



Nurse Practitioners 2006

**The results of a survey of
Nurse Practitioners
conducted on behalf of the
RCN Nurse Practitioner
Association**

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Employment Research Ltd

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Summary

The RCN Nurse Practitioner Association (NPA) commissioned Employment Research to undertake a survey of all 3,196 of its members. A postal survey (with on-line completion as an option) was conducted in spring 2006. At the close of the survey, 1,201 responses had been received (38% of the membership). Most of the results reported are based on the 1,021 respondents who are in nurse practitioner roles (i.e. analysis excludes respondents who are members of the NPA but not currently in NP roles).

Nurse practitioners are typically women in their mid forties (average age 45) who have been working as a nurse practitioner for five or six years. They report that the nurse practitioner role has provided them with an opportunity to advance their nursing career whilst maintaining a clinical focus (95%).

Two-thirds of NPs work in a primary care setting, whilst a quarter work in hospitals. About one in twenty work in NHS walk-in-centres and another one in twenty in minor injury clinics/units. NPs working outside of GP practices are more likely to report that they have advanced their NP roles

NPs are typically highly qualified - nearly three-quarters (72%) hold a degree and a further 10% are currently studying for one, and in 35% of cases this is at Master's level. Whilst most agree that they have access to the professional training and continuing development opportunities that they need, one in ten nonetheless see this as an area that they would like to see the NPA address on their behalf.

Respondents describe patients coming from numerous sources - 82% of NPs in both primary and secondary care take direct self-referrals, 77% referrals from GPs, 74% from other nurses and 63% from other health service staff.

60% of patients seen by the NP do not have a medical diagnosis. Nine out of ten NPs say taking a comprehensive history, making autonomous decisions and assessing the health needs of patients as very important in their job. These aspects, along with undertaking physical examinations, making new/initial diagnoses and making differential diagnoses are viewed as the core components of the NP role by the majority of respondents.

The length of consultations that NPs have with patients varied according to setting but is typically 15 minutes long, with longer initial consultations (20 minutes). Consultations for NPs working in GP practices are generally shorter than those for NPs in hospital settings.

The vast majority of NPs surveyed are positive about their jobs – they feel part of a team where they work (92%), they report that the quality of care is good (95%), their work is valued (85%) and they find it satisfying (81%). On top of this more than nine out of ten consider that their professional judgement is respected by nursing colleagues (95%) and medical colleagues (91%). However a sense of isolation was apparent, with half of all NPs surveyed describing their posts as unique within their organisation.

Pay variations for the NPs in the survey were evident. Where a clinical grade was quoted, 22% said they were I grade, 49% H grade, 24% G grade and 5% F grade. Of those that gave an Agenda for Change band, 21% reported Band 8, 56% Band 7 and 18% Band 6. 12% of respondents reported that they were paid on other pay-scales. Some respondents raised concerns about the lack of consistency in terms of how AFC had been applied to NPs and variation in resultant pay-band.

Almost all (98%) of the nurse practitioners surveyed make referrals to other health professionals and this is seen as an important aspect of the role by 87% of respondents. However, many NPs have experienced some problems in terms of the response to their referrals.

For example, the following refusals are reported, all on the grounds that NPs are nurses and not doctors:

- 44% of respondents have had an X-ray request refused (57% for NPs working in General Practice settings).
- 44% have had referrals to other clinicians refused, Again NPs in GP practices were more likely to have had their referral refused (54%).

Many regard the underlying problem as being lack of awareness and understanding of the scope of the NP role. Hence one in four respondents report that their NP role is not being used to its full potential. Regulation by the NMC is seen as a means of improving consistency of what is understood by the term 'nurse practitioner', whilst also acknowledging the status of the advanced level of practice at which NPs operate. One in three cite this as an issue that needs to be addressed, and one in five refer to promoting the status/profile of the role more generally.

Whilst others may be uncertain about the role, the views of NPs themselves are clear. Almost all (98%) report that nursing skills are important to their job and very few (8%), consider that their role is that of a 'mini-doctor'.

Despite this there are nonetheless concerns about the future of the role, in terms of potential threat from new Physician Assistant type roles, and as a result of funding pressures (particularly within hospital settings). One in five (21%) of NPs working in hospitals/other settings report that NP jobs in their workplaces are under threat, and that they are worried that they may be made redundant. At the same time, 47% report that they are increasingly having to absorb other people's workload.

There is also evidence that the growth in NP posts has been curtailed; the number of respondents taking up their current post gradually increased between 1990 and 2004, but fewer respondents had taken up their current post in 2005-2006 than in any of the preceding years. Whilst the majority (61%) report that the funding for their own post is secure, one in four are uncertain, and 9% disagreed and 4% strongly disagreed with this statement.

Benny Harston, Chair of the RCN NPA, has concluded "this survey has highlighted the significant contribution that NPs are making to patient care within the UK. Overall they are positive about their role, consider they provide value for money and in many instances see that there is a missed opportunity to utilise the NP role further within their health care setting. However barriers to their practice exist which negatively impact on the effectiveness and efficiency of their service and the patient care that they can offer. Promotion of the NP role is regarded as a priority and will be the focus of the Nurse Practitioner Association activities over the coming year".

1. Introduction

1.1 Aims and objectives

The RCN Nurse Practitioner Association (NPA) wished to survey its members. The aim of the survey was to inform the association's plans for the future, by:

- Getting a better understanding of who members are and where they work (profiling the membership of the Nurse Practitioner Association in terms of the range of employers, settings, variety of roles).
- Establishing the extent to which the association currently meets members' needs by seeking members' opinions of different Nurse Practitioner Association activities.

The first of these is seen as most essential, and has been the prime focus of the survey.

1.2 Methods

A postal survey of all 3,196 NPA members was conducted in April/May 2006. No identifiers were used and the survey was also made available on-line via the RCN website. A booklet style questionnaire (with a letter on the front and six pages of questions) was sent to members at their home addresses, with a reply paid envelope. No reminders were sent.

The research project has been informed by a previous study of nurses in advanced and/or specialist nursing roles, that was conducted by Employment Research on behalf of the RCN and Department of Health¹.

The questionnaire design was loosely based on the one used in the 'Maxi-Nurse' survey (which covered nurse practitioners as well as other nurses in extended or advanced roles). It covered current post and working situation, role and activities undertaken, qualifications, referral patterns, and a series of attitude statements, and biographical details. An additional section sought members' views regarding the NPA.

A group of nurse practitioners (identified by the association) met with a researcher to pilot the questionnaire. A discussion group was used at which participants were invited to complete the questionnaire before discussing it, and reviewing their overall impressions. Following the pilot, the questionnaire was edited before being circulated to the NP Association Steering Committee for further comment/suggestion.

At the close of the survey, 121 online responses and 1080 paper based questionnaires had been received (i.e. a total of 1,201). This is a response rate of approximately 38% (based on the number of responses relative to the total number of NPA members). A further 44 forms were returned after the survey was closed.

¹ Ball J (2005) *Maxi Nurses. Results from a survey of RCN members in advanced and specialist nursing roles*. Royal College of Nursing. London.

2. Profile of respondents

In this chapter we describe who the respondents are. Firstly establishing the number of NPA members that are currently in nurse practitioner roles, before going on to present an employment and demographic profile of nurse practitioners.

An opening question to the survey sought to establish whether or not the respondent is a nurse practitioner (NP). The results (in Table 2.1) show that three quarters (76%) are working as an NP in their main job. A further seven percent work as an NP in addition to their main job whilst five percent are in the process of becoming an NP. Four percent report that they used to work as an NP (and left sometime between 2000 and 2006).

However, a number of respondents (55 or 4%) report that they have never worked as an NP. Respondents not currently working as a NP were routed to the last sections of the questionnaire (where they were asked about their membership of NPA and for background details) and are thus excluded from much of the analysis, which focuses on respondents in NP roles. They were asked to describe their current role and responses fall into three main areas – practice nurses, community nurses, and clinical nurse specialists.

Table 2.1 Do you currently work as a nurse practitioner?

