

The WiPP 'SNAPshot Survey'

Supporting nurses and practice

**A national survey investigating employment conditions and professional
development support for nurses in
general practice
in the UK.**

May 2008

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The WiPP 'SNAPshot' survey of practice nurses

Executive Summary

A recent national survey of practice nurses across the UK sponsored by the Department of Health funded Working in Partnership Programme (WiPP) has produced data about levels of professional development support in practice. A total of 1,161 nurses participated in the on-line anonymous survey. The findings give an insight into factors that are associated with effective professional development and may therefore enhance nursing competence and quality of care.

These factors include employment standards, access to education and clinical supervision, GP/Nurse relationships and nurses' attitudes.

Key findings

- There are wide variations across the survey sample in employment conditions and levels of professional support for nurses working in general practice, with examples of excellent practice and some of unacceptable standards.
- Appropriate education is not universally available.
- Some nurses report working with inadequate training and support to maintain competence.
- There are clear links between good employment conditions (Human Resource Management) and nurses feeling well supported in their professional development.
- A strong working relationship with GPs and in particular, high level involvement in decision-making is linked to nurses feeling well supported.
- Nurses who feel positive about their role are more likely to seek appropriate support and share responsibility for professional development.

'SNAPshot' Survey

Background

General Practice Nursing is one of the newest, fastest growing and broadest areas of nursing. The practice nurse is often the first point of contact for patients with diverse health problems (Carey 2000). The scope of the practice-nursing role therefore covers a wide range of clinical areas and all age groups, from emergency care, to chronic disease management clinics.

There has been a focus on political change in primary care for a number of years and practice nurses have shown a flexible approach to adapting their role to meet the changing health needs of their patients and the contractual requirements between their GP employers and the NHS. As independent contractors, GPs are private employers of nursing staff, which means they do not have to adhere to NHS conditions of employment and the nurses are not part of the wider nursing hierarchy within the NHS (Gupta 2000). Whilst this results in a flat non-bureaucratic management structure that can respond swiftly to changing local healthcare needs, it also means that nurses must negotiate their working conditions directly with their employer. This independent status may have implications in terms of professional identity, career progression and standards of care.

NHS policy requires practice nurses to work to maximum capacity and efficiency, support the drive to promote self-care, manage long-term conditions without hospital admission, achieve QOF targets and provide quick access to first contact care (Cross 2006). Lord Darzi has ambitions for a world class primary and community service (Darzi 2007). To achieve this, practice nurses need to be adequately prepared and supported in the role.

Literature Review

A literature review was carried out in February 2007 to identify the extent of current information about levels of professional development support available to practice nurses.

There is evidence of wide variation in role, working conditions and educational opportunities within and across different Primary Care Trusts (PCTs) (Corbett 2004, Savage 2005). This appears to be a relatively unchanged phenomenon over time, when

compared to the survey carried out by the Social Policy Unit at York University (SPRU) of 12,589 practice nurses (Atkin and Lunt 1993). With the continued emphasis on developing services in the primary care sector (DH 2006) and increasing delegation of 'first contact care' (DH 2002) from GPs to nurses, the implications of these variations warrant investigation.

The literature explores practice nurse professional development from a number of perspectives, including aspects of Human Resource Management (HRM) and the effect this has on supporting nurses in their work.

Employment conditions

Current literature suggests widespread variations between practices in terms and conditions of employment, with regard to contracts, pay, appraisal, induction, holiday and study leave entitlement (Corbett 2004, Gray 2006, Longbottom et al 2006) but does not provide a complete national picture. Longbottom et al (2006), a team from Staffordshire University who carried out a comprehensive review of information available on the role, employment and professional development of practice nurses to inform the Working in Partnership Programme (WiPP, 2006), found that many nurses have never had an appraisal and do not have an up to date job description that adequately reflects their role. These findings come fifteen years after the RCN clearly identified that many practice nurses did not have job descriptions and that this made it difficult to identify their learning needs (RCN 1991).

In 2002, Torbay PCT undertook a local review in general practice (Phare 2002) and found a lack of equity in terms of service and in some areas, low levels of education to support the nurse's role. They decided to tackle the problem by developing a framework for professional and educational support and recommending standardised terms and conditions across the PCT area (Torbay PCT and Teignbridge PCT 2005).

There is also evidence of variability in pay scales, with a general reluctance among GPs to adopt the new national pay structure for nurses 'Agenda for Change' (Benison 2005). As independent contractors, GPs retain the right to decide on levels of pay within their own practice.

Educational programmes for practice nurses

The literature describes the patchy and uncoordinated nature of practice nurse education

(Stilwell 1991), with courses often varying considerably in content and quality between regions (Prime 2003). The RCN described educational preparation for the role in the 1980's as both "limited and haphazard" (RCN 1991, p2), and despite the fact that there is now a specialist qualification for practice nurses, it is not universally available and uptake is said to be patchy due to GP employment (Bell 2007), as the GP would be required to release the nurse from work, pay her whilst she was absent from the practice as well as paying for a locum nurse to cover the work.

The review carried out by Longbottom et al (2006) identified some excellent educational opportunities available but gaps in provision and wide variation across the country in access to courses. They also noted variations between PCTs in terms of commitment to practice nurse education and stated that there are no mandatory educational requirements for nurses in general practice.

Over a decade earlier, recommendations were being made to reduce anomalies by making local health authority organisations responsible for the employment contracts and continuing education of practice nurses (Jewell 1994). Now that training budgets for general practice are no longer held by PCTs but are directly given to practices as part of the 'global sum' (Lilley 2003) the responsibility for funding professional development of nurses lies, once again, firmly with GPs.

Professional development support in practice

All nurses are bound by the NMC code of conduct to maintain their competence (NMC 2004). A wide range of NHS policy documents stress the importance of appraisal, professional development plans, lifelong learning and clinical supervision for nurses, linking these with improved competence and ability to apply evidence based research to practice thus improving quality (DH 1998, 1998b, 1999, 1999b, 2000, 2002, 2006). The NHS Modernisation Agency has recently launched '10 high impact changes' (DH, 2007) following a review and meta-analysis of the literature on the relationship between good human resource practices and performance improvement. The team found that improved performance was associated with staff appraisal, staff involvement/partnership, good 'people management' and effective training and development, and these formed the basis of some of their recommendations. Supported by these findings and the requirements of Clinical Governance (DH, 1999b) all nurses, including those in general practice, should have access to a

range of methods of support in practice such as appraisal, mentorship, continuous professional development and clinical supervision. In their original position statement on clinical supervision, the UKCC (replaced by the NMC) (1996) stated that:

“Clinical supervision supports practice, enabling practitioners to maintain and promote standards of care”.

UKCC (1996, p3)

and:

“Every practitioner should have access to clinical supervision”.

UKCC (1996, p4)

These statements are supported in the current NMC guidance on clinical supervision (NMC 2006).

Sherlock (2003) discusses the use of Professional Development Plans (PDPs) in general practice, and describes the requirement set out in the white paper “Securing a quality workforce for the NHS” (DH 1998) for organisations to carry out appraisal linked PDPs for staff. However, there were no penalties for failing to do this in general practice, and as previously mentioned, (Longbottom et al, 2006) some practice nurses have never had an appraisal.

Corbett (2004), undertaking a survey in London, found that half the practice nurses sampled (n=61) had no appraisal in the preceding year, that practice nurse forums do not exist in all PCT areas in South West London and that there is uncertainty amongst the practice nurses about lines of professional accountability. Corbett recommended that PCTs should ensure

“proper employment, training and development of practice nurses to ensure fitness to practice”(Corbett 2004, p5)

Gray (2006) followed up this study two years later, and found that inequalities in these key areas persisted and some of her recommendations echoed the initial project.

Following a review of practice nursing across Scotland, which identified areas of concern including access to learning, lack of leadership and support, the Scottish Executive developed a Framework for Nursing in General Practice (Scottish Executive 2004). This framework provides a comprehensive, clear set of guidelines for good practice. Adherence to these standards is, however, optional as:

“Practices will not be assessed against the standards in any formal way, although it is recognised that individual practices may find it helpful to self assess against the standards as part of their own development plans” (Scottish Executive 2004, p10).

Three years after its implementation, a recent survey in Scotland found:

“Practice nurse opportunities for education, networking and peer support vary across Scotland” (Bell 2007, p114).

This suggests that there has been limited progress made in addressing issues of inequitable employment conditions and professional development support, despite quality related incentives in the new GMS contract, requirements under clinical governance, and the availability of resources such as the Scottish Executive Framework.

The literature reviewed highlights issues of continuing disparity around practice nurse employment conditions, education and professional development support across the UK. It appears that all of these elements are interlinked and that improving one (for example, education) does not necessarily have a positive effect while the others remain unresolved. The literature does not accurately measure the extent of the anomalies, nor does it provide a comprehensive national profile. Given the political emphasis on increasing the role and responsibilities of this professional group, it is important to address this lack of information and to ensure that practice nurses can access the resources they need to perform to the standard expected of them.

