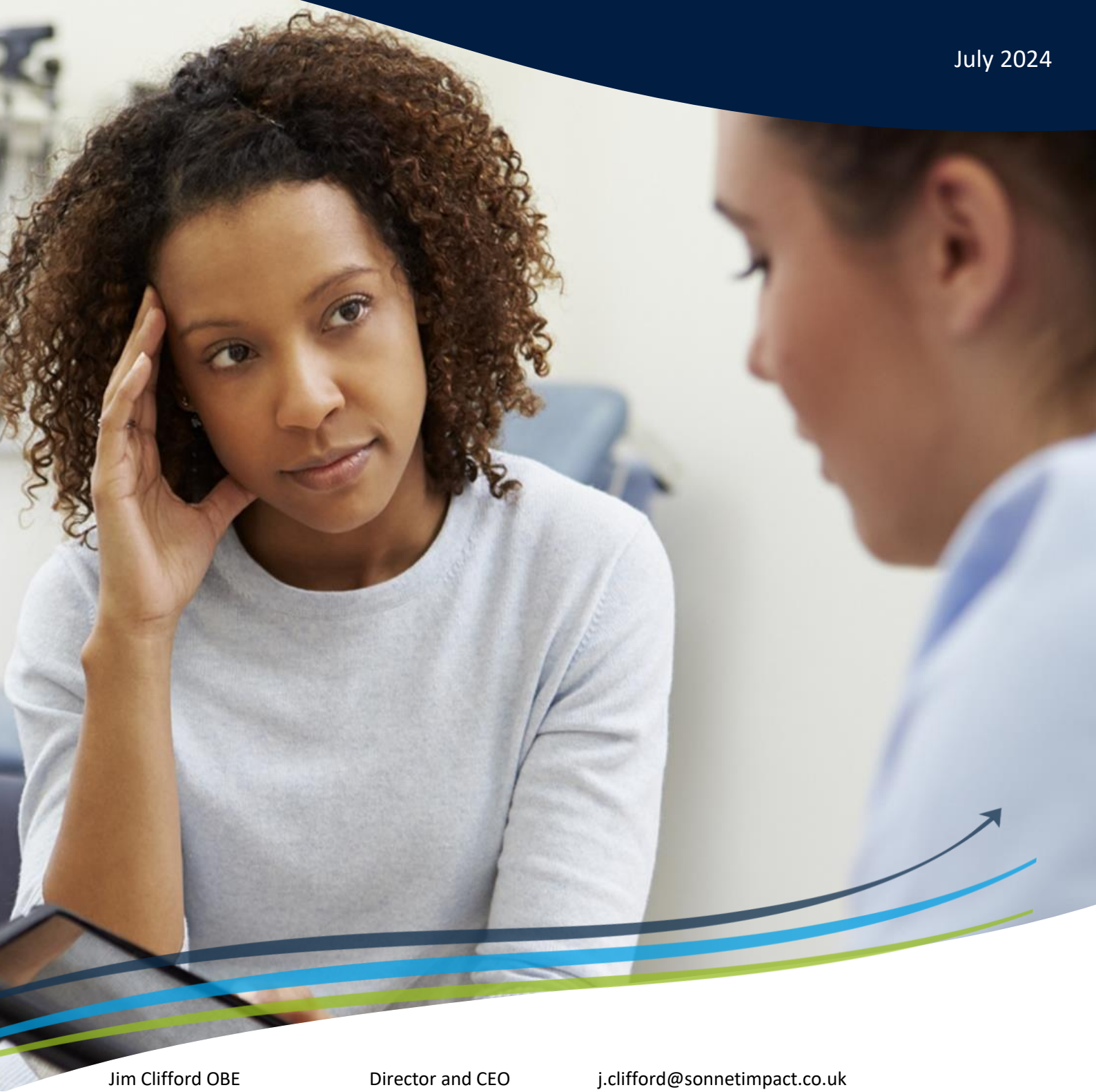
Leading the Way:

The role and value of nurses in general practice in England

Phase Three report

July 2024



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Forewords

Foreword from Paul Vaughan RN MSc

In the rapidly evolving landscape of healthcare, the role of General Practice Nurses (GPNs) has never been more critical. As the backbone of primary care, GPNs serve not only as caregivers but also as leaders, innovators, and advocates for community health. This report, "Leading the Way: The Role and Value of General Practice Nurses", is the culmination of comprehensive research commissioned by NHS England to illuminate the multifaceted contributions of these essential healthcare professionals.

General Practice Nurses operate at the intersection of clinical excellence and community engagement, providing pivotal services ranging from childhood immunisations to the management of complex long-term conditions. Their ability to prescribe and their involvement in specialised care programmes highlight their indispensable role in the healthcare ecosystem. Yet, despite their extensive contributions, there remains a significant gap in understanding and appreciating the full scope of their work and the impact they have on patients, practices, and the broader NHS.

This report is the third phase of a detailed investigation into the unique value GPNs bring to the health system. It builds on the findings from previous phases, which involved engaging with nurses and other healthcare professionals across multiple regions in England. By employing a mixed-method approach, including surveys and qualitative interviews, this research provides a robust analysis of the skills, knowledge, and best practices of GPNs, as well as the challenges they face.

The findings affirm that GPNs are pivotal in driving better health outcomes, reducing the need for secondary care, and enhancing the efficiency of primary care practices. They are the "super-connectors" of the health system, seamlessly integrating care at both regional and practice levels. However, to fully leverage their potential, it is crucial to address the barriers to their recruitment, retention, and professional development.

The recommendations put forth in this report aim to enhance the support and recognition for GPNs. By improving their career prospects, aligning their remuneration with their contributions, and ensuring their representation in

decision-making processes, we can unlock the full potential of general practice nursing. This not only benefits the nurses themselves but also translates to better care for patients and more resilient healthcare systems.

It is essential to acknowledge the dedication and expertise of General Practice Nurses. Their commitment to improving population health and their ability to adapt and innovate in the face of challenges make them invaluable to our healthcare system. This report is a testament to their vital role and a call to action to ensure they receive the support and recognition they deserve.

I would like to thank the Sonnet team, especially, Jim Clifford, Emily Hunter and Emily Hutchison, Sheffield Hallam University, Louise Brady, Primary Care Nursing Lead, NHS England, and GPN and practice staff across England that have contributed to this important and significant piece of work.

Paul Vaughan RN MSc
National Deputy Director – Community Nursing and Primary Care Nursing
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Foreword from Jim Clifford OBE MSc FCA FRSA

In the words of Aneurin Bevan in 1952, looking back at the founding of the NHS, "No society can legitimately call itself civilised if a sick person is denied medical aid because of lack of means." He was referring to financial means, for the most part, but, faced with the same question today, the "means" are also NHS capacity, its reach, and having suitable capability to meet the health needs of all the population. Much has changed since 1952 and whilst Bevan's and others' vision of free health services for all at the point of access has become a treasured reality in the UK, it has posed new challenges. The response of our health services through the COVID pandemic has become the stuff of legend, but what about growing numbers, an ageing population, living longer and looking to keep living well with multiple longer-term conditions?

In the two reports (2021 and 2022) on our earlier Leading the Way research we recognised the demands on Primary Care under the NHS Long Term Plan. In that work – the first to explore the role and value of nursing within general practice in England – our mixed-methods study with participants from many parts of the NHS and beyond identified and articulated what GP nurses do and how they bring value. Their skills – clinical and organisational, their insights into how people live and interact, their long memory in dealing with the same families over generations, the way they interact with patients, responding to their needs: all these and more make up this key third of the primary care workforce. The stories, evidenced and robust, of the value they bring in that were striking.

In the pre-publication review of findings, and in the professional response post-publication, the view was a firm "…that's right: that's how it is…" It left three further questions: how widely is that model seen in GP practices across England; where it isn't seen, what is getting in its way; and is there another model that also works? These have been answered in this, the third volume of Leading the Way. Built on further exploration of nurses' personal stories and experiences, and those of other professionals, it led into an England-wide survey of GP practices, spanning large and small, federated or grouped and standalone, urban and rural areas, with many nurses, with few or with none. The response rate to the survey was high, generating high confidence in the results, even allowing for the point that those that answer tend to be those most interested.

Now we have a more detailed view of how the model appears in different contexts. Nurses are bringing huge value to practices across the country, but differently in different ones. They enable those practices to meet their

patients' needs more deeply and more effectively than without their involvement. There are areas of practice in which they are most involved, and we have identified a number in which they could be more involved for the benefit of patients and practices alike.

General practice is unique within the NHS in that it is a network of private businesses delivering publicly funded services, rather than a group of public bodies. If we are looking for change to happen to embrace the opportunities identified, it needs to work for those businesses from their own perspectives, and not just for the wider public service delivery. This work shows that It does, and identifies how the practices can benefit too.

We, the research team, are so very grateful to all the wonderful nurses and other professionals who have helped us as we have explored your world. We hope you will embrace these findings and build upon them in pursuing Bevan's lasting vision of a society in which a sick person is never denied the right medical support because of lack of means.

Jim Clifford OBE MSc FCA FRSA
Director and CEO, Sonnet Advisory & Impact
Hon.Professor, Sheffield Hallam University

Executive summary

Introduction

General practice nurses (GPNs) are Registered Nurses regulated by the Nursing and Midwifery Council working across a range of roles offering a breadth and depth of expertise and skills in partnership with patients and families across the life course. General practice nursing teams lead programmes of care in areas including childhood immunisations, complex long-term conditions, cervical screening and women's health initiatives. In addition, as the workforce closest to their communities, they play a key role in the delivery, organisation, and co-ordination of primary care. GPNs provide care across every village, town, and city in England and fulfil key non-clinical roles in their practices.

This report is the third part of the *Leading the Way* research commissioned by NHS England to close an evidence gap around the role and value of general practice nursing. This work represents the first detailed research into GPNs and their role; it was the first time their role had been fully articulated and its unique value explored.

This research has been carried out in three phases:

- Phase One: Working with nurses and other professionals in three NHS regions (Nottinghamshire, London, and the South-West) to build and test a hypothesis around the role and value of GPNs[1]
- Phase Two: Further testing the hypothesis with practices from two additional NHS regions (the South-East, and the North-East and Yorkshire), developing a model of best practice for general practice nursing, and valuing the outcomes it brings to practices, patients, communities and the wider NHS[2]
- Phase Three: Testing the extent to which the best practice model identified in earlier phases is seen across England

In Phases One and Two we undertook focused research activities with nurses in six regions of England. In this third phase of work, we invited all practices in England to take part in our research. We took a mixed method approach across all phases: the application of that in Phase Three is outlined in Table 1.

It is vitally important that there is a good understanding across the whole health system, and not just in primary care, of the vital role that nurses play in general practice and the difference they make. Findings from Phases One and Two of this research have been used to inform and influence policy decisions within NHS England. Given the prior limited evidence base, findings have been used as a basis to make a case for investment in general practice nursing. Furthermore, the work has been used in local health systems and by nurses to demonstrate the value they add to their colleagues in these systems.

[1] Clifford, J., Barnes, K., Arora, R., and Raouf, S. (2021), Articulating the role and the value of nurses in general practice in England: Interim report. London: Sonnet

[2] Clifford, J., Barnes, K., Arora, R., and Raouf, S. (2021), Leading the Way: The role and value of nurses in general practice in England. London. Sonnet Impact.

Table 1: Summary of Phase Three methodology

Stage	Description	Number of participants
1. Stratification survey	This survey sought a true picture of the skills and knowledge mix in the GPN workforce. This information also provided a foundation for the next stage of research (qualitative interviews).	• The total number of responses was 299[3]
2. Qualitative interviews	Interviews with a selection of practices recruited via the stratification survey. These interviews assessed the extent to which the practices adhered to the best practice value-enhancing model of practice nursing identified in Phases One and Two, and informed the questions and scope of the survey of all practices.	• 19 interviews with 19 different practices • Only one practice did not employ a nurse at the time of the interview
3. A survey of all practices	The survey tested the extent to which the best practice model is seen across England. The survey gathered information about practices' workforces (the team members were involved in clinical and non-clinical activities) and their perceptions of general practice nursing.	• 967 responses, among which there was a maximum of 905 individual practices, representing 14% of all practices in England in 2023

In this report, we use the terms 'GPN', 'general practice nurses' and 'nurses in general practice' interchangeably. Within this group we do not include healthcare assistants (HCAs), whose qualification and supervision routes are different. Nursing associates are also not in the scope of this work as they are not Registered Nurses.

Findings from across the three phases of our *Leading the Way* research

Nurses bring significant value to patients, practices and the NHS

The role of nurses has evolved significantly from the traditional 'support-the-doctors' model to one in which nurses are a key part of our health system, close to patients and communities, playing an essential part in the daily running of general practices across England.

GPNs are very skilled and well-qualified professionals who have significant insights into the challenges facing patients who are living ever longer with long-term complex conditions. Encompassing knowledge in homeless health care, mental health, and learning disabilities, the GPN workforce can consistently marry the connections between practice, policy, education, and housing to improve population health.

From our research we identified that GPNs have a long history of connecting and engaging with the social determinants of health. GPNs have the opportunity to get to know patients, their families and circumstances, and

[3] Of these 299, 15 were identified as duplicates – i.e. a second response from a given practice.

can see the difference that they make in their patients' lives and to their health outcomes. Often patients feel comfortable to talk to nurses informally, disclosing information that is key to unlocking better health outcomes for them. Using the additional information shared by patients, nurses can identify the need for screening or diagnostic tests, and can recognise mental health needs or other support needs.

GPNs are hugely valuable because the work they do, and the way they do it, which leads to better outcomes for not only patients but also practices, their wider communities, and the NHS as a whole. Our research found that nurses are super-connectors, at regional and at practice levels; working in an integrated way comes naturally to most nurses.

The change nurses can drive and the value they can bring in health systems was explored via case studies in our earlier research.[4] In both of these case studies the impact of the nurses' activity was to improve health outcomes for affected patients and to reduce the need for treatment in secondary care. The nurse-led change programme of clinic redesign in Bath and North East Somerset explored in our earlier study is now bringing efficiencies and reach across 24 practices (see Figure 1 overleaf). The improved outcomes to their practices, patients, communities and the wider NHS as a result of this programme were valued at £5 million per year. Our earlier research also highlighted nurses' potential impact on the wider care environment, as demonstrated in the case study from Tower Hamlets. Nurses led a programme of change training care home staff to keep elderly residents hydrated, thereby reducing UTIs and burdens on local healthcare systems, and improving the residents' quality of life.

Nurses are leading the way in some practices and in select clinical areas across practices in England

Evidence from this latest phase of research shows that nurses are leading the way across England in select clinical areas in primary care. For example, nurses lead respiratory and diabetes services in the vast majority of practices in England: in 85% and 86% of practices respectively.

From our survey results we can see that in practices where nurses led services for cardiovascular conditions, nurses were more likely to be involved in a wider range of leadership and non-clinical activities. In these practices nurses also tended to lead services for respiratory conditions (99% of these practices) and diabetes (96%). Nurses led frailty services in a much higher proportion of these practices (34%) relative to the full group responding to our survey (19%). Practices where nurses led services for cardiovascular conditions were also more likely to involve nurses in non-clinical activities like training and mentoring staff, change management and networking with other healthcare professionals.

[4] Clifford, J., Barnes, K., Arora, R., and Raouf, S. (2021). Leading the Way: The role and value of nurses in general practice in England. London. Sonnet Impact.

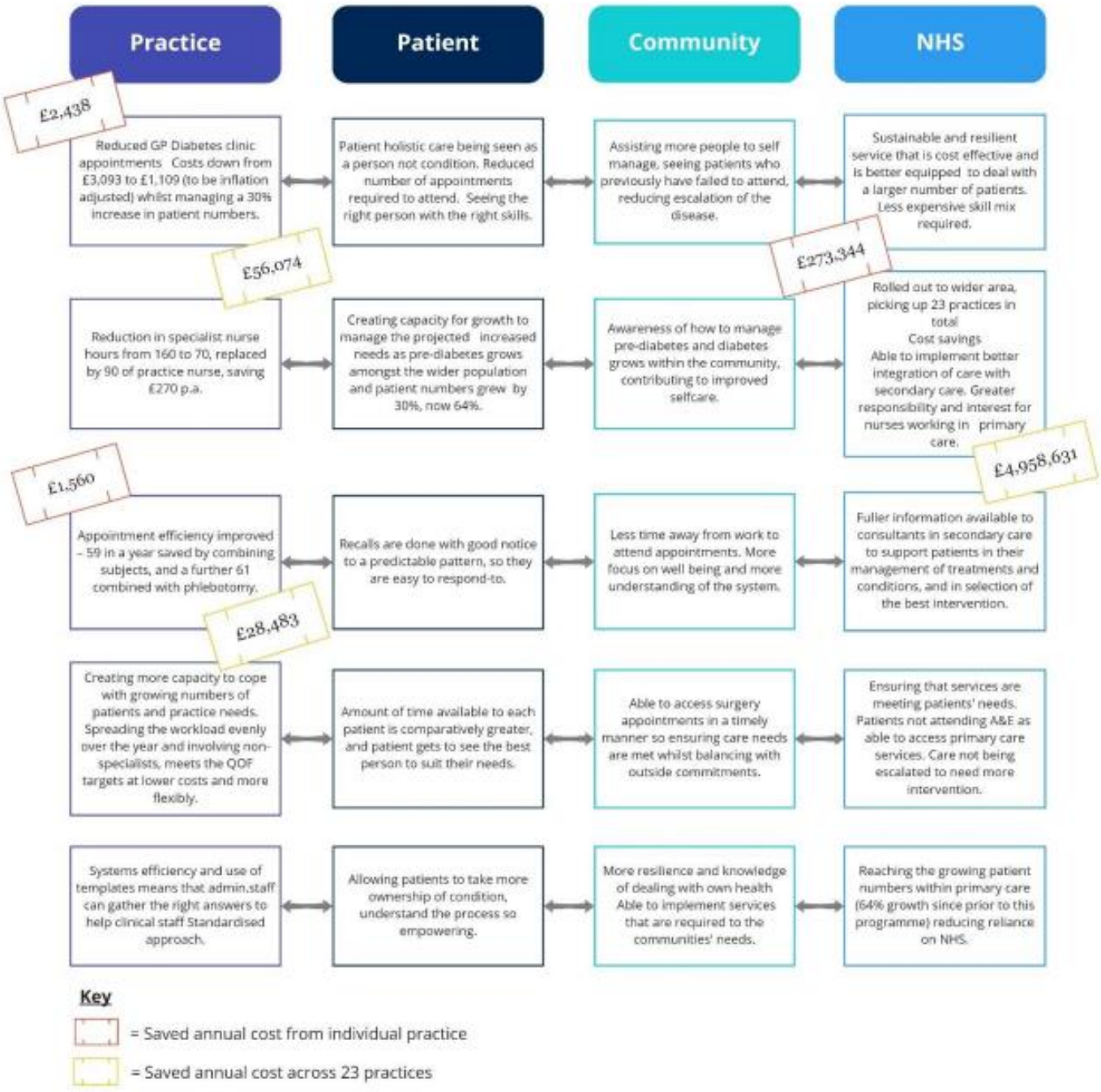


Figure 1: Diabetes clinic redesign case study

It appears that where practices are aware of the significant value that nurses can bring, this carries across all areas of their activities. In these practices nurses are more likely to reach their full potential. This may be facilitated by the size of their nursing workforce: practices that deployed nurses more effectively tended to employ a higher number of nurses on average. As a result of adhering to the best practice model of general

practice nursing, these practices were likely to gain additional income, to be more efficient in-service delivery and to deliver a good quality of care.

We found that practices in the South West were more likely to adhere to our GPN model of best practice. It is possible that regional governance – coordinating and working collectively – has made a difference to the experience of GPNs in the South West. This regional governance encompasses:

- A Nursing lead at regional level
- A link to the Primary Care Workforce Steering Committee
- Links to higher education and specialist training
- A centrally funded scheme that has proved nurses with no experience in general practice can thrive in their roles
- Activities to promote the CARE Programme
- Awards to celebrate GP Nursing

These are the specific areas of opportunity for greater GPN involvement and leadership

The NHS Long Term Plan set an ambition to 'support pharmacists and nurses in primary care networks to find and treat people with high-risk conditions' like cardiovascular disease.[5] However, in only a third of the practices responding to our survey did nurses lead cardiovascular services.

We found that nurses' skills and insights are well suited to leading cardiovascular, frailty and mental health services in particular, and there is much greater scope for GPNs to take on leadership roles for these in practices across England **(what we call 'Opportunity 1')**. We also see further opportunities for nurses to lead services for women's and men's support and sexual health[6] and learning difficulty health checks.

Our findings also show that there is greater scope in many practices for nurses to be involved in the following non-clinical activities (to which nurses' skills and insights are also well suited):

- Leading staff training, mentoring and management – these are key to developing a sustainable succession of nursing skills within each practice and more widely across primary care **(Opportunity 2)**
- Managing the ask of QOF, external networking and partnering with external agencies **(Opportunity 3)**
- Change management – nurses could lead programmes of change that would yield value to patients, practices and wider health systems

[5] Online version of the NHS Long Term Plan, Chapter 3: Further progress on care quality and outcomes, Better care for major health conditions, Cardiovascular disease, paragraph 3.69

[6] More nurses with women's health and women's sexual health as areas of specialism in primary care would help support deliver the aims and objectives of the 2022 Women's Health Strategy for England.

If practices across England were to harness nurses' unique mixture of skills and knowledge more effectively this could support more efficient delivery, more tailored and holistic care for patients, and communities' needs being better met.

This potential of GPNs has been recognised in other sector initiatives and strategies

Our research findings very much reflect observations and recommendations from other sector initiatives and strategies that recognise the potential of general practice nursing. The Long Term Workforce Plan recognises how nurses, with their holistic understanding of patients' needs and population health, can tailor primary care delivery to meet their communities' need more effectively.[7] A more active role for nurses in care planning and delivery should support primary care to meet its new scope per the NHS Long Term Plan.

Indeed, the Chief Nursing Officer Strategy emphasises that nurses could be playing key roles (where they aren't already) in:

- Prevention, protection and reducing health inequalities
- Person-centred practice
- Professional leadership and integration of care

This strategy also recognised that for nurses to be able to play these roles, support needs to be provided in the form of people and workforce development and facilitated by a more inclusive culture.

Recruitment and retention of GPNs are significant challenges

General practice nursing is hugely rewarding and satisfying, offering scope for progression, choice and autonomy. However, it is still not a well recognised or fully understood branch of nursing. General practice nursing is an exciting career opportunity that is hiding in plain sight. This is reflected in the challenges in retention of the current workforce and challenges in recruiting into GPN roles. In summer 2023 there were nursing vacancies in 22% of the 905 practices that responded to our survey.

Our research identified recruitment and retention as the key challenges to general practice nursing reaching its potential. These challenges are driven by several risks and barriers and are explored in this report, and an overview of these is provided below.

Challenges in recruitment are also likely to stem from a nursing role and offer that lacks a formal structure in terms of career progression and pay transparency that nurses have in other parts of the health system (notably NHS trusts). Nurses' terms and conditions are not consistent, getting in the way of creating a clean and vibrant 'market' in which there is a flow of talent around the sector. GPNs are employed directly by the practices themselves and are an integral part of the NHS system. However, each general practice operates as an

[7] NHS England (2024), NHS Long Term Workforce Plan

independent small business and delivers services under contract to the NHS, so decision-making about recruitment, retention and involvement is made across a network rather than determined centrally.

General practice has rarely been a 'first choice' career for newly Registered Nurses, and it is reported that many nurses only make a move to general practice mid-career, often because the role is flexible enough to fit around family life and other commitments. This does not need to be so: nurses can have great and developing roles in general practice, even from early in their careers. Training pathways need to develop, and the opportunities for young nurses to experience general practice at an early stage need to be there. It is important not to focus on the short term either – by investing in new talent each practice will improve primary care's collective access to talent for the future.

Difficulties in retaining nurses are driven by four factors. The first is pay and employment terms and conditions that do not reflect the value nurses bring. The second is that many nurses feel disempowered and that their concerns are not heard at leadership level (locally and nationally, and sometimes even in their own practice). The third is that nurses have faced problems in accessing opportunities for education and training. While there is the infrastructure available to support nurses to engage in training and development, we heard many examples of nurses not being able to access this or not having the time to complete training and development activities. The fourth factor is colleagues' lack of understanding of and appreciation for the role of nurses and what they do. Of the nurses taking part in our survey 21% disagreed or strongly disagreed with the statement that 'The role that nurses carry out within the practice is well understood by colleagues and patients'. Our research shows that nurses' clinical knowledge, expertise and skills are vast and complex yet are often downplayed or poorly articulated by GPNs themselves and underestimated by others.

Recommendations

The full value that a highly skilled and effective general practice nurse workforce can bring to its practices, patients, communities and the NHS is significant. If we want to ensure that this value is realised and nurses are able to reach their full potential, we need to make a range of changes to support them. We believe that the recommendations below would address the issues identified in this research.

It is worth noting that these recommendations align to those of the Fuller Stocktake report[8] into primary care that, recognises the potential benefits from:

- A more consistent and comprehensive training, supervision and development offer across primary care – including for practice nurses
- Retention strategies across early, mid and late career retention scheme covering nurses (and other roles)
- Better utilisation of nurses (among other roles)

[8] Dr Claire Fuller (May 2022), Next steps for integrating primary care: Fuller Stocktake report

Recommendations

We have five specific areas of recommendations arising from the cumulative learning from Phases 1, 2 and 3. These are as follows:

1. ***Improve the offer to general practice nurses***
    a. Socialise the implementation of Primary Care & General Practice Nursing Career & Core Capabilities Framework.
    b. Introduce remuneration for general practice nurses that aligns with the scope of practice and career progression for nurses.
    c. Ensure remuneration for general practice nurses is consistent across primary care and general practice.
    d. The terms and conditions[9] of general practice nurses need to be reviewed to be made consistent and comparable with those of other nurses working across the NHS.
    e. Ensure the sustainability of education and training budgets so that recruitment and retention of general practice nurses are supported and sustained. Here are some evidence-based and recommended examples of best practice:
        i. Legacy Mentorship
        ii. Nurses on Tour
    f. Seek commitment from employers to release nursing staff from delivery so they can undertake mandatory and discretionary training.
    g. Make student nursing placements in general practice easily obtainable and give practices the resources they need to manage these placements at Place level.

2. ***Nurses should be represented and empowered at every leadership level in the NHS***
    a. Nurses should have a key influencing and decision-making role in policy, practice, and education at every leadership and managerial level. They therefore need to be part of decision-making forums:
        i. At practice level
        ii. At primary care network (PCN) and integrated care board (ICB) level
        iii. In national forums

3. ***Improve awareness and understanding of the GPN role***
    a. Campaigns to raise awareness and understanding of general practice nurses should be targeted at:
        i. The general public
        ii. National policy makers
        iii. Whole primary care and community teams
        iv. Wider NHS staff
        v. Potential nursing recruits

[9] We note that key stakeholders are working together on T&Cs now, which is promising.