	Number	%
Yes, in my main job	909	76
Yes, in addition to my main job	85	7
Training to be a nurse practitioner	65	5
No, but I used	46	4
No, I have never worked as a nurse practitioner	55	5
Missing/Not answered	41	3
Total	1201	100%

Source: Employment Research, 2006

2.1 Demographics

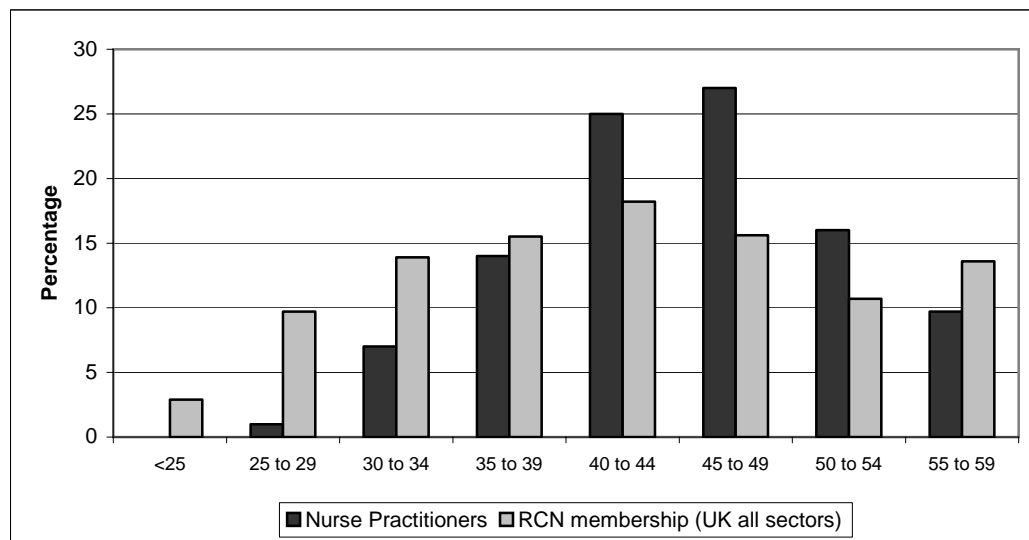
Looking now only at those respondents who indicated that they are employed as Nurse Practitioners all bar 4% of respondents are female, 97% are white and 88% are employed in England, 4% Wales, 6% Scotland, and 2% Northern Ireland. In comparison, a 2005 survey of a cross section of RCN members² finds 6% are male, 5% are from black and minority ethnic origins and more nurses are from Scotland (11%).

The average age of respondents is 45, which is older than that reported in the 2005 RCN survey of members (42). In addition, 78% of respondents are aged 40 plus and 47% are aged between 40 and 49. Nine per cent of those aged under 40 were men compared to 3% of those aged 40 plus.

² Ball J and Pike G (2005) *Managing to work differently: results from the RCN Annual Employment Survey 2005*, RCN, London

Figure 2.1 below shows the age profile of NPs responding to the survey compared to respondents to the AES.

Figure 2.1 Age profile of Nurse Practitioners compared to RCN membership and all qualified nurses



Source: *Employment Research, 2006*

2.2 Job title

Survey respondents were asked to give the job title (for their main nurse practitioner role). These open-ended responses were then classified into groups. Table 2.2 shows that more than half (56%) of respondents are working in generic nurse practitioner roles, most typically working in primary care/general practice and 21% are in specialist roles typically in secondary care settings. Younger respondents i.e. those aged under 45 are more likely to be employed in specialist roles (28% compared to 15% of those aged over 45 plus) but less experienced NPs (i.e. those with less than five years experience) are more likely to work in generalist roles (61% compared to 51% of those with more than 5 years experience as a NP). One in ten (9%) described their job title as an advanced nurse practitioner (some of these referred to a particular specialty/field of practice).

Table 2.2 Job titles of Nurse Practitioners – cases and percentages

	Number	%
Nurse Practitioner (NP) – generic/ Primary Care/General Practice	567	56
Nurse Practitioner Specialist (colorectal, ENT, emergency, etc.)	218	21
Advanced Nurse Practitioner (ANP) Generic/Specialist	86	9
Others	150	14
Total	1021	100

Source: *Employment Research, 2006*

2.3 Employer/work setting

NPs are split more or less evenly between those indicating they are employed by NHS Trusts/PCTs (49%) and those saying they are employed by GP practices (47%). Just four per cent of respondents indicated other employers, spread fairly evenly between the independent sector, higher education, industry and other occupations. More than eight in ten (84%) of those employed by GP practices are generalist NPs, while conversely 46% of those employed by NHS trusts/PCTs are specialist NPs.

Advanced Nurse Practitioners are more likely than other nurse practitioners to work in hospital units (29% compared to 14% of NPs), community settings (9% compared to 2% of NPs) and NHS walk in centres (11% to 5%).

Table 2.3 Employers of Nurse Practitioners – cases and percentages

	Number	%
NHS Trust/PCT	498	49
GP Practice	480	47
Independent/private health	7	1
Nursing bank/agency	2	0
University/HEI	5	0
Health authority/NHS Executive	2	0
Prison	1	0
Industry/occupational health	6	1
Other	19	2
Total	1022	100

Source: Employment Research, 2006

Reflecting the employer data, a half of all respondents reported that they spend most of their time at work in GP practices (54%), 16% are in hospital units, 8% in hospital wards/outpatients, 6% said that they work mostly in NHS walk in centres, 5% in minor injury clinics and the remainder were spread fairly evenly between medical assessment units, out of hours providers, community, primary care centres and mixed settings (1-2% working in each). Conflating these settings into GP practice and other settings it is noticeable NPs are more likely to work in practice settings, while Advanced NPs are more likely to be working in other settings.

Table 2.3 Where NPs work by type – percentages

	GP practice	Other settings	All
Nurse Practitioner (NP) generic/specialist	84	69	77
Advanced Nurse Practitioner (ANP) generic/specialist	4	13	8
Other	12	18	14
<i>Base n=</i>	<i>545</i>	<i>459</i>	<i>1004</i>

Source: Employment Research, 2006

Respondents were also asked about their field of practice. Two thirds of all respondents (67%) work in primary care, 9% in adult critical care and 8% in adult general care. Eight per cent indicated other settings and remainder were distributed evenly across a variety of specialties including, paediatrics, women’s health, community care, older people’s nursing mental health and learning disabilities, with around 1% in each case.

2.4 Grade/Pay band

Respondents were asked to indicate whether they were paid on a clinical grade, and Agenda for Change (AFC) pay band, or some other pay-scale. Just under half (46%) gave a clinical grade, 41% an AFC band and 12% reported they were on other pay-scales. Of those that gave a clinical grade (n=583) 22% said they were I grade, 49% H grade, 24% G grade and 5% F grade. Of those that gave an AFC band (n=430) 21% reported Band 8, 56% Band 7 and 18% Band 6.

Some respondents raised concerns about the lack of consistency in terms of how agenda for change has been applied to nurse practitioners and variation in the resultant pay-band (and saw this as area that they’d like more NPA support – see chapter 6).

One respondent commented:

‘I would like to see the NPA develop a profile for AFC. No-one wants to understand what we NPs do, and many will be happy to undervalue and match us to anything out there’.

Looking at the results presented below it would seem that there is less variation in the distribution across AFC pay-bands than there is across grades – a larger majority (57% as opposed to 49%) fall into the middle most prevalent category (band 7). However it could be argued that if the jobs themselves are consistent and the job evaluation process was applied consistently, the degree of homogeneity would be greater. Another comment:

‘AFC banding is ridiculous. No consistency nationwide at all – band 6, 7, 8 within one SHA’

Subsequent sections explore the level of consistency between NPs in terms of the activities they undertake and the level of qualification held.

Table 2.4 Grade/AFC band by NP type and setting – percentages

	Job title			Setting		All
	NP	ANP	Other	GP	Hosp/Other	
Clinical grade F	4	0	12	1	13	5
Clinical grade G	22	7	34	12	45	24
Clinical grade H	51	48	39	59	31	49
Clinical grade I	22	45	15	28	11	22
<i>Base n=</i>	<i>473</i>	<i>29</i>	<i>82</i>	<i>379</i>	<i>204</i>	<i>583</i>
AFC Band 6	20	2	29	9	23	19
AFC Band 7	62	55	39	51	60	57
AFC Band 8	18	43	32	41	17	24
<i>Base n=</i>	<i>318</i>	<i>56</i>	<i>66</i>	<i>118</i>	<i>312</i>	<i>430</i>

Source: Employment Research, 2006

Larger proportions of advanced nurse practitioners (ANPs) are employed on Band 8 (43%) or in clinical I grade posts (45%). NPs based in GP practices are generally on higher pay-bands than respondents in acute or other settings.

2.5 Working hours

Just over half (56%) NPs work full-time, a slightly lower proportion than recorded across all nurses responding to the 2005 AES (61%) and considerably lower than among all G-I grades in the NHS (75%). Younger NPs are more likely to work full-time (61% of those aged 30-39) than those 40 or over, but there is little difference in working hours in terms of the amount of NP experience.

Specialist NPs working in NHS hospital settings are more likely to work full-time than those in generalist roles in practice settings.

3. The posts and roles

This section looks at the posts and roles held by NPs. The chapter starts by detailing whether or not the post existed prior to the respondent taking up the position, the nature of patient consultations and referral patterns. The nature of the role in terms of activities undertaken is then described.

3.1 Development of NP posts

In 23% of cases the post existed prior to the respondent taking the job. Not surprisingly this was more prevalent among younger NPs (35% of those aged under 40 compared to 20% of those aged over 40). In only 15% of cases where respondents were over 50 did the post exist prior to taking the job. Conversely more of those aged over 50 were involved in establishing the post.