The SNAPshot Survey

Introduction

The Working in Partnership Programme (WiPP) was established following the introduction of the new GMS contract, to support workforce development in general practice. The review carried out at the beginning of the programme informed workforce project areas and also highlighted wide variations in working conditions for practice nurses. The WiPP GPN Toolkit was developed to provide a readily available resource providing advice and guidance on employment, professional development and standards of care in general practice nursing. In order to assess the effectiveness of this resource, it was important to identify current access to professional development support, availability of programmes to support the toolkit (i.e. mentorship, supervision, education) and any barriers to the implementation of recommendations made within the guidance. A national survey was therefore commissioned by WiPP to provide this information.

Aim

To provide data about role, employment conditions, access and barriers to professional development support for practice nurses.

Method

The survey used a mix of quantitative and qualitative methods, with open and closed questions. Ritchie and Lewis (2003) discuss the benefits of combining qualitative and quantitative methods in contextual research, and suggest that using both in tandem can allow for a deeper exploration, where a statistical enquiry might not fully capture the complex or delicate nature of phenomena. Quantitative data were collected but the approach to data management and analysis as a whole was from a qualitative perspective. Analysis was therefore descriptive and interpretive rather than statistical, as the purpose was not to quantify resources available, but to explore the range of pertinent issues and perceived factors affecting them. The survey was, by definition, a 'snapshot', and therefore superficial in nature. However, the issues being explored were wide ranging, so the sample needed to include practice nurses from all practice types, sizes and geographical locations. The sample therefore had to be large enough to achieve this, hence the choice of survey as a method.

Design

The questionnaire (appendix i) was designed using standards summarised from the WiPP General Practice Nursing (GPN) toolkit. These standards represent terms and conditions of employment that should be in place to ensure adequate preparation and support for practice nurses. They were developed following an extensive review of existing national frameworks and examples of good practice (Longbottom et al 2006), wide consultation and a working party to develop the toolkit, which was approved by the WiPP advisory panel. A pilot study was conducted with 28 practice nurses to test the questionnaire prior to commencement of the survey.

Ethics approval was discussed with the local research ethics committee, who decided that the survey came under the category of 'service evaluation' or 'audit' and did not therefore require an application for approval. An email was sent as confirmation of this decision. The National Research Ethics Service (NRES) guidelines were adhered to as good practice to ensure participants gave informed consent and had confidentiality assured. This was achieved using a Participant Information Sheet (appendix iii) followed by consent. Access to the results was restricted to the researcher and the computer company, and all responses were anonymous and numerically coded.

Sample selection

The total practice nurse population in the UK is estimated at around 20,000 (Young 2006). Sending a postal questionnaire to the total population could potentially result in the return of thousands of paper responses for analysis, which would be unmanageable for one researcher. The Internet was therefore a viable option but posed a problem with access, as there is no reliable national database of practice nurse email addresses. The decision was therefore made to use the WiPP website, endorsed by the NHS and available to all practice nurses in the UK.

The inclusion criteria were that all participants should be general practice nurses (GPNs) working in the UK. This was deliberately loose so as to include the views of any nurses currently working in the field, to achieve saturation of issues. The sample was self-selected and anonymity was guaranteed, as the only identifier was a reference number. The survey was widely publicised, with a postcard mail-shot to every practice in England, notices and editorials in practice nursing journals. The survey was also promoted in WiPP newsletters, and was accessed by visiting the survey site directly or via the homepage of the WiPP website. A 'pdf' paper version

was available to print off and post and paper copies were also distributed at several practice nursing conferences across the UK.

Data collection

Data were collected over a 3-month period from May to July 2007. The software programme 'iSalient' was used to collect all the electronic responses and to explore any associations between the quantitative findings by cross tabulating responses to more than one question. Qualitative data were obtained from three free text questions and the responses to these questions were wide-ranging. These data were organised for analysis using a systematic approach called 'thematic framework' (Ritchie and Lewis 2003). The themes that emerged from this process were grouped under the following categories;

Training Issues, Employment standards, PCT Issues, New GMS Issues, Professional Isolation/ Risks regarding safety, Positive Support, Sharing Responsibility, Roles and GP/Nurse relationship

The comments were also categorised as being 'positive', meaning they expressed satisfaction with the professional support received, 'negative', meaning they expressed dissatisfaction, or 'neutral', meaning they made comments unrelated to levels of support. 427 of the respondents (37% of the total sample) used the opportunity to answer the final question in the survey inviting them to make comments about support they receive. 163 of those (38%) made 'positive' comments, 211 (49%) made 'negative' comments and 54 (13%) made comments that were 'neutral'. These terms do not carry any value judgement, but are used with the meaning described above.

Findings

1.1 Respondents

The number of responses was 1,161, approximately 6% of the estimated total population of 20,000 practice nurses in the UK. During data collection, results were monitored at frequent intervals and variability in data between each monitoring was noted. Early variations decreased as numbers of respondents rose and patterns established with the first 120 respondents remained unchanged throughout the duration of data collection, indicating adequate saturation across a broad spectrum of issues and practice types.

To protect anonymity, participants were not asked to provide information about their geographical location in case this inhibited their response. However, some volunteered their location in the text comments. Areas mentioned included Dagenham, Wales, Manchester, Tayside (Scotland), London, Derby, Suffolk, Essex and Colchester, Bristol, Exeter. This would suggest a broad geographical spread.

1.2 Demographic profile

Most nurses were over 40, with almost half the sample (48%) aged between 41 and 50 and 30% between 51 and 60.

Over half (53%) had been in practice nursing over 10 years and 22% between 5 and 10 years. Only 13% had been in practice nursing less than 3 years, indicating a fairly stable population. About half the sample (45%) worked more than 30 hours a week.

Only 7% of nurses worked for a single-handed GP, but 12% worked as the only nurse. Although 33% worked in practices with 6-10 GPs, only 14% worked in teams of 6-10 nurses. The most common numbers of nurses in the practice were 2 (25%) and 3 (21%).

The large majority of nurses were 1st level registered (RN) (97%) with 7% holding the enrolled nurse (EN) qualification. A very small proportion had additional primary care nursing qualifications other than practice nursing; 4% were community nurses and 2% were health visitors.

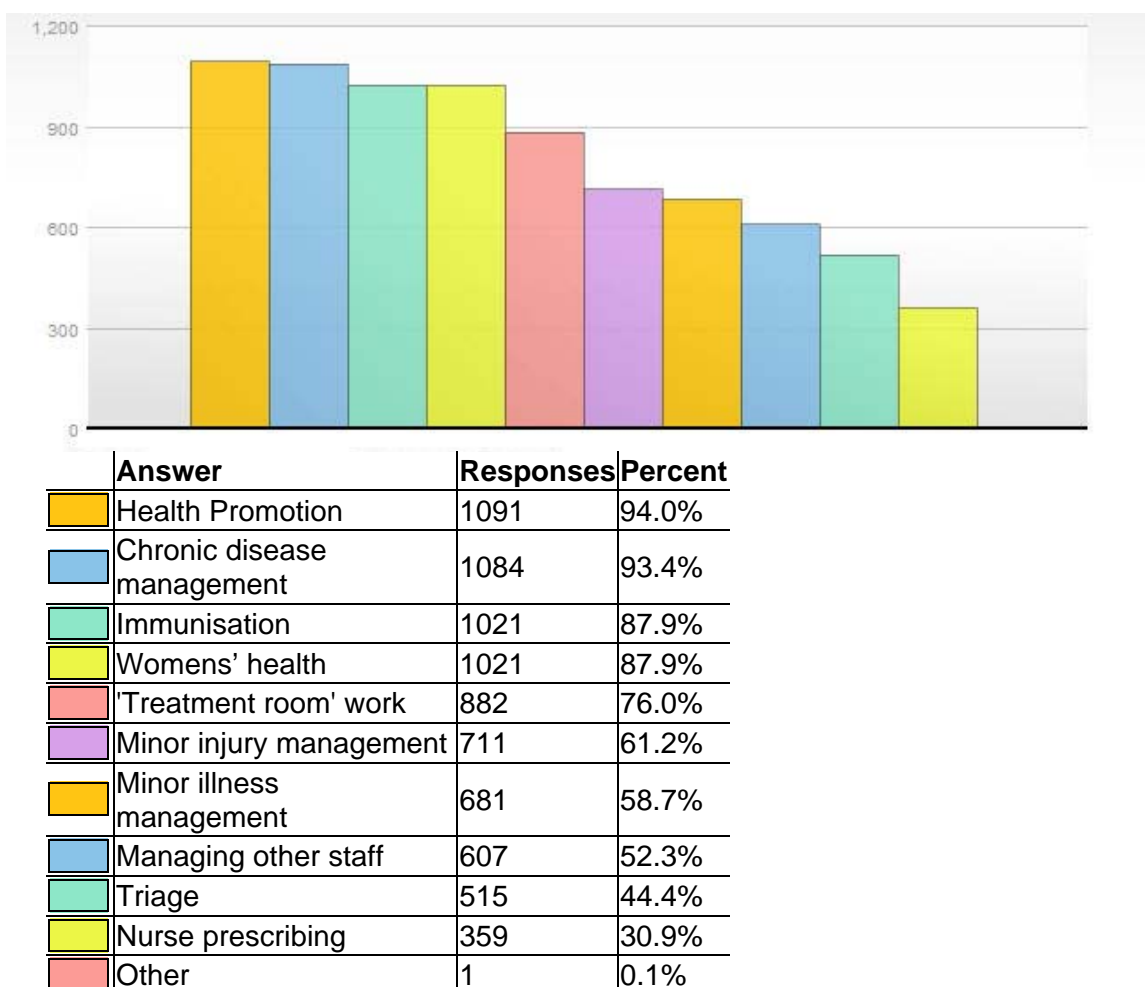
This profile is similar to the SPRU findings (Atkin and Lunt 1993), where most nurses were between 40 and 49, 92% were RGN and 10% EN, with 12% holding a community nursing qualification and 3% health visiting. Differences between the 1993 report and this survey were length of time in practice, with only 1 in 10 nurses in post more than 10 years in 1993, and number of hours of work, with the average being 18 hours per week in 1993.

