy release to support political level campaigning and a 'how-to' guide to support all levels of stakeholders in future iterations of the scheme.

GPN-ST Conclusion

Meeting the aims

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.

Managing execution

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 trainees 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 evidence from this research suggest that stakeholders uniformly agree the content and delivery structure of *Fundamentals*, as outlined by the working group and delivered by the majority of providers. UoH does not deliver this model. 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 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 trainees 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-ST 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 trainees. External mentors provided access for trainees to important nursing networks. Support for trainees was provided at STP/CCG level and this was important in transition to employment and ongoing into their roles.

Achieving outcomes

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 trainee 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 trainees that has not existed previously.

In conclusion this section has listen the key benefits and challenges identified throughout the research and iteration of the three key cases.

As a proof of concept, the scheme is successful.

As workforce development the scheme is successful.

The key lessons outlined lead to recommendations from this section which form the 'how to' guide. The aim of this document is to summarise key learning points which can be useful for stakeholders in future iterations of the scheme.

Summary

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

The conclusion sections of the first section '*Fundamentals'* and the second section 'GPN-ST' offer summaries of the key findings of each of those sections.

The combination of these key summaries is presented in a range of formats in this closing summary, which may be useful to share with stakeholders, alongside the Executive Summary of this full report.

Firstly, the evaluation leads to the identification of a theory of change for the culture of education of general Practice Nurses. This presentation of findings is useful for high level presentation of the findings as they relate to workforce development and culture change.

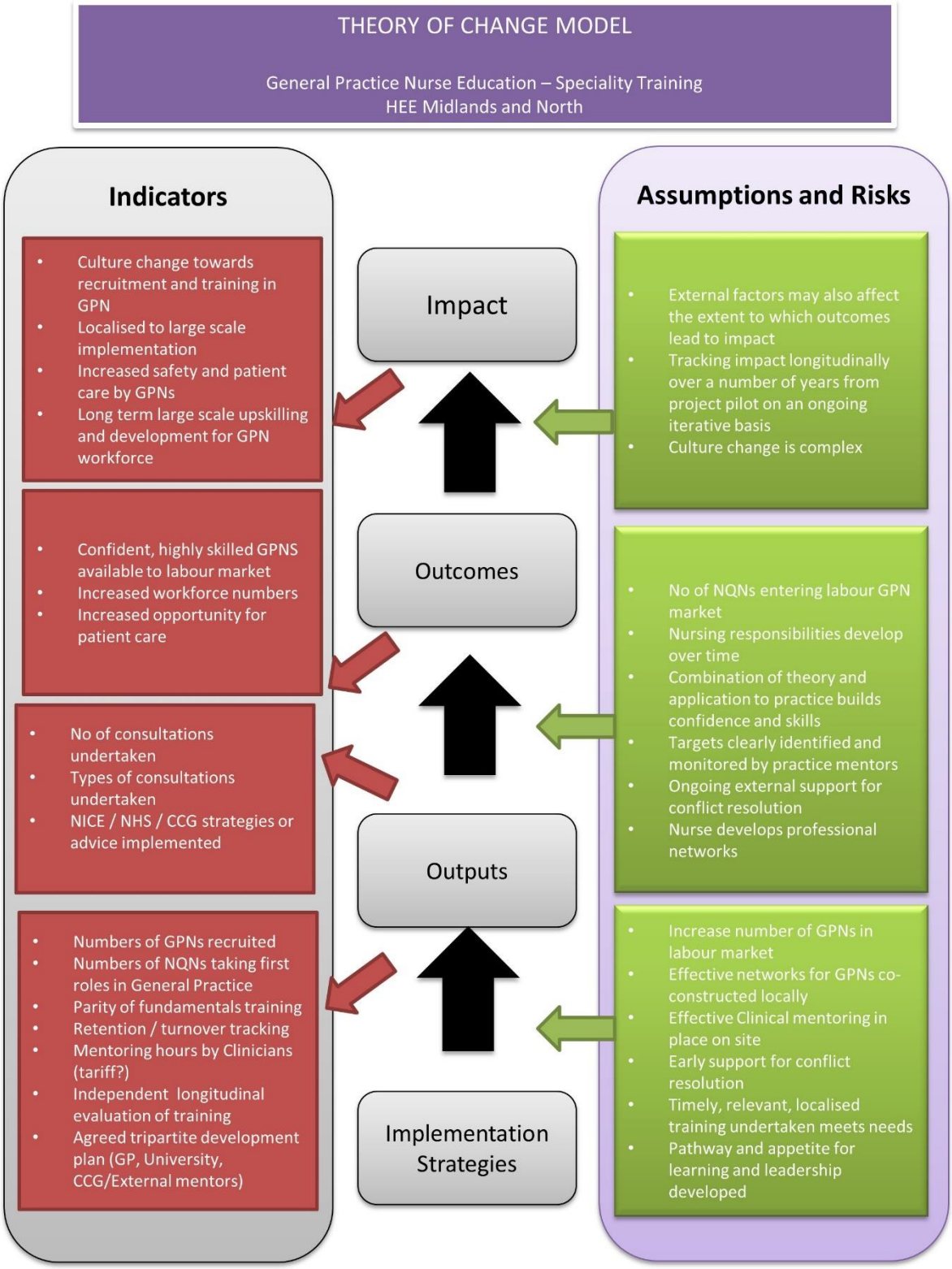
Secondly, a policy brief outlines the key findings of the scheme which may be useful to represent findings nationally, in particular at a political level of engagement.