Overall, nearly three quarters of NPs were involved in establishing the post (83% of those aged 50 plus).

In just under half of cases (49%) there is someone other than the respondent doing the same job in their organisation, with the same job title. Thus for half of all NPs surveyed, they are in unique posts, which can lead to a sense of isolation (discussed further in section 3.5). This is double-fold for those who not only work on their own but are also working in a highly specialised field of practice:

‘There are no other NPs who work like I do, and therefore no guidance and support available’.

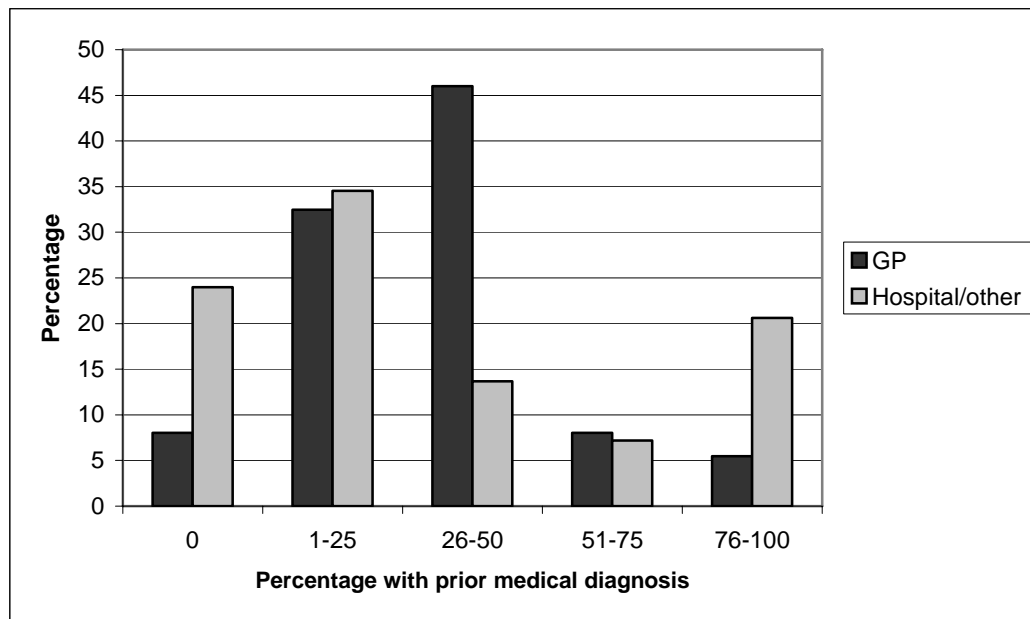
Of those working in NHS trusts two thirds (65%) are in posts where someone else is doing a similar job with the same job title, while the same is true for only 33% of NPs working in GP practices.

NPs and ANPs and those with other job titles are equally likely to be working in organisations where there is someone else with the same job title.

3.2 Patients and consultations

On average, approximately four in ten patients seen by nurse practitioners, already have a medical diagnosis for their presenting condition. Overall, NPs employed in GP practices are slightly less likely to see patients with a previous medical diagnosis (38%) compared to those employed in other settings (44%). But there is no difference between Advanced NPs and others in terms of patient with diagnoses. However, the situation is more polarised for NPs who are not in GP settings, as Figure 3.1 shows. A larger proportion of these NPs have no patients with prior medical diagnosis (24%), but on the other hand, there are also more that have almost all of their patients pre-diagnosed (20%).

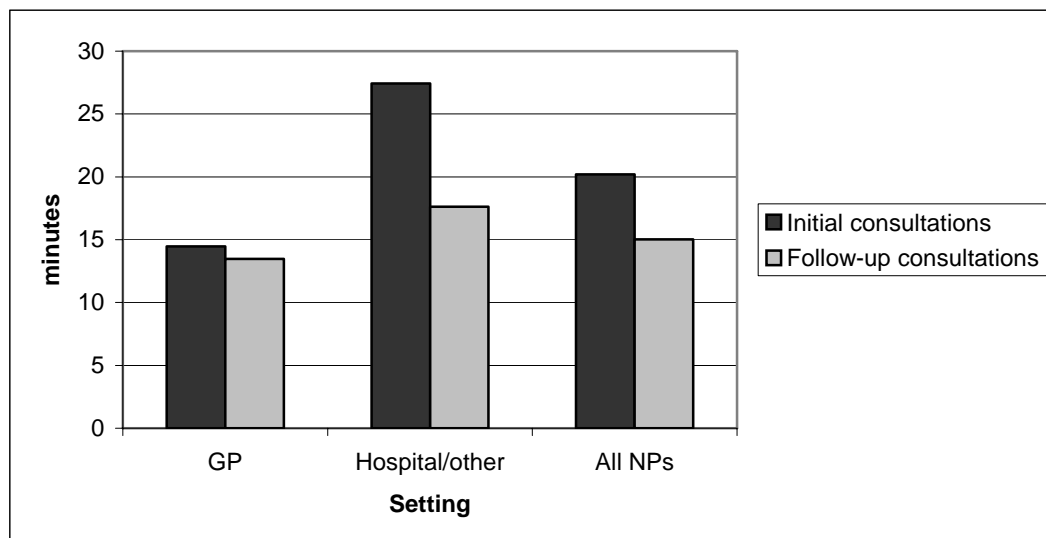
Figure 3.1 Percentage of patients seen with previous medical diagnosis by setting



Source: Employment Research, 2006

Across all respondents, on average, initial consultations last 20 minutes and follow-up consultations 15 minutes. However, there is variation between NPs based in GP practices and those in other settings with initial consultations in GP practices being no longer than follow up consultations i.e. 15 minutes but in other settings they had 25-30 minutes. For nurses working in the community initial consultations are reported at more than 40 minutes with follow up consultations averaging at about 25 minutes. NPs in medical assessment also report longer initial consultations at around 40 minutes.

Figure 3.2 Length of consultations by setting – minutes



Source: Employment Research, 2006

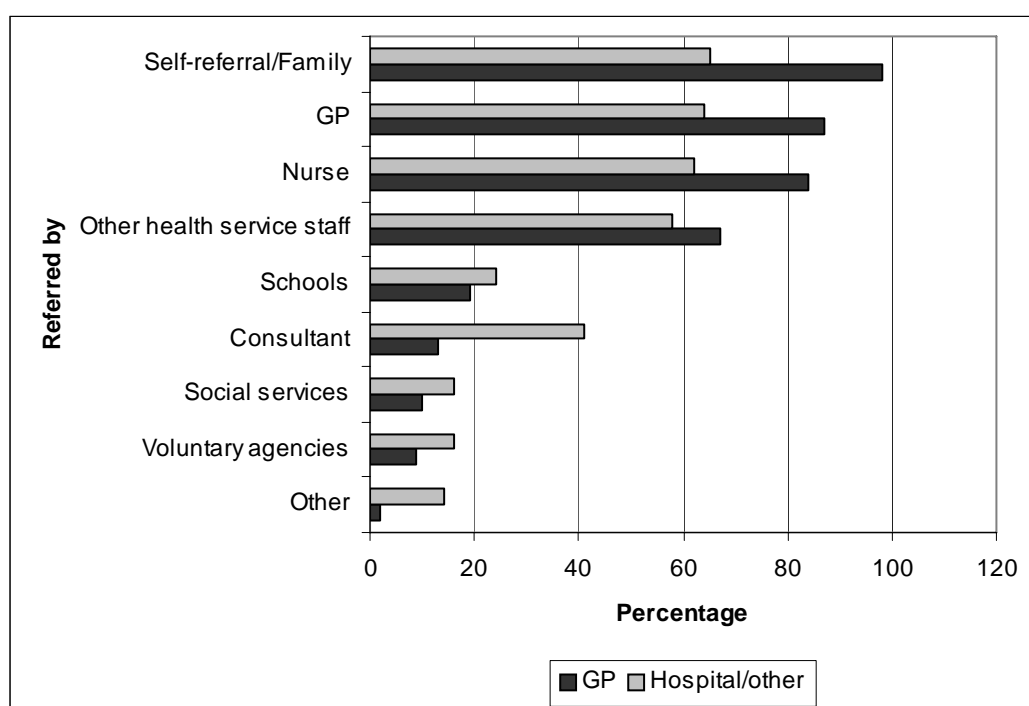
There is no difference in length of consultations in terms of length of experience as an NP or by other biographical variables, such as age and gender.

3.3 Referral sources & destinations

Most referrals to NPs are self-referred/family (82%) and three quarters of respondents (77%) said patients were referred from GPs, from other nurses (74%) or other health service staff (63%). There are, however, significant differences between nurses working in GP practices and other settings, as Figure 3.3 shows. Nearly all NPs in GP practices receive self-referrals compared to 65% of those in other settings. A similar difference is apparent in relation to referrals from nurses and GPs. However, NPs in hospital and other settings are more than twice as likely to receive referrals from consultants (41% compared to 13% of GP based NPs).