4. ***Address nurses' unsustainable workloads***
    a. Create more capacity for nurses to:
        i. Offer supervision to staff working in primary care and in general practice
        ii. Utilise and embed the professional nurse advocate role
    b. General practice and primary care nursing teams need to be integral to the Long Term Workforce Plan.
    c. Nurses need to ensure that they are using the breadth and depth of their expertise to work with local communities to create health, wellbeing, and social value for and with populations.
    d. Health systems need to encourage innovative ways of working in primary and community care to improve population health outcomes and support the workforce, e.g. utilising group clinics.
    e. Health systems should explore collaborative ways of working across primary and secondary care, drawing on the expertise of nurses in identifying innovation in services and harnessing their skills and expertise to deliver these new ways of working.

5. ***Continue research into practice nursing***
    a. There should be ongoing empirical research into the general practice nursing role and, given new ways of working across health systems, this research also needs to explore the role of community nursing colleagues.
    b. The NHS should develop research capabilities among general practice nurses and support the development of clinical academic career roles across primary and community care.
    c. NHSE and ICSs should support the application and conclusions from research studies into the general practice nursing profession.

1. Methodology

Phases One and Two methodology

This is the third phase of *Leading the Way* research into general practice nursing.

Phase One explored the experience of nurses in general practice by drawing together groups of nurses from practices in three areas of England. In two workshops they explored their own situations, the situations of their patients, and the way nurses worked within their practices. Findings from these workshops were drawn into initial views of how nurses worked, and the value nurses brought to their practices, patients, communities and the NHS.

Phase Two took that emerging story and tested it in three new areas of England, again with groups of nurses from different practices. Once we had a clear view of the value nurses deliver and how, we developed case studies of nurse-led change programmes and treatment journeys for patients. We valued these case studies to show the economic impact of what was being achieved by nurses.

The methodology underpinning Phases One and Two of *Leading the Way* is explained in Figure 2.

Figure 2: Methodology for Phases One and Two

Phase Three methodology

In Phases One and Two Sonnet identified the best practice model of general practice nursing. To build on findings from these earlier phases, the research questions for Phase Three were:

1. How widely seen is the best practice model of general practice nursing across England?
2. Which aspects come through most strongly and which are less recognised and delivered across England?
3. Where nursing in general practice is not showing this model, what is happening instead?
4. How can the model of best practice can be updated, and what all of this tells us about what NHS England can do to improve and enable the more effective delivery of value through general practice nursing?

We took a multi-stage mixed methods approach to Phase Three research (summarised in Figure 3), and below we describe each stage of research and who took part in each stage.

Figure 3: Mixed methods approach to Phase Three of this Leading the Way research

Stage 1: Stratification survey (led by Sheffield Hallam University with Sonnet support)

We designed and deployed a short, five question survey to gather data on the nursing workforce in practices across England. The purpose of this questionnaire was to understand the extent to which practices had a nurse staffing mix that aligned to the best practice model identified in Phases One and Two of this research. This questionnaire also sought to gain insight into the skills, qualifications and knowledge of the GPN workforce. To see the questions asked in this survey see the supplementary documents to this report.

Invitations to participate in this survey went out via information bulletins and social media accounts of NHS England and other sector bodies. It was also publicised via a number of channels including NHS England newsletters, Twitter and LinkedIn. All practices in England could respond. It was open from 18 July 2022 to 24 October 2022. It received 284 responses which represented around 4% of GP practices in England in 2022.

Responses to this survey provided us with information about respondents' regions. We compared this to the total number of practices in each region according to NHS Digital data from August 2023 (see Table 2). Practices in the West Midlands, the South West, East Midlands and Yorkshire and Humber were overrepresented in our response base. These regions broadly correspond with the areas in which NHS England had been undertaking engagement activities while the survey was open. Practices in London, the South East and North East were underrepresented in our group of respondents.

Table 2: Stratification survey respondents overview

Region	Survey respondents		All GPs in England	
	Count	Percent	Count	Percent
Midlands	101	35.6	1,276	20%
South West	43	15.1	542	9%
North West	45	15.8	962	15%
North East and Yorkshire	38	13.3	954	15%
London	25	8.8	1,170	18%
East of England	21	7.4	659	10%
South East	11	3.9	809	13%
TOTAL	**284**		**6,372**	

The final question of the survey asked respondents whether they would be willing to take part in later stages of the research (interviews and the survey of practices in England). We contacted several of these practices and invited them to participate in stage 2 of this research.

Stage 2: Qualitative interviews (led by Sonnet)

We carried out 19 semi-structured focused interviews (SSFIs) remotely on Microsoft Teams. Conversations were recorded and auto transcribed (with manual intervention to correct for errors). We analysed the transcripts through cycles of grounded theory to draw out key themes.

The purpose of the interviews was to gather information on the roles and responsibilities of nurses within interviewees' practices, and to explore barriers and challenges to nurses fulfilling their potential. We used the evidence gathered to understand the extent to which the practices aligned with the best practice model. All of our interviewees were from different practices:

- 12 were Practice Nurses, seven of whom had management/lead responsibilities in their job titles
- Two were Advanced Clinical Practitioners (also qualified in practice nursing)
- Four were Practice Managers, two of whom were also Partners
- One was a GP Partner

Table 3 shows where the interviewees' practices were across England.

Table 3: Regions of interview participants

Region	Count
Midlands	8
South West	2

Region	Count
North West	4
North East and Yorkshire	1
London	1
East of England	2
South East	1
North East	0
TOTAL	**19**

Stage 3: Survey of practices in England (led by Sonnet with survey carried out by Viewpoint Research CIC)

This survey sought to gather evidence from practices across England about their nursing workforce, other roles in their workforce and the staffing mix involved in clinical and non-clinical activities. Practices with nurses were invited to answer some different questions to practices with no nurses. You can find the survey questions and results in the supplementary documents to this report.

The survey ran from 6 July to 21 August 2023 following a brief pilot between 25 May and 14 June 2023. We sent three survey invitations over July and August to practices in the Oscar database of GP practices.[10] Invitations also went out via information bulletins and social media accounts of the following organisations:

- NHS England (Primary Care Bulletin, NHS England Tweets, Futures Platform, Training Hubs, leadership personal LinkedIn and Twitter accounts)
- Sonnet social platforms (Twitter and LinkedIn)
- Royal College of Nursing (RCN)
- Royal College of General Practitioners (RCGP)
- The Queens Nursing Institute (QNI)

We received 967 individual responses to the survey. Among these were 62 responses that were second responses from the same practice – we call these duplicates. Removing these duplicates (determined randomly within a duplicated pair – i.e. not based on respondent type or date of submission) left 905 individual practice responses. A further 87 responses could not be tracked back to practices – they responded to the survey via links in information bulletins and social media. There is potential that some of these responses could also be duplicates.

The number of responding practices at 905 represented approximately 14% of all practices in 2023.[11] With this number of responses (subject to response bias) we can have 99% confidence that answers may be up to ±5% different from the average answer for the whole population. For example, if the average result for our survey

[10] The GP Surgery database is compiled by Oscar Research; access is subscription-based. It covers all GP Surgeries across England, Scotland and Wales.

[11] In August 2023 there were 6,372 active GP practices in England (NHS Digital, GP and GP practice related data, epraccur, 25 August 2023).

question was 55%, we can be 99% confident that the average answer for the whole practice population would be between 50% and 60%.

We cleaned the dataset where we spotted anomalies. For example, in response to question 3 ('Please estimate the total number of Registered Nurses in your practice'), 22 out of the 804 responding to this question gave a number in the free text response box too large to be accurate (ranging from 7,500-18,000). We reviewed the rest of their responses, including free text responses, and they seemed to be reasonable and consistent. So, the rest of their responses were used in survey data analysis. We did, however, remove their responses to question 3.

We could identify the region of 818 practices that responded to the survey. Table 4 shows where they were based and how this compared to the national breakdown of all practice locations (according to NHS Digital data).

Table 4: Region of respondents to the survey of all practices

	Respondents		All practices in England	
Region	**Count**	**Percentage**	**Count**	**Percentage**
East of England	73	9%	659	10%
South East	97	12%	809	13%
North East and Yorkshire	118	14%	954	15%
London	118	14%	1,170	18%
South West	130	16%	542	9%
North West	135	17%	962	15%
Midlands	147	18%	1,276	20%
Total	**818**	**100%**	**6,372**	**100%**

Limitations to this research

Difficulty in finding practices with no nurses to take part in this research

As part of this research, we wanted to engage with practices with no nurses to understand why they did not have this role, and how their teams operated without this role. In spite of efforts at each stage of this research, we found it difficult to find such practices to take part in our research. We were able to engage only a small number of practices without nurses in this research. As a result, we have limited insight into what happens in these practices.

The stratification survey provided a pool of practices whom we could interview in the next stage of research. However, all respondents to this survey had at least one nurse in their workforce. So, we had to look elsewhere to find practices without nurses to interview.

We used NHS Digital data on the GP workforce to find practices without nurses and invited them directly to participate in our research. Before contacting them, we wanted to verify that they did not have the nursing role, so we reviewed their latest CQC reports and practice websites. From this exercise we learned that many practices that had been identified as employing no nurses in NHS Digital data actually did employ nurses. We did further desk-based research and used the GP Surgery database from Oscar Research to identify further practices that may not have had nurses. From this exercise we identified a possible further 24 practices without nurses. From our sector contacts we received details of one further practice with no nurses. We contacted these 25 practices and only one agreed to participate in this research.

We also spoke with several individuals from ICBs and training hubs across North East London, who estimated that there may be up to 17 practices in a suburb of North London that had no nursing roles, or that relied on part-time nurses or on locum nurses. However, we were not able to verify these practices' staffing composition; we therefore did not pursue interviews with them.

Only eight practices without nurses (whose responses we would verify) responded to our survey of all practices. They constituted under 1% of our survey respondents. During our research we found no single reliable source of information about the number of general practices in England that do not employ nurses. Based on our review of NHS Digital data and responses to our research we estimate that around 1% of practices do not employ any nurses. This provides context for our difficulties in finding and engaging with these types of practices in our research.

Practices that champion the GPN role were more likely to participate in this research

There is a risk that the practices that participated in our research adhered more closely to the best practice model than the average practice in England. Their interest in the subject matter of this research could have made them more motivated to take part. As a result, the findings presented in this report could paint a picture of English general practice that deploys nurses more effectively than is actually the case in reality. This bias may be particularly pronounced for the stratification survey given that invitations to participate in the survey were sent out primarily through channels that related to primary care nursing leadership, e.g. NHS England news bulletins. We sought to address this with the survey of all practices by using a database of general practices across England, and sending invitations directly to practices.

There were 70 survey responses which we were not able to trace back to individual practices

For our survey of all practices, we were not able to link 70 of the responses to any practice. This is because the respondent did not provide meaningful information about their practice name and location, and because they participated in the survey via links shared in social media and/or bulletins. The answers given by these respondents seemed reasonable upon inspection. We have therefore kept them in the group of 905 respondents whose answers are analysed for this report. There is, however, a risk that any of these respondents could be a second or third response from the same practice, which could skew results to a small extent. Overall, we believe that the conclusions drawn from this research would not change significantly if we were to remove these potential duplicates from the response base.

Survey respondents might have interpreted some questions differently

Our aim with the survey of all practices was to keep it simple and straightforward to ensure a high response rate. We included only a small number of definitions of terms in the survey which means that certain terms were left up for interpretation by respondents. For example, we did not define what it meant for nurses to 'lead or take particular ownership' of clinical activities. We also did not define what we meant by particular roles and responsibilities, for example, change management. However, where we did add a definition to the survey (to say that we were using the term GPN to encompass all nursing roles) it appears that not all respondents read this, with many indicating in the 'Other' role category that Associate Nurse Practitioners (ANPs) were performing these activities.

2. General practice nursing: evolving to adapt to healthcare system needs

From supporting doctors in the delivery of care to 'leading the way'

In our first two phases of research we discovered a profession in flux; one that had evolved, albeit by stealth, to meet the needs of patients. In this section we describe this transformation chronologically.

Nurses' roles and responsibilities have grown considerably since they were first introduced into general practice in 1966, when the first contract between GPs and the NHS was drawn up. In the original 'Traditional state' of general practice nursing, nurses were viewed largely as additional resource and support to GPs. In response to the changing needs of patients and growing demands on general practice, most practices now align to the 'Current state' model of general practice nursing (see Figure 4).

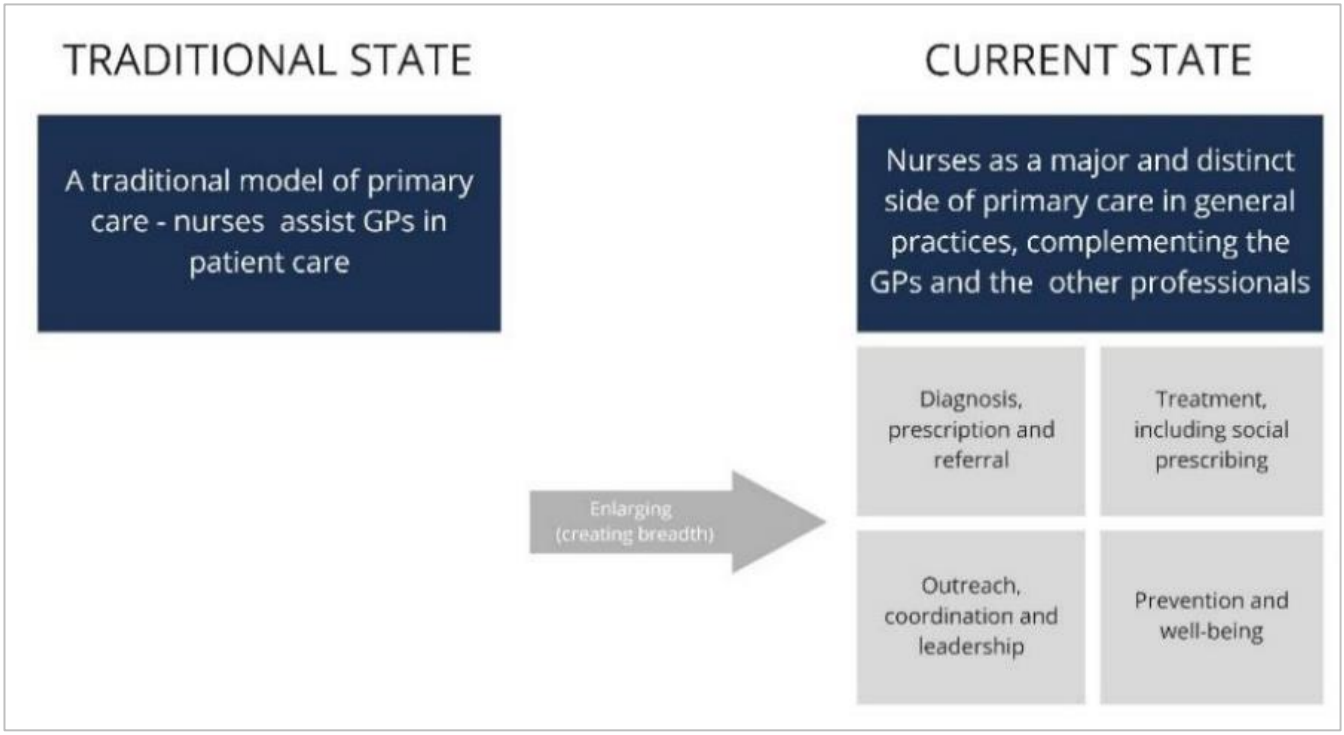


Figure 4: Nurses play an integral professional role in primary care, complementing that of GPs and other professionals

General practice nursing in this Current state has developed to span:

- Diagnosis, prescription, and referral
- Treatment of a variety of types, including access to social prescribing, delivered in a way that takes into account patients' social context and local healthcare system configuration
- Select areas of work in prevention and promotion of wellbeing in certain parts of the community, or services focusing on meeting particular patient population needs

- Outreach, coordination and leadership in the operation of primary care across wider areas

This Current state is the best practice value-enhancing model of general practice nursing that was documented in earlier *Leading the Way* reports, and that is explored further in this report.

What we know about the GPN workforce

In recent years while the total number of nurse full time equivalents (FTE) has increased, headcount has declined (see Table 5).[12] Demand has grown since the COVID-19 pandemic, but the number of nurses has not grown at the right pace to meet this increase.[13]

Table 5: General practice nursing numbers

Date	FTEs	Headcount
September 2019	16,573	23,834
September 2020	16,727	23,941
September 2021	16,510	23,544
September 2022	16,779	23,490
September 2023	16,903	23,284

Source: NHS Digital General Practice Workforce data

Every working day more than one million people attend an appointment at their local GP surgery. [14] In the month of September 2023 there were 32.6 million appointments recorded in GP practice appointment systems, [15] up from 26 million in September 2019. [16] In December 2022, practices in England carried out almost five times more appointments for suspected flu and flu-like illness than during the same period in 2018, and approximately 79% more appointments for suspected Group A Strep related scarlet fever and sore throat. On top of this, COVID-19 alone accounted for 250% more consultations in 2022 than appointments for flu and scarlet fever combined in 2018.[17] This shows that primary care services, and, by extension, nurses, are now expected to do more without a corresponding increase in their resources and capacity.

[12] NHS Digital General Practice Workforce data
[13] The Health Foundation (June 2022), REAL Centre Projections: General practice workforce in England Updated July 2022 Summary of findings
[14] Health and Social Care Committee (20 October 2022), The Future of General Practice – Report Summary, https://publications.parliament.uk/pa/cm5803/cmselect/cmhealth/113/summary.html
[15] NHS Digital (September 2023), Appointments in General Practice – September 2023, https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2023
[16] NHS Digital (September 2019), Appointments in General Practice – September 2019, https://digital.nhs.uk/data-and-information/publications/statistical/appointments-in-general-practice/september-2019
[17] RCGP (March 2023), Fit for the Future – GP Pressures 2023, https://www.rcgp.org.uk/getmedia/f16447b1-699c-4420-8ebe-0239a978c179/gp-pressures-2023.pdf

Exacerbating these capacity constraints are the challenges of recruiting and retaining GPNs. Earlier phases of this research recognised that the GPN workforce is ageing – meaning that the majority of nursing staff (79%) are aged 40-64 years.[18] When these older cohorts of nurses come to retire this will pose issues for staffing among practices,[19] particularly when there is a lack of newly qualified and younger nurses coming into general practice.

Projections of the number of GPNs (as well as general practitioners) by The Health Foundation show that by 2030/31 the shortfall of nurses is likely to have grown.[20] In all three of their scenarios demand grows by the same amount – reflecting underlying trends (like demographic pressures and morbidity trends) and additional demands on primary care per NHS Long Term Plan commitments. The three scenarios ranged from moderate to severe. The results from all three scenarios show a shortfall of nurses compared to demand – what differed among these scenarios, however, was the scale of the shortfall. In the scenario based on continuity of current policy, a shortfall of 1 in 4 general practice nurses was anticipated. In the worst-case scenario, it was 1 in 2. The researchers indicated that trends in workforce shortages that existed prior to 2020 had only been exacerbated by the pandemic.

Overview of the best practice model

On the basis of evidence gathered in Phase Two, we developed a model of best practice for GPNs – one that captures the routes through which nurses can add significant value to their practice, patients, communities and the wider NHS.

This best practice model featured eight **value drivers;** these are the segments that form the central circle in Figure 5. These are types of primary care nursing activities that make a difference to their practices, patients, communities and the NHS. Nurses create value through these activities. The model also features two **enablers**: things that facilitate nurses to do their jobs well. These are shown in the two concentric outer rings in Figure 5.

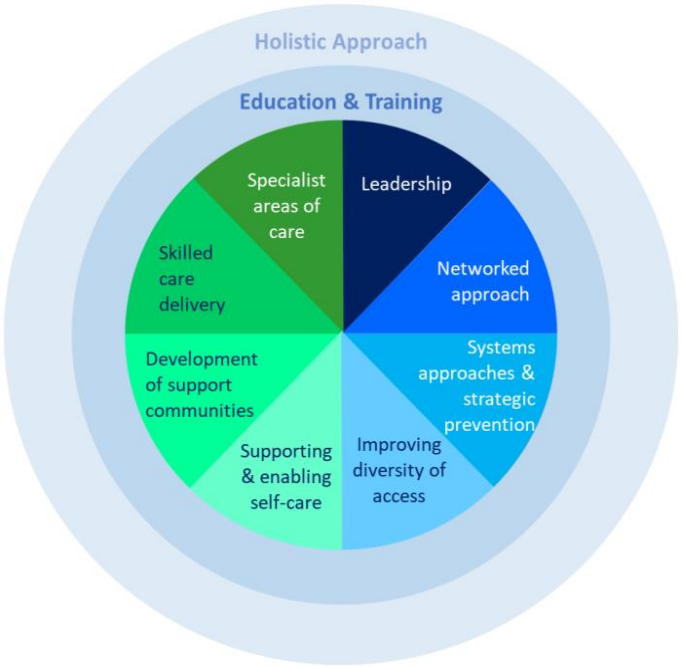


Figure 5: How GPNs create value

In Appendix 1 we evaluate the evidence gathered in Phase Three and assess the extent to which each value driver and enabler in this model hold true. In summary, our latest evidence still supports the best practice model. Much of the rest of the evidence in this section confirms this observation. However, some elements are not seen consistently across all practices in England, as evidence in this section also demonstrates. Furthermore, there are

[18] Clifford, J., Barnes, K., Arora, R., and Raouf, S. (2021), ibid
[19] Butler, S. (1 April 2022), Practice nurse workforce numbers: are we heading towards a problem?, Practice Nursing VOL. 33, NO. 4 | Professional, https://doi.org/10.12968/pnur.2022.33.4.155
[20] The Health Foundation (June 2022), REAL Centre Projections: General practice workforce in England Updated July 2022 Summary of findings

barriers to one of the enablers: training and education. Later in this report and in Appendix 1 we provide more detail on these barriers and explore what could be done to address them.

The role nurses play in practices

Data from our stratification survey have provided us with some insight into the specific roles of nurses in general practice. Almost all respondents (97.2%) reported that their practice employed a General Practice Nurse (the most common role among respondents). Table 6 shows that there were 782 General Practice Nurses working in the 276 practices with this role. The average practice therefore employed just under 3 General Practice Nurses.[21] By contrast only 99 respondents (34.9%) had Nurse Practitioners among their workforce, and together they employed 145 Nurse Practitioners; this represented an average of 1.5 Nurse Practitioners per practice.[22]

Table 6: Information about the GPN workforce from our stratification survey

Role	GP surgeries (count)	GP surgeries (percent)	People (count)	People (percent)	Mean per practice
General Practice Nurse	276	97.2	782	56.4	2.8
Nurse Practitioner	99	34.9	145	10.5	1.5
Advanced Nurse Practitioner	143	50.4	252	18.2	1.8
Other	110	38.7	207	14.9	1.9
Base	**284**		**1,386**		

During this phase of research, we heard many examples of nurses taking responsibility for a breadth of activities in their practice, as well as developing areas of special interest. Examples of these areas of special interest included diabetes, respiratory conditions, and women's health, and their activities included:

- Making referrals and social prescribing
- Providing information enabling patients to self-manage chronic conditions
- Promoting wellbeing and disease prevention
- Supporting public health through immunisations and vaccinations

From data from our survey of all practices we gained insight into which members of practice teams were involved in essential services (per the GP contract). We asked each practice which roles were involved in the delivery of clinical activities. Findings for essential clinical services (per the GP contract) are presented for all respondents in Table 7. The green colour gradient corresponds with the number in each cell, with the darkest green showing at 100% and no green at 0%. The darker the green, the higher the share of practices that involved the specified

[21] NHS workforce data from August 2023 indicate that on average there were 2.8 GPNs in each practice, so results from our survey data for this question seem to be line with the equivalent figure for the whole population of practices.
[22] NHS workforce data indicate that on average there were 1.9 ANPs in each practice with this role, so practices responding to the stratification survey appear to be similar to the broader practice population in this regard.

professions in those activities. The lighter the green indicates low involvement of those professions, and no green indicates no involvement.

These findings echo themes from our interviews and earlier research findings that nurses in most practices were involved in the following clinical areas:

- Adult vaccinations, e.g. pneumococcal polysaccharide vaccine (PPV) and Shingles
- Child vaccinations/immunisations, i.e., 6 in1 and MMR
- Cervical smears
- Contraceptive advice and/or prescription
- Long-term/chronic condition reviews and care/management plans
- Provision of preventative advice and promotion of healthier lifestyles to patients
- Leg ulcer treatment

These results also show that nurses provide that broad combination of services that meet their communities' health needs. It demonstrates nurses' focus on public health, supporting patients in self-management of chronic conditions and women's health. This evidence also suggests that nurses could have had greater involvement in some clinical areas in a large share of practices. For example, in 43% of practices nurses could be involved in providing menopause support (nurses were only involved in this service in 57% of responding practices).

Table 8 and Table 9 further disaggregate the results shown in Table 7:

- Table 8 shows the share of practices with nurses and other professions involved in those activities where nurses were involved in them
- Table 9 shows the share of practices with other professions involved in those activities in practices where nurses were not involved in them

These show us that where nurses were not involved in some activities, this led to greater involvement of GPs. For example, of the 502 practices in which nurses were involved in the delivery of menopause support (including HRT advice and/or prescription) in 79% of those practices GPs were also involved in this activity. These practices were likely to use a multidisciplinary team to deliver this service, which presumably allowed for GPs to be less directly involved in the delivery of this activity. However, in the 385 practices in which nurses were **not** involved in this activity, probably due to nursing capacity constraints or nurses not having the right qualifications, 98% of these practices had GPs involved in this activity, and it is likely that they would have been more directly involved in delivery.

Our interview findings support these observations on the transferal of responsibility from GPs to nurses. In several of our interviews nurses discussed that their involvement in clinical activities (such as minor illness clinics, smears, and long-term condition reviews and management) takes pressure off GPs and their workloads enabling them to focus on activities and services that only they can deliver.

What we can also see from the data is that nurses' involvement in an activity could have some bearing on other practice team members' involvement in this activity:

- For example, when nurses were not involved home visits and care home visits, the share of practices with HCAs involved in these activities also fell sharply
- In those practices where nurses were not involved in phlebotomy, there was a much higher share of practices involving phlebotomists in this activity (23% compared to 12% in practices where nurses were involved).