2. Results

2.1 Role

The respondents clinical role covered a broad spectrum of work areas with a fairly even spread among the most common four including health promotion, chronic disease management, immunisation and women's health (see Fig.1).

Fig 1. Does your role involve:



In response to the free text question at the end of the questionnaire inviting any other comments, some nurses commented on the broad spectrum of activities encompassed by their role, which is *“constantly changing and developing.”* (Respondent 640)

Respondent 207
“I have been a Practice Nurse for 5 years. (The) role has developed immensely, knowledge and current research and targets for gps has created an unbelievable demand on role of pns.”

17 nurses volunteered that their role was not clearly defined and sometimes misunderstood by GPs and patients.

Respondent 274
“My role within the Practice is not very well defined”

Respondent 329

“Patients do not know what nurses can and cannot do and become very surprised when a nurse can legally sign a prescription-or perform a duty which was traditionally the domain of a doctor”.

Respondent 363

“Dr's do not seem to have much of an understanding of the role of the practice nurse or the support needed to do the job”.

Some comments suggested a lack of control over how the nurses carried out their work.

Respondent 489

“Generally the nurses role is in support of the GP, working to the GP's agenda. Not always able to give adequate nursing care due to this.”

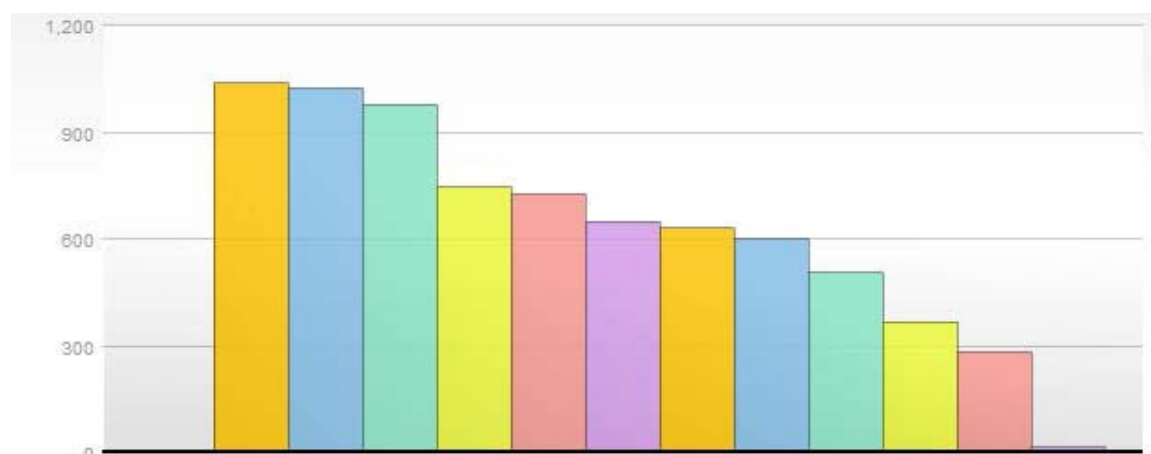
Respondent 213

“Non clinical practice manager often takes control of nursing service development without consulting the nurse team.”

2.2 Employment standards

The recommendations for employment standards made in the GPN Toolkit were used to design this question (see Fig.2). These represent terms and conditions of service that are considered indicators of 'good employment practice' (WiPP 2008). Participants were asked which of the employment standards were available to them in their practice. Standards being met by a high proportion of practices included, an employment contract (91%) and annual mandatory training such as anaphylaxis (90%). Whilst this represents a high proportion of nurses, the fact remains that almost 1 out of 10 nurses in the sample report being without an employment contract or mandatory training. Although annual appraisal was received by a high proportion of nurses, (85%) it would appear that follow up support was not always given, with 44% receiving help in achieving their professional development plan (PDP) targets following the appraisal.

Fig 2. Employment standards- In the practice where you work do you have:



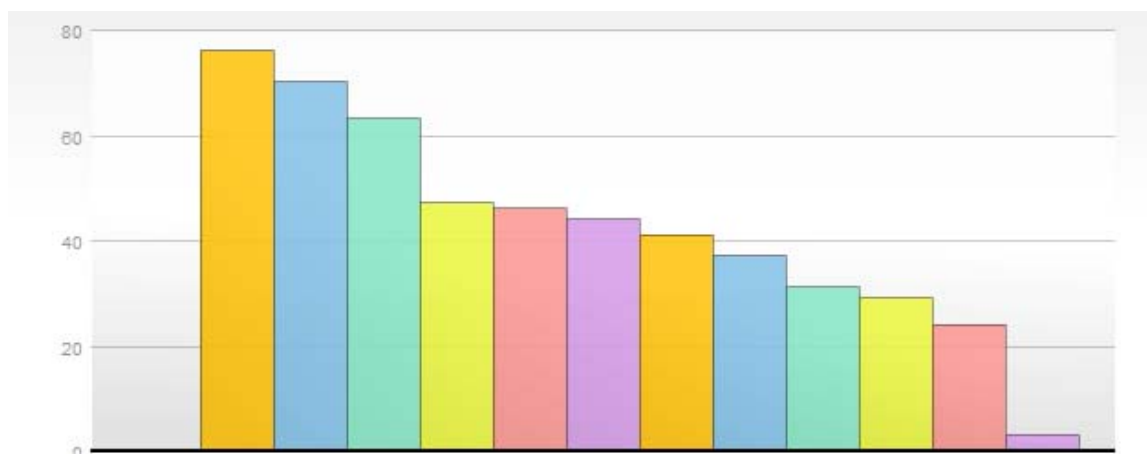
	Answer	Responses	Percent
	A contract of employment	1034	91.1%
	Mandatory annual training in anaphylaxis and Basic Life Support	1020	89.9%
	Annual appraisal	974	85.8%
	A comprehensive job description	743	65.5%
	Regular team meetings with the GPs	722	63.6%
	Protected time for study	645	56.8%
	Protected time for administrative work	627	55.2%
	A clear line of managerial responsibility	596	52.5%
	Support to achieve the goals in your PDP	502	44.2%
	Help in compiling a professional development plan (PDP)	365	32.2%
	Pay scales linked to Agenda for Change	279	24.6%
	Not Applicable	11	1.0%













Standards that were being met for fewer nurses included pay linked to Agenda for Change (24%) and help compiling a PDP (32%).

When cross-tabulated with number of GPs in the practice there were some interesting variations on these findings, with a relationship between size of practice and standards.

In practices with one GP (Fig. 3), particularly notable differences were a drop to 74% for appraisal, 55% for a comprehensive job description and 34% for a clear line of managerial responsibility. However, the Agenda for Change pay scales scored slightly higher than the overall figure, at 28%.