Other sources of referrals are primarily emergency/ambulance/A&E referrals, but also include industry, other doctors, out of hours teams and pharmacists.

Figure 3.3 Referral sources by setting – percentages



Source: *Employment Research, 2006*

In terms of where NPs refer to, only 22 out of 1009 do not refer patients on to another health service professional i.e. 98% of NPs make referrals. Almost all refer to allied health professionals (86%), three quarters (77%) refer to other advanced/specialist nurses, 77% refer to consultants and 74% refer to other health/social care providers. Thirteen per cent refer to other individuals including GPs, other hospital departments, other doctors, voluntary services/agencies and on call teams. NPs in GP settings were slightly more likely to mention all the above referral destinations but there was little difference by type of practitioner.

3.4 Activities within role

Respondents were presented with a list of 21 activities and asked to indicate the importance of each within their role. Table 3.1 summarises the overall findings sorted with the highest incidence of ‘very important’ at the top of the table.

Table 3.1 Importance of different activities – percentages (Base n=987)

	N/A	Not important	Quite important	Important	Very important
Take a comprehensive history	1	0	1	5	93
Assess health care needs of patients	1	0	1	9	89
Make professionally autonomous decisions	0	0	2	11	87
Undertake physical examination	1	1	4	12	82
Make new/initial diagnoses	3	1	4	16	75
Make differential diagnoses	2	1	6	16	75
Order investigations	3	1	9	26	61
Prescribe medication	15	1	7	16	61
Develop plans of care in collaboration with clients	4	3	11	24	58
Refer patients/clients to other health care providers	1	1	11	29	58
Undertake health promotion and provide health education	1	2	12	27	58
Coordinate/manage care programmes for individual patients & carers	3	2	13	25	56
Admit/discharge patients from your caseload	10	4	9	22	55
Screen patients for disease risk factor or signs of illness	5	4	13	25	52
Provide specialist advice/consultancy to health care professionals	5	2	16	27	50
Support people to enable them to manage/live with illness	5	4	18	24	49
Provide education/training to staff	3	1	15	32	49
Provide leadership within and external to your organisation	5	4	17	28	46
Provide counselling	5	4	30	31	30
Undertake specialist procedures	14	11	21	26	28
Initiate research	18	18	30	22	12

Source: *Employment Research, 2006*

A half or more respondents see 15 of the 21 activities as very important to their role. Nine out of ten NPs say taking a comprehensive history, making autonomous decisions and assessing the health needs of patients as very important in their job. In addition, three quarters of NPs say that undertaking physical examinations, making new/initial diagnoses and making differential diagnoses are very important. These could be viewed as the core components of the role, that are important in the majority of NP jobs.

The next tier of activities are undertaken in most NPs jobs, but are less common. A relationship is found between the importance attached to some of these activities and the type of post held. Advanced nurse practitioners are more likely to regard initiating research, providing education and training to staff, and providing leadership within and external to the organisation as very important, compared with nurse practitioners.

The number of activities viewed as important to their role also varies between post types. Across all respondents 12 of the 21 activities are viewed as very important to the role of NPs, whilst those respondents in GP settings have slightly more activities that they view as very important (an average seeing 13), NPs in other settings cite just 11 as very important. Advanced nurse practitioners have a larger range of activities that they see as very important to their role – on average 14 of the 21 activities.

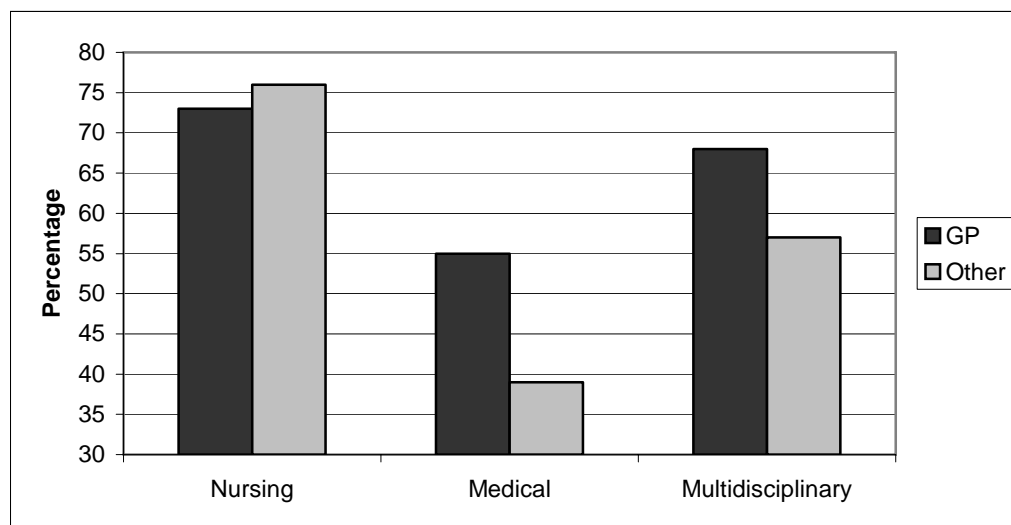
Fifteen per cent of respondents say they do not prescribe medication; these are primarily nurses in hospitals, where up to 50% do not prescribe.

3.4 Team working and line management

Respondents were asked to indicate which types of teams they work in. Three quarters of all respondents (74%) indicated that they are part of a nursing team, just under half (48%) report that they are working in a medical team and 63% reported multidisciplinary teams. Respondents were then asked to say which of these teams is most central to their role; 47% said nursing, 32% medical and 21% multidisciplinary. There was some difference again between those respondents in GP practices and those in hospital/other settings as Figure 3.5 below shows. GP based NPs are more likely to work in medical and multidisciplinary teams – 37% said the team most central to their role was medical compared to 26% of nurses in other settings.

Most frequently the line manager of NPs responding to the survey are GPs or GP partners (23%) or practice managers (20%). The next most often cited managers include: clinical lead nurses (10%), matron/modern matron (9%), specialist nurses (7%) and board or assistant board level (10%).

Figure 3.4 Teams worked in by NPs – percentages



Source: Employment Research, 2006

A half (49%) of all respondents have a nurse as their line manager but among NPs in GP practice settings only 16% have nurses as their line manager compared to 87% of NPs in other settings. Just over half of all respondents (53%) have someone else responsible for their professional support and this rises to 59% among NPs who do not have a nurse as their line manager (mainly nurses in GP practice settings). In 60% of cases a GP, practice manager or doctor provide professional support. Consultants (14%) and specialist nurses (10%) were also mentioned.

Six in ten respondents have someone responsible for their clinical supervision with no difference by type of NP or setting in which they are based. Again GPs/Practice managers and doctors were cited most (44%), consultants (13%) and specialist nurses (25%). Board level managers were mentioned as providing clinical supervision by 13%.

3.5 Views of the way NPs work

By and large NPs report high levels of satisfaction with the nature of their roles, responding positively to the items presented. Nearly all (92%) said they felt part of a team where they work but this said, 70% work primarily on their own and a third (34%) feel that sometimes they are isolated in their work (Table 3.2). For example:

'I am thoroughly enjoying the clinical work and patient satisfaction seems to be high. However I work in isolation and have found it difficult to set up and establish new ways of working'

Those working in settings where they are the only NP in the organisation are more likely to feel isolated in their work (61% compared to 48% of those working in organisations with other NPs). One in four (23%) respondents said that their role is not being used to its full potential.

All bar 2% of respondents say that their nursing skills are important to their job, nine in ten respondents (95%) said that their professional judgement is respected by nursing colleagues and only a fractionally smaller proportion said that their judgement is respected by medical colleagues. Also, eight in ten NPs say that other staff make appropriate use of the services in their role.

Whilst most are very positive about the job itself, there are some frustrations about the extent to which the role is understood by others. For example:

'Working as a NP is excellent and patients appreciate the choice it gives them. It is very fulfilling and good to have the skills to fully assess patients and complete an episode of care. However it has been a battle to overcome countless hurdles. A few consultants and the radiography profession seem to think that highly qualified nurses in primary care are somehow second rate. The sooner NMC provide us with proper registration the better'.

There is no difference in views between NPs and Advanced NPs but there is some variation between those respondents working in GP practices compared to those in other settings. GP practice nurses are more likely to agree strongly with the statement ‘my professional judgement is respected by medical colleagues’ (42% compared to 30% of NPs in other settings). Similarly, more NPs in GP practices agree strongly with the statement ‘other staff make appropriate use of the services in their role’ (23% compared to 16%). However, these differences are in the extreme opinions and do not reflect variation in propensity to agree/disagree.