Finally, a 'How-to' guide summarises key learning points and recommendations targeted at a wide range of stakeholders, from programme leads through practice staff to trainees, in order to provide useful guidance for future iterations of the scheme.

It is anticipated this range of outputs will ensure the evaluation work will have impact at a wide range of levels.

Appendices

Theory of Change Model



'How-to' Guide

Outline

This 'how-to' guide is designed to summarise the key findings from the evaluation research in a format that might be useful to stakeholders involved in future iterations of GPNE.

A wide range of stakeholders are involved in the scheme and hold the key to implementation success. Each scheme successfully employs a range of key stakeholders who must combine the successful and timely achievement of their responsibilities for the successful implementation and delivery of an education al scheme rollout. Furthermore, communication is crucial to ensure stakeholders are mindful of operations of others. A Stakeholder mapping process was undertaken to identify the audience for the report and how the evidence might have maximum impact for each group. The how to guide is separated into key sections which can be combined for maximum benefit. |It would be beneficial to all stakeholders to consider the advice not just for their own role but for others to gain maximum understanding of the interplay between roles. Equally one section can be detached for circulation to one particular group of stakeholders. All stakeholders need to be clear about each other's responsibilities. The task and finish group bring together the top-level stakeholders identified below. Is therefore crucial that strong relationships exist between the at Task and Finish level and practice level.

The following table highlights the key stakeholders and relevant implementation guides.

Job roles	Employer	Primary Guide type	Useful secondary guides
Funders and Commissioners	HEE / NHSE/I	Implementation	Education Practice Nurses
Localised workforce development leads	STP	Implementation	Education Practice Nurses
Localised GPN / Federation leads	STP/CCG	Implementation	Education Practice Nurses
University academic delivery	University	Education	Implementation Practice Nurses
GPs and Practice Managers	Practices	Practices	Education Nurses Implementation
Practice Nurse mentors	Practices	Practices	Education Nurses Implementation
GPN applicants	Individuals	GPNs	Education Practice

Feedback from stakeholders in the spirit of co-production is welcomed to ensure relevance.

Implementation guide

Introduction

There is an assumption those responsible for implementation will have read the main report for background.

Allocating and Managing Responsibilities

The lead responsible for the localised scheme project management is usually allocated to someone at CCG/STP level who initiated the bid and was involved in planning. Sometimes key responsibilities are transferred between winning the bid and implementing the scheme.

It is recognised that the CCG/STP project lead has overall responsibility for the scheme and reporting, the hands-on tasks can often be devolved to lower levels where contact with practices and nurses is more direct. Where this responsibility is not devolved there needs to be direct lines of communication and reporting between STP and other key stakeholders such as practices/GPNs and the University through regular networks and reporting. There is a risk of some distance in practice, understanding and motivation between staff at this level and those on the ground. However, these are mitigated by using experienced nurses in STP/CCG development roles. There are very positive examples of this provided in Case Study B and this approach is successfully under development in Case Study B. Nurse leads need to be in places in advance of the programme for maximum success.

The lead responsible for the localised management and co-ordination of nurses and practices on the ground can be devolved to Federation level. There is a very positive example of this provided by Case Study B. This has a range of affordances and constraints. The benefits are very close contact and flexible support for practice sites, and centralised support for the scheme which enables it to be responsive to iterative developments. An additional layer of management requires additional communications and can cause delays, for example to reporting.

Evidence emphasises the importance of networking and relationship building between CCG/STP staff and Federation/practice staff. There is evidence of a clear need to communicate with practices to clearly outline responsibilities between mentors, practice managers and other staff. The key skills the GPN-ST trainee is developing should be communicated to, and between, practice staff at key times to facilitate the right type of appointments in line with the trainee development. Practices should have clear commitment to the scheme and there is evidence that this can be successfully facilitated through MOUs or outlines communicated to practices, a sample are offered in the Appendices of this guide and may be useful templates.

Successful schemes invite practice managers to tap into tripartite meetings or practice mentor and trainee meetings to maintain updates to share with the broader practice staff and their role should be valued as opportunities for development.

Management leads take varying responsibilities at different points and in future planning it would be useful to decide where the responsibility for each implementation aspect falls and these should be well communicated. These responsibilities such as recruitment, mentoring, transition to employment and supporting the community of Nursing are discussed as they are relevant to each role throughout this guide.

Most sites key aim is to breach gaps in the workforce as demands increase and supply decreases through increasing attrition and retirement levels. Whilst there are developments at each site to monitor and analyse workforce statistics, there is limited capacity at the existing time to have accurate reporting on numbers of live vacancies and therefore impact of the scheme at a broad level. Therefore, the aim of each site to contribute to increasing numbers of available nurses in the region broadly cannot be accurately measured at the present time. It is likely that mechanisms for this level of tracking will develop over time and should be shared between sites in order that the broader impact of workforce development can be measured. This would also enable further longitudinal development.

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 timeline

Evidence from previous schemes demonstrates the need for sufficient lead time into the project and the risks associated with unrealistic timelines. Whilst it is recognised that lead times within NHS commissioning are often short, a primary recommendation for commissioners is the recognition of the time required for scheme implementation and the need for flexibility to be responsive to needs on the ground which might cause slippage.