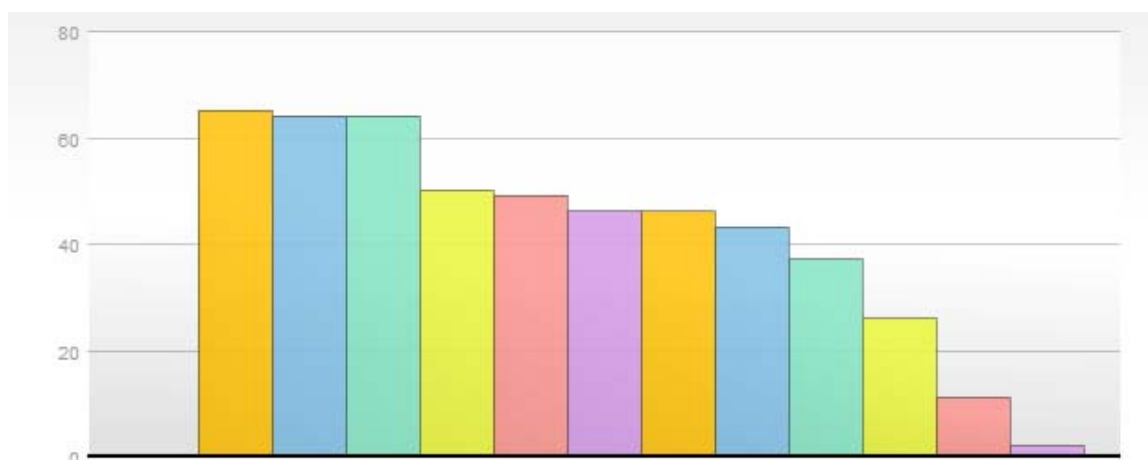
Fig. 3 Crosstab: employment standard with how many GPs – 1















	Answer	Responses	Percent
	Mandatory annual training in anaphylaxis and Basic Life Support	76	89.4%
	A contract of employment	70	82.4%
	Annual appraisal	63	74.1%
	A comprehensive job description	47	55.3%
	Protected time for administrative work	46	54.1%
	Regular team meetings with the GPs	44	51.8%
	Protected time for study	41	48.2%
	Support to achieve the goals in your PDP	37	43.5%
	Help in compiling a professional development plan (PDP)	31	36.5%
	A clear line of managerial responsibility	29	34.1%
	Pay scales linked to Agenda for Change	24	28.2%
	Not Applicable	3	3.5%

In larger practices there were also differences from the aggregated figures. Generally, the scores in practices with over 10 GPs (Fig. 4) were higher than the overall figures, with the exception of Agenda for Change pay scales, which were much lower at 15%.

Fig. 4 Crosstab: employment standards with how many GPs – more than 10



	Answer	Responses	Percent
	Annual appraisal	65	91.5%
	Mandatory annual training in anaphylaxis and Basic Life Support	64	90.1%
	A contract of employment	64	90.1%
	A comprehensive job description	50	70.4%
	Protected time for study	49	69.0%
	Regular team meetings with the GPs	46	64.8%
	A clear line of managerial responsibility	46	64.8%
	Protected time for administrative work	43	60.6%
	Support to achieve the goals in your PDP	37	52.1%
	Help in compiling a professional development plan (PDP)	26	36.6%
	Pay scales linked to Agenda for Change	11	15.5%
	Not Applicable	2	2.8%

There was a strong link between positive comments and a high score in employment standards, with 92% of positive respondents reporting having 7 or more of the good employment indicators.

This contrasted with those making negative comments, where only 13% reported having 7 or more of the good employment indicators.

Pay emerged as a prominent theme, with Agenda for Change being mentioned as a specific problem. Some GPs seemed to have adopted various aspects of it, such as holiday entitlement, but most were not willing to sign up to the whole package.

Respondent 213

"I feel strongly that there should be a proper official pay-scale that GP's must adhere to, so that we all get paid for our experience and ability".

Respondent 99

"I have no pay-scale, no cost of living rise for the past 2 yrs, no incremental rise".

Respondent 822

"In terms of conditions and pay I feel we are left behind compared with our NHS colleagues who get certain conditions as a matter of right when joining the NHS. Our pay and conditions depend on what the GP's have decided".

Sick leave was also an area mentioned as lacking in their employment terms.

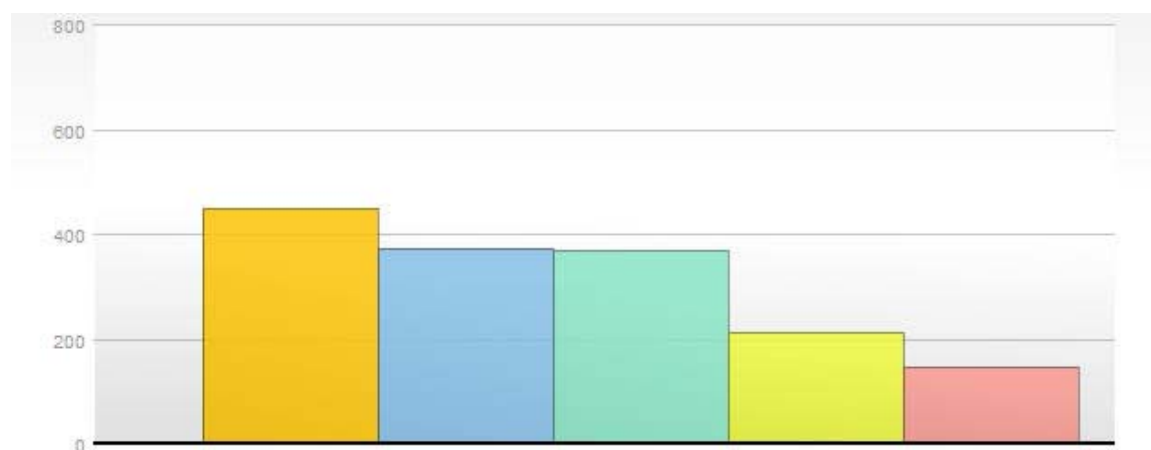
Respondent 946






"I cannot go off sick because they do not pay sick pay and when I questioned it they say they have never paid any of their staff before and I was not entitled to it. I have contacted my union who told me that they couldn't intervene as I am employed by them. Please help change this rule for me".

2.3 Induction

Standards based on recommendations for induction support when employing a new nurse in practice were also measured (Fig.5). Most seemed to gain their support from within the practice, with 35% receiving a formal in-house induction programme and 34% having a mentor. Only 13% attended a foundation course for practice nursing within their first year in post although 38% of the respondents had a local university running a practice nurse induction programme. Only 20% said they were assessed as competent when undertaking new tasks. A considerable number of the sample (42%) had none of the induction support listed at all.

Fig 5. Induction-when you were first employed at this practice did you:



	Answer	Responses	Percent
	None of the above	449	42.0%
	Complete a formal in-house induction programme	372	34.8%
	Have access to an identified mentor to support you in the role	368	34.5%
	Have an assessment of your competence in the tasks you were allocated	212	19.9%
	Complete a foundation practice nurse course within a year	145	13.6%

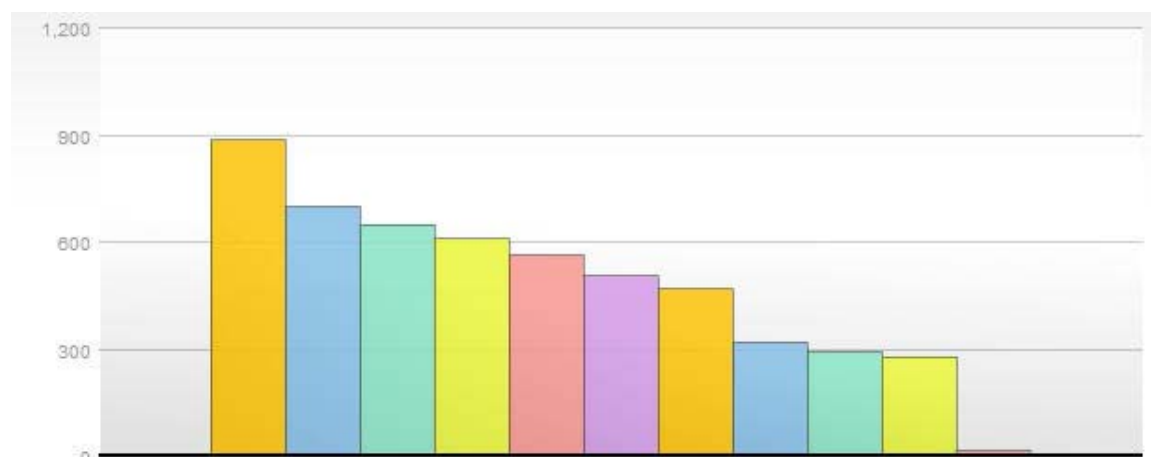
Again, size of practice was a factor, with formal in-house induction programmes more available in practices with more than 10 GPs (51%) than in practices with one GP (21%). This pattern was emphasised further when looking at numbers of nurses in the practice. Formal in-house induction was offered to 70% of those in practices with more than 10 nurses and to 21% of nurses who were the single nurse in the practice. Fewer nurses in larger practices undertook a foundation course in practice nursing within their first year, with 6% in practices with more than 10 GPs, compared to the overall figure of 13%. This was possibly as a result of larger practices doing more in house induction programmes. There was little difference between positive and negative respondents in their experience of levels of induction support when newly appointed which suggests that receiving induction is not an indicator of overall satisfaction.

2.4 Qualifications and training

The participants were asked about the post-registration training they had in preparation for their role (Fig 6). The question listed accredited courses commonly

available at Higher Education Institutions (HEIs), not intended to be exhaustive but covering topics related to the main areas of clinical responsibility.

Fig 6 Qualifications - what post-registration courses have you completed?