Table 3.2 Views of the nature of NP work – percentages (Base n=987)

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
I feel part of the team where I work	62	30	4	3	1
My nursing skills are important to my job	77	21	1	0	1
My role is being used to its full potential	30	41	7	21	2
I sometimes feel isolated in my work	13	41	12	24	10
I work primarily on my own	31	39	12	15	3
My professional judgement is respected by nursing colleagues	48	47	3	2	0
My professional judgement is respected by medical colleagues	37	54	7	2	0
Other staff make appropriate use of the services in my role	20	59	13	7	1

Source: *Employment Research, 2006*

3.6 Referral refusals

Respondents were asked specifically about respect for their professional judgement by indicating whether or not they had certain decisions refused or not because they are not a doctor. Despite the fact that the vast majority (91%) report that medical colleagues respect their professional judgment, many have at some point had their requests/referrals refused. Across all respondents 44% had had an X-ray request refused, 22% had other investigation requests refused and 44% of reported that they had had referrals refused, all on the grounds that they are nurses, not doctors.

Some went on to describe that the response to their requests/referrals is mixed. Whilst in the majority of instances their referrals are accepted (and there is a protocol covering referrals) there are a clinicians (consultants, physiotherapists, radiologists) or particular specialties that refuse/challenge their referrals. Hence a number comment that they have to have referrals/requests countersigned by a doctor.

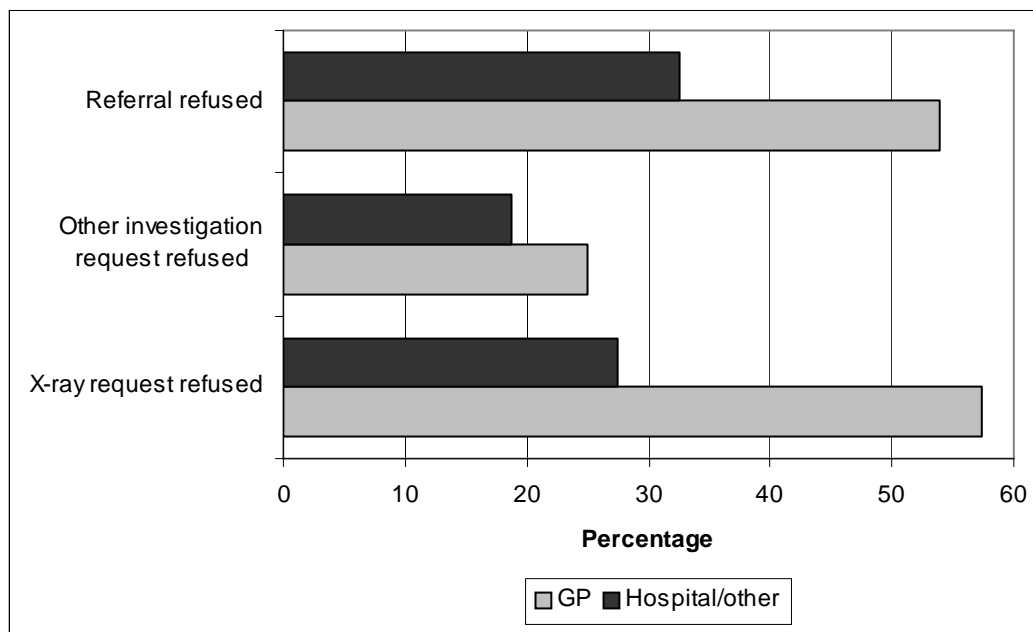
‘Some consultants refuse referral - insist it has to be a medic’

‘I can refer to any secondary area except acute general surgery, which is unreasonable when I only need to refer 3-4 patients a year.’

Again, many regard the underlying problem as being a lack of understanding and awareness of the NP role – other staff do not have clear grasp of the range and level of expertise covered by nurse practitioners in general, or the specific individual. Some comment that regardless of protocols, it has taken considerable time to build up the understanding and trust of other clinicians in order to secure their referral rights. Clearly this relates in part to the issues surrounding consistent education and regulation for nurses in advanced roles (an issue that is raised later).

More NPs in GP practice settings report having X rays and referrals refused, 57% and 54% compared to 28% and 33% respectively of NPs working in other settings (Figure 3.6). There is little difference independent of the employer and setting between NPs and Advanced NPs.

Figure 3.5 Refusals because not a doctor by NP setting – percentages



Source: *Employment Research, 2006*

4. Careers

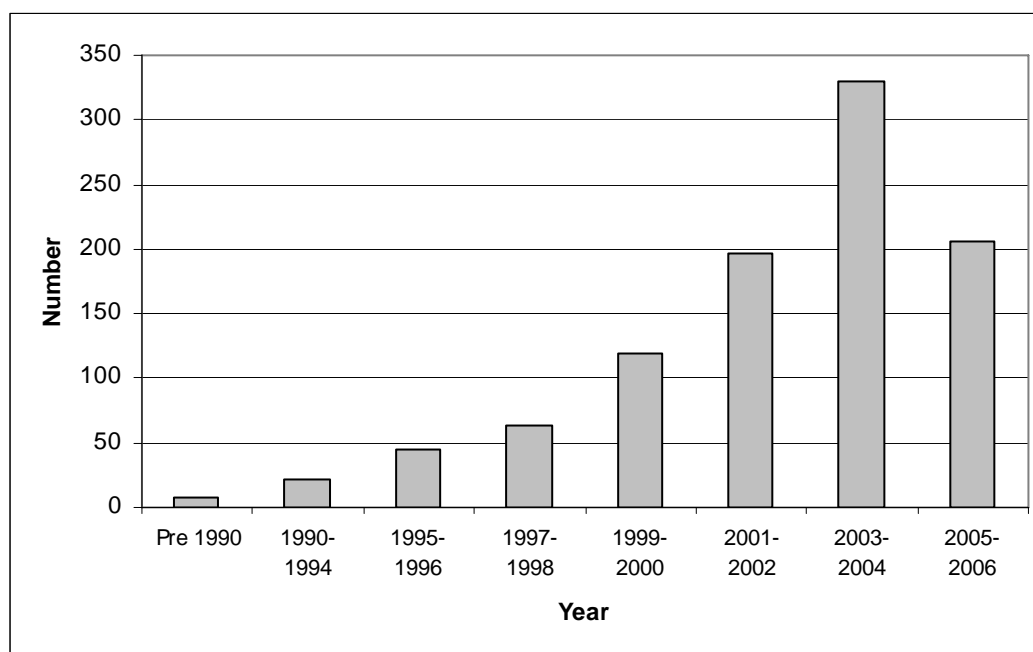
This section provides analysis of responses from NPs concerning their careers, how long they have been a Nurse Practitioner and qualifications.

4.1 Experience as a NP

The mean length of time respondents have been working as an NP is five years with 25% having worked as an NP for 2 years or less and 25% for more than 7 years. Just over half (54%) have less than five years experience working as a Nurse Practitioner. Nearly two thirds of Advanced NPs (63%) have more than five years experience compared to 44% of NPs. Partly reflecting this, more nurses in hospital/other settings have more than five years experience 50% to 42% of those in GP practice settings.

Figure 4.1 below shows that most respondents took up their current post quite recently. Three quarters of current posts were taken up in the last five years. Those NPs who took up their current post recently are much less likely to have been involved in developing the post, although still 60% or more of those who took their current post in the last three years were involved in establishing the post.

Figure 4.1 Year took up current post – numbers



Source: Employment Research, 2006

4.2 Qualifications

In light of the NMC proposals to regulate advanced nurse practitioners across the UK based on a standard that demonstrates “masters-level thinking”, the specific qualifications held is of particular relevance to nurse practitioners.

Nearly three quarters of all NPs (72%) hold a degree and a further 10% are studying for one – across all nurses the equivalent figure is approximately 20%. Nearly one in five hold a masters degree (18%) and 17% are studying for one. Looking at degree and higher degree qualifications together, 92% of respondents have or are studying for a degree or higher degree; just 8% have not been engaged in at least first degree level study.

The comments of many respondents are clearly in support of greater uniformity of NP preparation and practice, as a means of improving understanding of the role. For example one respondent says:

‘There is a lack of understanding of the role..... lots of nurses have the title of NP. Personally I think that one standard course should be available’

There is nonetheless some concern expressed about the pressure this places on individual staff to achieve increasingly high levels of academic qualification.

‘I think that nurses are put under continual pressure to attend academic courses..... please stop moving the goals, I have no intention of completing an Msc and feel that my degree, NP course, prescribing course and years of experience in patient care, will allow me to fulfil my role quite satisfactorily. GPs don’t have to get a masters degree.’

A half of all NP respondents hold an extended nurse prescribing qualification and 13% hold other qualifications. More NPs in GP settings than is the case among NPs in other settings hold a degree (78%) or an extended nurse prescribing qualification (67%), compared respectively to 64% and 30% of NPs in hospital/other settings.

Table 4.1 Qualifications held/studying by NPs – percentages

	Currently hold	Currently studying	Neither
Diploma	53	1	46
Degree	72	10	18
Masters	18	17	65
PhD/Taught doctorate	1	1	98
Extended nurse prescribing	50	13	37
Other	13	1	86

Source: Employment Research, 2006

Three quarters of NPs (74%) hold a post-registration qualification that is specifically related to working as a nurse practitioner. Among NPs in GP practice settings this rises to 81%, compared to 65% of NPs in other settings.