Table 7: Roles involved in essential clinical activities in each practice (share of practices where this role was involved)

Essential services	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Adult vaccinations, e.g. PPV and Shingles	891	98	7	1	1	1	1	16	34	0	1	0	0	0	0	0
Child vaccinations/immunisations, i.e., 6in1 and MMR	885	99	5	0	0	0	0	5	1	0	0	0	0	0	0	0
Smears	888	99	21	2	1	0	0	8	0	0	0	0	0	0	0	0
Contraceptive advice and/or prescription	887	85	68	18	6	9	2	3	1	0	0	0	0	0	0	0
Menopause support, including HRT advice and/or prescription	887	57	87	24	6	12	2	1	1	1	0	0	0	0	0	0
Phlebotomy	866	60	9	3	3	1	4	22	85	2	2	0	16	0	2	0
Minor ailments	879	62	68	28	17	14	24	4	5	1	0	0	0	0	2	0
Learning disability health checks/reviews	884	64	55	8	5	2	3	9	28	1	0	1	0	0	0	0
Home visits	887	42	91	35	6	3	29	5	15	1	0	0	0	0	2	1
Nursing/care home visits	829	38	83	24	5	5	19	4	10	4	0	1	0	0	3	0

*Table 8: Roles involved in essential clinical activities in each practice where **nurses were involved in this activity** (share of practices)*

Essential clinical services	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Adult vaccinations, e.g. PPV and Shingles	871	100	7	1	1	1	1	16	33	0	1	0	0	0	0	0
Child vaccinations/immunisations, i.e., 6in1 and MMR	880	100	5	0	0	0	0	4	1	0	0	0	0	0	0	0
Smears	881	100	21	2	1	0	0	8	0	0	0	0	0	0	0	0
Contraceptive advice and/or prescription	757	100	64	18	5	8	2	4	1	0	0	0	0	0	0	0
Menopause support, including HRT advice and/or prescription	502	100	79	25	7	14	2	1	1	0	0	0	0	0	0	0
Phlebotomy	522	100	14	6	4	1	6	28	85	2	2	0	12	0	1	0
Minor ailments	549	100	61	27	15	12	22	5	7	1	0	0	0	0	1	0
Learning disability health checks/reviews	565	100	43	7	4	2	3	9	24	1	0	1	0	0	0	0
Home visits	370	100	89	38	8	5	26	10	28	1	0	0	0	1	1	1
Nursing/care home visits	319	100	76	27	7	5	20	6	20	1	0	1	1	1	1	0

*Table 9: Roles involved in essential clinical activities in each practice where nurses were **not** involved in this activity (share of practices)*

Essential clinical services	Respondents (count)	Roles involved in activity (share of practices, %)													
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Adult vaccinations, e.g. PPV and Shingles	20	0	5	0	0	0	0	45	100	0	5	0	0	5	0	0
Child vaccinations/immunisations, i.e., 6in1 and MMR	5	0	20	0	0	0	20	60	0	0	0	0	0	0	20	0
Smears	7	0	43	14	0	0	14	57	0	0	0	0	0	0	0	0
Contraceptive advice and/or prescription	130	0	92	16	8	9	1	0	0	1	0	0	0	0	2	1
Menopause support, including HRT advice and/or prescription	385	0	98	22	5	9	2	0	0	1	0	0	0	0	1	0
Phlebotomy	344	0	1	0	0	0	1	14	84	1	3	0	23	0	3	0
Minor ailments	330	0	78	29	20	18	27	2	2	2	0	0	0	0	4	0
Learning disability health checks/reviews	319	0	75	11	7	2	3	8	36	2	0	2	0	1	1	1
Home visits	517	0	93	33	5	1	32	2	5	1	0	1	0	0	3	0
Nursing/care home visits	510	0	87	22	5	5	18	2	4	5	0	1	0	0	5	1

Table 10 shows the roles involved in additional clinical activities for all survey respondents. Similar patterns to the above can be seen in additional clinical activities (see Table 11 and Table 12): a higher proportion of GPs were involved in certain activities when nurses were not involved (e.g. Long-term/chronic condition reviews and care/management plans and fitting of long acting reversible contraceptives (coils and implants)).

Notwithstanding, the data show that HCAs were less likely to be involved in provision of preventative advice and promotion of healthier lifestyles to patients where nurses were not involved. Instead in these practices 'Other' groups were more heavily involved in their delivery. Examples of these other groups given by survey respondents were social prescribing link workers and patient participation groups. These findings suggest that in practices where ARRS roles were present it could have relieved pressure on nurses such that nurses no longer needed to be so heavily involved in the delivery of certain clinical activities.

Table 10: Roles involved in additional clinical activities in each practice (share of practices)

	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Long-term/chronic condition reviews and care/management plans	878	95	56	17	7	18	6	14	30	1	1	0	0	0	0	1
Patient community/support groups or clubs	224	31	24	4	4	3	2	7	15	64	0	3	0	0	1	0
Provision of preventative advice and promotion of healthier lifestyles to patients	754	92	54	22	10	22	12	24	59	13	1	1	0	0	0	0
Fitting of coils/implants	605	35	87	2	1	0	0	0	2	0	0	0	0	0	1	1
Leg ulcer treatment	508	99	3	0	0	0	1	18	32	1	0	0	0	0	1	0

Table 11: Roles involved in additional clinical activities in each practice where nurses were involved in this activity (share of practices)

	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Long-term/chronic condition reviews and care/management plans	834	100	54	17	7	18	6	15	31	1	1	0	0	0	0	1
Patient community/support groups or clubs	70	100	46	11	10	9	4	17	33	19	0	1	0	0	0	0
Provision of preventative advice and promotion of healthier lifestyles to patients	697	100	57	23	11	23	13	25	61	10	1	1	0	0	0	0
Fitting of coils/implants	213	100	66	2	1	0	0	1	3	0	0	0	0	0	0	0
Leg ulcer treatment	501	100	2	0	0	0	1	18	32	0	0	0	0	0	0	0

*Table 12: Roles involved in additional clinical activities in each practice where nurses **were not** involved in this activity (share of practices)*

Additional clinical services	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Long-term/chronic condition reviews and care/management plans	44	0	93	9	14	14	5	5	5	2	0	2	0	0	0	0
Patient community/support groups or clubs	154	0	14	1	1	0	1	2	6	85	1	3	0	0	1	0
Provision of preventative advice and promotion of healthier lifestyles to patients	57	0	21	2	2	5	2	11	35	49	2	2	0	0	0	0
Fitting of coils/implants	392	0	99	2	1	0	0	0	2	0	0	0	0	0	1	1
Leg ulcer treatment	7	0	29	0	0	0	0	29	43	14	0	0	0	0	29	0

General practice nursing is rising to the challenges posed in NHS Long Term Plan

An ambition of the NHS Long Term Plan was for primary care services to do more to meet the growing demands on our healthcare system from an ageing population with increasingly complex health needs. The Long Term Plan requires primary care providers to deliver the following:

- Efficient management of all elements within an expanded primary care delivery
- Stronger networks of support, coordinating health care resources and reaching into communities to improve wider population well-being
- Broader education of the general population and specific groups within it to seek and improve their own well-being individually and collectively
- Leading and running Integrated Care Systems across all areas of England

This requires a new model of primary care for the NHS – a new target operating model (or 'Future state', see the right-hand side of Figure 6).

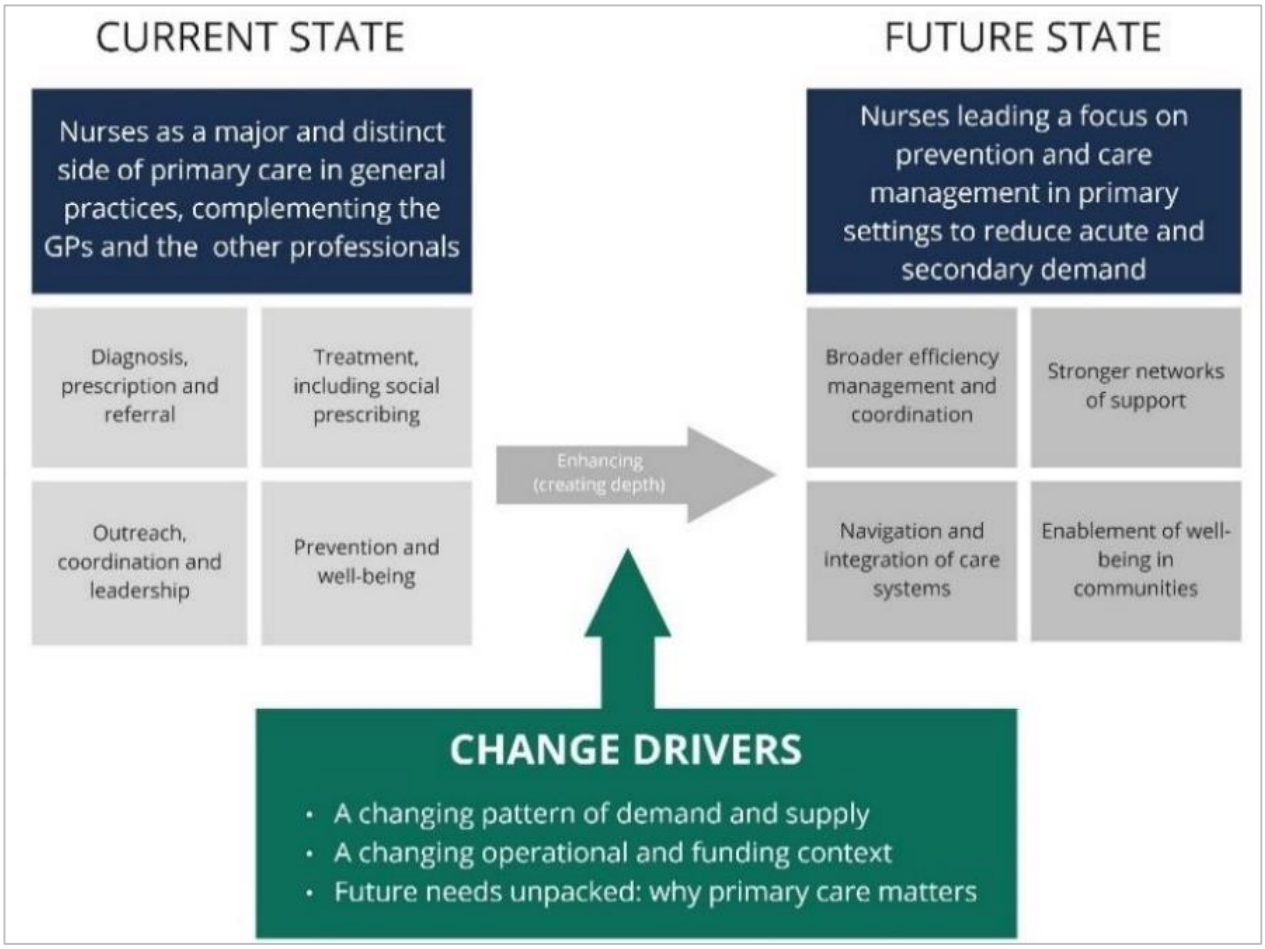


Figure 6: A developing model of nursing in primary care (current state to future state)

In this target operating model we see several significant changes:

- The remit of primary care expanded to include Urgent Treatment Centres. These remove some of the burden from A&E and enable a more effective and appropriately targeted provision of treatment
- Existing links with social care through expanded local networks, and are further enhanced by the wider roll-out of Integrated Care Systems as a key element of future primary care governance and coordination
- Secondary, tertiary, and quaternary care remain essentially as they are, but can expand their capacity marginally and refine their offer as investment in digital technology supports their functions
- The expansion of responsibility and scale of primary care, including wider and explicit responsibility for health promotion, health prevention and population health management

Nurses in general practice could and should play an important role in helping move to this future model. Throughout the three phases of this research, we have seen evidence of nurses stepping up to support the achievement of this new model (e.g., in a third of practices taking part in our research nurses lead services for cardiovascular conditions).

However, there continue to be barriers to GPNs being able to achieve their full potential. For the Long Term Plan to be realised and for general practice nursing to reach its full potential it needs greater recognition, focus and funding. Areas of particular importance are the education, training and leadership opportunities for GPNs, and investment in a pipeline of new nurses to counter the ageing of the workforce.

There are wider benefits to practices and the NHS of nurses taking a more active role in leadership of care delivery. We can look at examples such as the Primary Care Frailty project. This is a project led by nurses aimed at developing a system within GP practices that supports the identification, assessment and management of patients who are severely frail. This project moves practices from a reactive disease driven model to a healthy ageing model, achieving a reduction in unnecessary hospital admissions, increasing patient satisfaction, and reducing unnecessary GP appointments.[23]

Nurse-led care for patients with a number of long term complex conditions has been shown to save GPs time by reducing the frequency of appointments that patients need and minimising cases where work is replicated, such as duplicate blood tests.[24] Research has also shown that nurse-led care within this area is linked to better patient outcomes. One study of adult patients with long term complex conditions who attended a Nurse Practitioner clinic, found that within the first 12 months, clinical targets for patient health were being met, large improvements in health-related quality of life amongst patients were seen, and the use of hospital inpatient and emergency services also decreased.[25]

[23] The Queen's Nursing Institute (2020) Summary of QNI Community Nurse-led Innovation Projects focused on improving health and well-being outcomes for people with frailty
[24] NHS England (2022), *Primary Care and Community Nursing: A national update - Case Study 1: Saving GP time and increasing uptake through personalised, multimorbid chronic disease reviews.*
[25] Bonner, A., *et al* (2020) A multimorbidity nurse practitioner-led clinic: Evaluation of health outcomes

3. Practices where nurses' value is recognised and realised

Based on data from the survey of all practices we look at two different groups of practices in which nurses are likely to be deployed to their full (or fuller) potential. This analysis can tell us about the characteristics of these practices relative to other practices. Table 13 summarises the two markers we use of practices being at the forefront of best practice.

Table 13: Elements of best practice model

Practices in which nurses….	Reason for selection
Lead or take ownership of services for patients with cardiovascular conditions	The NHS Long Term Plan set an ambition to 'support pharmacists and nurses in primary care networks to case find and treat people with high-risk conditions'.[26] Our survey data show that most practices have nurse-led services for patients with diabetes (86%) and respiratory conditions (85%) respectively. However, only a third of practices responding to our survey reported having nurse-led services for patients with cardiovascular conditions. So, we believe this is a good marker of being at the forefront of best practice. This also suggests there is an opportunity for improvement in at least 2/3 of practices.
Have a high degree of involvement in non-clinical activities	In our earlier research, we heard examples of nurse-led programmes of change – where services were transformed to improve care quality and access, and to improve the efficiency of service delivery. This kind of activity is change management: projects or programmes involving the transformation of practice activities. The activities being transformed could be clinical or non-clinical. In the survey of all practices 33% of respondents with nurses indicated that their nurses are involved in change management. We have used this to proxy for best practice when it comes to involvement of GPNs in non-clinical activities.

To explore what is different about these practices, we need to compare them to all practices responding to our survey. Figure 7 and Figure 8 present results from all practices responding to the survey – these are responses to select questions and are presented in infographic form – two pages for each group analysed. These will serve as benchmarks for other groupings of practices. Key observations from these figures are that among the 897 practices responding to our survey that employ nurses:

- Over a fifth (22%) of practices responding had nursing vacancies
- Our survey respondents were more likely to be in the following size ranges than the national breakdown of practices:

[26] Online version of the NHS Long Term Plan, Chapter 3: Further progress on care quality and outcomes, Better care for major health conditions, Cardiovascular disease, paragraph 3.69

    - 1 to 9 employees
    - 10 to 24 employees
    - 50 to 99 employees
- Our survey respondents were less likely to be in the following size ranges than the national breakdown of practices:
    - 25 to 49 employees
    - 100+ employees
- Nurses led services for diabetes (86%) and respiratory conditions (85%) in the majority of these practices
- In 33% of practices nurses led services for patients with cardiovascular conditions and in only 19% of practices did nurses lead frailty services

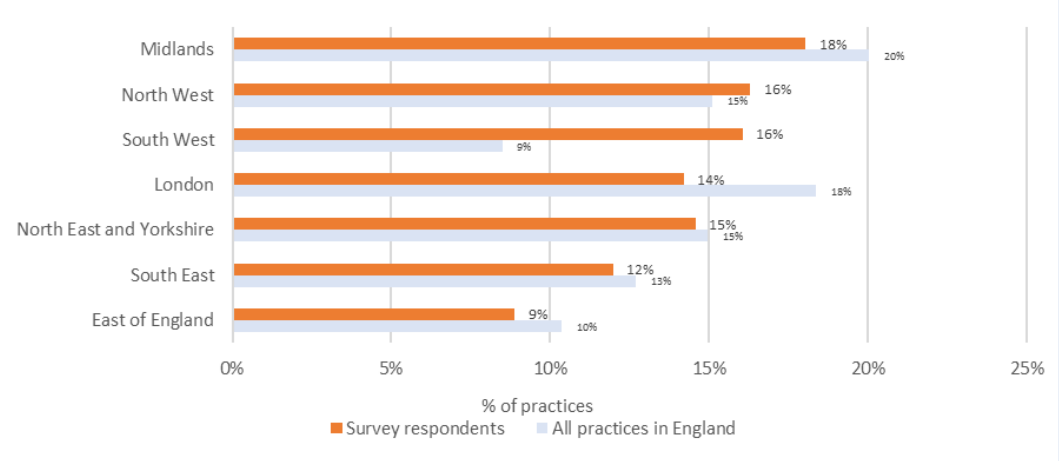
We asked about the clinical activities that nurses were involved in (along with other staff) and these showed that over 50% of respondents had nurses involved in 5 to 7 different clinical areas.

The two pages of analyses from the full sample follow below.

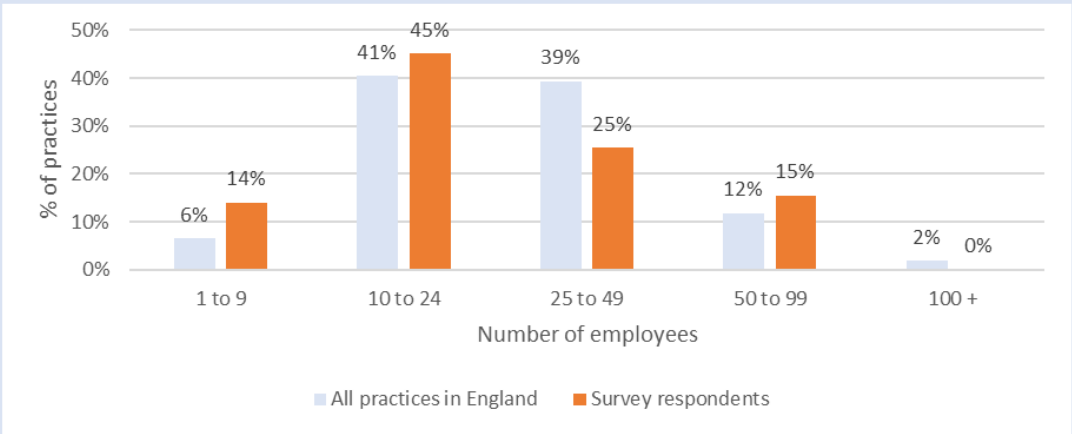
Key survey results: Practices with nurses (n=897)

Practice information

Commissioning region

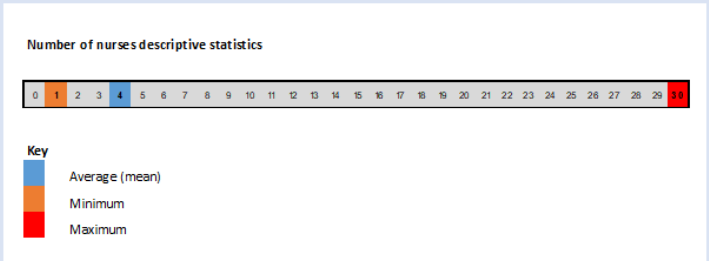


Size (number of employees)



Information about their nurse workforce

Number of nurses in the practice (min, max, average)



Do you have any nursing vacancies at present?
This shows that 22% (202) of practices responding to our survey have at least one nursing vacancy.

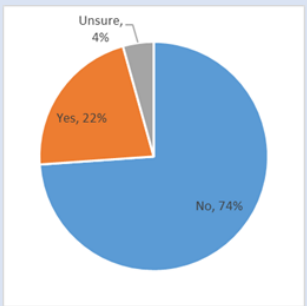
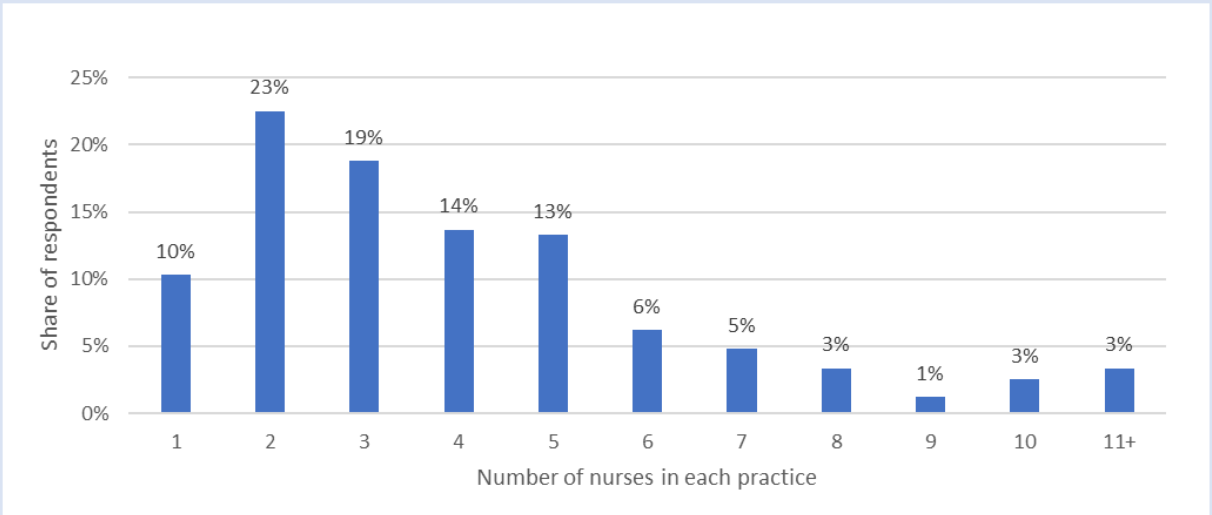


Figure 7: Overview of survey results for practices with nurses (part 1)

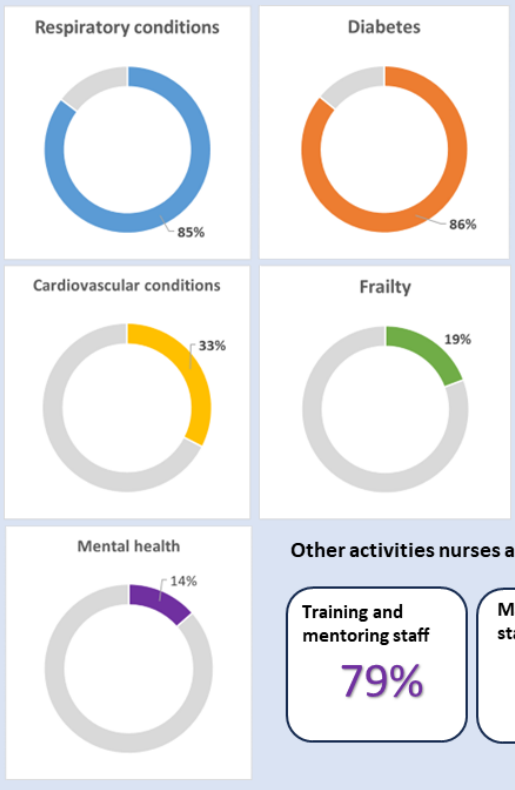
Key survey results: Practices with nurses (n=897)

Number of nurses in each practice



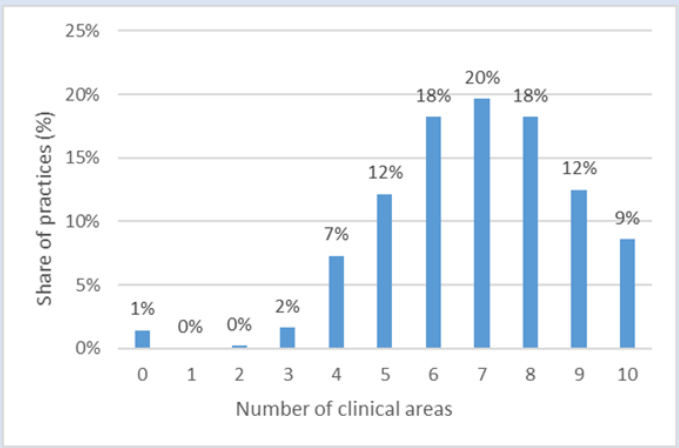
Nurses' responsibilities

Areas nurses lead or take particular ownership over
(% of practices in which nurses lead these areas)



Degree of nurses' involvement in clinical areas

In the survey we asked whether nurses are involved in a range of clinical areas. The chart below shows the number of services nurses are involved for respondent practices. For example, this shows that in 20% (178) of practices responding to our survey GPNs are involved in 7 different areas.



Other activities nurses are involved in (share of practices where GPNs are involved in these activities)

Training and mentoring staff	Management of staff	Change management	Managing the ask of the QOF	External networking
79%	68%	33%	67%	59%

Figure 8: Overview of survey results for practices with nurses (part 2)

Practices in which nurses led or took ownership of services for patients with cardiovascular conditions

There were 291 practices responding to our survey that reported nurses leading services for cardiovascular conditions. Figure 9 and Figure 10 overleaf provide an overview of these practices.

Benchmarking their results against all respondents to our survey with nurses gave rise to the following observations:

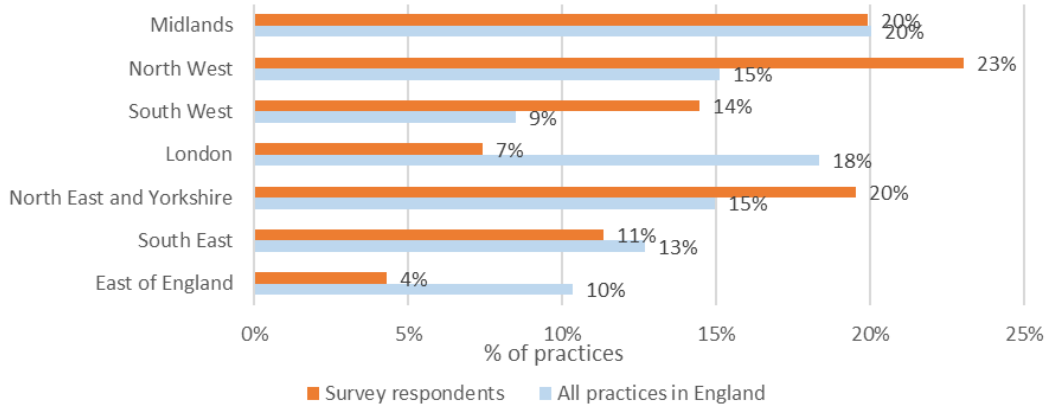
- They were larger (proxied by the number of employees) and had a slightly bigger nurse workforce
- In almost all of these practices nurses led services for respiratory conditions (99%) and diabetes (96%)
- These practices were much more likely to have nurses leading frailty services (34% compared to the overall result of 19% for all participants)
- They were more likely to involve nurses in non-clinical ("other") activities like training and mentoring (88%), managing staff (81%) and managing the ask of QOF (79%)
- Nurses were more likely to be involved in a higher number of essential clinical services
- These practices were more likely to be in the North West, South West or North East and Yorkshire
- They were less likely to be in the East of England and London

The size of a practice is likely to be a factor in nurses being able to develop special interest areas. With a higher level of staffing and resourcing, particularly among nurses, it provides nurses scope to develop expertise in a given area. It would also give nurses the opportunity to be involved in non-clinical activities. That said, where nurses were able to demonstrate what they are capable of, data showed that this responsibility was likely to carry across areas.