	Answer	Responses	Percent
	Cervical cytology screening certificate	883	82.7%
	Childhood immunisation	696	65.2%
	Ear care	647	60.6%
	Asthma diploma	607	56.8%
	Diabetes diploma/equivalent	561	52.5%
	Family planning certificate	502	47.0%
	Coronary vascular disease and hypertension	466	43.6%
	Nurse Prescribing	316	29.6%
	Travel health diploma/equivalent	290	27.2%
	Tissue viability/wound care	276	25.8%
	None of the above / Not applicable	12	1.1%
	Other	1	0.1%

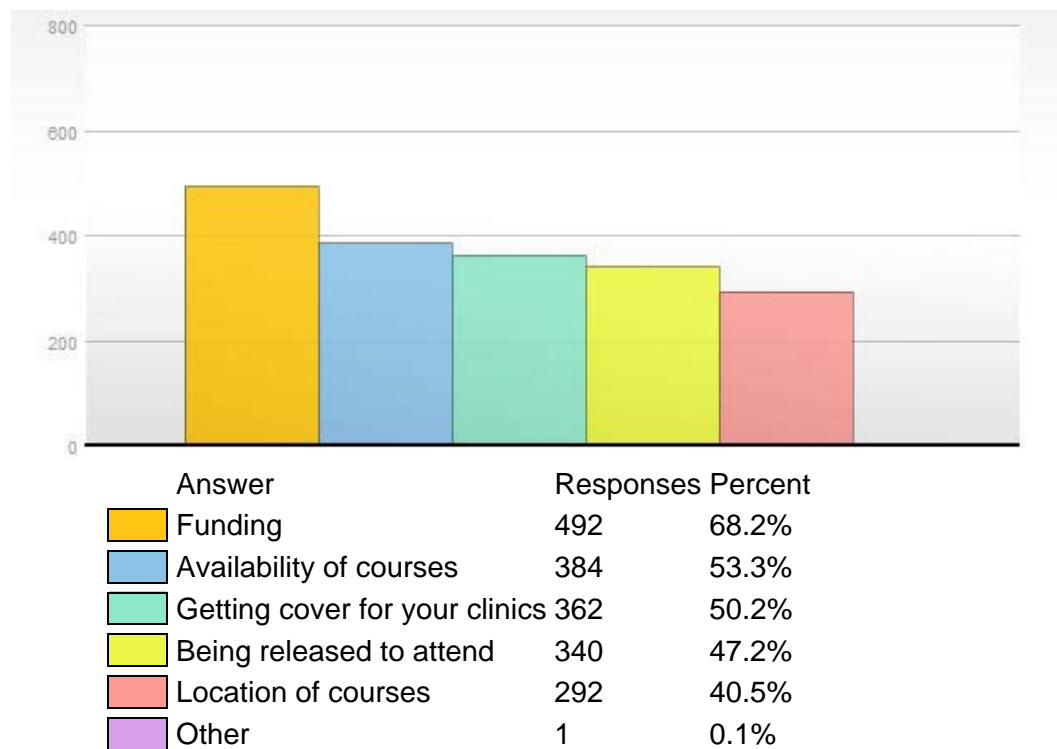
Looking at the relationship between what the nurses do and what they are trained to do revealed some slight variations. Cross-tabulating those nurses who prescribe with those who have done the course revealed that 13% of those who prescribe have not acquired the relevant qualification, which is a cause for concern. 88% of the sample have 'women's health' as part of their role and 87% of these have the cervical cytology certificate but only 51% have the family planning certificate. This suggests that potentially up to 49% of those carrying out 'women's health may be required to give contraceptive advice without having a formal training in the subject. 93% do

'chronic disease management'; 57% have the asthma diploma, 52% are diabetes trained and 43% have done a coronary vascular disease course.

With regard to professional qualifications and title, 12.7% have the Nurse Practitioner qualification, but a higher number (15.4%) are using the title. 15.5% have the Specialist Practitioner Practice Nursing qualification. 48% are trained assessors of pre-registration students and could therefore potentially teach students in general practice.

700 nurses said they experienced obstacles to accessing training and 492 of those said funding was an obstacle.

Fig 7: If you have obstacles to training, are these:



In the free text question concerns were voiced about both the absence of appropriate courses, and difficulty in accessing them.

Respondent 81
"We desperately need a regular accessible affordable course to prepare nurses for general practice".

Respondent 930
"For the last 2 years training and support has been sadly lacking, getting worse, from outside the surgery. I gather 1 out of the 2 more local universities... have stopped

courses and the other seems to have reduced relevant ones... it has taken 7 months to put our new nurse on a training course for cervical smears... even mandatory updates are difficult to access”.

Respondent 231

“I am expected to take on new roles with minimal training & poor support. I would have liked to do the practice nurse induction training but by the time I found out such a course existed it was decided that after working 2 years in a practice it was too late for me”.

This linked with comments about the potential risks inadequate access to training could present to patient safety.

Respondent 613:

“I fear that nurses will increasingly be asked to undertake delivery of care for which they are ill prepared”.

Respondent 840

“I never feel I am up-to-date on anything.”

Respondent 437

“I assess asthma and have no course”

Respondent 269

“I am currently self-taught”

Respondent 502

“Need for a mandatory standardised programme which should be well funded and undertaken before nurses commence in posts for the sake of patient safety.”

2.5 Professional Isolation/ Risks regarding safety

Concerns were expressed regarding nurses undertaking tasks and roles they felt unprepared for.

Respondent 60

“ I feel I am often asked to work outside my competencies, without proper training”

Respondent 179

“The lead practice nurse said that she did everything when she first became a practice nurse without any supervision. She just taught herself. She thinks that I should be the same”

Respondent 346

“I was asked to carry out asthma reviews. My knowledge was limited, but I decided to do the clinics to gain experience within this field”

Respondent 879

“I think that nurses coming into practice now are getting thrown in at the deep end and it seems unsafe sometimes. Many nurses seem unable to say no which gets them into difficult positions”.

Many of these comments related to the lack of access to mentors and clinical supervisors to provide support.

Respondent 1152

"I feel practice nurses need more support, we often work on our own or hours opposite another nurse's so do not see many colleagues. It is difficult to know the norm if you have little to compare your experiences to".

Respondent 1355

"I worked as an isolated nurse in a rural practice without a mentor or clinical supervision even though at interview I had been assured I would be supported and trained having qualified just two months previously".

Respondent 1135

"There was training some years ago within the PCT for Clinical Supervision for Practice Nurses. Thereafter no provision for individual clinical supervision or opportunities for those trained to put it into practice".

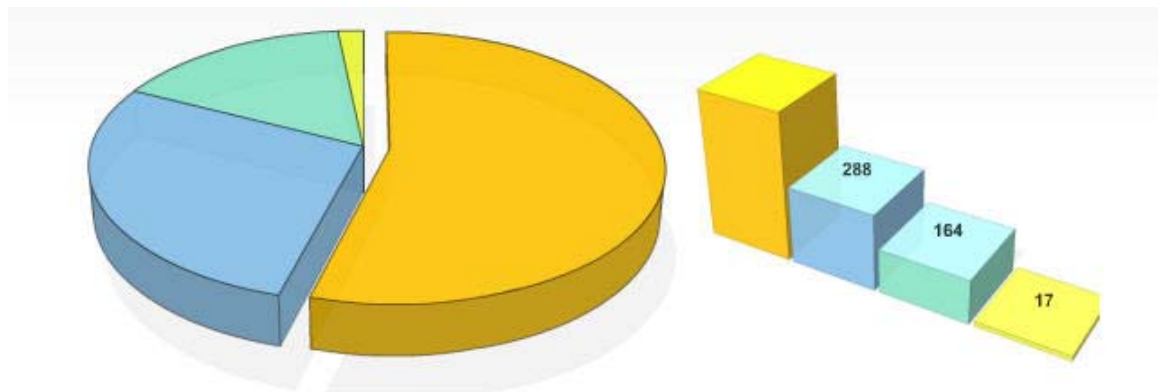
Some commented on the difference that this type of support can make to the quality of service provided by GPNs.

Respondent 137

"I work in a very supportive practice that makes best use of an experienced PN team. I also work as a PN assessor for QOF for the PCT and generally I find that practices who support and develop their nurses have the best PNs"

The issue of adequate preparation leading to competence to carry out the practice-nursing role was explored by asking participants whether they had been asked to undertake tasks they did not feel competent to perform (Fig. 8).

Fig 8 Have you ever been asked to undertake a task you did not feel competent to perform?



	Answer	Responses	Percent
	Rarely	558	54.3%
	A few times	288	28.0%
	Never	164	16.0%
	On many occasions	17	1.7%

Whilst very few nurses reported having been asked on many occasions to undertake a task they did not feel competent to perform (1.7%), almost 1 in 4 nurses (28%) did report this happening ‘a few times’ and only 16% said it had never happened. This suggests that in some cases there is either poor preparation for the role or unrealistic expectations by those delegating tasks, both of which could be avoided by assessing the competence levels of new staff. When asked what action they had taken when faced with a task they did not feel competent to perform, (53%) nurses refused to do the task, (53%) requested further training, (34%) asked for supervision and (11%) sought advice from a mentor or PCT advisor. In the group that had the Nurse Practitioner qualification, this seemed less of a problem, with a higher percentage (24%) reporting they had never had been asked to undertake a task they did not feel competent to perform.

Out of the 413 respondents who explained the consequences of their refusal to carry out the task, very few had experienced a problem. 9% had a variety of negative consequences, ranging from an “angry GP” (respondent 381) to “redundancy” (respondent 410).