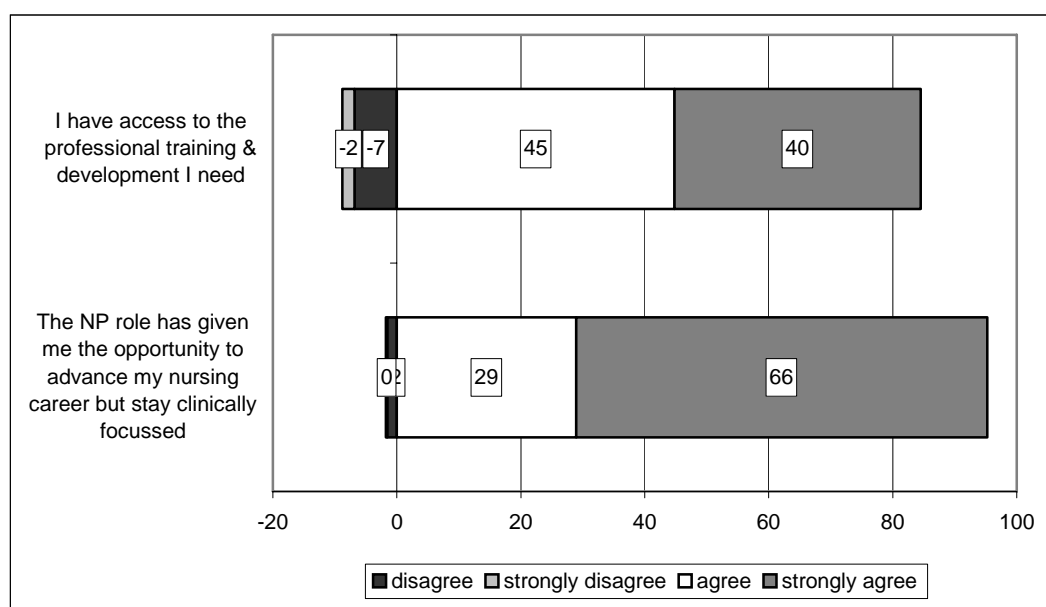
In 71% of cases where a post-registration qualification is held the qualification was from an RCN approved programme of preparation for NPs. NPs in GP settings are more likely to report that the programme was RCN approved (79% compared to 60% of NPs in other settings).

In one in four cases the programme was at masters level but here however there is no difference between respondents in relation to their work setting. Advanced NPs are more likely to report that the programme was at masters level (46% compared to 20% of NPs).

The range of specific qualifications held (for a sample of respondents) are listed in the appendix.

Looking at the views of nurses about their professional and career development, most are satisfied. 85% of NPs agree that they have access to the professional training and development they need and 95% say that the NP role has given them the opportunity to advance their nursing careers while remaining clinically focused.

Figure 4.2 Attitudes to career and professional development – percentages



Source: Employment Research, 2006

There is little or no difference between Advanced NPs and others but NPs in GP practice settings are more likely to agree strongly with both statements but the overall sentiments are more or less the same between both groups. Although the questions are slightly different, the finding for ‘I have access to the professional training and development I need’ is more positive than is the case among all nurses as reported in the 2005 RCN AES³.

³ Ball J and Pike G (2005) *Managing to work differently: results from the RCN Annual Employment Survey 2005*, RCN, London (question included: ‘my employer provides me with the opportunity to keep up with new developments related my job – just 9% agreed strongly and 51% agreed)

5. Life as a Nurse Practitioner

This section of the report deals with the views of respondents to aspects of life working as an NP. Table 5.1 reports the response to a series of attitude statements that are concerned with perceptions of what it means to be a nurse practitioner and the future of the role.

Table 5.1 Life as a Nurse Practitioner views – percentages (Base n=987)

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
My nursing skills are important to my job	77	21	1	0	1
I am given the support I need to do my job well	22	53	13	10	2
I see myself now as a mini-doctor	2	6	14	40	38
I am confident about the future of NPs in the UK	18	38	25	16	3
NP posts where I work are under threat	4	10	22	41	23
I do not see the role of Physician Assistant/MCP as a threat	9	31	30	20	10
I am worried that I may be made redundant	5	9	18	33	35
The funding for my post is secure	23	39	25	9	4
I am increasingly having to absorb other people's workload	13	34	23	27	3

Source: Employment Research, 2006

Again it is apparent that most respondents are positive about most aspects of their working lives as Nurse Practitioners. However, a significant proportion of NPs do feel that there are difficulties. Thus whilst three quarters (75%) agree that they are given the support needed to do their job well, nearly half (47%) say that they are increasingly having to absorb other people's workload.

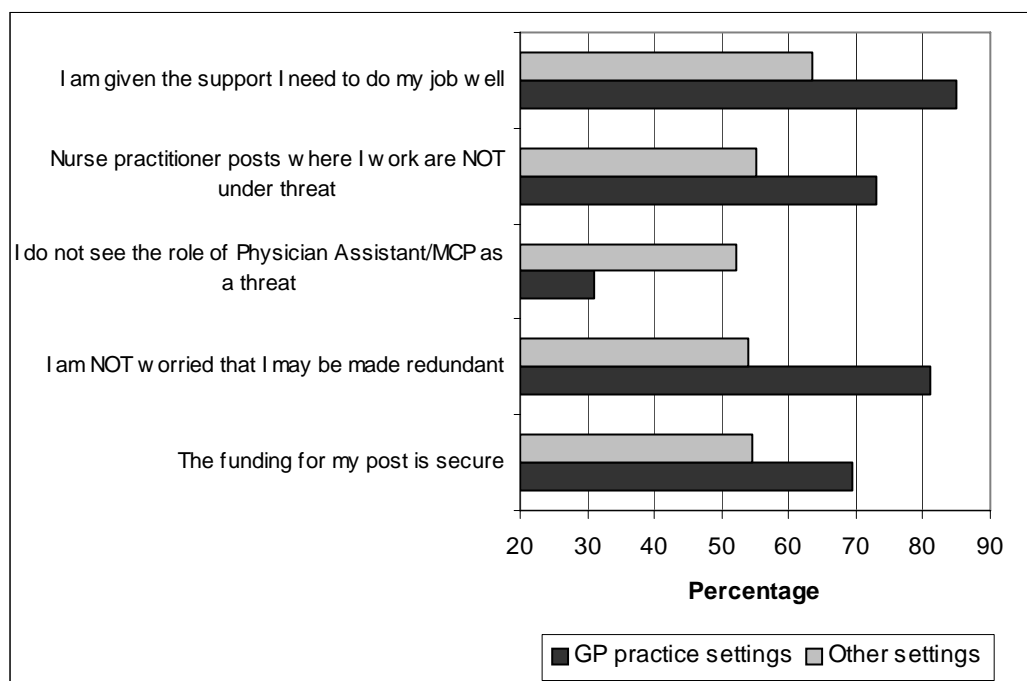
Most respondents (61%) report that the funding for their post is secure, 64% say that Nurse Practitioner posts are not under threat and two thirds (68%) say they are not worried about being made redundant. There are nonetheless a significant number (roughly one in seven) who are concerned about future job security. This is strikingly different than the view of job security recorded in the 2005 annual employment survey – 80% of a cross section of nurses reported that they were not worried about being made redundant.

Whilst relatively few are worried that their own post may be made redundant, there is less confidence in the future of NPs in the UK – 19% did not feel confident of the future and a further 25% are uncertain.

There are mixed views about the possible role of the Physician Assistant/MCP with 30% saying they feel it may be a threat and 40% disagreeing, not viewing its introduction as a threat.

Very few respondents see themselves as “mini-doctors” (8%) and nursing skills are viewed as important to the job by virtually all (98%).

Figure 5.1 Working life as an NP – percentages agreeing by setting



Source: Employment Research, 2006

Figure 5.1 highlights the main variation within the sample with NPs in GP practice settings holding generally more positive views than those in hospital/other settings. This is especially the case in relation to the following statements:

- Funding security, with 70% agreeing that funding for their post is secure compared to 55% of NPs in other settings,
- Support provided to do their job well, 85% agree that this is the case in contrast to 63% of NPs in other settings,
- Fewer are worried about redundancy or that their posts may be under threat – 7% of those in GP practices compared with 21% in hospitals/other settings.

However, on the downside, more NPs in GP practices are more likely to be worried about the possible introduction of the MCP role (52% to 31% of NPs in other settings).

In addition to seeking views of respondents concerning their NP role they were also asked to give their views on a number of more general aspects of work satisfaction. These items were included so that some comparison with the results of other nurses in the nurses could be provided as a benchmark.