There are key critical points in the implementation which require attention, and likely significant workload increase, for Project Managers. The highest workload is in recruitment and set up of the scheme and there is another minor spike in the closedown of the scheme and transition of GPNs to employment. Workload planning should take allowance of this, as case studies have shown where early planning and flexible working has not been enabled these key roles were outsourced to short term consultancy contracts. Where short term consultants are employed for support, there should be clear time allocation for Project Managers to liaise with and enable a suitable handover with the consultant when they move on from the scheme. Risks identified where this does not happen are that key data is lost and early relationships take longer to develop.

The recommendations proposed are with recognition that stakeholders will need to adapt to localised needs and commissioning demands. The proposed timeline within the recommendations is ideal scenario and where not achievable mitigating steps and additional support can ensure the scheme moves forward.

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

Recruitment of practices and GPN-ST trainees is a critical point in the scheme requiring significant investment of project management time compared with other sections of the project.

The timeline proposed is cyclical for sites which intend to recommission an ST route (in the immediate future in response to Fellowship funding). Dates are suggested in relation to a potential late September / early October course start (with the recognition that courses and schemes may also have January and March options for which the timeline can be adapted)

HR support is required in advance of roles starting. Many experienced nurses who transfer to GPN training will, at some point, take a pay cut. Approaches to salaries should be clearly identified by Project Managers. The SWOT analysis table may be a useful reference point (see page 206).

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

Project Managers need to decide on whether GPNs will be employed by practices or the CCGs

Where GPNs are employed by practices, there is a period of support and negotiation required to translate requirements to practices and ensure there is clear understanding of the scheme requirements.

Where GPNs are employed by the CCG, there will still need to be negotiation with the practice to ensure they understand and commit to their responsibilities and don't just see the placement as a free member of staff. CCG will need to provide more support to these trainees to transition into employment than those who

Whichever scheme similar levels of success and similar numbers transition into GPN roles with on average 6/`0 staying at hits sites, 3/10 finding new employees and 1/10 not completing or taking roles outside GP.

The SWOT analysis table from the main report may be a useful reference point (see page x)

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

The *Fundamentals* interim evaluation identified some key differences between the schemes in the local area funded by HEE. Whilst most sites completely support the generic model of *Fundamentals* and rolling it out, some sites disrupt this by offering alternatives and branding them as initial GPN training, such as UoH, and this causes much misunderstanding in the sector. The research found evidence that GPs often seek the cheapest route to GPN training, and whilst a 9 month *Fundamentals* pathway may not be the 'cheapest' route available, it provides a broader and deeper level of education that all stakeholders universally agree is required for the role and the development of the role. The research has identified that alternatives are simply skills training and do not offer the level of wraparound support required for successful transition into the role. Furthermore, the *Fundamentals* course offers ongoing relationships, a network, a safety net and a leadership movement for GPNs which is not afforded in skills training.

This research suggests that the '*Fundamentals*' badge should only be afforded to 9-month 60 credit courses at PG level with standard items included mapped to the RCGP competencies. Furthermore, a network of course leads should be facilitated to discuss standardisation of these courses. HEE should not commission and should actively discourage the development of alternative courses. Project Managers should be made aware of the range and types of courses on offer with '*Fundamentals*' as the gold standard course. This work should link with wider developments to standardise GPN in particular the work of Sue Cross in London and Angie Hack nationally with Qi. (check where this is at and include links to anything published)

The research evidences the need for a pathway for development for GPNs and there is evidence about a range of current pathways. Further work is needed to establish and share good practice at this level. This research recommends evaluation of GPN pathways, and the way GPNs are trained in the MDT, for example the Primary Care academy in Case Study site B.

Key existing partnerships are highly beneficial to successful scheme operationalisation such as in Case Study A. This was demonstrated by the speedy set up of sites 4&5 based on partnerships with CCGs in the area and BCU as identified through the interim report. The *Fundamentals* evaluation identified several sites with existing partnerships upon which successful pathways can be built – for example the high-level networking and CCG partnerships taking place with Keele University. This highlights the benefits of both building relationships with local HEIs and

Recruitment involves several key points. The University does not become involved in recruitment until the course induction, on the assumption that in being identified by the CGG as ST scheme they meet the requirements for the *Fundamentals* course. However, there is evidence at some ST sites (cases study C) and several *Fundamentals* sites that University staff play a key role in encouraging NQNs into employment and training post qualifying. This suggests there is a key advantage to being in early discussions with Universities about the opportunities of future schemes to facilitate the engagement of NQNs. Furthermore, these partnerships encourage the idea that GP can be a first destination.

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

Mentoring is vital to the scaffolded learning undertaken by GPNs and should be considered an integral part of executing the scheme successfully.

Practice mentors have a key role and should have a line of communication and support and a network. Practice mentors need to have allocated time by the practice, and this may need support. Trainees benefit with a 1:1 or 1:2 mentoring ratio, any higher leads to limits on the number of mentoring trainees receive. Mentoring time is often limited by the demands of the job and Project Managers may need to support trainees to access the correct levels of support. Practices should treat trainees as supernumerary until they are confident. Even when confident in one skill they should have the opportunity to develop others. Practices may need to be reminded by Project Managers of their commitment to and investment in the scheme (and that is not just a free member of staff)

External mentoring models should be defined in the [planning of the scheme and feed into wider opportunities for networking and development across the profession. A range of models can be successful. Practices can be asked for small additional funding to support this role to employ external mentors. Mentoring can also be provided by lead nurses or external companies. Mentoring should not be provided by the University as this limit the opportunities for GPNs to engage with their wider network.