Respondent 192

“I left after being harassed and bullied because I felt there was lack of support, supervision and training for tasks that I did not feel competent in”.

Despite the fact that the experience of these nurses is apparently rare and they are in a small minority within this sample, their experience is a cause for concern, particularly as practice nurses often work on their own which may make them vulnerable in this situation. The vast majority (81%) of the 413 who described the consequences of their refusal to carry out the task stated that their refusal was accepted and they either received training or supervision. This suggests that overall, when nurses are confident enough to assert themselves on professional grounds they are usually treated with respect.

2.6 Training topics requested

699 (65.5%) answered positively to the question “Is there any training you still require to carry out your current role?” 668 of those identified specific topics (Fig 9)

The highest training priorities broadly matched the most common clinical roles i.e. management of long-term conditions, travel health and women’s health. 89 nurses requested prescribing training, which suggests that although a minority have this role (31%), it is a high training priority.

Fig 9

Locally held updates on all clinical topics	138	Prescribing review/update	5
Asthma/COPD	114	Smoking cessation	4
Prescribing	89	Teaching and assessing	4
Family planning	85	Specialist Practitioner	4
Diabetes	84	Mentoring	4
Management	55	MSc	3
Cardiovascular disease/heart failure	47	Obesity/weight management	3
Travel health	42	Infection control	3
Minor illness	31	Minor operations	3
Advanced clinical assessment skills	25	Lab results/ haematology	3
Women’s health	20	ECG’s	2
Chronic disease management	19	Health Promotion	2
Cervical cytology	17	On-line courses	2
Leadership	17	Audio/hearing aids	2
Triage	16	BSc	2
Wound care, including leg ulcers	13	Child protection	1
Information Technology	13	Cryotherapy	1
Minor injuries	12	Business skills	1
Nurse Practitioner	12	Allergies	1
Spirometry	9	Cauldicott Guardian training	1
Ear care	9	Drugs and alcohol	1
Mental health	6	Elderly care	1
Dermatology	6	Palliative care	1
Chronic kidney disease	6	Practice Based Commissioning	1
“Formal qualification”	6	Eating disorders	1
Hypertension	5		

The number of different training topics totalled 52, with 24 of the topics being requested by less than 5 nurses. This illustrates the broad spectrum of training

required by often small numbers of nurses which is a challenge for Higher Education Institutions (HEIs) in the design of training programmes, as it is not financially viable to put on courses for very small numbers. The highest training priority of all was 'locally held updates on all clinical topics'. This was not reflected in education curricula, with only 44% saying their local university provided such study days. 53% of respondents reported that poor availability of courses is an obstacle to training. 39% of respondents had a local university running a practice nurse foundation programme and 35% with the specialist practitioner course in practice nursing.

Some respondents highlighted the dangers of a lack of continued updates and support following prescribing training.

Respondent 248

"In my opinion there needs to be mandatory refreshers for v300 prescribers (similar to midwives who have to do 5yrly refreshers)... I cannot understand PCTs not realising this is one of the biggest risk areas... I monitor my own prescribing patterns and keep up to date. I fear I am one of the few. I see practice nurses who have not had any training in clinical skills prescribing, out of work or patient pressure, far beyond their competencies. This is becoming custom and practice. The NMC needs to take action urgently."

Respondent 352

"All the fuss over prescribing, I got trained and then...nothing. I struggle to keep up to date and daily fear that I have no support (unless I arrange it myself). At present, it does not exist. It is disgraceful that we can just be left to prescribe with no support"

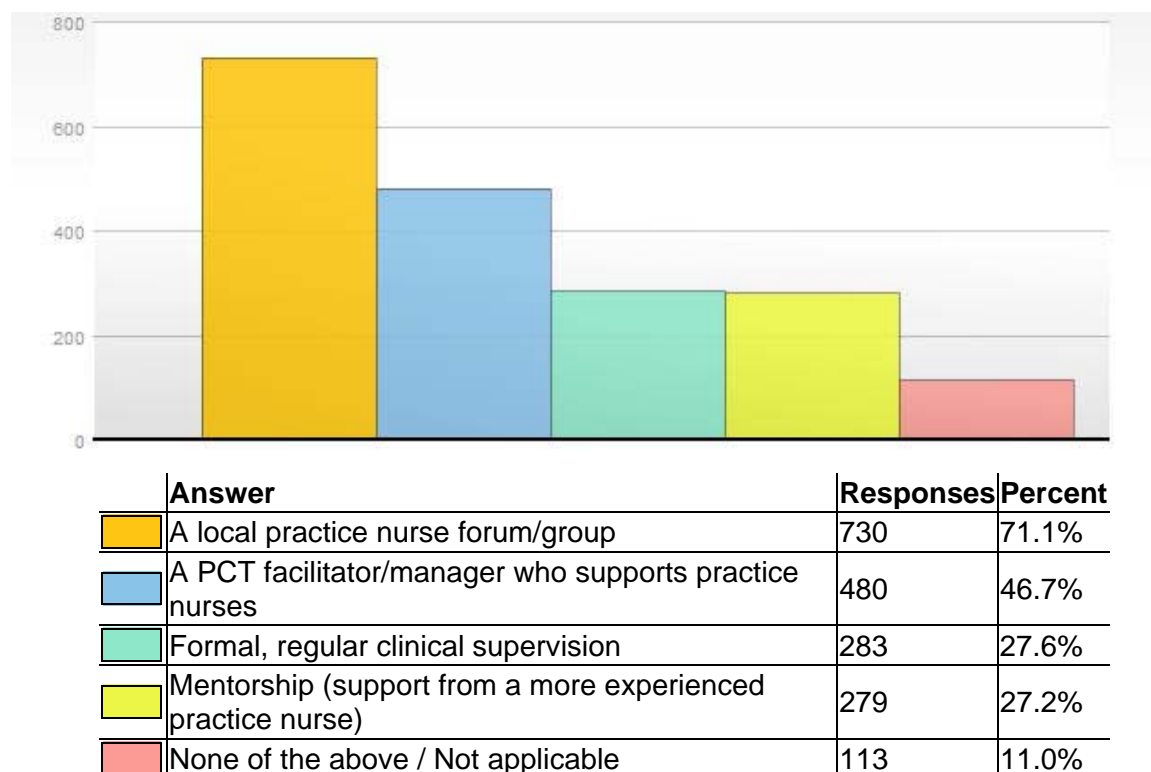
These comments indicate a lack of follow-up study days on the topic but also suggest a blurring of responsibility with regard to prescribing and competence.

2.7 Professional support

Recommendations for professional support looked at access to on-going resources to support the nurses in practice (Fig.10). The responses to this question identified local practice nurse groups as the most available resource (71%). Less than half (47%) had access to a PCT facilitator and many commented that they were likely to lose the one they had due to PCT restructuring. Just over a quarter of the respondents had access to regular formal clinical supervision (27%) and/or a practice nurse mentor (27%).

Considerably higher numbers of positive respondents received clinical supervision (36%) compared to negative respondents (5%). Perhaps surprisingly, mentorship was not more available to those working in bigger nursing teams.

Fig 10. Professional support - do you have access to:



There was no notable relationship between having a PCT facilitator and levels of professional support, standards of employment or access to education, except that slightly higher numbers of nurses with a PCT facilitator said they had education provided by their PCT (90% compared with 81%). A higher proportion of the negative respondents had no PCT nurse (57%) compared with the positive respondents (39%).

2.8 PCT Issues

Many comments focused on recent PCT reorganisations resulting in a reduction in provision of resources for GPNs.

Respondent 353

“With the re organising of the pct's, there is feeling of abandonment”.

Respondent 1289

“In the past training and support has been very good, however due to the lack of funding in the NHS there is no funding support or training for practice nurse. There is no support from the PCT at all or any one to help advise with practice nurses problems/training and a lot of practice nurses are doing their role untrained”.

Respondent 692

"It feels at the moment that we have gone back in time by 10 years and that we are again fighting for recognition and support by the PCT".

Respondent 1310

"The main problem in this area is lack of PCT support- no local lead P/Nurse at PCT level and P/N's no longer have access to PCT funding for university modules, even if they have started a diploma/degree pathway".

Some of these comments illustrated a lack of understanding about the inclusion of training monies in the new GMS Global Sum allocated to GPs rather than being held by the PCT as previously. In addition, the change in PCT role from provider to commissioner has exacerbated the issue regarding practice nurse support. However, from the nurses' point of view, they were acutely aware of a reduction in resources available.

Others commented on the lack of nursing influence in the development and implementation of health policy.

Respondent 920

"PCT and SHA are so involved in doctor's roles and commissioning and re-organising that nursing at either a strategic or practice level is left as an afterthought. It is a constant struggle to get nursing views taken onboard by the health authorities and GP's as a group. It is relatively easy to sort things out at a practice level but there is minimal liaison and input from nurses at grass roots level with senior NHS, PCT, SHA etc."