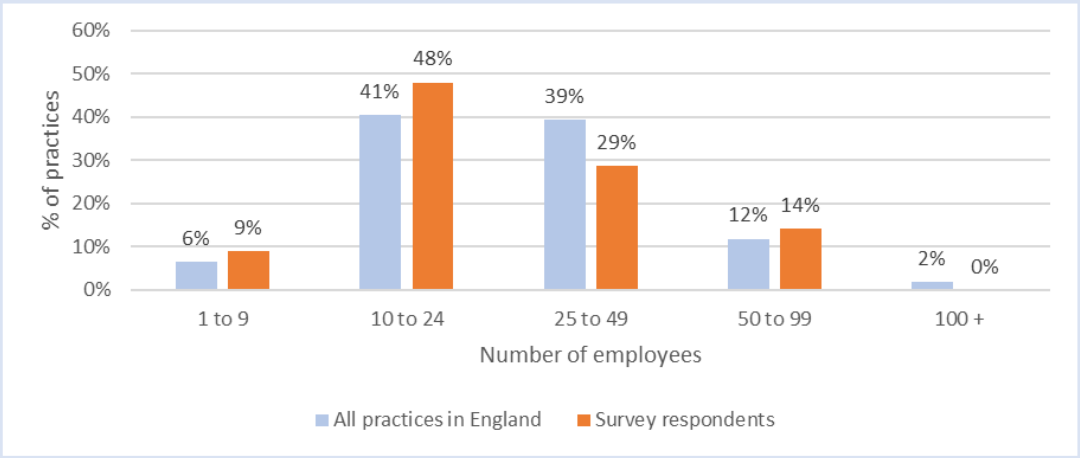
Practices in which GPNs led cardiovascular conditions (n=291)

Practice information

Commissioning region

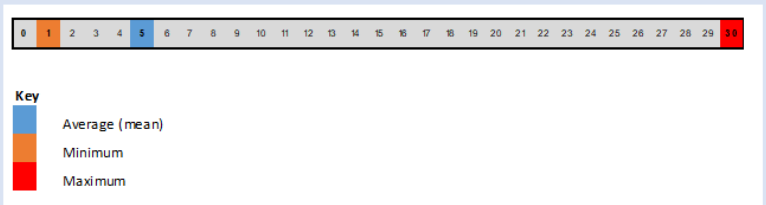


Size (number of employees)



Information about their nurse workforce

Number of nurses in the practice (min, max, average)



Do you have any nursing vacancies at present?
This shows that 23% (66) of practices responding to our survey had at least one nursing vacancy.

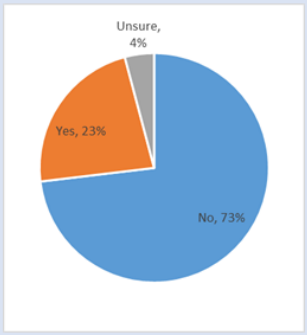
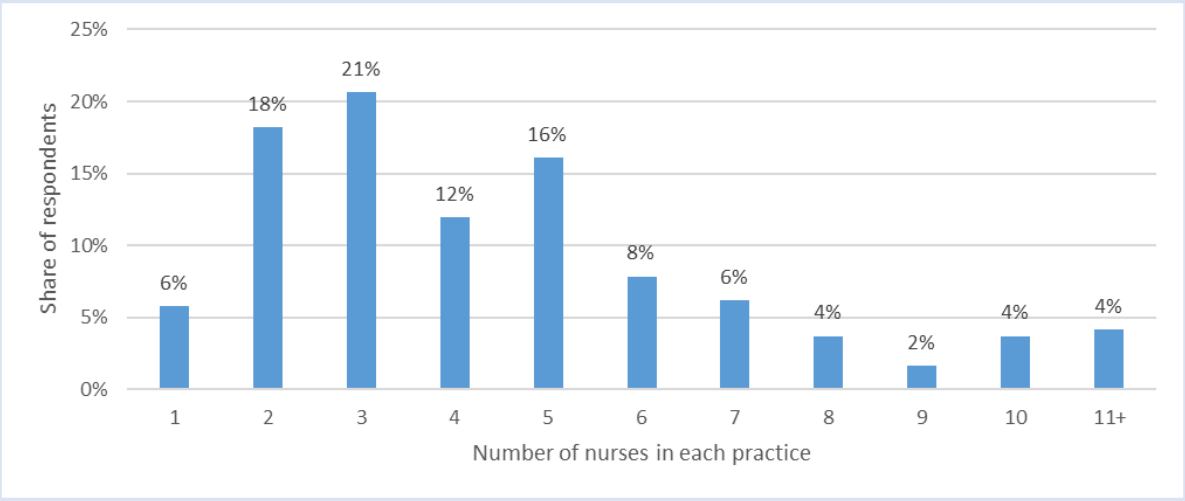


Figure 9: Overview of survey results for practices in which GPNs led services for cardiovascular conditions (page 1)

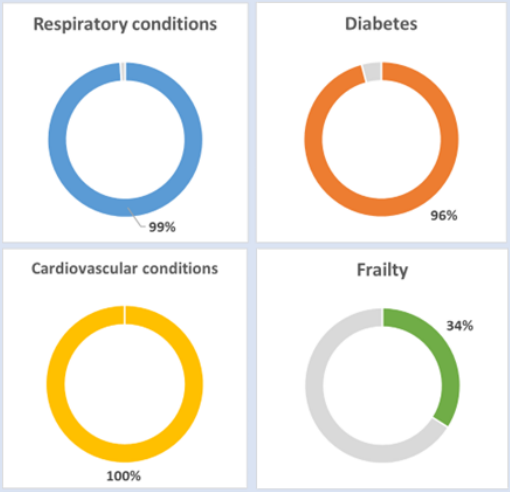
Practices in which GPNs led cardiovascular conditions (n=291)

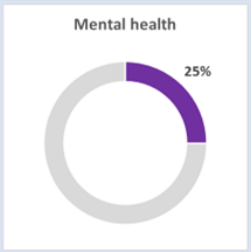
Number of nurses in each practice



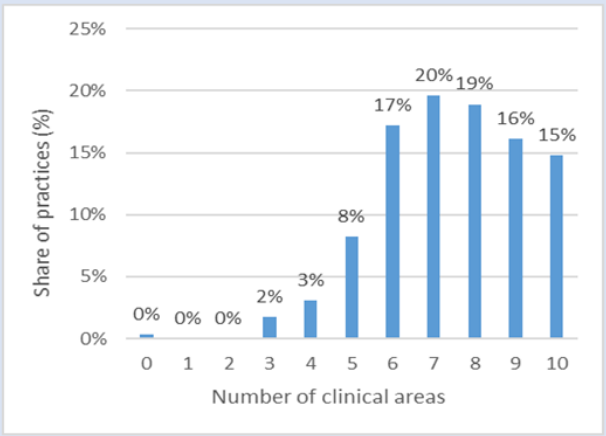
Nurses' responsibilities

Areas nurses led or take particular ownership over
(% of practices in which nurses led these areas)





Degree of nurses' involvement in clinical areas
In the survey we asked whether nurses are involved in a range of clinical areas. The chart below shows the number of services nurses were involved for respondent practices. For example, this shows that in 20% (57) of practices responding to our survey GPNs were involved in 7 different services.



Other activities nurses were involved in (share of practices where GPNs were involved in these activities)

Training and mentoring staff	Management of staff	Change management	Managing the ask of the QOF	External networking
88%	81%	42%	79%	72%

Figure 10: Overview of survey results for practices in which GPNs led services for cardiovascular conditions (page 2)

Practices in which nurses were involved in change management

In the survey of all practices 33% of respondents with nurses indicated that their nurses were involved in change management. We have used this to proxy for best practice when it comes to involvement of GPNs in non-clinical activities.

Following some patterns seen above, practices in which nurses were involved in change management (see Figure 11 and Figure 12):

- Were likely to be larger in terms of staff numbers and have a larger nursing staff
- Nurses were more likely to lead the clinical areas of respiratory conditions, diabetes, frailty and cardiovascular conditions
- Nurses were much more likely to be involved in other non-clinical activities like managing the ask of QOF and networking
- Were overrepresented in the North West
- Were underrepresented in London

This corroborates the observation above that where nurses had greater involvement in leadership of a practice (where they were essentially “stepping up”), this was seen across all areas in the practice.

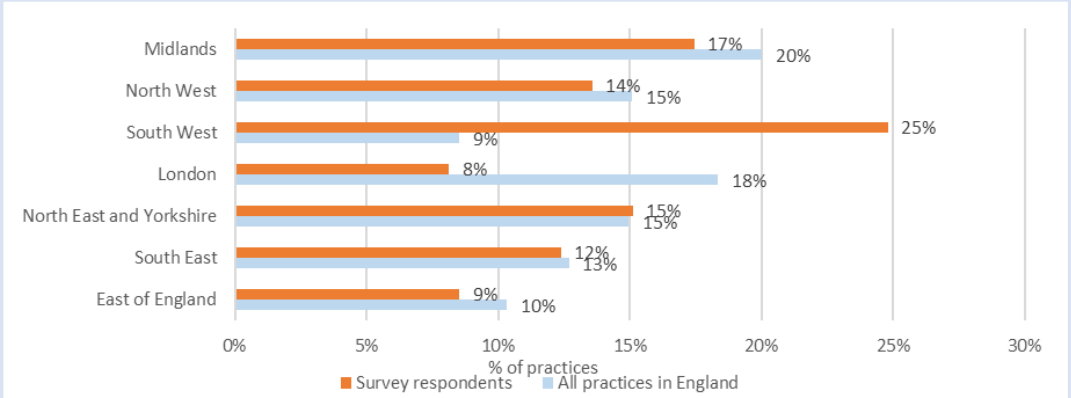
Table 14, which follows after the two pages of summary results for this group, shows the mixture of professions involved in the delivery of essential clinical activities in these practices. This can be compared with Table 8. It is worth noting that in practices where nurses led change management, there was a higher share of nurses involved in the following activities than compared to the broader group of all practices with nurses:

- Menopause support, including HRT advice and/or prescription (68% vs 57%)
- Minor ailments (74% vs 62%)
- Learning disability health checks/reviews (70% vs 64%)
- Home visits (52% vs 42%)
- Nursing/care home visits (48% vs 38%)

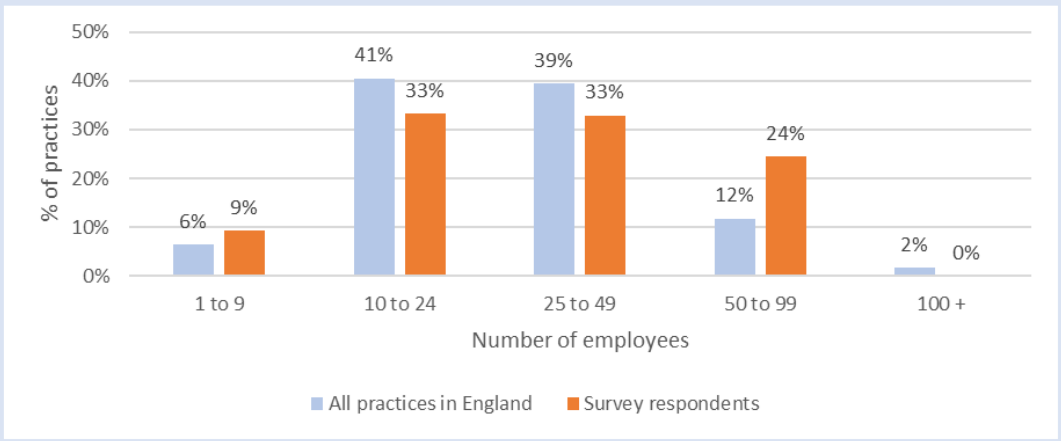
Practices in which nurses were involved in change management (n=289)

Practice information

Commissioning region

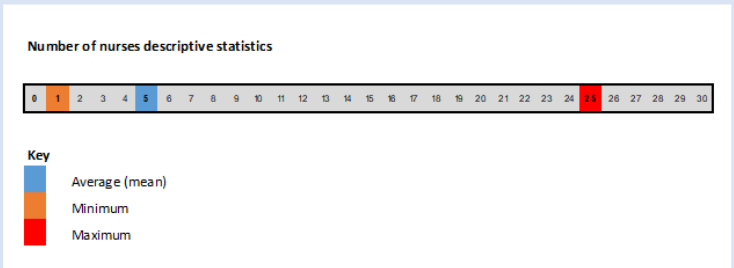


Size (number of employees)



Information about their nurse workforce

Number of nurses in the practice (min, max, average)



Do you have any nursing vacancies at present?
This shows that 24% (70) of practices responding to our survey had at least one nursing vacancy.

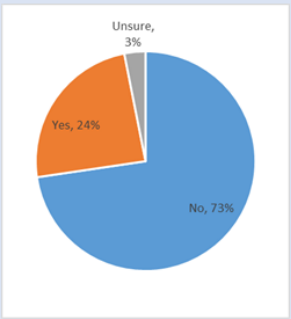
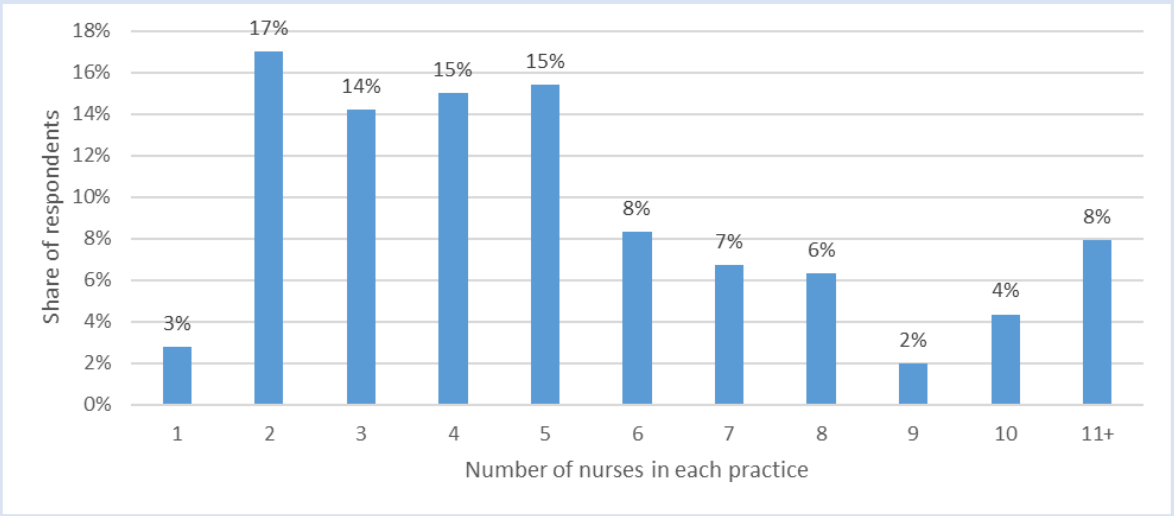


Figure 11: Overview of survey results for practices in which GPNs were involved in change management (page 1)

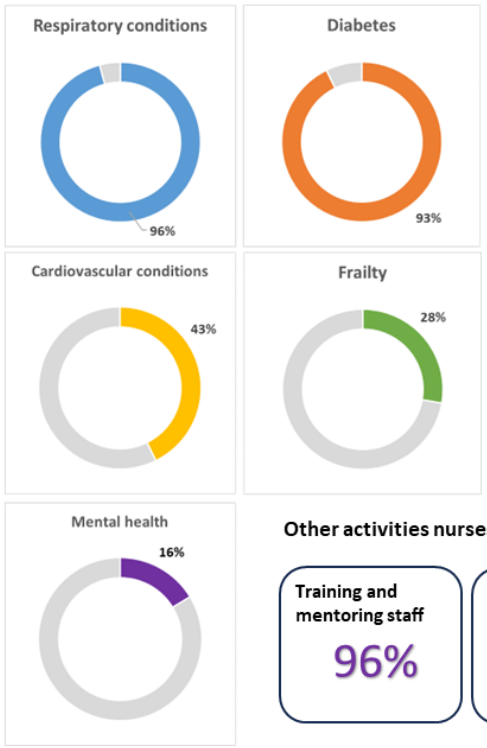
Practices in which nurses were involved in change management (n=289)

Number of nurses in each practice



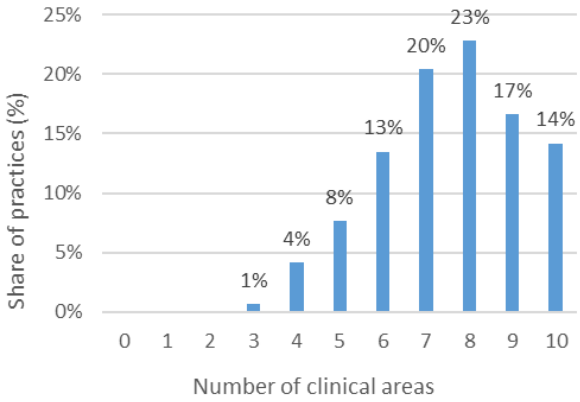
Nurses' responsibilities

Areas nurses led or take particular ownership over
(% of practices in which nurses led these areas)



Degree of nurses' involvement in clinical areas

In the survey we asked whether nurses were involved in a range of clinical areas. The chart below shows the number of services nurses were involved for respondent practices. For example, this shows that in 23% (66) of practices responding to our survey GPNs were involved in 8 different services.



Other activities nurses were involved in (share of practices where GPNs were involved in these activities)

Training and mentoring staff	Management of staff	Change management	Managing the ask of the QOF	External networking
96%	94%	100%	86%	87%

Figure 12: Overview of survey results for practices in which GPNs were involved in change management (page 2)

Table 14: Roles involved in essential clinical activities in each practice (share of practices where this role was involved)

Essential services	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Adult vaccinations, e.g. PPV and Shingles	288	98	5	1	2	1	2	22	39	0	0	0	0	0	0	0
Child vaccinations/immunisations, i.e., 6in1 and MMR	288	100	5	1	1	0	0	7	0	0	0	0	0	0	0	0
Smears	289	100	24	2	1	0	0	11	0	0	0	0	0	0	0	0
Contraceptive advice and/or prescription	288	88	72	23	8	9	3	3	1	0	0	0	0	0	0	0
Menopause support, including HRT advice and/or prescription	287	68	91	30	9	17	3	2	1	1	0	0	0	0	0	0
Phlebotomy	282	64	11	5	5	1	5	29	87	1	3	0	21	0	2	0
Minor ailments	286	74	71	35	21	15	29	5	7	1	0	0	0	0	1	0
Learning disability health checks/reviews	286	70	51	11	6	2	3	9	35	1	1	1	0	0	0	0
Home visits	287	52	92	43	8	3	34	7	17	1	0	1	0	0	2	1
Nursing/care home visits	272	48	84	30	8	5	21	4	10	3	0	1	0	0	4	0

Large practices

The results above indicate that working in larger practices may give nurses further opportunities to get involved in non-clinical activities and to lead clinical areas. We present the key survey results for the largest practices responding to our survey (with 50 - 99 employees). These show that while size is a driver of practices being able to follow the best practice model, it is not the sole determinant of this.

We can see this in the following observations in Figure 13 and Figure 14, which follow this explanation:

- In 29% of large practices nurses led cardiovascular conditions. The equivalent figure for all practices employing nurses was 33%, and therefore quite similar
- In 23% of large practices nurses led frailty services. The equivalent figure for all practices employing nurses was 19%. By contrast, this share was much higher for practices where nurses led cardiovascular conditions (34%)

Indeed, in around 20% of small practices (with between 1 and 9 employees) that responded to our survey, nurses led cardiovascular conditions and were involved in change management. It appears that factors other than size can determine GPNs' roles and responsibilities.

That said, practice size may be a more significant determinant of the GPN workforce's role in non-clinical activities. This may be because there are more opportunities (or there is more necessity) for nurses to be involved in operational activities in larger practices:

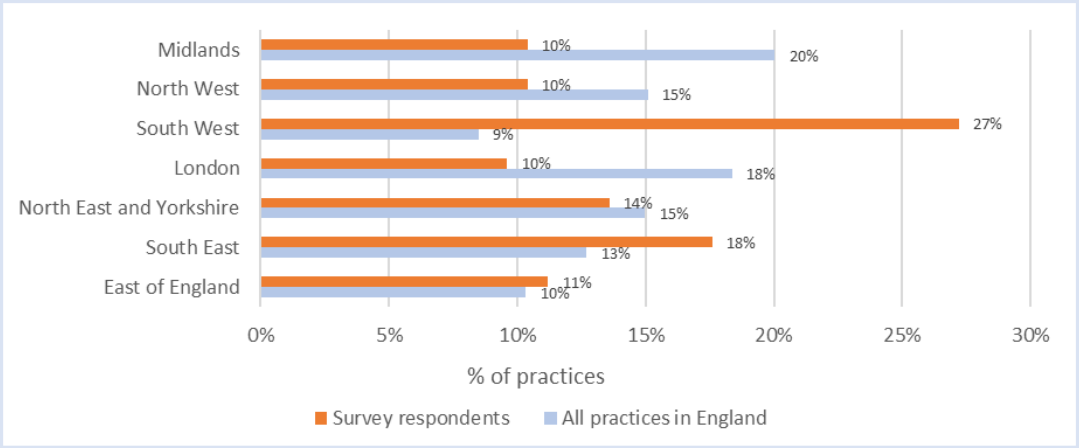
- In 93% of these practices nurses trained and mentored staff – compared to 79% across all survey respondents employing nurses
- In 82% of these practices nurses managed staff – this again was higher than the 68% of survey respondents employing nurses
- There were also relatively large and positive differences for these groups when it comes to managing the ask of QOF and networking

Among this group there was no appreciable different between the mixture of professions involved in the delivery of essential and additional services compared to practices with nurses, so we do not present those results here.

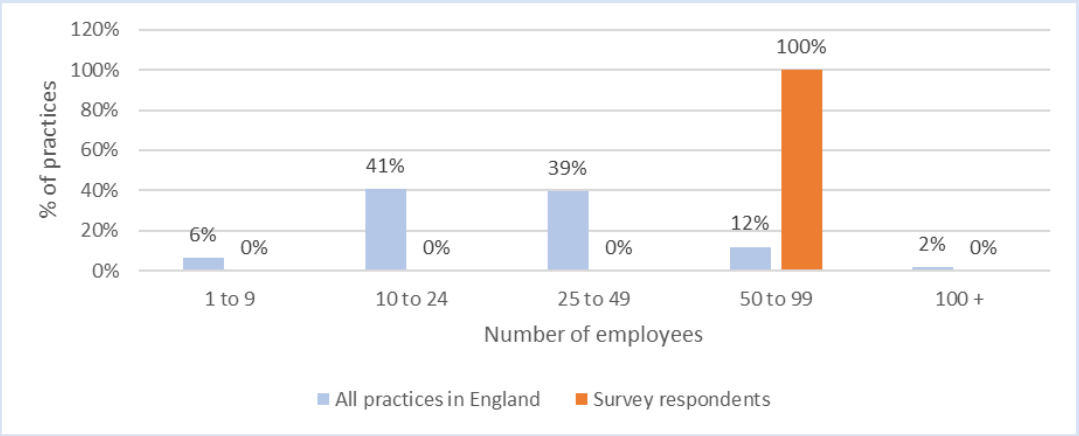
Large practices with 50 to 99 employees (n=125)

Practice information

Commissioning region

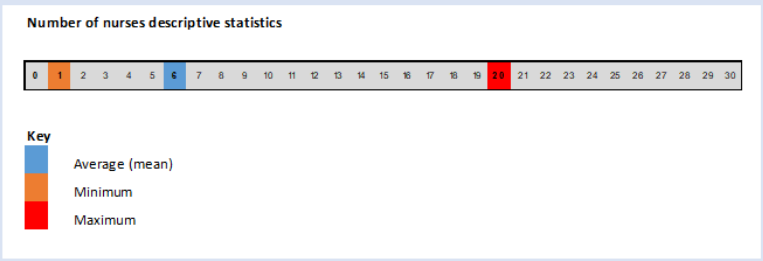


Size (number of employees)



Information about their nurse workforce

Number of nurses in the practice (min, max, average)



Do you have any nursing vacancies at present?
This shows that 31% (39) of practices responding to our survey had at least one nursing vacancy.