The SWOT analysis table from the main report may be a useful reference point (see page x)

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

Scheme leaders are responsible for formative and summative evaluation of the scheme.

Formative evaluations can inform the successful development of the scheme. They should be planned to take place at critical points with groups of trainees and individuals. They should also be emergent to any arising demands. The formative evaluation should inform the project management role.

The task and finish group support the formative evaluation of the project management of the scheme.

Formative evaluations also afford excellent opportunities for relationships building and cross site learning. It is important they are fully open dialogue and not just happy sheets for promotional material. Most universities have good examples of formative feedback processes.

Summative evaluation data currently collected is simply the number of trainees retained from commencement to end of course and those transitioned into GP employment.

This data should be mapped to longer term workforce modelling to show the massive impact the scheme has on developing the broader workforce. This works needs to be undertaken and regional and national level. This data will emphasise the benefits of the scheme on workforce.

It is suggested that summative qualitative data could be collected through exit interviews with GPNs and practice. For ease of facilitate this could take a rang e of methods including templates, interviews and multimedia contributions. This data could usefully support the scheme going forward.

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

Education and Support guide

Intro

It is anticipated that HEIs will have read the full report for background.

Scheme outline

The *Fundamentals* interim evaluation identified some key differences between the schemes in the local area funded by HEE. Whilst most sites completely support the generic model of *Fundamentals* and rolling it out, some sites disrupt this by offering alternatives and branding them as initial GPN training, such as UoH, and this causes much misunderstanding in the sector. The research found evidence that GPs often seek the cheapest route to GPN training, and whilst a 9 month *Fundamentals* pathway may not be the 'cheapest' route available, it provides a broader and deeper level of education that all stakeholders universally agree is required for the role and the development of the role. The research has identified that alternatives are simply skills training and do not offer the level of wraparound support required for successful transition into the role. Furthermore, the *Fundamentals* course offers ongoing relationships, a network, a safety net and a leadership movement for GPNs which is not afforded in skills training.

This research suggests that the '*Fundamentals*' badge should only be afforded to 9-month 60 credit courses at PG level with standard items included mapped to the RCGP competencies. Furthermore, a network of course leads should be facilitated to discuss standardisation of these courses. HEE should not commission and should actively discourage the development of alternative courses. Project Managers should be made aware of the range and types of courses on offer with '*Fundamentals*' as the gold standard course. This work should link with wider developments to standardise GPN in particular the work of Sue Cross in London and Angie Hack nationally with Qi.

Pathway

The research evidences the need for a pathway for development for GPNs and there is evidence about a range of current pathways. Further work is needed to establish and share good practice at this level. This research recommends evaluation of GPN pathways, and the way GPNs are trained in the MDT, for example the Primary Care academy in Case Study site B.

Fellowship funding provides opportunity for continuation of the scheme and associated developments.

Partnerships

Key existing partnerships are highly beneficial to successful scheme operationalisation such as in Case Study A. This was demonstrated by the speedy set up of sites 4&5 based on partnerships with CCGs in the area and BCU as identified through the interim report. The *Fundamentals* evaluation identified several sites with existing partnerships upon which successful pathways can be built – for example the high-level networking and CCG partnerships taking place with Keele University. This highlights the benefits of both building relationships with local HEIs and STP leads.

Recruitment involves several key points. The University does not become involved in recruitment until the course induction, on the assumption that in being identified by the CGG as ST scheme they meet the requirements for the *Fundamentals* course. However, there is evidence at some ST sites (cases study C) and several *Fundamentals* sites that University staff play a key role in encouraging

NQNs into employment and training post qualifying. This suggests there is a key advantage to being in early discussions with Universities about the opportunities of future schemes to facilitate the engagement of NQNs. Furthermore, these partnerships encourage the idea that GP can be a first destination.

Mentoring

Universities splay an important role in facilitating mentoring and providing wraparound pastoral care. Responsibilities for external mentoring should be identified and HEIs are likely to play a key role. External mentoring models should be defined in the [planning of the scheme and feed into wider opportunities for networking and development across the profession. A range of models can be successful. Practices can be asked for small additional funding to support this role to employ external mentors. Mentoring can also be provided by lead nurses or external companies. Mentoring should not be provided by the University academics as this limits the opportunities for GPNs to engage with their wider network. Academics should however provide pastoral mentoring and link with the wider network to support nurse development. Universities can be key to training, and QA, both practice and external mentors.