Respondent 280

"Nurses are the major workforce providing primary care services, meeting QOF and delivering PMS/GMS services but standards, support and monitoring, training provision etc is all left to individual practices to sort out. This leaves everything left to the individual GP's and nurses as to whether their services and practices are meeting a good standard and safe. There is great scope for increased skill mix and nursing advancement in both commissioning and provision of services. It is a great over-sight of the NHS."

2.9 New GMS Issues

The new GMS contract and work generated as a result of it prompted comment from 20 respondents, mostly concerning the Quality Outcomes Framework (QOF).

Two respondents felt this system had benefits:

Respondent 165

"I believe that QOF and nurse management are integral to delivering patient care"

Respondent 801

"Since the introduction of QOF it has improved standards and raised the GP's awareness of the clinical needs of the nurses"

The remaining 18 said that QOF put them under considerable pressure and created a focus on achieving financial targets, sometimes to the detriment of patient care.

Respondent 1188

"I feel that pressure is applied to the practice nurses to reach targets and this can affect quality of care provided i.e. cutting down appt times to fit in more patients etc".

Respondent 1096

"Huge increase in pressure within my role since introduction of QOF, very money orientated service now rather than caring service".

Respondent 808

"I feel that the GPs I work for are only interested in meeting their QOF targets and in being remunerated for locally enhanced services. I am not rewarded for meeting targets (even though my employers are doing very well) and am constantly being put under pressure to take on more QOF commitment".

Respondent 840

"I have become a box-ticker and drug-pusher for chronic disease and am being forced to ignore my desire to treat the person first".

Two respondents linked QOF with deterioration in the working relationship between GPs and GPNs.

Respondent 1211

"As the business of General Practice has become increasingly financially focussed (points mean prizes - QOF) there has been less interest in what nursing staff need by way of training to do the job and more on maximising the number of boxes ticked for the least amount of effort. The GP partners seem to have become de-motivated since the introduction of QOF in respect of innovation".

Respondent 1236

"Previously the GPs were very supportive and approachable and there was good communication between all members of the PHCT. All the nurses felt very well respected as professionals but in the past few years they have become more money orientated. They quibble about us having time for admin, phone calls etc and cannot understand why we don't see patients from the time we arrive until the time we leave. Whereas in the past we were one happy family now we are firmly divided into the doctors and the nurses".

Whilst many of these comments give an insight into the factors that adversely affect nurse satisfaction with support for their role, much of the data identified factors that have a more positive influence.

2.10 Positive Support and GP/Nurse relationship

163 of the 427 respondents (38%) who answered the free text question about support expressed satisfaction with the support and preparation they received for their role. These respondents were usually older (58% aged over 50) than those who made negative comments about support (13% aged over 50) and they used general

terms such as 'supportive' 'fair' 'development encouraged' 'approachable' 'excellent' to describe their practice. The respondents that gave fuller answers specifically identified having meetings, mentorship, clinical supervision and good relationships as being additional key factors contributing to feeling well supported. A recurrent theme was that the respondents felt they were part of a strong team.

Respondent 823

"I work in a very supportive practice, we have weekly meeting with GP's, & other staff members. I also attend clinical supervision meetings monthly & have other nurses to discuss any issues within the practice. One of the GP's has a designated role for responsibility for staff welfare".

Respondent 859

"Very well supported and appreciated within my practice, no problems experienced. You need to have a good relationship with the GP's".

Respondent 316

"Working as a nurse partner have an excellent group of GPs who recognise our worth - we are allowed to run our service without obstacles. All nurses are mentored on monthly basis and education seen as basis of practice."

Respondent 871

"I am employed directly by general practitioners, and they have proved good, supportive employers. They are both fair to, and appreciative of, their workforce. In their employment my professional qualifications and practice have continuously developed, and I have a highly satisfying career".

Some identified mutual respect and assertiveness as aspects of a successful team.

Respondent 477

"Being, assertive but flexible and enthusiastic seems to be the best way to get the best out of the Practice.

Respondent 177

"I think I am one of the lucky ones in terms of where and with whom I work. However it is a 2 way street and nurses need to be vocal about their needs and sell their worth".

Respondent 543

"I have worked for 3 practices. I have found that if the GP's are unable to respect professionally their nursing colleagues then they are unable to support and develop them effectively. I would encourage nurses to be aware of their worth and professional value to their employers and to speak up for themselves where development is concerned or consider moving on..."

This awareness of their own influence and ability to create a better environment seems to be something recognised by very few respondents. The variability in respondents' perceptions of their personal influence was illustrated by two opposing views about the advantages of having GPs as employers.

Respondent 333

"I much, much prefer working for a GP practice than for the PCT!! (which was overly bureaucratic and inefficient). At least now there is an easy and accessible chain of command and I feel respected and my training needs are met. This was NEVER the case in the five years I spent as a District Nurse. GP's are, in my experience, very good employers".

Respondent 448

"Working for GPs who employ us makes it difficult to complain or change things, as you are beholden to them"

These comments suggest that where the respondents felt confident about their working relationship with GPs, they saw general practice as a workplace with many benefits. Conversely, if respondents did not feel confident, this seemed to affect their whole outlook. The most negative comments came from nurses who appeared to feel very powerless using words like 'undervalued' or 'handmaiden', indicating that they did not consider they had an ability to influence the situation and lacked a sense of empowerment.

Respondent 680

"Generally feel unsupported and undervalued. Things usually move forward if the GP's want it to".

Respondent 1194

"I am only a "workhorse""

Respondent 761

"We are still often made to feel we are just employees and should "know our place".

Respondent 840

"If a query is raised they remind us of how many unemployed senior nurses there are available."

Respondent 1265

"Often the nurses feel like handmaidens and, although are pushed/encouraged to take on more responsibilities and training, do not see this reflected in their pay packet".

One respondent challenged this balance of power, seeing it as inappropriate in a professional sense.

Respondent 1291

"It seems crazy to me that one profession should be able to dictate the professional development of another profession".

This respondent demonstrates a sense of recognising the rights of nurses to assess their own development needs but stops short of articulating the ways in which this

should be achieved. This apparent impotence was further illustrated by one nurse who claimed to have no opportunity to develop her potential in general practice.

Respondent 1349

"I don't feel that I have any opportunity to progress educationally at the practice. There will be no opportunity for promotion for a very long time. I have asked for education at level three but have been turned down. I have no support at the practice in combating this problem. The development of practice nurses is not a key issue as it does not form part of what the GPs and manager see as a benefit to the needs of the practice. Very limited, extremely frustrating place to be when there is so much potential in primary care for nurses, and able, enthusiastic, determined nurses who are unable to access the opportunities available because GPs don't see a need."

2.11 Sharing Responsibility

A minority (10%) of those reporting positive support displayed recognition that they should make their own contribution and take some professional responsibility for seeking appropriate support.

Respondent 786

"I do a lot in my own time - realising that if I want to develop I need to take responsibility and go beyond what is available through work"

Respondent 834

"Luckily as a Nurse we have a competency and accountability requirement in our code. I always ask myself if I have met these. I have always been someone who reads a lot and keeps up to date whereas I have found other colleagues do not bother"

Respondent 1267

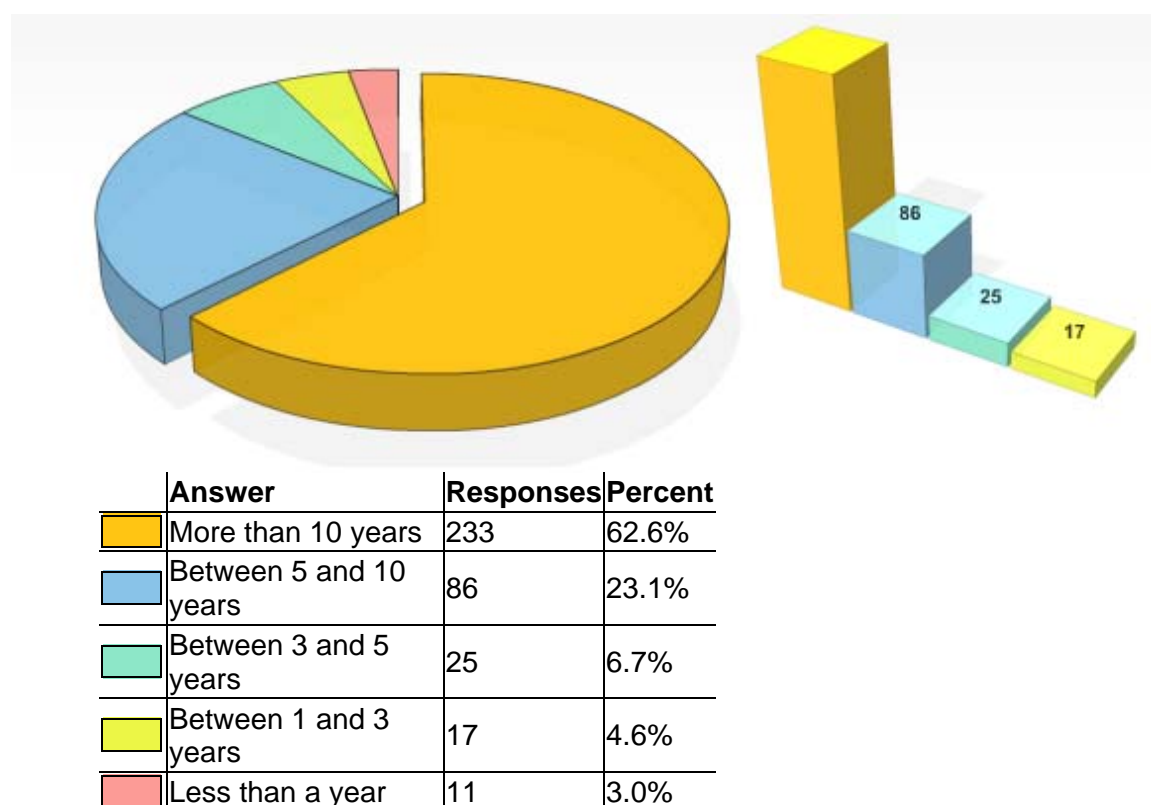
"My GPs have been happy to encourage and support, but also required a commitment from myself e.g. I had to pay my own fees for my Adv NP course, and substantial travel expenses (200 mile round trip once weekly for 3 years), and the first year do in my own time, with 4.5 hours paid weekly leave the next 2 years, but training support and mentorship was willingly given"