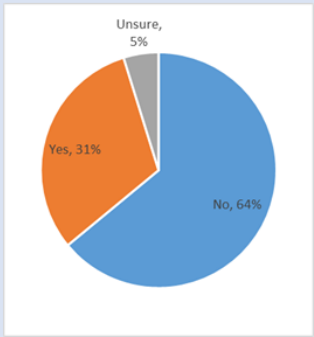
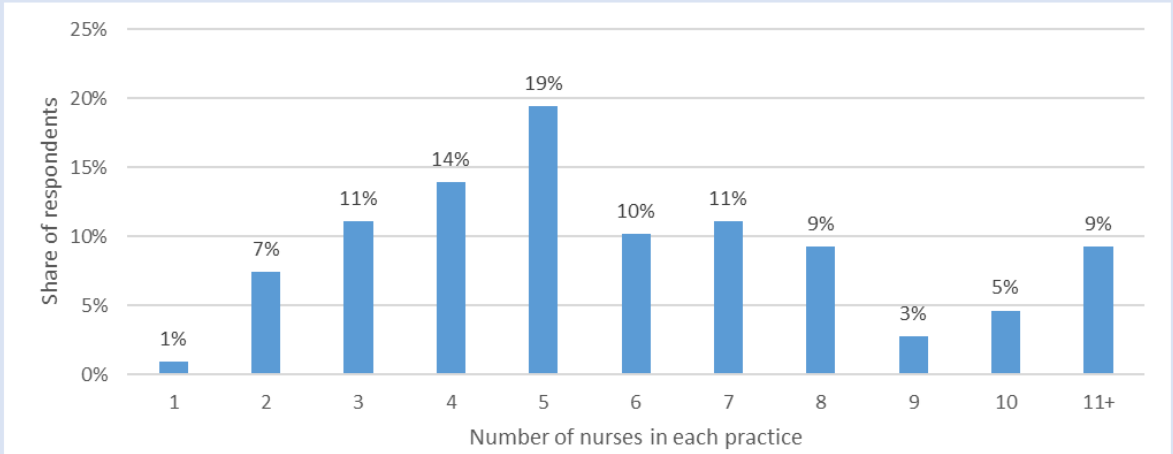


Figure 13: Overview of survey results for large practices (page 1)

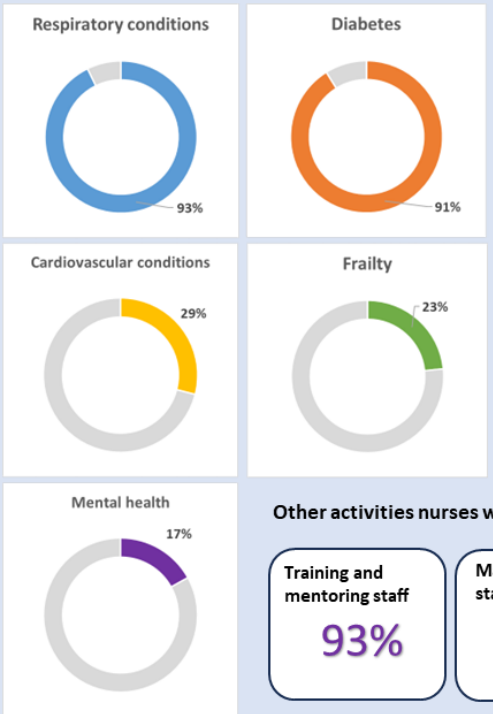
Large practices with 50 to 99 employees (n=125)

Number of nurses in each practice

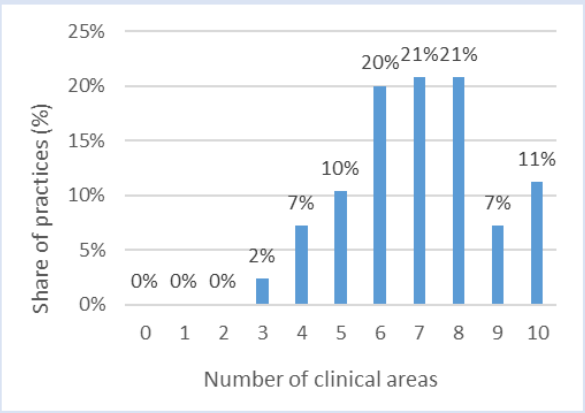


Nurses' responsibilities

Areas nurses led or take particular ownership over
(% of practices in which nurses led these areas)



Degree of nurses' involvement in clinical areas
In the survey we asked whether nurses were involved in a range of clinical areas. The chart below shows the number of services nurses were involved for respondent practices. For example, this shows that in 21% (26) of practices responding to our survey GPNs were involved in 8 different services.



Other activities nurses were involved in (share of practices where GPNs were involved in these activities)

Training and mentoring staff	Management of staff	Change management	Managing the ask of the QOF	External networking
93%	82%	50%	67%	74%

Figure 14: Overview of survey results for large practices (page 2)

Practices in the South West

Results above indicate that practices in the South West were overrepresented among practices following our best practice model. This may be partly driven by their size, but we are also aware of support infrastructure in this region that allows GPNs to step up. In particular the South West has established:

- A Nursing lead at regional level
- A link to the Primary Care Workforce Steering Committee
- Links to higher education and specialist training
- A centrally funded scheme that has proved nurses with no experience in general practice can thrive in their roles
- Activities to promote the CARE Programme
- Awards to celebrate general practice nursing

Box 1 provides a case study of the infrastructure supporting GPNs in the South West to lead the way.

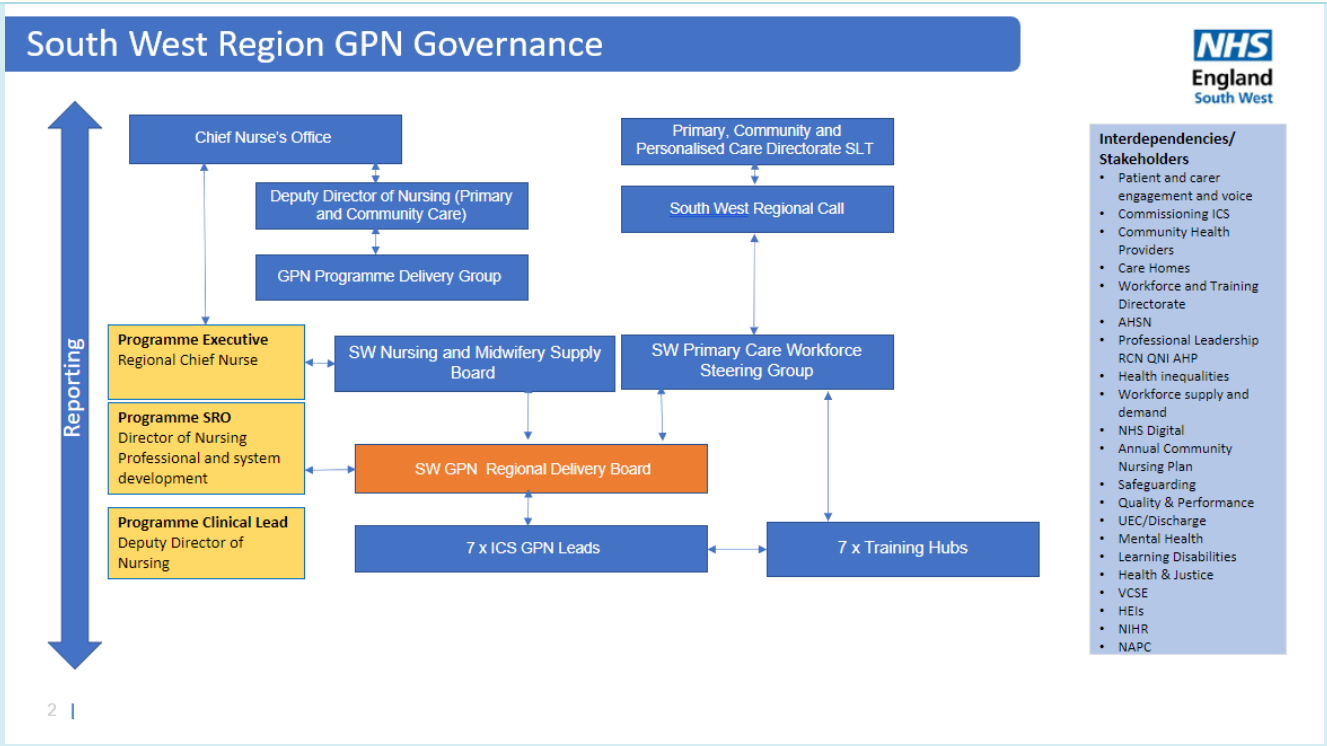
Box 1: Regional Governance of the General Practice Nurse Workforce

The South West appointed a GPN Lead for the GPN 10 Point Plan (10PP) programme and ensured that the post was filled by a general practice nurse. At the end of the GPN 10PP programme, the post was kept, and altered to add other complementary workstreams to it. Prior to the GPN 10PP the local GPN leads had organised meetings among themselves. During the GPN 10PP programme, there had been regular meetings with a reporting structure for the funds allocated during the GPN 10PP programme. Following the end of the programme, these meetings were kept as quarterly meetings with a report from each system on their progress in GPN workforce.

The GPN Lead also attended the Primary Care Workforce Steering Committee, which led to engagement with the training hubs and then to the quarterly Primary Care Workforce System meetings, a meeting with each system's training hub and the Regional Primary Care Workforce Team. Each system was encouraged to invite their own GPN Lead to this meeting.

The Regional GPN Lead also made connections with Workforce, Training and Education to link up strategies around student nurses, nursing associates, professional nurse advocates and HEIs. They also linked into research via the South West Nursing Research Network, and the digital workstreams, ensuring that GPNs had a voice in all these spaces. They worked with the Primary Care Academy, leading to the support of GPN Respiratory Ambassador champions across the South West.

In 2021/22, the Primary Care Team had an underspend, and the GPN Lead submitted a number of business cases, two of which were successful. These were for the New2GPN programme and the GPN ICS Strategic Lead Programme.



The New2GPN Programme provided funds for each ICS to pay for the salary and training for two new GP practice nurses at band 5. The aim was to prove to GP practices that they can hire nurses without a background in general practice. The scheme was very popular, with more applicants and surgeries applying to be hosts than there were places. The result showed an increase in surgeries being willing to hire nurses without any GP experience.

The Strategic GPN ICS Lead programme provided funding for systems to recruit a Strategic ICS GPN Lead for 0.6WTE, band 8b for a year. This person's role was to look at the needs of the GPN workforce in their system and create a workforce plan for it. This created leadership posts for GPNs in systems, and they generated some successful projects. The Legacy Nurse Programme came from one of the postholders (now nationally adopted) and the Nurses on Tour (student nurses on a bus going round GP surgeries) – a programme originating in the North East, and subsequently replicated in the South West) was another Project to develop understanding of general practice nursing amongst the nursing profession.

Throughout all of this, the GPN Programme Lead in the South West also promoted the CARE Programme, ensuring that every system had access to courses, attended system GPN conferences, conducted work on equality, diversity and inclusion in the general practice workforce in the South West, linked in to mental health, children and young people and learning disabilities and autism. They joined general practice nursing to community nursing at a regional level. They created and ran a Celebration of General Practice Nursing (an Award Ceremony), to ensure that GPNs got recognition and reward for their work. This event helped to bring GPNs to the attention of the wider leadership team, both within systems and NHSE regionally.

This wide variety of actions, the drive of the system GPN leaders and the support of senior leaders both in nursing and primary care, has supported improved nursing recruitment and retention in the South West.

4. Practices where nurses' value is not more fully realised

In this section we explore where we have seen departures from the best practice model in our research – these are:

- Practices with nurses who did not lead any clinical activities
- Practices with nurses who were not involved in any non-clinical activities
- Practices employing only one nurse
- Practices employing no nurses

Practices with nurses who do not lead any clinical activities

In our survey of all practices, respondents could indicate that nurses in their practices 'do not lead in or take ownership of any particular areas'. Of the 897 practices with nurses responding, 63 (7%) respondents selected this response. Compared to our full survey respondent group these 63 practices (see Figure 15 and Figure 16):

- Were smaller and more likely to have a smaller nurse workforce
- Involved nurses in a higher number of clinical areas
- Were less likely to involve nurses in non-clinical activities – particularly change management
- Were more likely to be in London, North West and the Midlands
- Were less likely to be in the North West and Yorkshire, the South East and the East of England

There were also some subtle differences in the broad staffing mix for clinical activities. See Table 15 for the mixture of professions involved in the delivery of essential clinical activities in these practices. This can be compared with Table 7 for the general population of practices. Among these 63 practices there was a lower share of nurses involved in the following activities than compared to the full group of practices with nurses:

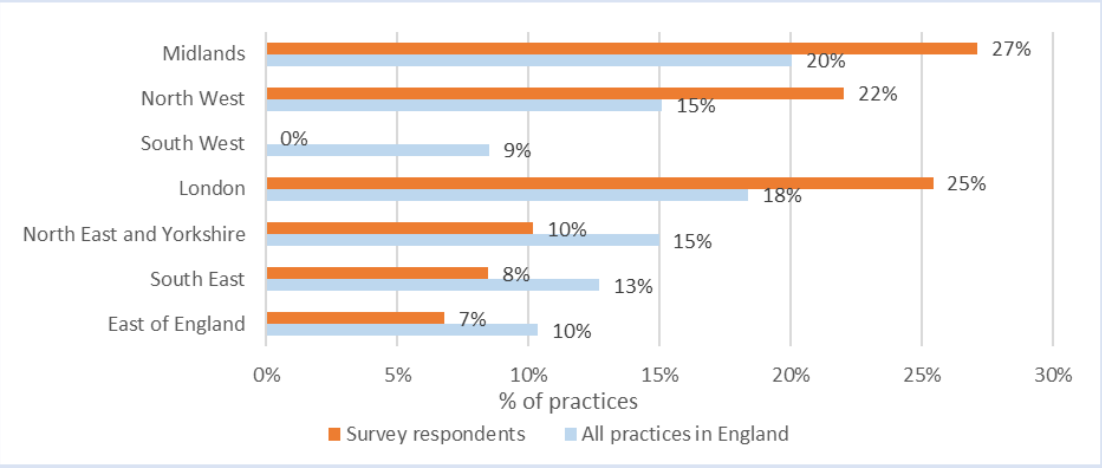
- Menopause support, including HRT advice and/or prescription (48% vs 57%)
- Minor ailments (27% vs 62%)

Interpreting these findings through the lens of our previous research, there may be implications for these practices, their patients and communities as a result of this of this staffing mix. With nurses developing no particular areas of expertise, these practices may be less efficient – with GPs performing activities in which they do not need to be involved. Furthermore, patients may not benefit from the more holistic approach that nurses take and may be less motivated to engage in their own care if they do not receive the broader support and advice that nurses are able to offer.

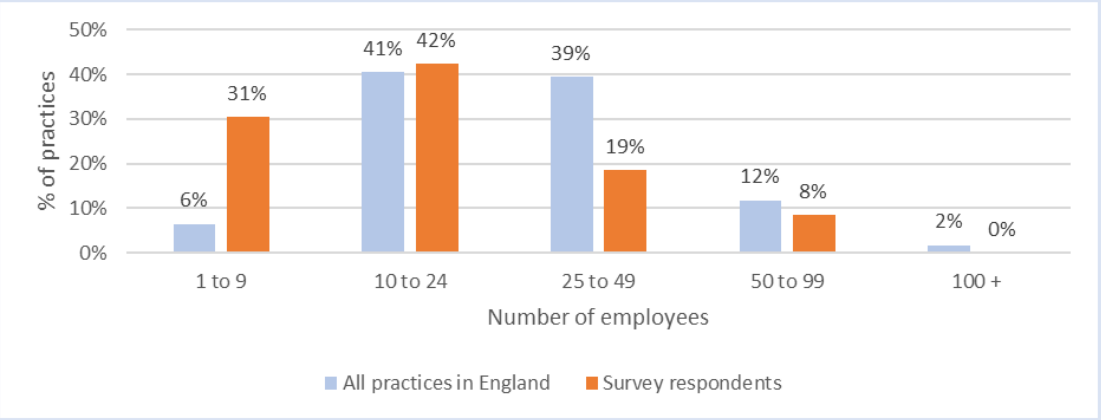
Practices in which GPNs led no clinical areas (n=63)

Practice information

Commissioning region



Size (number of employees)



Information about their nurse workforce

Number of nurses in the practice (min, max, average)

Do you have any nursing vacancies at present?
This shows that 24% (15) of practices where nurses led no clinical activities had at least one nursing vacancy.

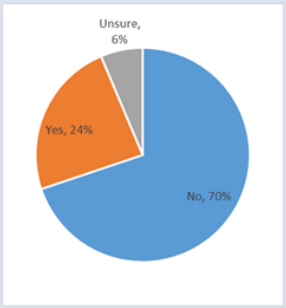
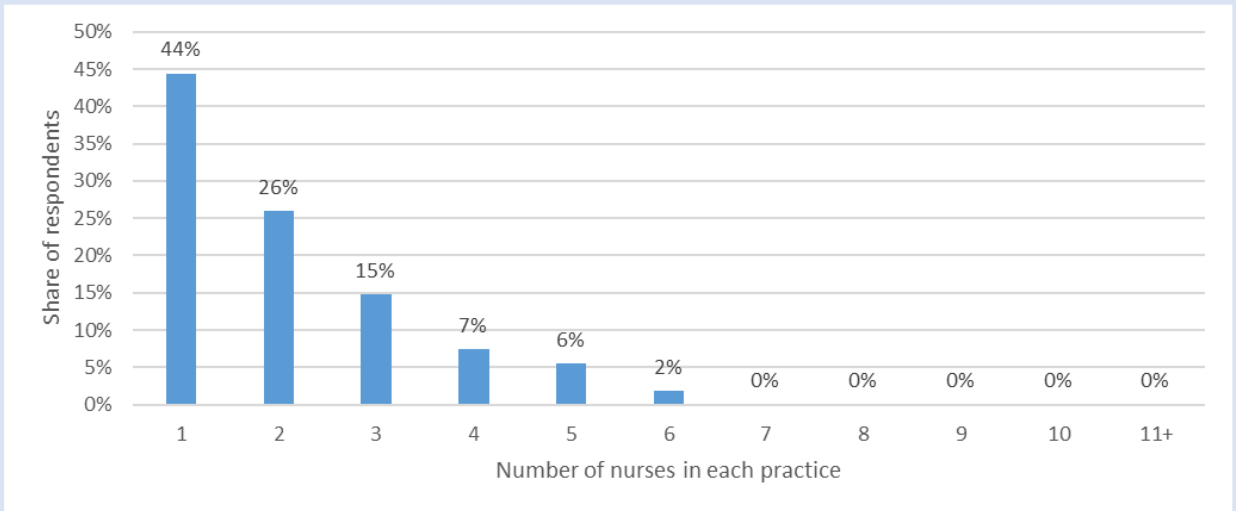


Figure 15: Overview of survey results for practices in which GPNs led no clinical areas (page 1)

Practices in which GPNs led no clinical areas (n=63)

Number of nurses in each practice

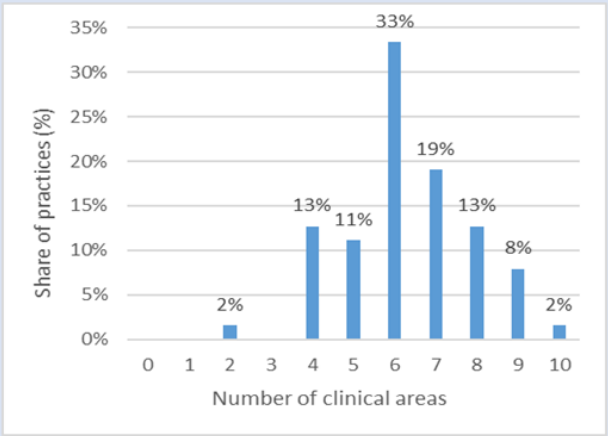


Nurses' responsibilities

Areas nurses lead or take particular ownership over
(% of practices in which nurses led these areas)

Degree of nurses' involvement in clinical areas

In the survey we asked whether nurses were involved in a range of clinical areas. The chart below shows the number of services nurses were involved for respondent practices. For example, this shows that in 33% (21) of practices responding to our survey GPNs were involved in 6 different services.



Other activities nurses were involved in (share of practices where GPNs were involved in these activities)

Training and mentoring staff	Management of staff	Change management	Managing the ask of the QOF	External networking
55%	32%	8%	33%	25%

Figure 16: Overview of survey results for practices in which GPNs led no clinical areas (page 2)

Table 15: Roles involved in essential clinical activities in each practice (share of practices where this role was involved)

Essential service	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Adult vaccinations, e.g. PPV and Shingles	63	95	10	3	2	3	2	11	21	0	0	0	2	0	0	0
Child vaccinations/immunisations, i.e., 6in1 and MMR	62	100	10	2	0	0	0	3	0	0	0	0	0	0	0	0
Smears	63	98	22	0	2	0	0	2	0	0	0	0	0	0	0	0
Contraceptive advice and/or prescription	63	84	71	13	3	8	0	2	2	0	0	0	0	0	2	2
Menopause support, including HRT advice and/or prescription	63	48	89	17	5	11	0	0	0	0	0	0	0	0	2	0
Phlebotomy	58	55	9	0	2	2	2	16	83	0	3	0	12	0	2	2
Minor ailments	60	27	73	23	20	13	18	3	5	2	0	0	0	0	0	2
Learning disability health checks/reviews	62	60	63	11	13	3	0	3	26	2	0	0	0	0	0	2
Home visits	63	40	94	29	5	2	21	6	10	0	0	0	0	0	2	0
Nursing/care home visits	56	38	82	21	5	5	16	4	13	4	0	0	0	0	2	0

Practices with nurses who were not involved in any non-clinical activities

Of the practices taking part in our survey that employed nurses, 6% (52) reported that nurses were not involved in any of the following non-clinical activities:

- Training/mentoring clinical professionals/staff members/students within and/or outside of the practice
- Management of team members, including continuing professional development
- Managing the ask of QOF
- Acting as a point of contact for staff within the practice to raise issues/concerns to
- Networking with health care professionals outside of the practice, i.e., within your PCN
- Policy implementation
- Managing the ask of CQC
- Change management

Common features among these practices (see Figure 17 and Figure 18) were that they:

- Were smaller and has a smaller nursing staff
- Had a much smaller share of nurses leading key clinical areas
- Were more likely to be in London and less likely to be in the South West and North West

Table 16 shows the mixture of professions involved in the delivery of essential clinical activities in these practices. This can be compared with Table 7. Not only in these practices were nurses less likely to **lead** key clinical areas, they were also less likely to be **involved** in certain clinical areas. These specific clinical areas have a high degree of GP involvement across all respondent practices and therefore may be more complex or may involve more risk:

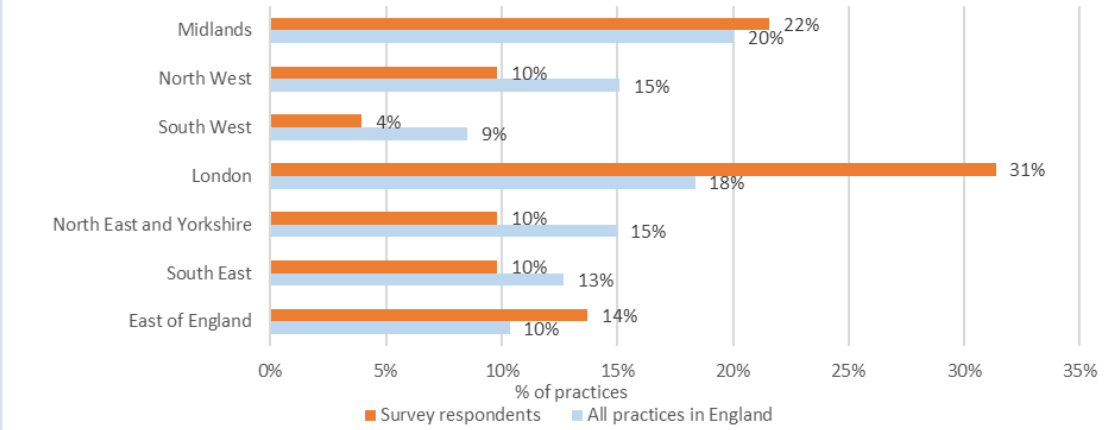
- Menopause support, including HRT advice and/or prescription (41% of practices have nurses involved in this activity vs 57% for all practices with nurses)
- Minor ailments (35% vs 62%)
- Learning disability health checks/reviews (48% vs 64%)
- Home visits (29% vs 42%)
- Nursing/care home visits (18% vs 38%)

These findings indicate that many of these practices were operating according to the 'traditional' model of general practice nursing, with nurses supporting GPs directly in the delivery of care. As a result of this model, it is likely that nurses in these practices were not reaching their full potential. Nurses in these practices were not networking and bringing best practice back to their organisation. Nurses in these practices were not managing the ask of QOF; instead, GPs were more likely to be heavily involved in this activity. The quality of care for patients was likely to be negatively affected, and the wider community affected if nurses were not able to reach out to ensure the whole community's needs were met, and not just the needs of those presenting themselves to the practice.

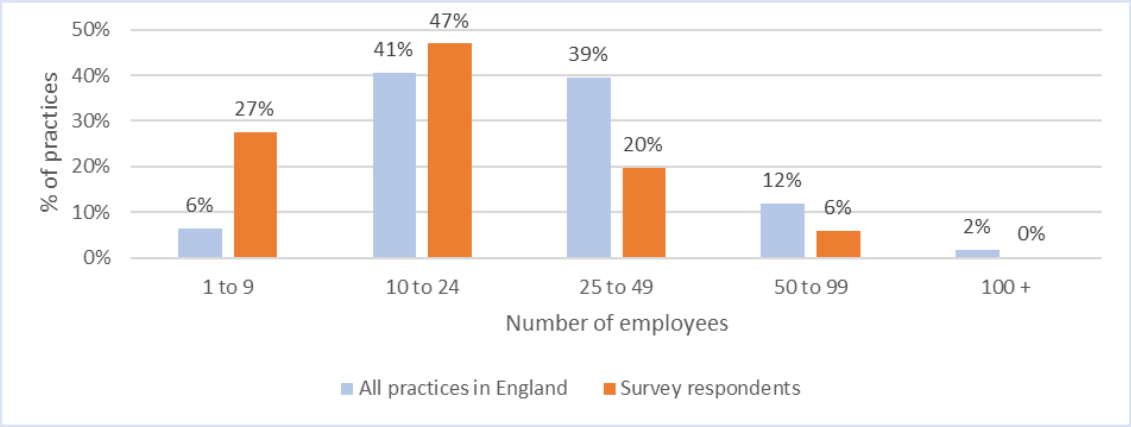
Practices in which GPNs did no "other" activities (n=52)

Practice information

Commissioning region



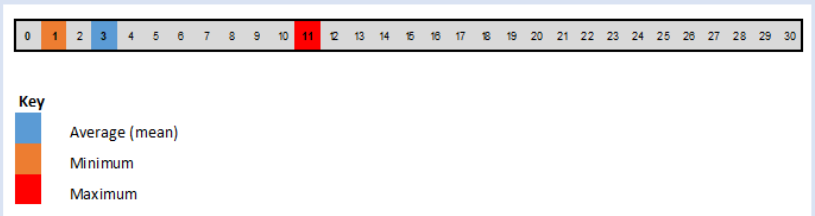
Size (number of employees)



Information about their nurse workforce

Do you have any nursing vacancies at present?
This shows that 27% (14) of practices responding to our survey had at least one nursing vacancy.