Table 5.2 Views of work – percentages

	Strongly agree	Agree	Neither	Disagree	Strongly disagree
I feel my work is valued	35	50	8	6	1
I feel satisfied with my present job	30	51	9	9	1
The quality of care provided where I work is good	55	40	3	2	0

Source: Employment Research, 2006

Although the results to this type of analysis are not directly comparable (as the questionnaire design and coverage can influence results) it is clear that NPs covered in this survey are considerably more positive compared to a cross section of nurses surveyed in 2005 about their jobs, quality of care and the extent to which their work is valued. These differences remain even when contrasted with those on a similar grade. For example:

- 85% of NPs agree that their work is valued compared to 65% of G-I grade nurses across all settings and specialties
- 81% are satisfied with their present job (68% all G-I grade nurses).
- 95% say that the quality of care provided where they work is good (84% all G-I grades).

6. Views about the RCN Nurse Practitioner Association

This section of the report looks at membership of the RCN Nurse Practitioner Association (NPA) and what NPs want out of the NPA. This section includes responses from those nurses who are not currently working as a NP.

6.1 Reasons for membership of NPA

Respondents were asked why they are members of the NPA. The responses were categorised into themes (up to 3 codes per respondent) and the frequency of each response is presented in Table 6.1. Interestingly, 7% of respondents answered that they were not aware of being a member of NPA.

Table 6.1 Reasons for NPA membership – percentages

	% cases
Keep up to date/information (clinical issues/NP issues/prescribing, etc.)	65
Support/Guidance/Advice from NPA – professional support	32
Networking/colleague and other NP support/like minded professionals	30
Share knowledge/best practice/protocols, etc.	10
To have a voice/be part of national org./lobbying for NPs/be part of consultations	9
To be recognised/help promote NP role/status/develop role/raise profile	8
Education/training	7
Not aware was a member	7
Training to be an NP, planning to become an NP in future	3
Linked to course undertaken/automatic membership	2
Because my role is similar to NP role, do same job, am other advanced nurse	2
For conference (other events)	1
Indemnity/legal/tribunal support/advice	<1
<i>Base n=</i>	<i>920</i>

Source: Employment Research, 2006

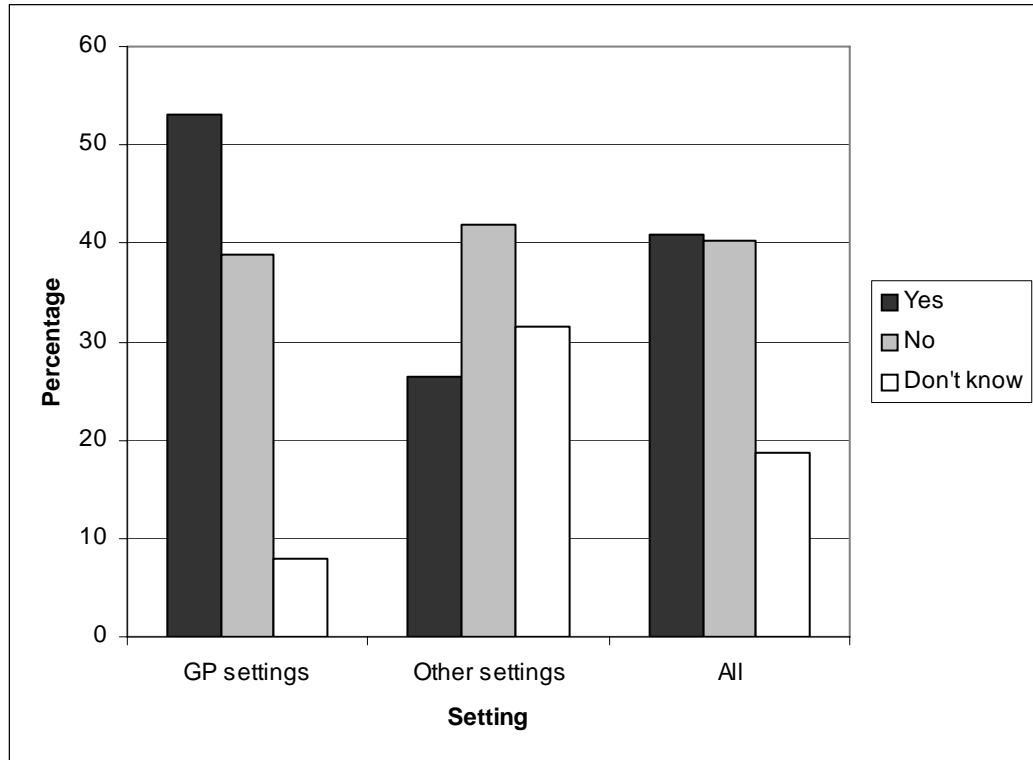
The most frequently cited reason for being a member of NPA is to keep up to date. After this, receiving support/guidance and using NPA as a means of networking with colleagues are equally important. The lobbying role of NPA is given as a reason for membership by one in ten.

Respondents who are currently not a Nurse Practitioner are more likely to mention that they are members because they intend to become an NP in future as their reason for belonging to NPA. The other two main reasons given by those who are not currently NPs, are that it is a means of keeping up to date, that their role is similar to that of NP.

6.2 Local NP groups

Four in ten (41%) respondents report that they have a local Nurse Practitioner group but a further 19% do not know if they have one or not. There is a significant difference between NPs in GP practice settings and those elsewhere as Figure 6.1 shows. Clearly nurses in other settings are much less likely to know about their local NP group (32% reporting they don't know compared to just 8% of those in GP practice settings).

Figure 6.1 Do you have a local Nurse Practitioner group – percentages by setting



Source: Employment Research, 2006

Overall, of those respondents who have a local NP group, nearly eight in ten (79%) report that they go to meetings. Again there is a big difference between NPs in GP practice (83%) and those in other settings (69% saying they go to meetings).

6.3 Views of NPA services and remit

Respondents were asked which of the services offered by the NPA they find most useful. Approximately three quarters of all respondents provided a details. Table 6.2 below summarises the results, with the newsletter (63%) and to a lesser extent the website (20%) seen as the most useful services offered.

Table 6.2 MOST useful services offered by NPA – percentages

	% cases
Newsletter	63
Website	20
Networking	5
All	4
Never received anything/very much/not aware of any services/never use any.	4
Conferences	1
E-mail group/web group/messages received by e-mail	1
Others such as: Clinical forums, discussion Groups, support/lobbying on behalf of members, clinical guidelines/protocols/etc. (eg. X-ray referrals)	5
<i>Base n=</i>	<i>866</i>

Source: Employment Research, 2006

Following on from this question, NPs were then asked if there are any further services/facilities that they would like to see the NPA offering. Table 6.3 shows the list of preferences given by members. One in three want to see more local NP groups, events, training and forums and one in five are interested in education/training and more information about current issues, such as Agenda for Change.

Table 6.3 Further services/facilities wanted from NPA – percentages

	% cases
Local NP groups/events/training/forums etc.	33
Education/training/CPD	21
More information/communication (e.g. AFC/KSF/current issues, etc.)	21
On-line services (e.g. professional development, more interactive website, e-mail newsletter, etc.)	11
More/enable networking (e.g. with other NPs/NP Educators/NP Leads, etc.)	11
More lobbying (e.g. for nurse prescribing, etc.)	10
More support	9
Clinical guidelines/protocols/help in developing policies (eg. X-ray referrals)	6
Workshops/meetings/conferences	6
Job advertisements (up to date information)	2
Legal advice/support/tribunals, etc.	2
Job descriptions, clearer definitions of NP	2
Social events	1
Support for Research	1
<i>Base n=</i>	<i>455</i>

Source: Employment Research, 2006

Respondents were then asked what they see as the important issues that NPA should be addressing on behalf of Nurse Practitioners. Table 6.4 summarises these responses. Many of the responses are interlinked to the theme of role consistency/clarity and how this can be achieved. Hence three in ten see campaigning for ‘NMC regulation/registration’ and recognition of the title on register as the most important issue that NPA should be addressing. Linked to this, about a quarter want to see the profile and status of NPs raised. One in five say that they’d like the NPA to campaign to ensure greater standardisation in the qualifications of those using the title Nurse Practitioner. The broader (but related) issue of role definition and clarification was referred to by 13%.

As noted earlier in the report, the way in which AFC has impacted on NPs is an issue, and was seen as an area that the NPA should address by more than one in five respondents.