Evaluation

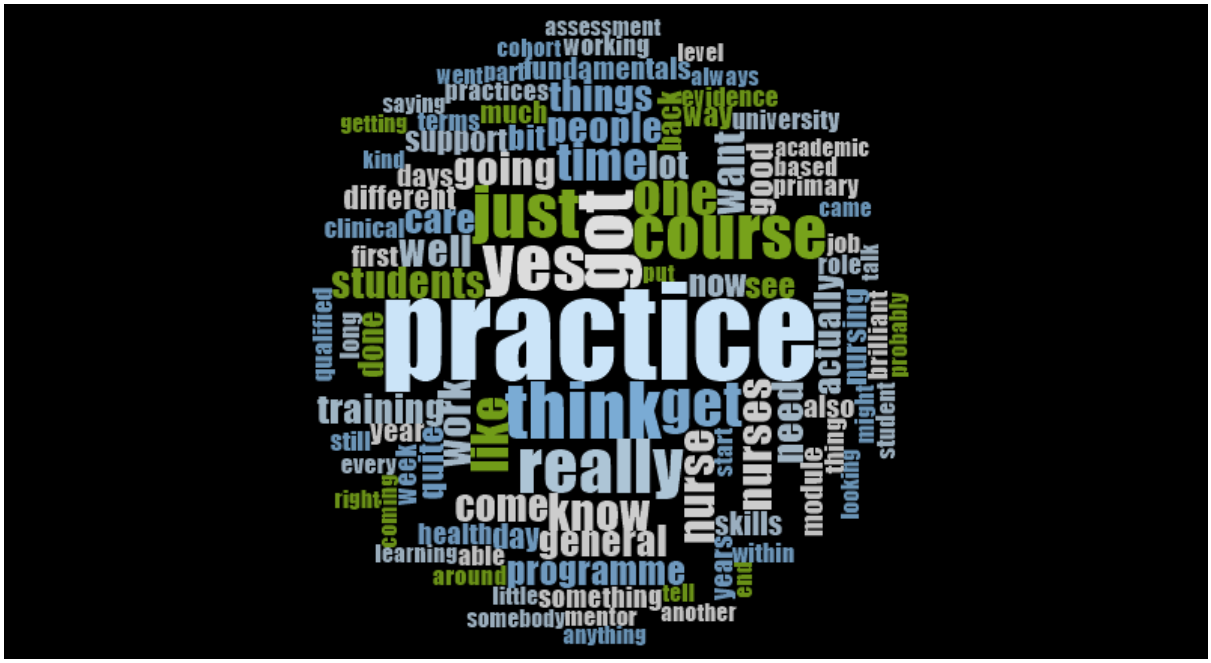
Formative evaluations can inform the successful development of the scheme. They should be planned to take place at critical points with groups of trainees and individuals. They should also be emergent to any arising demands. The formative evaluation should inform the project management role.

Formative evaluations also afford excellent opportunities for relationships building and cross site learning. It is important they are fully open dialogue and not just happy sheets for promotional material. Most universities have good examples of formative and summative feedback processes. These should be shared through key relationships and networks and devolved to practice level where possible. Likewise, evaluations from practices and STPs should be shared with Universities to inform community development cross sectors.

Recommendations

- A standardised model of *Fundamentals* course
- Promotion of *Fundamentals* + ST as parallel to GP ST1
- *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 cheaper alternatives
- Pathways should be developed and shared
- Partnerships with other key stakeholders are important and time should be allowed to nurture these and participate in important local networks as many already do
- Practice mentoring should be supported through pastoral care o university and any issues arising shared with project management
- External mentoring is important part of course, range o model may be implemented
- Universities can regulate and educate mentors to develop the broader community
- Shared commitment towards building a community of practice - *Fundamentals* should support trainees to engage with wider network of GPN

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



In the past it has been difficult for Nurses to enter into a career in General Practice. Experienced nurses were poached between practices and vacancies always existed.

General Practice has changed. In the past a nurse worked in a treatment room and supported the Doctors. Many current GPNs have been in post for a long time and many are due to retire soon. The demands on General Practice have changed with more patients, more elderly and long-term conditions and a reducing supply of GPs. There are lots of new roles and new opportunities for a range of professionals in Primary Care and this is supported by government policy and funding. Many CCGs and STPs have devolved funding to support General Practice Nurse development in their local area.

This scheme has been designed as a pathway into General Practice with education, training and support to transition into the role. It is suitable for experienced nurses from any background as well as newly qualified nurses.

How can I get involved?

You will need to apply for an ST scheme with vacancies – these are usually annual and advertised 3-6 months before funding available. It is a good idea to make contact with local representatives at STP/CCG level to ensure you are aware of what is happening in your area.

If you are successfully recruited, you will host a GPN in an initial 9-month training post. They will be paid a salary which will be funded for the duration of the training. Term and conditions have to be negotiated with individuals, but some will have high expectations aligned to AfC. There are however alternative benefits which can be offered including regular working hours with more flexibility than other working environments, and good opportunities for development.

You will host the GPN 4 days per week and the scheme will require investment from the practice in terms of practice mentoring support time allocation. The GPN is a supernumerary post, although by the end of training they will be able to work autonomously for the practice.

What and how will a GPN-ST learn?

Your GPN will work for 4 days per week in practice and have one day per week for learning. Your GPN will spend one day per week at University for 9 months learning theory and skills to put into practice at work. You will provide support by an experienced mentor in your practice and an external mentor will visit to support you both. Your GPN will also be supported with pastoral care from your University a through access to networks.

What future will the GPN have?

Over 90% of candidate retain a career in GP. Over 60% of host sites retain their GPN into a permanent post in the practice. There are pathways for development for GPNs. into advanced practice, prescribing, mentoring, leadership and research. There are development pathway innovations such as Primary Care skills academies which you can tap into.