Number of nurses in the practice (min, max, average)



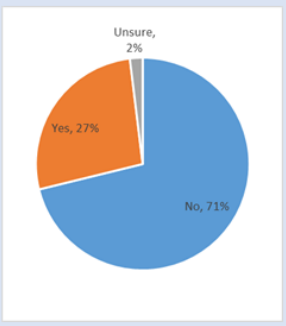
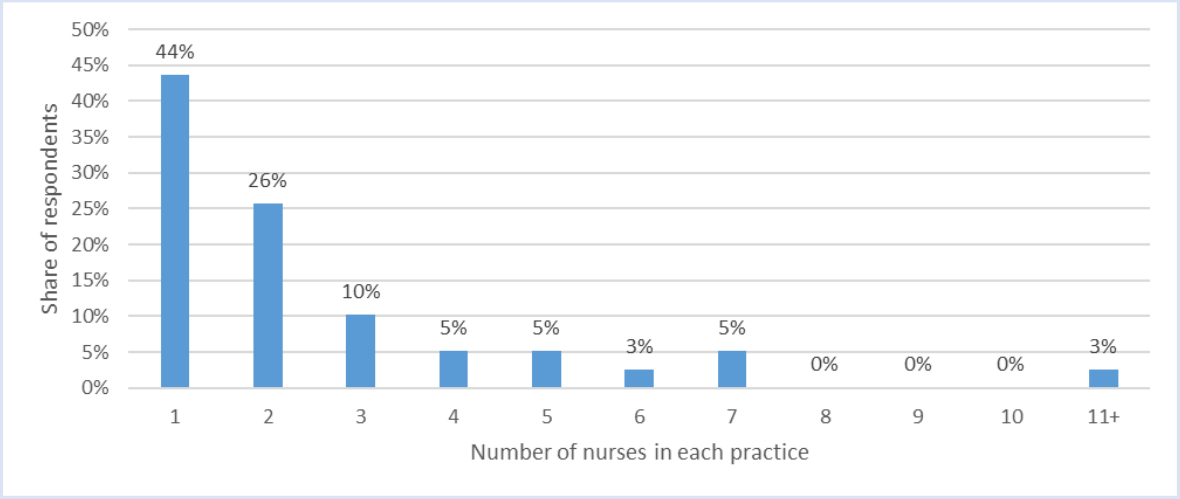


Figure 17: Overview of survey results for practices in which GPNs were not involved in any non-clinical areas (page 1)

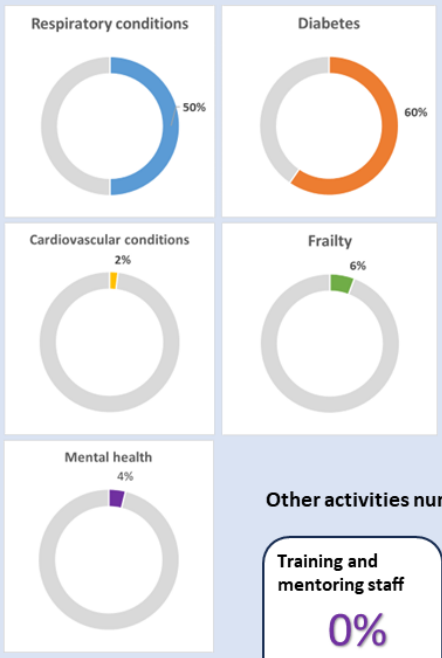
Practices in which GPNs did no "other" activities (n=52)

Number of nurses in each practice

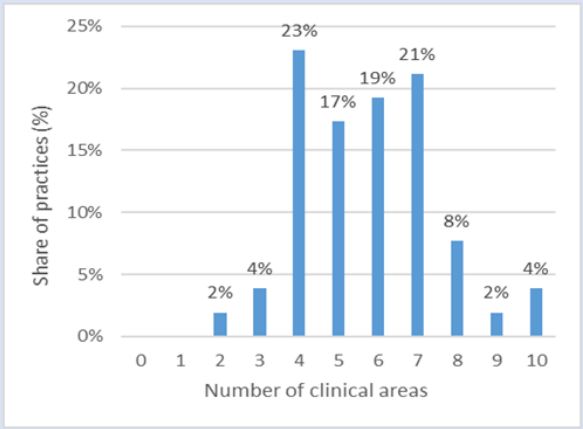


Nurses' responsibilities

Areas nurses lead or take particular ownership over
(% of practices in which nurses led these areas)



Degree of nurses' involvement in clinical areas
In the survey we asked whether nurses were involved in a range of clinical areas. The chart below shows the number of services nurses were involved for respondent practices. For example, this shows that in 23% (12) of practices responding to our survey GPNs were involved in 4 different services.



Other activities nurses were involved in (share of practices where GPNs were involved in these activities)

Training and mentoring staff	Management of staff	Change management	Managing the ask of the QOF	External networking
0%	0%	0%	0%	0%

Figure 18: Overview of survey results for practices in which GPNs were not involved in any non-clinical areas (page 2)

Table 16: Roles involved in essential clinical activities in each practice (share of practices where this role was involved)

Essential service	Respondents (count)	Roles involved in activity (share of practices, %)														
		Nurse	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	Nursing associate / Trainee nursing associate	HCA	Other	GP Assistant	Care coordinator	Phlebotomist	Assistant practitioner	External provider	Advanced clinical practitioner
Adult vaccinations, e.g. PPV and Shingles	52	96	12	2	0	6	2	6	23	0	0	0	2	0	0	0
Child vaccinations/immunisations, i.e., 6in1 and MMR	52	100	8	0	0	0	0	0	2	0	0	0	0	0	0	0
Smears	50	98	4	0	0	0	0	2	0	0	0	0	0	0	0	0
Contraceptive advice and/or prescription	52	73	60	8	4	10	0	2	0	0	0	0	0	0	2	0
Menopause support, including HRT advice and/or prescription	51	41	75	14	2	10	0	0	0	0	0	0	0	0	2	0
Phlebotomy	49	47	6	0	2	2	0	2	69	2	0	0	18	2	4	0
Minor ailments	52	35	69	15	23	8	12	2	0	2	0	0	0	0	2	0
Learning disability health checks/reviews	52	48	73	8	12	4	2	6	19	0	0	0	0	2	0	0
Home visits	52	29	98	19	4	0	21	4	12	2	0	0	0	0	2	0
Nursing/care home visits	44	18	82	14	7	5	18	2	14	2	0	0	0	0	7	0

Practices with only one nurse

Our findings show that larger practices with a larger number of nurses provide opportunities for nurses to develop areas of clinical speciality and could provide the opportunity for them to get involved in non-clinical activities. There are, however, practices with a smaller number of nurses where nurses do lead a number of activities. This is, in some cases, because their nurses are supported to go above and beyond, and in other cases it is because there are no other staff or nurses to deliver these activities.

One nurse we interviewed indicated that she had been the only nurse in her practice for 18 months after her GPN colleague retired and the practice struggled with recruiting someone else. When asked how this was for her, she said:

> *'Very busy. And very isolating… that period of 18 months where I was on my own, I was doing absolutely everything, the ordering It was just nonstop…'*

While this nurse did not discuss the impact that this might have had on the practice, she certainly expressed that it took a toll on her, and that the workload was simply not sustainable for one nurse.

Another nurse interviewed who worked in a relatively large practice mentioned that she was the only nurse in the practice on a Friday. About those solo days, she said:

> *'I don't like it. Because the demand of stuff that nurses need to do, when I'm the only one, it will all fall to me because I'm the only one who can do certain things… At least when there's a few of you there, you can kind of work together you know, everyone can take a bit of the load.'*

Both interviewees discussed the difficulties in carrying out their roles with no GPN colleagues around to support them. This highlighted importance of teamwork among GPNs and the importance of ensuring nursing teams, whether small or large, are supported and have the resources to do their jobs effectively.

Where nurses are under such pressure in performing the day-to-day tasks to support the running of the practice, they are unlikely to be able to develop areas of expertise and lead clinics. Their time for further training would be constrained and the opportunity to manage changes in services extremely limited. It is unlikely that they would be empowered to develop a broader and more advanced set of skills to meet population needs, or the management skills to lead aspects of practices' business. These practices might therefore be missing out on the value to patients, practices and communities that are available when nurses are able to step up.

Practices with no nurses

Of the eight practices without nurses taking part in our survey:

- Five out of eight were small – employing between one and nine people

- Two out of eight employed between 10 and 24 people and only one was larger, employing between 25 and 50 people
- Three were in London, three in the North-West, one in the East of England and one was in the East Midlands

Of these eight practices, seven reported wanting to employ a nurse but there were barriers to recruitment (see Table 17 – each participant could identify multiple barriers). Reflecting the known national shortfall of GPNs relative to demand, the most common reason given by respondents for not currently employing a nurse was a lack of candidates. For a small number of these practices barriers to hiring also included that candidates did not have the right experience, and that candidates were not the right fit for the practice. The one practice without nurses that did not want to employ a nurse said that they had no need for the role as they had access to community nurses and/or nurses within their PCN.

Table 17: Barriers to hiring nurses (n=8)

Response	Count
Lack of candidates	7
Candidates interviewed are not the right fit	3
Candidates do not have the right experience	2
We cannot afford to hire nurses	0
We do not have the time to recruit	0
Our practice's terms and conditions do not meet candidates' expectations	0

We had one interview with a practice with no nurses and spoke to a GP Partner of this practice. This interviewee placed great emphasis on the point that they wanted to employ a nurse but had faced recruitment challenges. When asked to tell us about this situation, they said:

> *There is a complete lack of GP nurses. The workforce is really limited. And to recruit a nurse has become increasingly difficult…We [once] had an amazing nurse. So, she was a district nurse, and we took her in, and we trained her up to be a GPN. And then we supported her while she did her Advanced Nurse Practitioner. She was with us for a number of years...*

Our interviewee went on to discuss that this former nurse had done all she could at practice level, and that this was a wider challenge – finding a "nurse that just wants to do nursing". There is a point worth discussing here about the opportunities to progress and lead within the GPN career. While this nurse had been supported to progress to an ANP role, they had not felt there was the opportunity to develop further. If GPNs had greater opportunity to progress to leadership roles, might this aid career satisfaction and retention and create huge value for practices?

As a result of having no nurses on their team the practice distributed the workload among existing staff where possible. For example, utilising the skills of practice-based pharmacists who were able to carry out long term condition reviews, and for certain clinical activities such as adult vaccinations and wound dressings, they had upskilled their HCAs. However, this model was not able to fulfil all the activities that a nurse would typically carry out. For clinical activities such as childhood immunisations, smears, and house-bound reviews, they were having to refer externally.

When discussing the overall impact of not having a GPN in their practice, this interviewee shared a few thoughts:

> *Not having a nurse is massive. Because you're doing stuff that you don't need to be doing (as a GP) … Fine, I don't mind doing it…But it is one less appointment for the stuff that nobody else can do...*

They also went on to discuss that not having a nurse was impacting QOF because the practice was not managing to hit certain points and subsequently, they lost out on income.

Similarly, our survey data could tell us in the eight practices without nurses which other professionals cover the clinical service roles that nurses would otherwise fulfil (see Table 18). Many used a locum nurse to carry out smears (6/8) and to deliver contraception advice (5/8). In almost all of those practices (7/8) GPs would be involved in providing menopause support. In 5/8 of those practices HCAs would carry out phlebotomy. For non-clinical activities it was predominantly GPs and practice managers who would be responsible for the following activities:

- Training and mentoring staff
- Managing staff
- Acting as a point of contact for staff within the practice to raise issues/concerns to (predominantly the practice manager)
- Change management
- Policy implementation (predominantly the practice manager)
- Networking with health care professionals outside of the practice
- Managing the ask of QOF
- Managing the ask of CQC
- Developing patient or community support programmes or groups (predominantly the practice manager)

In the absence of nurses practices are likely to have higher costs due to the need to use locum nurses to deliver services. Furthermore, GPs would be drawn further into the delivery of services, and their practice managers would be more fully involved in non-clinical activities. Finally, using locum nurses to deliver activities would reduce the ability of practices to develop a good and long-term knowledge of their patients and community.

Table 18: Which clinical members of staff in the practice would typically carry out these activities - count of practices (n=8)

Clinical activities	GP	GP registrar	Physician associate	Practice pharmacist	Paramedic	HCA	We would use a locum nurse	We would refer externally	Other	Details of other
Smears	2						6		1	Pay for provision at a hub
Contraception advice	3						5	2		
Menopause support	7						3			
Treatment and management plans for chronic conditions	3	1		1		2	3			
Prevention and wellbeing promotion for patients	3	2	2			4	3			
Phlebotomy						5		2	1	Phlebotomist
Minor ailments	6	1	2			1	2			
Vaccinations including child vaccinations	3					2	3	1	1	Pay for provision at a hub

5. Opportunities for nurses' value to be recognised and realised

In this section we explore the specific clinical areas that our research shows that nurses' skills, leadership and knowledge could be harnessed more effectively.

If practices across England were more consistently to harness nurses' unique mixtures of skills and knowledge the additional benefits likely to be felt include practices being more efficient, patients receiving more tailored and holistic care, and communities being better served by sharing of best practice and patient outreach. Given nurses' holistic understanding of patients' needs and population health, they could use this expertise to help shape care in their practices and areas to reflect their communities' needs (per the Long Term Workforce Plan).[27] This greater involvement would also support primary care meet its new scope per the Long Term Plan.

The Chief Nursing Officer Strategy recognises the same potential for the professional impact of nursing. This notes nurses' important role in our health system in prevention, protection and reducing health inequalities, person-centred practice and professional leadership and integration of care. This strategy also recognises the need for people and workforce development and an inclusive culture in enabling nurses' professional impact.

Comparing the practices analysed in sections 3 and 4

Several themes have emerged from our analysis of practices where the *Leading the Way* model is more closely adhered to, and those in which it is run only in part. In Table 19 we show key results by the practice types explored in sections 3 and 4, and compare them to the whole practice population. It is worth noting that there may be some practices that appear in one or more of each of these types (e.g. some practices where nurses lead cardiovascular services will also be in the group in which nurses are involved in non-clinical activities).

The key results shown in Table 19 are:

- The number of practices of each type
- The average (mean) number of nurses, and the range of nurse numbers in those practices
- The percentage of those practices that get nurses to lead a range of clinical areas, and the percentage that involve nurses in a range of non-clinical activities

We can see in Table 19 that some practices have a very small number of nurses. In all practice types some practices have as few as one nurse. We know that 22% of practices in our respondent group have nurse vacancies, and more than that number would recruit if they thought they could find people to fill the vacancies. These observations suggest that:

- Practices want to hire more nurses
- Practices get them involved in interesting and complex areas of service delivery
- We need more nurses coming into this branch of the profession, and staying and advancing there

[27] NHS England (2024), NHS Long Term Workforce Plan

Further key observations relating to Table 19 are that the share of nurses leading clinical services and the share of nurses involved in non-clinical activities vary significantly across practice types. This leads to the following three observations:

Table 19: Comparison of the practice types across key metrics

Key metrics	All practices with nurses	Nurses lead cardiovascular services	Nurses are involved in change management	Large practices	Nurses lead no clinical areas	No nurse involvement in non-clinical activities
Number of practices	897	291	289	125	63	52
Number of nurses in the practice:						
Average	4	5	5	6	2	3
Range	1-30	1-30	1-25	1-21	1-6	1-11
Clinical areas that nurses lead (percentage of practices):						
Respiratory	85%	99%	96%	93%	0%	50%
Diabetes	86%	96%	93%	91%	0%	60%
Cardiovascular	33%	100%	43%	29%	0%	2%
Frailty	19%	34%	28%	23%	0%	6%
Mental health	14%	25%	16%	17%	0%	4%
Non-clinical activities in which nurses are involved (percentage of practices):						
Training and mentoring	79%	88%	96%	93%	55%	0%
Staff management	68%	81%	94%	82%	32%	0%
Change management	33%	42%	100%	50%	8%	0%
QOF asks	67%	79%	86%	67%	33%	0%

Opportunity 1 – Opportunity for greater nurse leadership for cardiovascular, frailty and mental health services
We know that nurses are particularly effective in understanding patients' wider needs and situations to develop ways for them to manage their own chronic conditions. We know that they are also effective in building networks of support around patients that moderate the need for further professional involvement. With those aspects likely to be real strengths in cardiovascular, frailty, and mental health services, it begs the question that nurses should lead these services in most practices.

In most practices in the study nurses did lead respiratory and diabetes work – this was the case in 85% and 86% of practices respectively. We can see that these shares increase for larger practices (in which 93% and 91% of

practices nurses led respiratory and diabetes services respectively). However, these shares are even higher for those practices where the nurses lead cardiovascular services (99% and 96% respectively).

Among the 52 practices where nurses had no involvement in non-clinical activities, only 50% to 60% of these practices got nurses to lead respiratory and diabetes services respectively. For these practices, the shares of nurses leading cardiovascular, frailty and mental health services were also much lower. Only between 1 and 3 of these practices had nurses leading these services.

Across all practices that responded to our survey only 33% had nurses leading cardiovascular services. Interestingly the share of large practices with nurses leading cardiovascular services was even lower at 29% so it is not purely the size of practices that allow nurses to lead and develop areas of particular specialism.

These observations show that there is likely to be 'carry over' – where nurses skills and knowledge are recognised in practices they are likely to lead or be involved in clinical and non-clinical areas and are more likely to be resourced to be able to perform these roles. We can see that in practices where nurses lead no clinical areas the maximum number of nurses in those practices is six.

This therefore represents an opportunity to increase nursing leadership across clinical services across most practices, particularly in cardiovascular, frailty and mental health services. These are areas to which nurses' skills and insights are well suited. There may be a capacity issue in this, but we should be solving that rather than not getting nurses to lead where they are most effective.

Opportunity 2 - Leading staff training, mentoring and management of others

The second opportunity relates to a greater potential role for nurses in training, mentoring and managing others. When nurse-led these activities are key to developing a sustainable succession of nursing skills within each practice and more widely across primary care.

In Table 19 we can see a very high percentage of certain practice types (large practices, practices with nurses leading cardiovascular services, and nurses involved in non-clinical activities) have nurses involved in training and mentoring, and staff management. This share is markedly lower for practices where the nurses do not lead any clinical areas.

Given that practices have, for the most part, several nurses, and HCAs, why aren't nurses more consistently involved in training and managing others across practices? Given their wide skills and contextual knowledge, this seems like a missed opportunity in many practices around the country.

Opportunity 3 - Nurses managing the ask of QOF, external networking and partnering with external agencies

The third opportunity arises in two other non-clinical areas: managing the ask of QOF and external networking. We know that nurses contribute to QOF categories. We also know from our Phase 2 research (explained further in

the next section) that GPNs are involved in external networking – with other practices, with entities such as schools and care homes, and with wider health providers.

When we look at whether nurses are involved in these activities in Table 19 we see a real spread. For example, across the whole respondent group only 50% of practices have nurses involved in managing the ask of OOF. This share is much higher – 86% – in practices where nurses are involved in change management, but it is only 33% in practices where nurses have no involvement in clinical activities.

This presents a clear and beneficial opportunity for practices. Nurses having greater involvement in these areas across the practice population would maximise practice income, would give nurses more authority, and would generate more insight into overall practice dynamics so they could seek other areas of improvement: at least a double gain.

6. Risks and barriers to general practice nursing reaching its potential

Below we explore the risks and barriers that prevent practices from adopting elements, or the full model, of best practice. In Appendix 1 we set out our revised view of the model of best practice based on our research findings from Phase Three. These risks and barriers stand in the way of nurses reaching their full potential, and for general practice nursing to deliver the full possible value to practices, patients, communities and the wider NHS. We have revisited the risks highlighted in our earlier report, reframed them in light of the evidence gathered in this study, and we have added further risks identified in this phase of research.

Risks to value

Risk 1. Lack of a clear development pathway linked to undefined and unspoken roles

In our earlier research we highlighted that there is a lack of recognition and awareness of the GPN role: what it really entails, and the value that it yields for patients, practices, communities, and the NHS. The GPN role is not a role formed from an overlap of other disciplines, but a clear, identifiable discipline in its own right, however, it lacks recognition, investment, training, and the establishment of a clear career pathway. This last point in particular, around the lack of a clear career and development pathway, creates a big risk for both the existing GPN workforce and for the future of the workforce. While a Primary Care and General Practice Nursing Career and Core Capabilities Framework does exist and identifies, among other things, clearly defined career levels for GPNs, this is yet to be widely socialised and used in practice.

In this phase of the research, we heard that GPNs are dissatisfied with the lack of progression and development opportunities available within the role. Not only does this limit the value that they are able to create, but it also creates a threat against retaining GPN talent.

> *She's 24, she doesn't want to be my age and still sitting doing the same job. She wants a career path, she wants to know that she can train in this, move on to that, do this, eventually become a lead nurse, you know?*

A nurse reflecting on the attitudes of her practice against development and progression

We heard that practice attitudes and willingness to support GPNs in their development can be a big barrier to career progression. This is accompanied by the lack of banding that applies to the GPN role, unlike other nursing roles. This makes it very difficult to recognise and demonstrate the level at which they are performing their roles and creates a sense of stagnation for those wanting to show progression. In one interview, a nurse discussed how a high performing GPN had left their practice because the GPN felt as though they had achieved all they could with their role and within the practice and so needed to leave to progress further.

Risk 2. Variation in employment terms and conditions across practices

We have previously highlighted the huge variation in working arrangements, pay, and terms and conditions of employment of general practice nursing staff. Being employed directly by practices means that nurses do not have the guaranteed leverage of Agenda for Change guidance around salaries. While some practices may mirror Agenda for Change, independent contractors are not obliged to adopt it. Pay banding is also not applicable to the GPN role and so GPNs do not benefit from the level of structure and standardisation around career and salary progression that other NHS staff have. We heard in this phase of the research, that this poses a risk to the workforce as it deters nurses from entering the GPN workforce – particularly younger nurses.

This phase of the research provided strong evidence that this risk is felt deeply in the workforce, particularly in interviews with GPNs. A nurse interviewed discussed feeling as though GPNs are "*at the mercy of*" their GP Partners, when it comes to their pay and terms and conditions of employment, going on to say, "*we're very much at their whim as to what they feel we're worth which is very frustrating*".

The nurses that we interviewed were generally unsatisfied with their pay and employment terms and conditions. However, one area that stood out as a real pain point was the lack of maternity pay. The absence of good maternity leave and maternity pay for many GPNs deters younger nurses who might be thinking about the possibility of starting a family from entering general practice. Some of our interviewees spoke of general practice nursing as a good career option for nurses once they have had children as it offers a better work-life balance and more convenient hours.

The maternity rights that you have as a practice nurse are not as good as you get in a hospital… You're not going to get young people coming in very easily because they're only gonna get the statutory minimum maternity leave pay.

A Partner Practice Manager sharing thoughts when reflecting on why general practice does not attract younger nurses

I would advise somebody to do their Advanced Nurse Practitioner qualification or their work in the hospital until they've had their family and then come to us.

A nurse when discussing one of the younger nurses (aged 28) in her practice

In our earlier research, we highlighted the lack of transferability of pay and employment terms and conditions between practices, which acts as a barrier to moving practices for nurses. This is because nurses prefer not to put at risk the benefits they have accrued in a particular practice. This therefore limits the extent to which expertise, best practice and experience can spread across practices. In a network of small and medium-sized enterprises (SMEs) like general practices there needs to be an easily reached pool of nurses from which practices are able to recruit to meet their staffing needs. However, since there are barriers to nurses leaving their existing practices, it is much harder for other practices to fill vacancies. This creates workforce issues, especially when practices operate with gaps in nurse staffing for extended periods of time.

In this phase of research, we heard that nurses are very aware of the disparities across practices and that GP surgeries that pay well and that offer good employment conditions and benefits are more successful in recruiting and retaining GPNs. Conversely, there were GPNs who were not happy with their pay and terms and conditions who would be willing to move if they were offered better elsewhere.

The most common reason people leave a practice is because they've been offered a bit more somewhere else, some practices are very good, and do pay more, because to

One Clinical Nurse Manager/ANP

The lack of consistency and standardisation across practices, in line with the points discussed above, poses a huge risk to the sustainability of the workforce both by wearing down the current cohort of GPNs and by deterring newly qualified and younger nurses from coming into general practice.

Risk 3. Training and development opportunities vary widely

GPNs play a crucial role in the internal training and upskilling of their colleagues, both for GPNs who may be new to the practice or less experienced, and other staff members (most commonly, but not limited to, HCAs and Nurse Associates). However, beyond internal training and learning that happens on the job, GPNs themselves can have limited scope to take the time they need to engage in training and learning. We highlighted in our earlier research that training and development opportunities vary widely, which influences not only how nurses feel about taking up a general practice role, but also how patients experience care. In our survey of all practices, we asked respondents when nurses engage in mandatory and further training. Table 20 shows the results: a large share of nurses had to carry out mandatory training (59% of respondents) and further training (71%) partly in their own time.

Table 20: When nurses find the time to carry out training (share of practices responding) (n = 874)

	Percentage of respondents	
Response	**Mandatory training**	**Further training**
Practice hours	36%	23%
Their own time	4%	5%
A combination of both	59%	71%
Unsure	1%	1%

Every bit of training we do is a fight…I've been asked on numerous occasions to do the training in my own time.

Nurse

I think the biggest challenge is getting training… because it involves finances, and if you can't get funding elsewhere, then you know, it's trying to get it from the partners.

A nurse on the biggest challenges of being a GPN

The topic of disparities across training and development opportunities was strongly supported in the interviews. In relation to external training, such as training courses and qualification programmes, this was discussed as a big challenge and a risk to the best practice model. Interviewees spoke about difficulties in accessing training, getting funding for it, and finding the time to carry it out.

Difficulty in accessing training is a risk to retention, care quality, and innovation in services. If GPNs do not feel as though they have opportunities to develop and progress in a practice, they are less likely to stay. It also poses risks as GPNs can only offer services and deliver care in areas in which they are trained. As such, barriers to training limits the care nurses can deliver, which has an impact on the practice and its patients.

Our lead nurse has just managed to do her spirometry training. She did that via the primary care network, but, if she hadn't been able to be funded via that, we wouldn't have been able to offer spirometry at the practice

One nurse interviewed discusses the importance of nurse training to their practice's offer

Risk 4. Restrictions on time, capacity and patient access reduce the breadth of insight and action the nurse can bring to bear

In this research phase, we heard that the impact and value that nurses can bring is often limited by the time and capacity that they have available. In the interviews, we heard about the increase in patients presenting with complex long-term conditions who may also have had a backlog of issues to discuss. These patients required more time and more extensive care than nurses had the capacity to offer, particularly within their standard appointment time frames. Nurses could not treat such patients fully, and instead had to work out what they could do for the patient within the limits of their time. This was a frustrating experience for many of the nurses interviewed, although we recognise that this is unlikely to be an issue exclusive to GPNs and is seen across the NHS.

Risk 5. The GPN role entails non-clinical activity including practice administration. If nurses are not prepared for this, or helped to see its benefits, these responsibilities may feel like a burden

In earlier phases of this research, we heard that, for some nurses, the need to have non-clinical skills and be involved in the running of their practice could put some off working in general practice or be a driver for some to leave primary care. In this phase of research, we did not hear much from nurses themselves about the risks associated with picking up non-clinical activities. (This may be the case because we were interviewing nurses who had chosen to work in general practice. Speaking to nurses who were not working in primary care would have been a better source to corroborate this risk.)