Table 6.4 Issues members want to see addressed by NPA – percentages

	% cases
NMC regulation/registration (e.g. Recognition of title on register)	30
Promoting role/status/raising profile – VALUE role	23
Pay/conditions	19
Standardisation of qualification/training – those without recognised qualifications should NOT be able to use same title. Too many nurses using NP title when not qualified	18
AFC issues – banding/not addressing NP issues/primary care	14
Role definition/clarification/understanding/awareness of what role is	13
Protection of NP role/title (e.g. In relation to physicians assistants/Medical Care Practitioners (MCPs), / community mat	13
Education/training/ongoing CPD – access/funding/better	11
Prescribing (rights/skills/framework)	10
Referrals/investigations rights	9
Less pressure for academic qualifications (eg. Masters); already doing job.	
What will happen to NPs without? Recognition	5
Be voice for NPs/Advocate for NP issues/promote views/influence policy.	4
Promote specific sub-groups/specialties (e.g. Acute)	3
Sign off sick notes/medical certificates	2
Support	2
NPs more united (better networking/intercollegiate communication)	2
Career structure/progression	2
Partnership - NPs to become partners	1
Funding of NP posts/recruitment and retention/redundancies	1
<i>Base n=</i>	<i>786</i>

Source: Employment Research, 2006

When asked if respondents were interested in attending the national NPA conference on 7th September, two thirds (64%) said ‘yes’ and there was no difference here between NPs in GP practice and other settings. Of the 381 respondents who said they were not interested prior commitments were the most frequently cited reasons (31% - see Table 6.5). One in four say that it’s too expensive and they cannot get funding to go, one in five (19%) say that they are too busy and 13% mention travel issues and the location of the conference.

Table 6.5 Reasons why cannot make NPA conference – percentages

	% cases
Cannot make date...prior commitments/holiday, etc.	31
Cost/expensive/cannot get funding	25
Time/workload/busy	19
Location/travel	13
Not applicable to line of work (attending other conferences more applicable)	10
Staff cover/Time off	8
Childcare issues/young family	7
Not an NP, no longer an NP, retired/leaving	4
No good – waste of time/money/rubbish/badly organised etc.	3
Too elitist	1
Not aware of it!	0
<i>Base n=</i>	<i>381</i>

Source: Employment Research, 2006

Appendix: Qualifications

The qualifications recorded from the 121 on-line responses are presented alphabetically.

Q14b 'What nurse practitioner qualification do you hold?'
Autonomous Practice in Minor Injury/Illness Management (60 credits at level 3)
A 19
A33 Autonomous Practice level 3 three models Post graduate certificate in Advanced Practice - includes clinical examination skills in advanced practice / diagnostic reasoning skills
Autonomous nurse practitioner with supplementary and independent nurse prescribing.
Autonomous Practitioner
BA Hons Nurse practitioner pathway. RCN affiliated course
BSc (Hons)
BSc (Hons) (Primary Care)
BSc (Hons) Health Studies with Nurse practitioner diploma
BSc (Hons) Health Studies, NP Dip.
BSC (Hons) in health studies (nurse practitioner pathway)
BSc (Hons) Nurse Practitioner
Bsc (Hons) Nurse Practitioner incorporating RCN ENB A33 award.
BSc (Hons) NP
BSc (Hons) Nurse practitioner (primary care) London South Bank University
Bsc advanced clinical nursing practice
BSc Honours Nurse Practitioner
BSc Hons (NP pathway) RCN Swansea 1994
BSc Hons degree nurse practitioner rcnA33
Bsc Hons nurse practitioner
BSc Hons Nurse Practitioner
BSc in specialist nursing practice
BSc Nurse Practitioner
Bsc Nurse practitioner degree (primary health care)
BSc Nurse Practitioner
BSC Primary Health Care Nursing. Nurse Practitioner (Nescot 1995) (A33 Autonomous Practice)
BSC (Honours) Primary Healthcare
Bsc (Hons) Nurse practitioner primary health care
BSc (Hons) nurse practitioner
BSc (Hons) Primary Health Care
BSc (Hons) Nurse Practitioner degree (RCN accredited)
Bsc Hons Nurse Practitioner
BTEC Laser Light and Associated Therapies, BTEC Administration and Best Practice Botulinum Toxin Type A Upper Face
Clinical decision making
Clinical skills module
Diabetes diploma, asthma diploma
Directly related courses Minor Injuries and Minor Illness - no course that states qualification as NP
Emergency Nurse Practitioner Modules(2)(Napier University)
Advanced Aural Care Module (RGU Aberdeen)
Endoscopy Practitioner
ENP 33
Family planning and sexual health Diabetes in primary care
MA Health Care Practice (Nurse Practitioner)

Master Health assessment,
Master of Medical Science in Applied Health Care Studies (Advanced Clinical Practice)
Masters degree, Specialist Practitioner
MSC Advanced Clinical nursing
MSc Advanced Clinical Practice
MSc Advanced Nurse Practitioner
Msc Clinical Nursing
Msc Nurse Practitioner Diploma NP
NP diploma, Bsc hons nursing degree
Nurse Practitioner BSc Hons
Nurse practitioner certificate
nurse practitioner course
Nurse Practitioner Diploma
Old equivalent a33 latterly known as autonomous practice from oxford brooks university
paediatric pulmonary
PGD
Post grad certificate in primary care
Post grad diploma
Post Graduate Certificate in first contact care
Post Graduate certificate in professional practice (3 level 4 module Health Assessment with reflective component)
Post graduate certificate nurse practitioner(masters)
Postgraduate Diploma- nurse practitioner studies-Primary Care
Principles of Physical Assessment Currently undertaking MSc in Advanced Clinical Practice
RCN AUTONOMOUS PRACTITIONER
RCN award
RCN Award - Primary Care Nurse Practitioner
RCN Diploma in Nurse Practitioner, Affiliation with Honours degree with Manchester University
RCN Nurse Practitioner Award
Specialist Practitioner
Specialist practitioner
Specialist practitioner
Specialist Practitioner
Specialist practice general practice
Supplementary and extended nurse prescribing

Q15: ‘What other post registration qualifications do you have that are relevant to your practice as a NP?’
405 neonatal intensive care course 904 course
A51 A33 CPT ENB 901 RSCN extended/supplementary prescribing
Asthma Dip., Allergy Dip., FP cert.
Asthma diploma, Family Planning, Teaching certificate, Copd Diploma , Ear Trainer.
Ba Hons acute and critical care, ENB 199
BMedSci Community Health Care Nursing BA Health and Social Welfare (Open University) ENB Family Planning In Society (901)
BSc(Hons) Nursing/ Midwifery
BSc(hons) Practice Nursing, Advanced Diploma COPD, Diploma Asthma, Family Planning certificate, Diploma Aural Care, Certificate CHD
Cert Diabetes Care, Diploma in Asthma, Studying for MSc NP at Sth Bank
Cert. Management of Diabetes in Primary Care. ENB health Education
Certificate in Health Promotion Diploma Health and Social Care
Clinical Leadership degree
Clinical skills course at Northumbria university paediatric course at Guys clinical skills course in acute MI and

thrombolysis
Contraception and sexual health
Critical care Masters level, Health promotion certificate, Advanced life support provider
Degree Courses as above
Developing the role of Nurse Practitioner Module
Diabetes in Practice
Diploma in Therapeutics Supplementary Prescriber MCGI - UKCC higher level of Practice Pilot
diploma modules- asthma, COPD, spirometry, cytology, women's health, family planning, practice nurse diploma
Ed.D. Ph.D.(Tissue Viability)
Emergency Nurse Practitioner Qualification level 3. 1996 Stand Alone Master Module Practice Based Learning. South Bank University. 2005
ENB 136, 978,998.
ENB 199 (level 3)
ENB 8103 Family Planning Certificate Diabetes nursing Diploma
ENB 928 diabetes care
ENB 998 BSc Specialist practitioner community health
ENB Autonomous Practice Certificate in Asthma Management Advanced Diploma in COPD Diabetes Diploma ENB Family Planning Cert
ENB R71 family planning certificate. NARTC Diploma in Asthma Care
European Paediatric Advanced Life Support Advanced Life Support
Extended and supplementary prescriber
Extended and supplementary prescribing
Extended formulary and supplementary prescriber
Extended Nurse Prescribing
Extended Nurse prescribing. Asthma diploma.
Extended/supp prescribing.
Family Planning Autonomous Practice a55 Asthma Diploma
Fertility and fertility control
Grad dip district nursing, pg dip health promotion, asthma dip, sexual/family planning dip
Law and the nurse - critical practice emergency and primary care practitioner clinical examination extended nurse prescriber
MA Nurse Practitioner Development
Management of minor illnesses Ext and supp nurse prescriber
Masters degree in Health and Social care Bsc Hons in community Nurse (CHCN award and SNPC in general practice. PGCFHE/Practice educators award
Minor illness/injury, asthma diploma, fp cert
Msc Nurse practitioner
Non-medical prescribing provisional pass awaiting final results
Nurse Independent Prescriber
Nurse Practitioner DIP HE
Nurse Prescribing
Nurse prescribing
Orthopaedics and spinal injuries
Physical skills Teeside University
Prescribing
Prescribing , Minor Illness and chronic disease qualifications
RGN RHV Asthma and COPD diplomas
RSCN
RSCN RHV
Specialist Clinical Examination Clinician in Primary and Emergency Care
Wound care module; Advanced assessment skills module - King's College London- level 3