These nurses also commented on the benefits of effective team working, in terms of good collaboration and shared goals. Their comments displayed a positive attitude towards their practice, despite sometimes having no better access to courses or professional development resources than those who complained about the lack of these. On balance taking all the comments as a whole there are indications that overall, those nurses who are positive and demonstrate assertiveness, experience better support.

2.12 Decision-making

The question about decision-making explored the extent to which nurses felt involved in decisions about nursing matters within their practice. The results showed a strong link between high levels of involvement in decision-making and positive comments about support, with 70% stating they were 'very involved'. This contrasted with the group who made negative comments about support, where 5% of the group reported being 'very involved' in decisions. There were clear relationships between length of service, size of practice and level of involvement in decision making. Generally those in practices with fewer GPs tended to be more involved in decisions, with the optimum being 2 partners. Of those who said they were very involved, 63% had been in practice for over 10 years (Fig 11).

Fig 11 Crosstab: length of service with decision-making – very involved



2.14 Size of Practice

Despite individual comments to the contrary, there was no relationship between size of practice, measured by number of GPs, and levels of actual professional development support received. Some nurses attributed aspects of good support to the size of the practice, for example, small practices making communication easier, or large practices affording more opportunities for development, but the data did not

support these assumptions. Bigger practices did have better employment conditions and there was a link between this and positive comments from the respondents but this did not equate to better induction, training or support.

3. Discussion

One of the key criteria used in making a judgement about the value of a study is whether the conclusions derived from the study have any reality in the wider setting. In qualitative research this is referred to as transferability (Lincoln and Guba 1985) and involves demonstrating similarities in context and characteristics between the sample and the parent population. Ritchie and Lewis (2003) suggest that establishing whether a sample achieves this depends on the degree to which the sample represents the parent population in terms of inclusivity, by containing the diversity of issues central to the parent population and therefore achieving saturation.

The extent to which this study achieves transferability can be partly determined by assessing whether the sample allowed for inclusion of all the issues of importance to the total practice nursing population. This is reflected by the consistent repetition of themes by respondents and the fact that once a critical number had been collected (120 responses or 10% of the sample), no further themes were introduced thereafter. In addition, the sample represented a broad range of size, type and location of practice setting.

The survey findings provide current national data about the support practice nurses receive for the work that they do. Many of the issues regarding access to professional development highlighted in the literature remain unresolved, despite recommendations in professional guidance (RCN 2005), policy (DH 1998, 1999b) and local and national frameworks (Torbay and Teignbridge PCT 2005, Scottish Executive 2004, WiPP 2006). Many of these are linked to employment conditions and Human Resources Management (HRM) and there is documentary evidence that effective HRM has a positive association with performance (Hyde et al 2006, Rafferty 2005, DH 2007). The survey identifies characteristics that are linked to nurses feeling positive about their professional development. It is possible that putting such elements in place when they are absent could influence nursing staff, making them feel more positive and more likely to use opportunities. The survey identifies good terms of employment, effective team working, regular meetings, mutual respect and inclusion in decision-making as factors linked to nurses feeling positive about professional development. Providing this information to GPs and practice managers

may help them to improve the recruitment and retention of high quality nursing staff, thereby enhancing practice performance.

The findings also show that nurses identify, mentorship, clinical supervision and access to education as important factors in professional development support for their work and this is supported by the literature, which demonstrates the role played by these factors in achieving and maintaining competence (NMC 2006, DH 2007). The provision of these resources is inadequate in places, thereby making nurses and patients vulnerable and jeopardising safe practice.

According to the survey, education provision does not always meet the needs of the nurses and this again is supported by the literature (Longbottom 2006). Even where appropriate courses are available, barriers to access include funding and being released from work to attend. The biggest demand is for regular study days to update knowledge across a broad spectrum of topics and these are locally available for less than half of the survey sample

There is limited evidence that some nurses may be carrying out tasks that they are not trained to perform, and this has implications for public safety. It is also in breach of nurses' professional code of practice (NMC 2004).

Conclusion

In summary, the main factors identified by the respondents in this survey as important for maintaining professional development are supported by NHS policy and professional guidance documents. There are gaps in the provision of these in practice.

Continued wide variability in employment standards within general practice and inequitable access to external resources to maintain clinical competence could have implications for the quality of patient care and these issues should therefore be investigated further.

Recommendation

The results of this survey should be shared with those in a position to consider the implications in relation to the full political and professional context, with a view to addressing the consequences of continuing inequalities in professional development support for General Practice Nurses.

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Appendix (i)

Copy of pdf questionnaire

Appendix (ii)

Summary of standards from 'GPN Toolkit'-All practice nurses should:

<p>Employment</p> <p>Have a robust contract, within 2 months of commencing employment</p> <p>Have a comprehensive job description</p> <p>Have current NMC registration</p> <p>Satisfy the PREP requirements for practice</p> <p>Have at least one year post-registration experience</p> <p>Have their pay linked to AfC through the KSF</p> <p>Have a clear line of managerial responsibility</p> <p>If the GPN has responsibility for managing others, she has had appropriate training</p> <p>Have protected time for CPD</p>	<p>Training and Education</p> <p>Complete an in-house induction programme for first two weeks with an identified member of staff</p> <p>Complete a foundation practice nurse course within one year of employment</p> <p>Have access to an identified mentor; a senior practice nurse to support them in their new role</p> <p>Have a clear study leave policy</p> <p>Have an annual appraisal</p> <p>Compile a PDP with which agreed goals and action plans</p> <p>Complete training courses relevant to the level of the job they are employed to do (see grid below)</p> <p>Have annual mandatory training (eg.anaphylaxis)</p> <p>Receive appropriate training for any new or advanced roles</p>
<p>Professional development support</p> <p>Regularly attend practice team meetings with GPs</p> <p>Have a source of professional advice and support outside the practice</p> <p>Belong to a professional organisation or union</p> <p>Work within their scope of competence</p> <p>Have access to regular, formal clinical supervision</p> <p>Belong to a local practice nurse forum/group</p>	<p>Quality</p> <p>Have their competence in a new role assessed by the practice</p> <p>Regularly update protocols based on the latest national guidance</p> <p>Maintain a 'competence file' providing a safe record of what they can and cannot do</p> <p>Engage in peer review</p> <p>Practice is involved in Quality Team Development and Quality Practice Award</p> <p>Carry out regular audits</p> <p>Evaluate patient satisfaction with GPN care</p>

Appendix (iii)

Participant Information Sheet

The Working in Partnership Programme (WiPP) web-based General Practice Nursing Toolkit was launched in November 2006. The project was funded by the Department of Health and the Toolkit was developed to provide a range of stakeholders including practice nurses, practice managers, GPs and PCTs, with the tools to increase skills, enhance the practice nursing image and improve recruitment and retention. However it is difficult to assess the impact of the Toolkit, as at present, there is still a lack of accurate information regarding employment conditions and professional development support amongst the practice nurse workforce. In addition, resources to support some of the recommendations made in the Toolkit, such as training programmes and clinical supervision, are not available universally, and those that are do not always conform to consistent standards. Depending on where they practice, nurses working in general practice have very different experiences in relation to access to training and working terms and conditions. Therefore as part of the WiPP programme, this national survey is being carried out to investigate the realities of working as a practice nurse, to establish a national profile of the levels of preparation and support they receive for the work that they do and gaps in the provision of professional development resources.

The on-line survey, which can be accessed on the WiPP website (www.wipp.nhs.uk) is quick and simple to complete. Participation is anonymous and therefore totally confidential. The results will be presented to the Department of Health and published in the nursing press.

The researcher, Sue Crossman, is a lecturer in primary care nursing at University of East Anglia and has experience in carrying out surveys in general practice nursing. Sue can be contacted by email on suecrossman@netcom.co.uk or by telephone on 07799 054112.