Recruitment

Practices should be involved with recruitment, time and planning should allow for this. It is an opportunity to begin building relationships the nurse and the wider network and feel ownership of the scheme at a local level.

HR issues may arise, salary expectations may be high from transferring experienced nurses. Whilst secrecy around terms and conditions maybe preferred it should be recognised that trainees belong to a network where they will hear about alternative hosts and their arrangements.

There is evidence NQNs can be good GPNs

Trainees benefit from up to one month induction at the practice shadowing key staff and understanding how things work before starting the course.

60-70% of GPNs retain employment at their host site at the end of the scheme which is evidence of the success of the scheme for practices.

Mentoring

Practice mentoring is the responsibility of the practice and time should be clearly allotted. This time investment represents the early investment to the practice required and to be realised by the end of the scheme.

A scaffolding model is used which mimics the model of GP f1 training.

External mentoring is provided through the scheme., Some models may require nominal financial support from practice. Relationships between internal and external mentors are key to the development of the scheme and should be facilitated through tripartite meetings and contact with STP. External mentors may be regulated by the University or the STP. They should provide 5 hours per trainees and should not overlap the hours to multiple trainees in one location.

External mentoring gives trainees and practice mentors access to a wide network of support and allows them to contribute to wider nursing development.

More specific info about commitment and times to meet?

Relationships and responsibilities

Evidence emphasises the importance of networking and relationship building between CCG/STP staff and Federation/practice staff.

Information devolved to practice from University and STP level doesn't always land with the right people. There is a need to communicate within practices between mentors, practice managers and other staff. The key skills the GPN-ST trainee is developing should be communicated to practice staff at key times to facilitate the right type of appointments in line with the trainee development.

Practice staff should be allowed time for mentoring and project review.

Successful schemes invite practice managers to tap into tripartite meetings or practice mentor and trainee meetings to maintain updates to share with the broader practice staff and their role should be valued as opportunities for development.

Growth of GPN Nursing

Practices supports GPN development across the sectors by employing and training a GP Nurse, but more work and wider support is needed.

Evidence shows the demands on General Practices to develop workforce in new ways. This scheme provides evidence of the need and benefits of mimicking the F1 training model and providing funded supernumerary training posts for GPNs with standardised recognised training and wraparound support. This model matches the GP F1 training model and enables the trainee to become aa confident and autonomous HCP with leadership potential, meeting the ultimate needs of Primary Care.

GPs should be encouraged to recognise the value of a standardised *Fundamentals* training scheme with wraparound support and a pathway to development for GPNs. There is evidence of early recognition and support for the scheme from participants and evidence of culture change in the sites studied. There is evidence that GPN-ST trainees have the potential to be significant contributors to leadership, developing and changing practice and culture for future GPNs and the benefit of Primary Care.

GPN Guide

'So, you are thinking about being a General Practice Nurse...'

What is GPNE-ST?

In the past it has been difficult for Nurses to enter into a career in General Practice.

General Practice has changed. In the past a nurse worked in a treatment room and supported the Doctors. Many current GPNs have been in post for a long time and many are due to retire soon. The demands on General Practice have changed with more patients, more elderly and long-term conditions and a reducing supply of GPs. There are lots of new roles and new opportunities for a range of professionals in Primary Care and this is supported by government policy and funding. Many CCGs and STPs have devolved funding to support General Practice Nurse development in their local area.

This scheme has been designed as a pathway into General Practice with education, training and support to transition into the role. It is suitable for experienced nurses from any background as well as newly qualified nurses.

How can I get involved?

You will need to apply for an ST scheme with vacancies – these are usually annual and advertised 3-6 months before posts are available (to allow you to apply and serve notice) Sometimes Universities advertise these posts to those completing their degree. It is a good idea to make contact with local representatives at STP/CCG level to ensure you are aware of what is happening in your area.

If you are successfully recruited to a post in Primary Care, it will be an initial 9-month training post. You will be paid a salary, but it will not be AfC and term and conditions have to be negotiated with individual practices in Primary Care and terms are variable. There are however alternative benefits including regular working hours with more flexibility than other working environments, and good opportunities for development.

What and how will I learn?

You will work for 4 days per week in practice and have one day per week for learning. You will spend one day per week at University for 9 months learning theory and skills to put into practice at work. You will be supported by a mentor in your practice and an external mentor will visit to support you both. You will also be supported with pastoral care from your University a through access to networks.

What future will I have?

Over 90% of candidate retain a career in GP. There are pathways for development into advanced practice, prescribing, mentoring, leadership and research.

Template MOUs for Practice partnerships

GPN-ST Project – Study time and Work-Based Learning for the *Fundamentals* of Primary Care Nursing Course

The study days outlined below equate to 28 days (196 hours) this is equivalent of 1 day a week for the 28 weeks of the 9 month contract. In addition, it is recommended that trainees are allocated a further 5 hours a week study time (140 hours) within their contracted hours of work.

Practices can negotiate with the trainees when the 5 hours a week equivalent should be taken to allow for weeks when they have more than one study day in a week or none.

In addition to the study days trainees are being offered a variety of tutorial/ lectures and support time online some in the evenings. These sessions are optional but if accessed should be taken from the 5 hours a week study time.