However, some nurses who we interviewed said that it was difficult for them to get to grips with the large amount of administration and computer-based work required in the role, which was a burden in an already incredibly tight schedule. We heard that some nurses did not feel well trained or geared up to manage the amount of computer-based admin that the role entails. There is a risk that if GPNs struggle with this, it may take up a disproportionate amount of their time, cause frustration, demoralisation, and dissatisfaction in the role.

They're done, done with all the bureaucracy and the admin. I don't mean to be ageist, but the older nurses really struggle with the IT and it really demoralizes them because they lose confidence…

A GP Partner discussing the amount of administration involved in the role and its impact on retention of GPNs

This is a factor that we know is affecting retention across the entire general practice workforce, not limited to GPNs. Research has shown that increased administration and bureaucracy is one factor that contributes to job dissatisfaction amongst GPs and hence could be a factor affecting retention.[28]

Risk 6. Additional demands under the NHS Long Term Plan and boundaries between remits of care provision becoming increasingly permeable may add pressure to an under-resourced arena

GPNs, like the rest of the primary care workforce, are feeling the weight of the higher demand on primary care. A key driver of this higher demand in the new role for primary care per the NHS Long Term plan, which sees the distinction between primary and secondary care becoming increasingly blurred. Higher demand without the commensurate resources and support required to meet it creates a significant risk for the workforce and for patient care.

Several of our interviewees, especially those who have worked in general practice for many years and have seen this shift take place, discussed the additional demand placed upon general practice and GPNs in recent years. Some interviewees observed that GPNs are picking up work that previously would have fallen within the remit of other professionals or even within secondary care. Furthermore, some types of appointment now fall solely or primarily within the remit of GPNs and the associated demands on their time exceed GPNs' capacity.

This additional demand poses a big risk to the sustainability of the GPN workforce if not met with the resources and support required to manage it. One nurse when describing her working day, said, "*you just feel like that proverbial swan, you are literally going like that [flapping motion] all of the time and barely staying on top of it".*

Typically, I'm giving 150% all of the time, and I guess that's got a shelf life.

A nurse on being "*thinly stretched*" all of the time

The pressure on the system is absolutely horrendous and so we are struggling…to do the things we need because we're firefighting all the time…I don't think there's much give in the system…it wouldn't take much for that to fall down.

A nurse

[28] Marchand and Peckham (2017), Addressing the crisis of GP recruitment and retention: a systematic review

The consequence of being constantly under pressure is that GPNs are not able to deliver services that make the most of their skills and knowledge. One interviewee discussed the situation of two nurses qualified to prescribe within their practice. Neither nurse had had the capacity or confidence to actually use their prescribing qualifications. Taking on additional responsibilities, such as prescribing, requires an environment where there is ample time and support available to nurture GPNs in gaining the confidence needed to put newly acquired skills into practice. Without this support, skillsets may go underutilised, with some nurses not able to reach their full potential.

At the minute, neither are prescribing within their fields. There's so much on everybody's plate as is that even though they've got that qualification, I think they're reluctant to use it, perhaps reluctance is not the right word, apprehensive of using it when they're already so busy and stretched as it is.

A practice nurse team lead on nurses who are not prescribing in spite of having qualifications to do so

New risks and challenges identified in this phase of research

Risk 7. Practices are struggling to fill GPN vacancies

Practices are short on staff and there is a lack of suitable candidates to fill these vacancies. Our survey of practices found that in August 2023 22% had open vacancies for nurses. Of the eight practices without nurses responding to this survey, seven wanted to recruit nurses but there were barriers. The most common barrier for these respondents was a 'lack of candidates', followed by 'candidates interviewed are not the right fit' and 'candidates do not have the right experience'.

Sometimes practices do not have the resources to train less experienced nurses, making the pathway into general practice more difficult to access for those nurses who haven't previously worked in primary care. This contributes to a cycle of practices struggling to recruit due to lack of suitable candidates, and suitable candidates continuing to be few and far between as newly Registered Nurses and those without general practice experience struggle to gain the necessary experience to join the primary care workforce. Practices often wish to employ 'over-ready' GPNs rather than invest in training them, which is creating a significant risk for both the existing and future workforce.

I probably worked 18 months on my own, before we successfully recruited. You really want somebody that has done their immunisation or vaccination training, done their smear training, got their basics, but getting somebody with that straight out of nurse training, or a year out of nurse training, you're not going to find it.

A nurse on her practice's recruitment challenges with applicants who lack general practice experience

Surgeries won't take them because they don't have any qualifications and they (the surgeries) don't want to bother doing any training…There is a particular course that nurses new to practice can do. But of course, it's getting the funds, you know, it's always getting funding.

A nurse on her practice's recruitment process

Implications of this recruitment challenge for practices include that:

- They may be less efficient if more expensive or less qualified staff are involved in running these organisations
- They may be less resilient if a smaller staff base is drawn into deliver the same volume of work
- They lose out on the unique approaches and insights that nurses bring to patient and preventative care

Risk 8. Reliance on nurses to train others can add further pressure, pulling them away from clinical roles

GPNs play a huge part in the internal training and upskilling of staff members and other nurse colleagues who may be new to the practice or less experienced. Interviewees spoke of GPN involvement in training as something that is hugely positive in having an impact on their colleagues, the practice, and patients. We heard that patients receive a higher quality level of care with less risk when nurses train other staff. Training and upskilling other staff can also create fulfilment within jobs and aid career progression and retention. Indeed, Legacy Mentor Programmes which appoint experienced nurses, usually later in their careers to provide coaching, mentoring and pastoral support to newly registered/appointed nurses, have been shown to provide a rewarding opportunity for older nurses, supporting their retention.

However, we have heard that where practices rely on nurses to carry out training without their capacity, time and willingness taken into consideration, this can create a risk, especially for older nurses. Some of our interviewees spoke of limited time and capacity, and in some cases, particularly where nurses were approaching retirement, a lack of willingness to train others.

Barriers

Separate to the risks we identified in our earlier research, we also identified multiple structural, behavioural, and systemic barriers to the value of GPNs being fully utilised and recognised.

Barrier 1. GPNs believe that their role is not fully understood nor recognised for its complexity by others

GPNs feel as though they are regarded as 'only' a nurse, and by implication something less valuable than other professionals, for example, GPs. Some GPNs feel as though they are taken for granted and that their work is overlooked. This may be by patients, colleagues including GPs, other health care professionals, and the general public. While the GPN role has evolved over time to absorb more and more responsibility, it has not had a formal re-evaluation, and has not been recognised for its importance. The changing nature of general practice nursing has not been communicated to the wider health system, let alone to external audiences. The GPN role generally

lacks a profile within general practice and nationally, contributing to it being overlooked and misunderstood, despite the value that it brings.

Interviewees (whether nurses, other clinicians or in administrative roles) indicated that GPN role is often perceived as easy, basic, and one dimensional, but that this is contrary to the reality of the role. As a result, the role is undervalued and underappreciated.

I think if you took us all away, they (other GP staff) would be really shocked at what they have to do for themselves and what they have no clue about.

A nurse on the lack of understanding and appreciation that direct colleagues have of the GPN role

People don't realize the depth of a GP practice nurse … I just think it needs more recognition of what they do because they do quite a difficult job and I think people at the hospital (those working in secondary care) just see them as like an entry level nurse

A partner and practice manager

Misunderstanding of the role is a separate issue yet seems to be inextricably linked to the value and appreciation that nurses feel they are missing. Some of the nurses interviewed felt as though this was reflected in their pay, employment terms and conditions, and treatment by management. Indeed, one nurse said that it feels as if GPNs are an '*invisible workforce*'.

I think that a lot of nurses think that nursing in general practice is just about doing dressings and sticking a plaster on something. I don't think the breadth of what we do is out there.

A semi-retired nurse sharing her thoughts on why there is a lack of younger nurses coming into general practice

Figure 19 shows results from a series of questions in our survey about the extent to which respondents agree that nurses' roles in primary care are understood and valued. It shows that the vast majority of respondents strongly agreed or agreed with these statements. For example, when it came to nurses in their practice being valued by patients virtually all respondents agreed or strongly agreed this was the case. However, it is worth noting that:

- 12% of respondents felt that their colleagues do not value the practice nurses
- 15% of respondents did not feel that colleagues and patients understand what nurses do

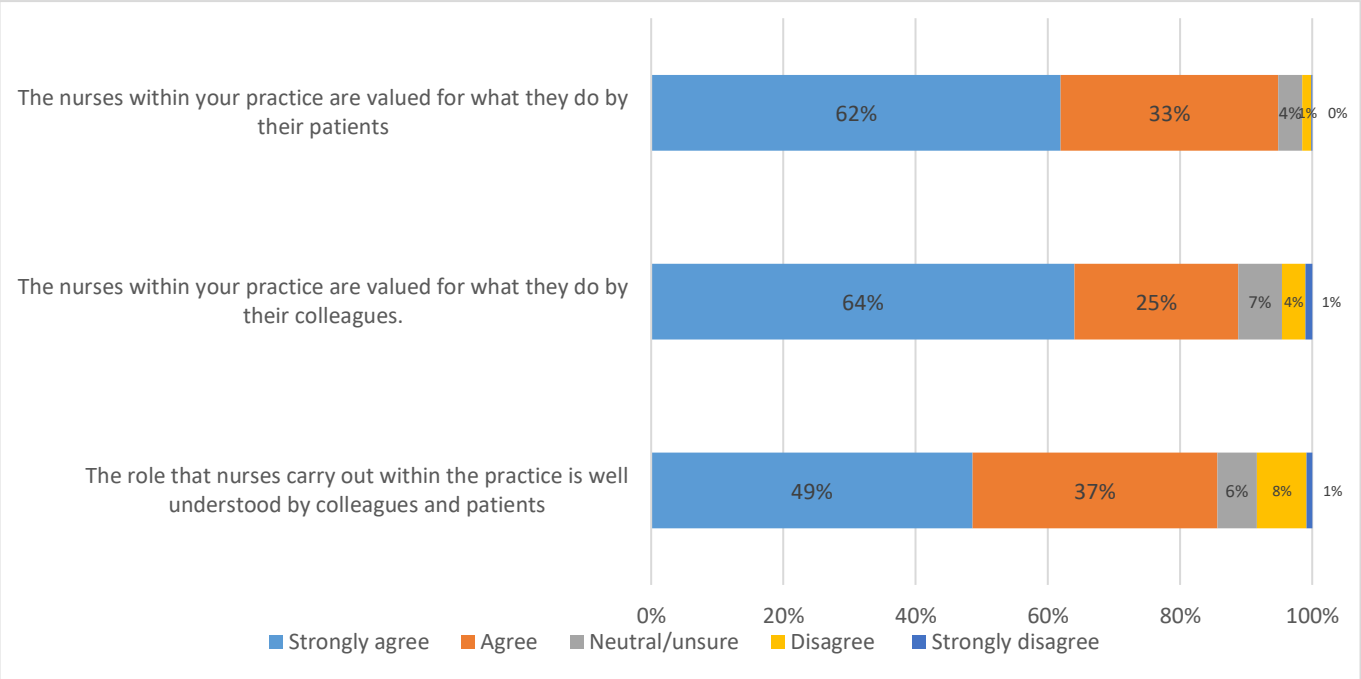


Figure 19: Extent of agreement with key statements relating to nurses' roles being valued and understood (n= 953 for the first two statements and n=949 for the third)

Breaking down responses to these questions by the role of the survey respondent paints a slightly more nuanced picture:

- 74% of practice managers strongly agreed that nurses are valued by patients, and in comparison only 37% of nurses said the same
- While 96% of practice managers strongly agreed or agreed that 'nurses are valued for what they do by their colleagues', only 71% nurses felt the same. 16% of nurse respondents were neutral or unsure and 12% disagreed or strongly disagreed with this statement
- 65% of nurses strongly agreed or agreed that the role is well understood; the equivalent figure for practice managers is 95%
- 19% of nurses disagreed that the GPN role 'is well understood by colleagues and patients', and 2% strongly disagreed with this statement

Barrier 2. Barriers to career development, training, and progression

While GPNs have a degree of control over specialisation, training and development choices, this may be limited by ways of working in their practice and challenges accessing funding and support for these activities. Infrastructure for training and development exists. For example, Training Hubs work to address local training needs by bringing together education and training resources from NHS organisations, community providers as well as local authorities. However, nurses need to be released from their duties for specified periods of time to take advantage of these training and development opportunities. Ultimately, GPNs are reliant on their practice approving and funding training and supporting them in their career growth.

We heard from our interviewees that getting development opportunities can be a real challenge when it feels as though their practice is not on the same side. One nurse interviewed said that she had not had an appraisal for three years consecutively despite asking for one on several occasions.

(The practice) want bums on seats. They want you here seeing the patients and I get that we couldn't be on a training course every five minutes, but equally, if you want to develop your staff, if you want them to lead, they've got to progress,

A nurse on the challenges of securing development opportunities

Barrier 3. There is a lack of recognised pathways into the GPN profession

Several interviewees, especially the nurses closer to retirement, expressed deep concern for where the next generation of GPNs is going to come from.

I can't see that we're going to get enough nurses in general practice in the years to come. I've got four years to retirement and in my head…I'm trying to plan for when I'm not there.

A nurse

As discussed earlier in this report, there is a perception that general practice nursing is a career that is suited to family life and often attracts nurses later in their careers. This perception is compounded by the lack of recognised pathways into GP nursing for newly qualified nurses. The lack of recognised career pathways in to GP nursing goes hand in hand with the role itself being poorly recognised, misunderstood and downplayed. Together these form a barrier to addressing the issue of the ageing workforce.

During their training, student nurses do not often get to work in general practice nursing and therefore do not get to visualise it as a career option. Research has shown that placements for student nurses can lead to: [29]

The workload we carry would make it nearly impossible to have the time to spend with [nursing students]. … I'm mostly working on 10 minute appointments. I just don't know that general practice lends itself to student nurses in a way.

A nurse

- Improved understanding of the role
- A wish to revisit this nursing speciality later in their career
- A better experience for nursing students in competency attainment and preparation for employment
- More effective use of resources in promoting the GPN career and in supporting the development of the workforce

[29] NHS England (2019), The Atlas of Shared Learning – Case study – General Practice placements for pre-registered nurses

Recruiting more student nurses into general practices could address the issue of the ageing workforce. However, some interviewees mentioned not having the capacity to accommodate trainee nurses, which may, in part, explain the lack of placements available, along with lack of funding.

Some practices have sought to address this and the GPN Ten Point Plan set an aim to increase the number of preregistration nurse placements available. There has been a slight increase in younger nurses coming into general practice as a result of the GP Ten Point Plan.[30] There are also examples of local action to create interest in the GPN role: in Gloucestershire[31] and Northumberland[32] student nurses are accompanying GPNs to do health checks on public with the bus.

Up until this last nine months maybe, we'd never had student nurses in the practice before, and I pushed for that, because I think it's important for them as students to see what we do as a career option for them and not just all the glory of working in A&E.

A nurse

Notwithstanding these activities, further sustained action is required across England to recruit nurses into the workforce at the pace required to meet demand.

Barrier 4. There are challenges for nurses taking on leadership roles

Despite GPNs being encouraged to take on leadership roles by the wider NHS and relevant bodies such as the Queens Nursing Institute (QNI) and the Royal College of Nursing (RCN), interviewees indicated that there are barriers to nurses taking on these roles. Taking on leadership responsibilities outside of the practice requires time away from their direct roles and requires practice approval. The practice needs to see the value in nurse involvement and needs to be prepared to invest this time into the wider PCN. As well as support from their practice, GPN involvement in leadership requires a wider ecosystem of support and willingness from other leaders to take on board their views – this is not always the case.

We're getting there, but certainly by no means an effective voice yet…[We] hope that when conversations are had, the nursing team are actually involved in those conversations rather than just usually the last people to hear.

A nurse from an area where GPNs fought for nursing representation on the PCN

[30] NHS England, *General Practice – Developing confidence, capability and capacity. A ten point action plan for General Practice Nursing*, General Practice Ten Point Action Plan (england.nhs.uk)
[31] University nursing students go on tour to deliver NHS primary health care in community - University of Gloucestershire (glos.ac.uk)
[32] Newcastle's new community health bus will be 'almost a pop-up GP surgery' - Chronicle Live

7. Conclusions and recommendations

This research has shown that GPNs across England have been leading the way towards the future of primary practice as they work alongside GPs, physiotherapists, pharmacists, phlebotomists and other healthcare professionals to meet the needs of their local population. This phase of research has confirmed that GPNs across England are highly skilled and resourceful professionals who play an essential part in the daily running of general practice. Our survey data show that in 86% of practices with nurses, nurses lead diabetes services and in 85% of practices nurses lead respiratory services.

Nurses' roles are not only limited to clinical delivery. Nurses are significantly involved in non-clinical activities, often demonstrating leadership among their peers. Examples of non-clinical activities led by nurses include:

- Education and training of their colleagues
- Networking outside of their practices
- Driving forward protocol and change management
- Administrative activities such as auditing and stock control
- Managing the asks of CQC and QOF

GPNs are hugely valuable because of the work they do, and the way they do it, which lead to better outcomes. The value their work brings is felt by four different groups: practices, their patients, the wider community, and the NHS as a whole. Patients feel able to talk to nurses informally, disclosing information that is key to unlocking better health for them; this allows nurses to identify the need for screening or diagnostic tests, or for mental health support or other support needs. Improved outcomes for patients as a result of GPNs may include better health overall, reductions in 'flare-ups' of chronic conditions, more wounds or post-operative sites that heal more effectively, or better programmes of care that manage multiple needs in streamlined appointments.

We do not see all aspects of the *Leading the Way* best practice model in operation across all practices in England. For example, patient support groups and community groups seem to have declined since the COVID-pandemic, and it appears that health professionals other than nurses are more likely to be involved in their delivery. Another example is that in only a third of the practices surveyed did nurses lead services for cardiovascular conditions. It appears that there is a large minority of practices in which GPNs could be deployed more effectively. In these practices, nurses' unique mixture of skills and knowledge should be harnessed so they can have greater involvement in clinical and practice leadership.

The value that nurses bring is reflected in the importance of nurses to general practice. Almost all practices employ nurses. Almost all of the practices without nurses that took part in our research wanted to employ nurses, they simply faced difficulties in recruiting them. Practices are struggling to fill vacancies. In our survey 22% of practices reported having nursing vacancies. The reasons given for practices not being able to fill vacancies were:

- A lack of candidates

- Candidates were not the right fit
- Candidates did not have the right experience

There are some risks and barriers that get in the way of effective recruitment and involvement of nurses in general practice. These risks and barriers get in the way of nurses being able to deliver the full value they can. We are not articulating clearly enough what it is that nurses in general practice do and the value they bring. This, in turn, means general practice nursing will not be sought-after as a career opportunity by younger nurses. We exacerbate this at practice level by those within the practice not really understanding what their nurses do, and their profiling of that to patients furthers that view.

Variation in and lack of transparency over terms and conditions hamper recruitment. Recruitment not only needs clarity about the role and its virtues, but also a fluidity in the market meaning it is possible for nurses to move, or stay, and for the practices to tap into a market of enthusiastic potential employees.

Retention is also a challenge. We heard that nurses are under pressure from unsustainable workloads and time constraints. For some nurses these are compounded by low pay rises and non-portable employment terms and conditions.

General practices, while NHS-funded, are private businesses, and function in many ways like other small and medium-sized enterprises. Specialisms exist for nurses, but they are supported by broader business management and operational management skills and experience. Nurses need to be prepared for this. They need to expect it and embrace it, but also that they need training in it. With business graduates getting training in organisational and human psychology, systems and controls, why do we not have business knowledge and market-creation taught on general nursing courses? If not these, then certainly they should be on elective modules specific to this branch of the profession.

Finally, we need to get nurses' experience and insights more involved not just in practice leadership but also in the NHS at regional and national levels. Time away from clinical and non-clinical delivery within the practice is seen as a concern. However, it is through these roles that the nurses bring back to the practice ideas, insights and contacts that will develop the business and the effectiveness of delivery.

The value that a highly skilled and effective general practice nurse workforce can bring to its practices, patients, communities and the NHS is significant. If we want to ensure that this value is realised, we need to make a range of changes to support the profession, now and into the future. This has also been recognised in key sector documents and plans like the NHS Long Term Plan, the Fuller Stocktake, the Long Term Workforce Plan, the Chief Nursing Officer Strategy, among others.

Opportunities for greater involvement in clinical leadership and non-clinical activities

In summary, our survey findings show that there is greater scope in many practices for nurses to lead clinical services and to be involved in the delivery of non-clinical activities. Practices could gain more value by deploying nurses in the following areas:

Opportunity 1	Leading cardiovascular, frailty, and mental health services – these are areas in which nurses' skills and insights are well suited.
Opportunity 2	Leading staff training, mentoring, and management – these are key to developing a sustainable succession of nursing skills within each practice and more widely across primary care, as well as building wider skills amongst other professionals.
Opportunity 3	Managing the ask of QOF, external networking, and partnering with external agencies. Nurses are well equipped and skilled to perform these roles, to the advantage of both patients and practices.

Recommendations

We have five specific areas of recommendations arising from the cumulative learning from Phases 1, 2 and 3. These are as follows:

1. ***Improve the offer to general practice nurses***
    a. Socialise the implementation of Primary Care & General Practice Nursing Career & Core Capabilities Framework.
    b. Introduce remuneration for general practice nurses that aligns with the scope of practice and career progression for nurses.
    c. Ensure remuneration for general practice nurses is consistent across primary care and general practice.
    d. The terms and conditions[33] of general practice nurses need to be reviewed to be made consistent and comparable with those of other nurses working across the NHS.
    e. Ensure the sustainability of education and training budgets so that recruitment and retention of general practice nurses are supported and sustained. Here are some evidence-based and recommended examples of best practice:
        i. Legacy Mentorship
        ii. Nurses on Tour
    f. Seek commitment from employers to release nursing staff from delivery so they can undertake mandatory and discretionary training.
    g. Make student nursing placements in general practice easily obtainable and give practices the resources they need to manage these placements at Place level.

[33] We note that key stakeholders are working together on T&Cs now, which is promising.

2. ***Nurses should be represented and empowered at every leadership level in the NHS***
    a. Nurses should have a key influencing and decision-making role in policy, practice, and education at every leadership and managerial level. They therefore need to be part of decision-making forums:
        i. At practice level
        ii. At primary care network (PCN) and integrated care board (ICB) level
        iii. In national forums

3. ***Improve awareness and understanding of the GPN role***
    a. Campaigns to raise awareness and understanding of general practice nurses should be targeted at:
        i. The general public
        ii. National policy makers
        iii. Whole primary care and community teams
        iv. Wider NHS staff
        v. Potential nursing recruits

4. ***Address nurses' unsustainable workloads***
    a. Create more capacity for nurses to:
        i. Offer supervision to staff working in primary care and in general practice
        ii. Utilise and embed the professional nurse advocate role
    b. General practice and primary care nursing teams need to be integral to the Long Term Workforce Plan.
    c. Nurses need to ensure that they are using the breadth and depth of their expertise to work with local communities to create health, wellbeing, and social value for and with populations.
    d. Health systems need to encourage innovative ways of working in primary and community care to improve population health outcomes and support the workforce, e.g. utilising group clinics.
    e. Health systems should explore collaborative ways of working across primary and secondary care, drawing on the expertise of nurses in identifying innovation in services and harnessing their skills and expertise to deliver these new ways of working.

5. ***Continue research into practice nursing***
    a. There should be ongoing empirical research into the general practice nursing role and, given new ways of working across health systems, this research also needs to explore the role of community nursing colleagues.
    b. The NHS should develop research capabilities among general practice nurses and support the development of clinical academic career roles across primary and community care.
    c. NHSE and ICSs should support the application and conclusions from research studies into the general practice nursing profession.

These are the detailed recommendations, but how do these come together in an overall programme of change in this part of primary care? It appears that there are four arenas that sum up what we need to make those routes to improvement happen. These are to:

A. Change the narrative

Whether within your practice, on the national stage, on the practice website, or across university course material we need to speak about nursing in general practice. We need to speak about it not as the traditional 'support-the-doctors' model, but as a key – a unique – part of our health system, and the closest part to patients and communities. General practice nurses are very skilled, and well-qualified professionals, with huge insights into the challenges of patients living ever longer with multiple complex long-term conditions. We should broadcast that.

B. Develop the networks, and how the nurses manage and lead them

Nurses are super-connectors, at regional and at practice levels. They can deliver change within healthcare systems. Note the example from Bath and North East Somerset in the Phase 2 report, is now bringing efficiencies and reach across 24 practices. Note also nurses' potential impact on the wider care environment, as demonstrated in Tower Hamlets with the great work done by nurses to change the way care homes tackle hydration of the elderly, so reducing UTIs and burdens on local healthcare systems.

C. Change the infrastructure and systems

Nurses' terms and conditions are not consistent, getting in the way of creating a clean and vibrant 'market' in which there is a flow of talent around the sector. Training pathways need to develop, and the opportunities for young nurses to experience general practice at an early stage need to be there. It is important not to focus on the short term either – by investing in great new talent each practice will improve primary care's collective access to talent for the future.

D. Attract more nurses and support them to reach their potential

There aren't enough new nurses coming into this branch of the profession. Where there are nurses in practices, we have identified three key opportunity areas (and there are probably more) in which nurses can have greater involvement in practice leadership and delivery.

Are we in this position because of a lack of nurses willing to join primary care, a lack of knowledge in practices about how to deploy nurses effectively, or a reluctance to do it? The evidence probably suggests that it is all three. Nurses taking part in our research recognise a lack of knowledge among other practice staff of what nurses can do, and what they actually do. This situation may improve but for that to happen it is important to showcase examples of best practice and the value that can bring, demonstrating the difference that nurses can make when they are deployed to their full potential. This may inspire changes in the level of nursing staff and what roles they perform in practices.

Appendix 1: Evidence for the *Leading the Way* best practice model

Overview of the best practice model

In Phase Two of this project, we conducted research in six areas across England to discover how nurses were working in their practices and local areas to make a difference. On the basis of that evidence, we developed a model of best practice for GPNs – one that captures the routes through which nurses can add significant value to their practice, patients, communities and the wider NHS.

This best practice model featured eight **value drivers;** these are the segments that form the central circle in Figure 18. These are the categories of primary care nursing activities that make a difference to their practice, patients, communities and the NHS. Nurses create value through these activities. The model also features two **enablers**: things that facilitate nurses to do their jobs well. These are shown in the two concentric outer rings in Figure 18.