For the rest of the time trainees will be working in General Practice under the direct supervision of their Practice Assessor and Practice Supervisors. In the early stages trainees should be supernumerary to allow them to access learning experiences and observe a variety of clinicians in the practice. As they progress, they will gradually be able to work more autonomously but for the duration of the course they should have access at all times to a Practice Assessor or Supervisor for support. A minimum of half a day a week throughout should remain supernumerary to allow for them to be assessed and observed in order to complete the requirements of the portfolio and competencies.

Outline guide provided by HEI for Practices – BCU (Developing case study D)

General Practice Nursing Specialty Training (GPN -ST) – Memorandum of Understanding (MOU)

THIS AGREEMENT IS MADE BETWEEN:

(1) XXXXX Training Hub whose principal place of work will be (INSERT ADDRESS)
(2) GPN whose principal place of work will be (INSERT ADDRESS)
(3) PRACTICE whose principal place of business is at (INSERT ADDRESS)

1. **Scope**

This Agreement covers the delivery of GPN-ST training and funding arrangements for GPN-ST trainers on the XXX course with Health Education East Midlands and associated parties.

2. **Purpose**

The purpose of this Agreement is to clearly identify each party's responsibility for ensuring the successful delivery and experience of the GPN-ST Programme.

4. **Agreement Period**

The Agreement will commence on INSERT DATE and will continue for the duration of the INSERT PLACE OF EDUCATION course.

This MOU has been created to map out the role of each person involved in the clinical practice activities, as well as the minimum role criteria. The support is offered to the LTH approved Lincolnshire Practice Nurse enrolled on the GPN course at Bishop Grosseteste University (BGU), from March 2020. A training grant will be made available to each LTH approved practice supporting their GPN on this course which is subject to the parties adhering to this Understanding as set out in the agreement below.

Training Grant

A training grant will be made available to each practice to the maximum amount of (INSERT AMOUNT). All trainees will receive the University day funding and the second day will be administered pro rata against the contracted hours in practice.

LTH will administer this training grant. The expectation is that the first fully funded day will cover attendance at University, or in practice during University holidays and the second funded day will be for protected time for work-based learning in order for the learner to consolidate their skills.

The grant will be administered in 3 payments as follows –

1st May 2020

1st August 2020

1st November 2020

Should the trainee leave the course future instalments will not be paid. Should the course learning be interrupted, the training grant scheduled payments may be subject to change.

The Practice Nurse Trainee will:

Work at least 20 hours per week at the GP surgery at which they are employed (not including time at university)

Keep their practice manager and internal supervisor regularly informed of subjects being learnt at University, so that taught subjects can be practically applied by both the Mentor and GPN Trainee within practice.

Provide their GP practice with a course timetable

Inform GP practice of absence from university or insight days

Meet regularly with Mentor and Training Hub Clinical Educator to monitor their progress. For example, start, mid-point and programme end. These meetings must be evidenced.

The GP Practice/Internal supervisor Role

The role of this person is to provide internal support to the GPN trainee to enable them to successfully complete the GPN programme and work collaboratively with both the Training Hub Clinical Educator and BGU Programme team.

Provide day to day support to the GPN trainee and ensure that action plans are jointly created with the GPN Trainee, adhered to and successfully achieved.

This person can also be delegated clinical tasks by LTH Clinical Supervisor if appropriate and will work closely with the LTH team in order to support the learner in practice.

Internal Supervisor role criteria

- Be NMC registered
- Possess prior experience of supporting learning and supervising students in practice
- Committed to supporting a GPN trainee at their practice, within clinical environments
- Arrange timely subject specific clinics so that the GPN Trainee can apply their learning in clinical settings
- Appropriately raise any practice concerns with both the GPN trainee and the Lincolnshire Training Hub, so that appropriate support and action plans may be put in place to ensure that the GPN Trainee is able to successfully complete their programme of learning and become a competent GPN.

Training Hub Clinical Educator Role

As part of the XXX GPN programme, GPN trainees will complete a competency framework whilst working in their GP practice.

The Hub Clinical Educator will support the completion of this framework through visits to the GP Practice, remote access and providing assistance to both the GPN Trainee and GP Practice/Internal supervisor as and when required.

The Hub Clinical Educator will support GPN Trainee learning in practice and also ensure that the practice education is of high quality and remains consistent.

At programme end, provide preceptorship to support the GPN Trainee's transition into General Practice.

Role Criteria:

- Be NMC Registered
- Have completed SSSR supervisor/assessor course
- Possess prior experience of supporting learning and supervising students in practice
- Be committed to providing practice support to allocated GPN Trainees
- Provide up to 15 hours practice support per GPN Trainee across the duration of the GPN course at XXX.

Raising Concerns: Guidelines for GPN and Training Hub Clinical Educator

1. Patient safety is compromised clinical educator (LTHCE) to inform the student to STOP unsafe practice with immediate effect. LTHCE to discuss concern and any subsequent consequences with the student at the time of the event.

Details of discussion including dates and times:

2. LTHCE to inform the practice manager (PM) and/or clinical lead (CL) and ensure a record of events

Who was informed:

Date informed:

3. LTHCE to ask PM or CL to inform whoever is responsible for nursing and quality within the CCG and ensure that LTHCE is aware of this correspondence

Who was informed:

Date informed:

4. LTHCE to inform program team at BGU

Who was informed:

Date informed:

5. LTH to inform HEE Midlands and East

Who was informed:

Date informed:

6. Record any further action indicating resolution of the concern and any lessons learned

Agreement

To confirm agreement and acceptance of the XXX training grant please sign below to confirm full understanding and agreement of the MOU document. There will be expectation that a member of staff from the practice attends the Clinical Supervisor course from June in order to improve mentorship in practice. Additional places will be made available should demand require so.

	Name	**Signature**
GPN Trainee		
Practice Manager		
Partner		

Confirmation of number of contracted hours per week the practice holds for the GPN Trainee PLEASE INSERT HERE

For and on behalf of XXX Training Hub

……

Outline guide provided by HEI for Practices – Case Study Site B

Policy Brief

The follow draft policy brief is a suggested outline document for editing and personalisation. The aim of the document is to present an outline of the key relevant issues from this research to a specific audience – GPs, practice managers or policy makers, who might not otherwise have time to read the full report or executive summary and might prefer a document of brevity which draws attention to key recommendations.

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.

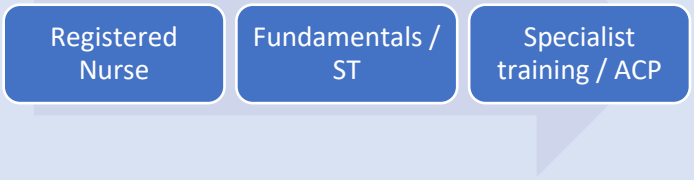
Analysis of themes arising in student motivation show that many experienced nurses desire the opportunity to provide ongoing support to patients, and have a varied workload, as well as appreciating the lack of shift work. There is evidence from all sites of proof of concept that general practice is suitable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

Bibliography

Bruner, J.S., 2009. *The process of education*. Harvard University Press.

Buchan, J. and Seccombe, I., 2018. *Nurses work: an analysis of the UK nursing labour market*. Routledge.

Curtis, L. and Burns, A., (2016) Unit Costs of Health & Social Care. Available online at http://www.pssru.ac.uk/project-pages/unit-costs/unit-costs-2016

Carson D. (2009) Urgent Care in General Practice, *Primary Care Foundation,* available online at http://www.primarycarefoundation.co.uk/images/PrimaryCareFoundation/Downloading_Reports/Reports_and_Articles/Urgent_Care_Centres/Urgent_Care_May_09.pdf

Primary Care Workforce Commission (2015). The future of Primary Care: creating teams for tomorrow. *London: Primary Care Workforce Commission*.

Entwistle, N., 2000, June. Promoting deep learning through teaching and assessment. In *Assessment to Promote Deep Learning: Insights from AAHF's 2000 and 1999 Assessment Conferences* (pp. 9-20).

Gerada, C., & Riley, B. (2012). The 2022 GP: our profession, our patients, our future: British Journal of General Practice. 62 (604): 566-567

GMC. (2016). *The state of medical education and practice in the UK*. Available online at https://www.gmc-uk.org/-/media/documents/SOMEP_2016_Full_Report_Lo_Res.pdf_68139324.pdf

Ipsos, M.O.R.I., Research. (2016) The recruitment, retention and return of nurses to General Practice Nursing in England. 2016.

Kirkpatrick, D.L., (2006). Seven keys to unlock the four levels of evaluation. *Performance Improvement*, *45*(7), pp.5-8. Available online at https://onlinelibrary.wiley.com/doi/epdf/10.1002/pfi.2006.4930450702

Marsden, P., 2020. Pay, terms and conditions for Primary Care nursing teams. *Practice Nursing*, *31*(5), pp.216-218.

McNaughton, E., 2006. General Practice specialty training: an innovative programme.

NHSE. (2014). Five year forward view. Available online at https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHSE. (2015). Building the Workforce–the New Deal for General Practice. *Secondary Building the workforce: the new deal for General Practice*. Available online at https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/building-the-workforce-new-deal-gp.pdf

NHSE. (2016) General Practice Forward View. Available online at http://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf *(accessed 28/11/2019)*

NHSE. (2019) General Practice – Developing confidence, capability and capacity: a Ten Point Plan for General Practice Nursing. Available online at https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-ten-point-plan-v17.pdf (accessed 28/11/2019)

NHSE. (2017). *Next Steps on the NHS Five Year Forward View*. Available online at https://www.england.nhs.uk/wp-content/uploads/2017/03/NEXT-STEPS-ON-THE-NHS-FIVE-YEAR-FORWARD-VIEW.pdf

Queen's Nursing Institute, 2015. General Practice Nursing in the 21st Century. *QNI*.

RCGP General Practice Foundation (2012) *General Practice Nurse Competencies*. Available online http://www.rcgp.org.uk/membership/practice-team-resources/~/media/1E0765D171B44849876EAFC97E96F1.ashx

Royal College of General Practitioners, 2016. The RCGP curriculum: core curriculum statement. *London: Royal College of General Practitioners*.

Rouse D. N. (2011). Employing Kirkpatrick's evaluation framework to determine the effectiveness of health information management courses and programs. *Perspectives in health information management*, *8*(Spring), 1c.

Rogers Everett, M. (1995). Diffusion of innovations. *New York*

Sanders, D. and Welk, D.S., (2005). Strategies to scaffold student learning: Applying Vygotsky's zone of proximal development. *Nurse educator*, *30*(5), pp.203-207.