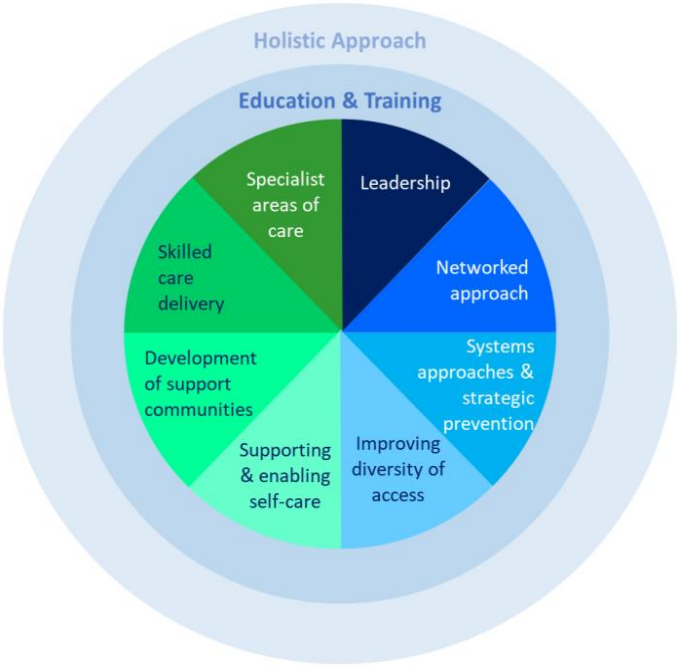


Figure 20: How GPNs create value

Evidence of the best practice model across England

Below we explain each value driver and enabler in greater detail, and then explore evidence of these seen in the course of this final phase of research.

Value drivers

LEADERSHIP

This can take multiple forms, including in management and development roles within the practice, regionally, and nationally; in making decisions and leading care across the range of general practice work; and leading in specialist fields.

In our earlier findings we defined leadership as a process of social influence which maximises the efforts of others towards achievement of a goal. Leadership – as distinct from management – is a key skill that we found is highly developed in GPNs and seen at multiple levels. Examples of nurses' leadership included:

- Being alert to patterns of behaviour and responding to them (leading insight)
- Self-reliance in analysing needs and initiating a response (self-leadership)

- Proactive research and design of a response, often in collaboration or consultation with others (leading design)
- Facilitation of responses, including catalysing and coordinating resources (leading others)
- Developing guidance and support to broader adoption and continued improvement of responses (leading strategically)
- Providing well-being support and support for self-care (providing leadership for patients)

We drew on case studies in our previous reports of nurse-led programmes that improved services in the local areas to benefit patients. One case study was of a diabetes clinic redesign. The nurse leading this programme that stratified diabetes patients into five risk levels to identify those who needed to be seen more urgently. Among other actions, the nurse built and restructured the practice team delivering these services.

In this phase of research, our survey of all practices revealed that a third of respondents said that nurses in their practice were involved in change management. In this research we define change management as projects or programmes involving the transformation of practice activities, clinical or non-clinical. The example of involvement in change management demonstrates how GPNs show leadership as described above (self-leadership, leading design, leading others).

In many practices responding to our survey, nurses were likely to be involved in non-clinical activities:

- In 67% of practices, nurses were involved in managing the ask of QOF
- In half of the practices responding, nurses were involved in managing the ask of the CQC
- In 58% of the practices responding, nurses were involved in policy implementation
- In 60% of the practices responding, nurses acted as a point of contact for staff to raise issues/concerns to

Their involvement in non-clinical activities shows nurses' leadership through maintaining, upholding, and strengthening practice, protocols, and processes, similarly demonstrating leadership as described in our earlier research. GPN leadership was a key theme that emerged from our interviews as part of Phase Three research.

One interviewee discussed the impact of her nursing team leading a change against a core process:

> *We've changed the way that we now recall patients for long term conditions. Previously it was a very manual way of doing things … and it was wholly unsuccessful… We've gone far more digitalized and have employed a computer system who will do that … and it's working extremely well, we're now running a month ahead the whole time*.

Another nurse interviewed discussed how leadership underpins her role within her practice and what this entails:

> *I'm constantly looking at getting everyone up to speed, really … so I'm looking at who's not doing any training, who needs a little bit of an update of things … we have a clinical meeting every week [at which] I represent the nurses…I would be disseminating that information across the team, and that kind of thing.*

Phase Three findings confirm that nurses play a significant leadership role in practices in both clinical and non-clinical areas.

Networked approach

This is sharing expertise and insight both within and beyond the practice, so that patients get the care they need and service delivery benefits from best practice wherever it originates.

Our earlier research highlighted that the GPN role is underpinned by a networked approach, in which nurses have an open style of working, high levels of mutual support, and readily develop and engage in a variety of networks. These networks include practice teams, nursing teams within practices, and networks external to the practice – community organisations, other practices, and nurses, and other professionals within the wider NHS. We found that this approach facilitates skills and information sharing, mutual support and development, collaboration in 'getting the job done', and enables continuous improvement and pragmatic problem-solving.

In this phase of the research, supporting our earlier findings, we found that in 59% of practices nurses network with external health care professionals. Interviewees provided further detail that nurses in their practices worked with health care professionals in other primary and secondary care services. Reasons for this networking included facilitating individual patients' care journeys and sharing learnings regarding best practice with other healthcare providers.

Nurses sharing their knowledge and expertise within practices and beyond creates the following positive impacts:

- Nurses and other professionals have up-to-date knowledge and are up-to-speed with their peers
- Training and upskilling of others increase job fulfilment, aids career progression and improves retention of other staff
- The wider nurses' knowledge is shared, the greater the safety net for the practice, i.e., if one nurse is on leave, someone else has the same knowledge/skillset to be able to pick up their work
- Patients receive a higher quality of care with lower risk

Phase Three findings around nurses' approach to networking therefore confirm this element of the best practice model.

Systems approaches and strategic prevention

This is understanding the progression of diseases, their causes and outcomes; designing and delivering education and prevention programmes; taking a health population view to improve health at community level.

Our earlier findings drew attention to a systems-approach that GPNs take to strategic prevention. We highlighted the importance of prevention as a cornerstone of the NHS Long Term Plan. We found that GPNs regularly take the lead in designing and implementing approaches to care that focus on prevention and condition management. This is aided by a deep understanding of how conditions progress or heal over longer periods, and how patients are affected by their social and psychosocial contexts. With this knowledge and an approach rooted in pragmatism and effective problem-solving, GPNs tailor their advice to meet each individual's needs and to support the patient to control and manage their own condition(s).

Where multiple patients share care and advice needs, our earlier research showed that nurses often would take the lead in designing education and health management services for them. This involves identifying and designing solutions to close gaps in provision (e.g., healthy eating groups, or group consultations). Enabling community-led prevention by understanding and working within the local context is an important factor in ensuring effective use of practice budgets. Managing and delivering public health programmes, such as seasonal flu vaccinations, should have an impact on the wider health system, improving outcomes for communities and health populations, and reducing the need for expensive (and often disruptive) treatment in acute or a bed-based care setting.

In this phase of the research, we have seen evidence to support the view that GPNs are a crucial component in prevention and health promotion. Our survey identified that almost all practices with nurses offered long-term/chronic condition reviews and care management plans and in 95% of those practices, nurses were involved in that activity. Our survey also found that nurses were the most common profession to be involved in providing preventative advice and promoting healthier lifestyles, with just over 9 out of 10 practices with nurses involved in this activity. Similarly, our interviewees indicated that nurses were essential for promoting and upholding public health and prevention of acute illness amongst patients and communities. This was particularly important in relation to immunisations.

One ANP interviewed discussed how nurses bring health promotion into most of their appointments:

> *We weave in health promotion from a perspective of encouraging uptake of screening programmes… if somebody's coming in for their cervical smear or contraception appointment, you opportunistically discuss sexual health and health promotion in that forum.*

We asked the same interviewee to picture how their practice might run without nurses and they shared that it would be catastrophic for prevention and health promotion:

> *[Without nurses] your long-term condition management registers and the actual quality of the care of that patient would just go to pot…You've also got your routine things, your baby immunisations, your cytology, etc… there wouldn't be appointments for those things without nurses*.

This phase of research has strongly supported and built on the systems approach and strategic prevention element of the best practice model, demonstrating the crucial role that GPNs play in upholding and supporting public health.

Improved diversity of access

This is providing a complementary and different approach to that of GPs and other healthcare professionals that is more appropriate to some patients and situations.

In our earlier research we heard that GPNs are instrumental in ensuring that their practice reaches the whole community and is visible and accessible to all. Furthermore, people are not all the same and their situations can change rapidly; GPNs are flexible in their approach and tailor these to patients. We found that GPNs' approach to engagement with patients complements that of doctors and of specialist health professionals, and it is only by being able to offer the best of all approaches that general practice can provide the best possible and most equitable access to care.

A strong theme that emerged from earlier phases of this research was that GPNs may be easier to talk to than other professionals in the practice. We heard that conversations between a GPN and a patient would feel less remote or medicalised, and not judgmental. This finding is supported by the Ipsos Veracity Index (2023) which found that Nurses are the most trusted profession in Britain.[34]

Some examples from our earlier research of nurses improving diversity of access included nurses offering appointments of variable lengths and delivering clinics or 'outreach' services in places where patients are likely to be. For example, delivering prostate checks at a local football ground, or women's health clinics in a safe space accessible to a city's sex workers.

In this phase of the research, an interviewee described nurses as creating a sense of '*safety and comfort*' for patients, especially elderly patients or those who may feel nervous or intimidated in reaching out for help. Among the survey respondents in practices with nurses, 95% strongly agreed or agreed with the statement that *Nurses' people and relationship skills allow us to maintain a higher level of engagement with the practice population*.

In response to the following statements, 71% of respondents to the survey strongly agreed (38%) or agreed (33%) with the first, and 77% strongly agreed (44%) or agreed (33%) with the second:

- Nurses are best placed to connect patients with wider systems of support outside of the practice

[34] Ipsos (2023), Trust in politicians reaches its lowest score in 40 years

- Nurses are best placed to address health inequalities amongst the practice population and improve diversity of access to care[35]

Similar themes emerged from interviews around the value that nurses' people and relationship skills can bring to patients. One nurse told us:

> *…Nurses have a better rapport with patients, they seem to get more out of patients. Patients are more open with nurses; I don't know whether they still see doctors a little bit on a pedestal… I think the nurses are just a little bit easier to talk to for a lot of people.*

In this phase of the research, we heard fewer specific examples around how nurses improve diversity of access to care. However, our findings highlighted the strength and adaptability of nurses' people and relationship skills. These support the idea that nurses can improve diversity of access; further research could shed light on exactly how nurses improve accessibility of care for patients across England.

Supporting and enabling self-care

Recognising that health conditions are mostly managed at home and supporting patients to play their part in staying well.

Our earlier research looked at the importance of patient self-care as a key component of public health management and the NHS Long Term plan, which commits to 'better support for patients, carers and volunteers to enhance "supported self-management" particularly of long-term health conditions'.

We highlighted the role that GPNs have to play here, both in helping to identify health concerns that are common across populations, and in delivering preventative advice and support to prevent health needs from escalating in the future. The emphasis on public health rightly prioritises keeping people well, keeping conditions under control, and avoiding the frequency and severity of acute episodes that drain NHS resources and which are preventable. The economic implication here is important, but so too is the well-being of the individuals and communities that nurses support in this way.

In this phase of the research, we heard in our interviews that nurses play a key role in enabling patients to take ownership of their health and in supporting them to practise self-care. Nurses were described in our interviewees as educators and disseminators of information and knowledge for patients, particularly for those with chronic

[35] It is worth noting, however, that in response to both of these bulleted statements between 21% and 25% of survey respondents were neutral or unsure. This may be because it was difficult for these respondents to judge the extent to which nurses make a difference here relative to other staff. Alternatively, it may be because respondents did not understand the question. To keep the survey as short as possible we did not ask respondents to explain their answers so we could not discern which was the more important driver of these responses.

conditions, providing these patients with self-management and care plans to keep on top of their conditions and reduce risk of escalation and crisis.

As discussed above, our survey findings confirm that nurses were commonly involved in providing preventative advice and promotion of healthier lifestyles to patients. Of all of the practices offering this service, in 93% nurses were involved in this activity.

We have seen similarities in this phase of research between this element of the best practice model and, as discussed earlier in this report, the systems approach to strategic prevention that GPNs take. Our Phase Three findings demonstrate that nurses played a crucial role in equipping patients with the knowledge and skills to manage their own conditions. By enabling effective self-care and chronic condition management, nurses were reducing the likelihood that patients' conditions advance unchecked, leading to more expensive secondary care being required in the future.

Development of support communities

Helping patients to tap into support from those around them, either by signposting or facilitating support.

In our earlier phases of research, we heard how communities of support are extremely valuable, but often under-appreciated. Combining the empathy of those with shared experiences, the support of carers, and the encouragement to persevere, these communities are a powerful force. Related to their support for self-care, nursing teams often initiated, designed, facilitated and supported the continuation of communities of support for various diseases and health conditions. For example, we heard of nurse-led 'Leg Clubs' to help those with circulatory or mobility problems manage their conditions. Similarly, group consultations have been shown to be highly beneficial in facilitating shared learning amongst patients and clinicians, and through providing a safe space for people with similar conditions.[36]

In this latest stage of research, we found that patient community and support groups or clubs were only offered by 25% of practices with nurses. We heard in interviews that the development of support communities (and hence nurses' involvement in them) had been left behind in some practices due to COVID limiting the ability of people and groups in particular to come together.

A nurse interviewed said the following about the impact of COVID-19 on support clubs and groups:

> *We don't have any sort of support clubs or groups from the practice that we organise and that's just down to time really. We used to have the patient participation groups, but that's not really run since COVID, it all seems to have gone a bit astray*.

[36] NHS England (2024), Group consultations: Together, patients are stronger

Another nurse, when asked if their practice is involved in any kind of patient/community support groups:

> *Not at the moment. Well, we've got the carers clinic, but that has just come back online, and with clinics, we want to try and move them towards a more supportive meeting where carers can actually meet each other. But we haven't got that far yet with COVID, to be quite honest.*

While nurses were often involved in this activity in many practices (31% of practices offering this service involved nurses in this activity), these groups and clubs appeared to involve 'Other' roles more commonly (in 69% of practices). These other roles included social prescribers (76 respondents), health and wellbeing coaches (23), external providers (18) and non-clinical roles e.g., practice managers and receptionists (7). The involvement of other roles is likely to have been facilitated by ARRS.

This phase of the research has called into question how commonly seen this element of the best practice model is. The halting of many support clubs and patient groups across practices post-COVID should be flagged to commissioners and NHS England. The reasons for them not being resumed should be explored, and where it is a lack of resources to enable practices to resume their operation, these should be provided. Other research has shown that such support groups, as well as group consultations, are highly valuable in supporting shared learning among patients and clinicians.

Skilled care delivery

Competence and confidence based on robust training and a wealth of experience.

We highlighted in our earlier phases of research that the level of academic qualification required to practise as a nurse is high (degree level). Just as important is that nurses have the skills to deliver care with a high degree of competence, and the skills to operate in a general practice environment. Skills necessary in general practice include risk management, autonomous working, safe delivery of care, additional knowledge of immunisations, cervical cytology and wound care. Skilled delivery of care by GPNs is strongly rooted in the professional standards of nurses as individuals, underpinned by the eight principles of nursing.

We found the nursing skillset to be flexible and was commonly tailored to meet individual practice or community requirements. For example:

- Deploying the skills that are uniquely held by nurses to deliver prevention programmes (such as cervical screening and childhood immunisations)
- Upskilling to provide specific services where these are needed by the practice (for example, diabetes prevention in areas of high prevalence)
- Building specialist teams across practices (such as long-term condition management) such that responsibility for delivery is shared and outcomes can be improved with the benefit of area-wide insight)
- Attracting income to the practice through contracts for skilled service offerings

We also highlighted that in addition to using their skills to deliver patient care, nurses shared their knowledge and skills by training or mentoring other staff in their practices and sometimes beyond. In some practices training was delivered primarily through peer supervision, peer support and peer development.

In this phase of the research, we saw strong evidence for this aspect of the best practice model. Nurses are highly qualified, to undergraduate degree level or equivalent. Many nurses have gained post-graduate level qualifications to become advanced clinical practitioners or specialists so they might diagnose and prescribe in certain areas.

Our survey data in Table 21 show that the most common level of qualification for nurses in GP practices is an undergraduate degree (350 nurses), closely followed by a post-graduate degree (307 nurses). While more practices employed nurses with post-graduate degrees (131 practices) than undergraduate degrees (128 practices) there appears to be fewer of these nurses working in each practice, with a mean of 2.3 compared to a mean of 2.7 for nurses with undergraduate degrees. This confirms our earlier finding that a significant proportion of nurses hold post-graduate degrees. The prevalence of undergraduate diplomas reflects the demographic profile of GPNs as an ageing workforce; nursing did not become an all-degree profession until 2009.[37]

Table 21: Respondents and number of nurses by highest qualification

Role	GP surgeries (count)	GP surgeries (percent)	Nurses (count)	Nurses (percent)	Mean*
Post-graduate Degree	131	46.1	307	27.14	2.3
Undergraduate Degree	128	45.1	350	30.95	2.7
Undergraduate Diploma	88	31.0	175	15.47	2.0
Post-graduate Diploma	78	27.5	192	16.98	2.5
Post-graduate Certificate	39	13.7	82	7.25	2.1
Other	20	7.0	25	2.21	1.3
Base	**284**		**1,131**		

Table 22 shows that 69% of the practices surveyed employed a nurse with non-medical prescribing qualifications and 75% employed nurses with teaching or mentoring qualifications. On average there were 2.4 nurses with these qualifications per practice for the ones who responded positively to these questions.

[37] RCN (2017), The Voice of Nursing

Table 22: Number of nurses with other qualifications (n = 284)

Role	GP surgeries (count)	GP surgeries (percent)	People (count)	Mean*
Non-medical prescribing qualifications	195	69%	467	2.4
Teaching/mentoring qualifications	213	75%	518	2.4

When it comes to training others, our survey findings showed that almost 8 out of 10 nurses were involved in training and mentoring of other staff. Almost all of our interviewees spoke of nurses' vital role in training and mentoring of other nurses, HCAs, phlebotomists, nurse associates, and student nurses. One interviewee spoke of the positive difference that GPN involvement in training can make to the workforce, describing how one of their now Registered Nurses was a student on placement with them, and gained employment with them following this. Furthermore, their phlebotomist and three of their HCAs had previously been receptionists but were trained internally by the nursing team to perform these new roles.

This phase of the research provided ample evidence of nurses' skill in the delivery of care, and the significance to patient care of nurses sharing these skills with others in their practice.

Specialist areas of care

Developing individual areas of excellence and responsibility**.**

Our earlier research showed that the role of GPNs includes a wide variety of specialisms, with considerable academic training and practical professional skills to back this up. The GPN role and its specialisms are truly complementary to those of doctors and other professionals in the practice. Specialisms can range from diagnosis and triage as part of an urgent care team, to dealing with minor procedures and post-operative care in 'treatment room' settings, which reduces the demand on secondary care facilities.

We found that specialist care offered by GPNs often reflects the specific needs of the community. The needs and priorities of commissioners can also determine the opportunities available to nurses to specialise, as does the readiness of practices to invest in additional training. Nurses' moves between practices can be prompted by a desire to increase specialisation or to train in additional skills not available or required by nurses' current practice.

Findings from this latest research show that it is commonplace for nurses to develop specialisms in certain clinical areas and to take ownership over these in their practice, demonstrating clinical leadership. Among the practices we interviewed, the most common areas interviewees spoke of nurses leading were long term or chronic conditions such as diabetes, asthma and COPD (respiratory). In several interviews examples were given of nurses leading services in women's health, notably with a strong focus on menopause and sexual health clinics.

Our survey data (see Figure 21) show that, for the 905 practices responding to our survey:

- In 86% (767) nurses took ownership of the area of diabetes
- In 85% (762) nurses led or took ownership of respiratory conditions services

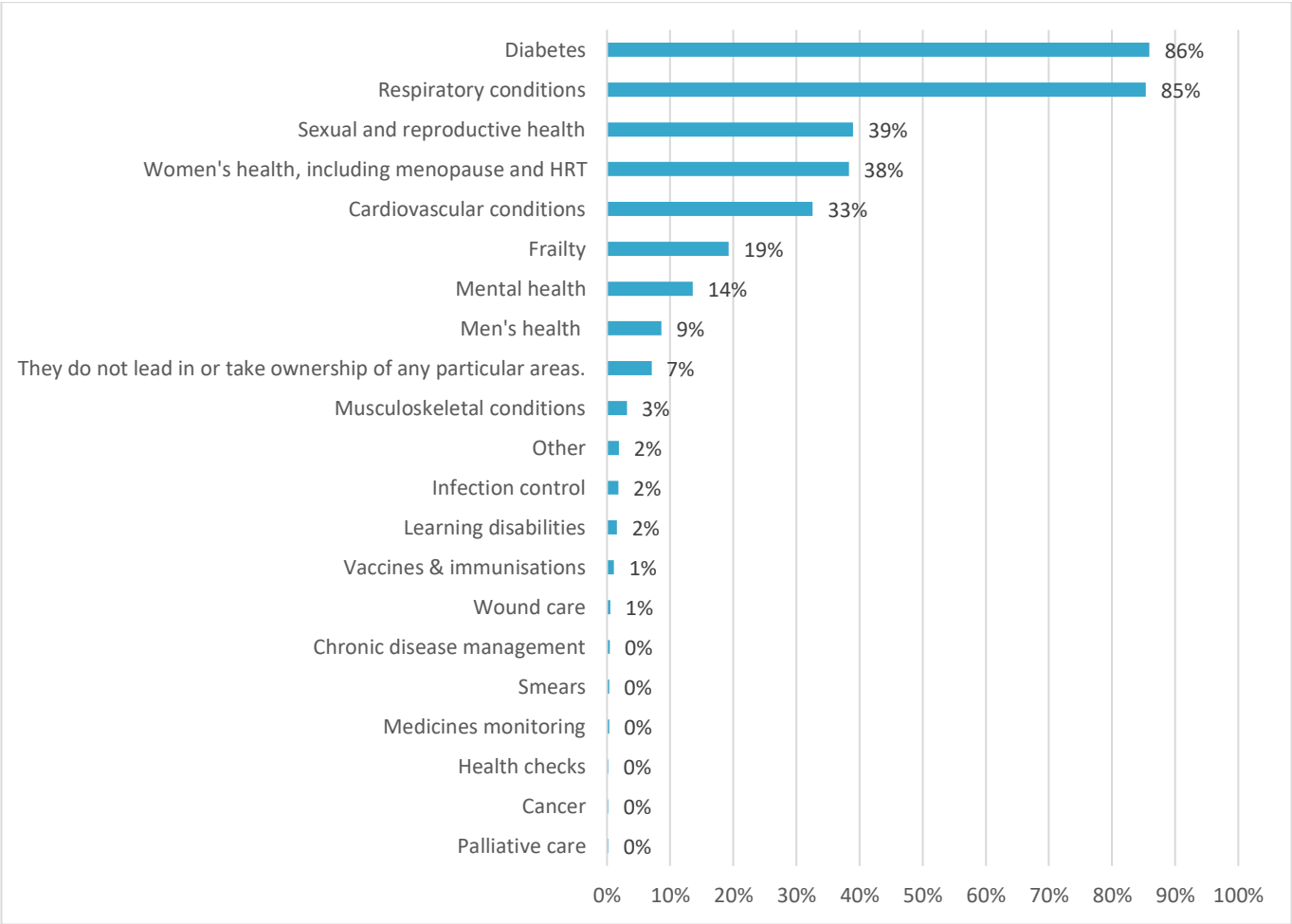


Figure 21: Share of practices in which nurses lead or take particular ownership of these clinical areas (n = 893)

Other services that nurses commonly led were sexual and reproductive health, women's health, and cardiovascular conditions (though these only applied to around a third of practices responding to the survey). A partner and practice manager interviewee shared with how their team of nurses all undertake an element of clinical leadership:

> "*They all share leadership roles amongst them. One of them leads on diabetes, one leads on asthma, one will be an expert on health checks, one will be an expert on learning disabilities. They all have a speciality within the team, and they lead in their own speciality*."

Another interpretation of these findings is that in up to two-thirds of practices, there was an opportunity for nurses to lead areas, like cardiovascular conditions, frailty, sexual and reproductive health, women's health[38] and men's health. An alternative interpretation of our findings is that respondents might not all have had the same understanding of what it is to 'lead' an activity, and, as such, the real share of practices with nurses leading these activities could be higher than those presented in Figure 21.

To conclude, this phase of the research strongly supports the theme of GPN involvement in specialist areas of care.

Enablers

HOLISTIC APPROACH

The **holistic approach of nurses** is their patient-centric approach that is grounded in realism, pragmatism and curious enquiry. Of course, other healthcare professionals also have some of these factors at their disposal. However, our earlier research showed that this particular combination of value drivers makes GPNs unique.

Our earlier research developed a picture of best practice whereby nurses in general practice possess all eight of the value drivers and draw on them constantly, skilfully, and intuitively. It is a skillset and a role that is hard to substitute – the whole genuinely is far greater than the sum of its parts. This approach encompasses nurses actively checking a patient's comprehension and reinforcing messages until they are sure the patient fully understands what is required of them. It is an approach consolidated by the training they receive, namely, to understand the patient and their concerns, to take a person-centric and not a condition-centric view and to respond accordingly.

In **this phase of the research**, this approach was recognised by our survey participants; 97% of practices responding to our survey strongly agreed (76%) or agreed (21%) that they have nurses in their practice because *Nurses' people and relationship skills allow us to deliver a better quality of care*.

While the evidence is not extensive (it is difficult to test for a 'holistic approach'), findings from Phase Three provide evidence for this element of the best practice model.

[38] More nurses with women's health and women's sexual health as areas of specialism in primary care would help support deliver the aims and objectives of the 2022 Women's Health Strategy for England.

EDUCATION & TRAINING

The nature of the **education and training** of GPNs, which prepares them for working independently and flexibly in a role that demands a wide range of skill and deep expertise in certain areas of specialism.

In the **previous phases of research,** we highlighted the importance of education and training for GPNs. Training should prepare nurses to work confidently, competently and safely within the Nursing Principles. It is second nature to nurses in general practice to assess and manage risk, to work within their capabilities and to put the patient first. Education and training should not only encompass the teaching of clinical knowledge and expertise, but also the professional approach that is so important in a general practice setting, where nurses are often expected to work to a high level of autonomous clinical decision making.

In **this phase of the research**, we gained insight into the types of qualifications nurses hold (see discussion above under Skilled Care delivery). When it came to nurses' own further training and development the picture became more complicated. Among our interviewees there was a mixed appetite for gaining additional qualifications. Reasons given included time constraints, lack of practice support, or because some were approaching retirement. Beyond nursing qualifications, in our research we heard that training and education opportunities once nurses became part of the general practice workforce were not equally accessible across practices in England. We also heard that there was a lack of recognised training and progression pathways between entering the GP workforce and in taking post-graduate qualifications.

This latest research confirms the importance of education and training to GPNs. It is concerning, however, that it is difficult for some nurses to access or pursue training and development when in role.

Appendix 2: Select bibliography

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