Articulating the role and the value of nurses in general practice in England: Interim report

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Jim Clifford OBE FRSA	Director & CEO	j.clifford@sonnetimpact.co.uk
Katie Barnes FRSA	Associate Director	k.barnes@sonnetimpact.co.uk
Roshni Arora	Executive	r.arora@sonnetimpact.co.uk
Sami Raouf	Analyst	s.raouf@sonnetimpact.co.uk

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Disclaimer

This project has been commissioned by, NHS England and NHS Improvement, and undertaken by Sonnet Impact. This report represents the projects interim findings as of January 2021. Research work is ongoing, and is expected to be reported-upon in April 2021. Whilst every effort has been made to ensure that the findings in this report are complete and accurate, they do not represent a complete analysis of all of the information that is now emerging in the project, and consequently the final report can be expected to show both further information and may draw different conclusions.

Enquiries

All enquiries or requests for further information about the matters in this report should be addressed to Sonnet Impact by email to contact@sonnetimpact.co.uk.

Contents

Research Publication Notice 2
Contents 3
1. Project Overview 4
3. Value analysis 1: Who benefits from GPNs? 8
4. Value analysis 2: Where does the value come from? 10
5. Value drivers explained 13
6. Great ideas: innovation and leadership in healthcare and wider wellbeing 22
7. Harnessing the value: Risks, barriers and enablers 25
8. Forward thinking: A developing model of nursing in primary care 28
9. Future needs unpacked: why primary care matters 32
10. Conclusions and next steps 35
Appendix 1: General practice nurses: analysis of numbers 37
Appendix 2: List of Participants 40
Appendix 3: Bibliography 41

1. Project Overview

The brief

Nurses working in general practice are highly skilled and vital professionals who play an essential part to the daily running of the general practice.   General Practice Nursing is unique in that it spans all age groups throughout the life course and across all fields of nursing. The role of the General Practice Nurse (GPN) is very diverse with a wealth of opportunities to deliver high quality personalised care across the practice population. They provide expert clinical care, take the lead in helping patients to manage their health conditions, and act as a 'super connector' between other healthcare professionals within and outside the practice. The clinical knowledge, expertise and skills required for the role are vast and complex and are often poorly articulated by GPNs themselves and underestimated by others. In addition, an understanding of the social determinants of health influenced by the lifestyle that is adopted, and the community that is lived in, means that the role brings a wider view of delivering health and wellbeing outcomes. GPNs bring specialist skills which complement those of the other professions in primary care. They bring an essential insight to the patients, their situations and what can work for them. Despite this, the profession remains something of a well-kept secret, its role unclear and the range and depth of its essential contribution to effective primary care only partially seen. There is no common understanding across the NHS of the true *value* that nurses bring to primary care, and it is difficult to raise the profile of nurses working in general practice in the eyes of NHS colleagues, patients and the general public.

If the role, value and impact of this branch of the profession is not clear, it is at risk of under-investment - financially, in ongoing education and training, in its own networks and capabilities, and in how other parts of the NHS work with and through it. Without a renewed focus, adequate funding and a pipeline of new nurses coming into the profession, nursing in general practice will contract and primary care and the people they support with their healthcare will lose out. Without change, the true potential impact of the profession is likely to be only partially realised.

At the same time nurses in general practice will be a lynchpin of the future NHS. Their role and skills are critical to the delivery of the NHS Long Term Plan, and in making the new models of care function effectively in the context of making the best use of budgets and resources and increasing demand. This project is designed to articulate the value of general practice nurses (GPNs), and to catalyse a step change in appreciation of the profession, in order that it may be enabled to grow and contribute to its greatest potential. Articulating the value of GPNs can give reason to invest in this profession, and enable a greater return on that investment to be realised.

Project outline

The research has been commissioned by NHS England and NHS Improvement as part of their GPN 10 Point Plan programme of work.

The project is designed in two phases:

- Phase One: Working with nurses and other professionals in three NHS regions to build and test a hypothesis around GPNs' role and value.
- Phase Two: Further testing the hypothesis in three additional NHS regions, developing the valuation model and finalising reporting.

Methods and participants

Findings from Phase One of the project are summarised in this interim report. This phase of the work involved engaging groups of nurses working in general practice across three NHS regions (Nottinghamshire, London, and the South West). In each region, information was gathered by means of:

1. **Workshop 1**, using story -telling, thinking rounds and system analysis techniques to articulate the valuable difference that nurses in general practice make with reference to 3 beneficiary groups (patients, the practice, the community).

   [*Note that this workshop was replaced by individual SSFIs (semi-structured focus interviews) for the South West region.]*
2. **SSFIs** with one GP and the Practice Manager from each participating practice.
3. **Desk research**, providing local context for workshop findings (local health challenges, demographics, etc).
4. **Workshop 2**, testing interim findings and further developing our hypothesis with participants from Workshop 1.

…and overall by:

5. Two project **Steering Group** meetings, checking course and providing guidance on participation.
6. Additional **SSFIs** with individuals recommended by Steering Group members or the practices themselves.

This report

This report is a summary of what has been learned from Phase One. Reflecting the overall brief, it brings together views, insight and evidence from a range of sources to create an emergent picture of the role and value of GPNs - something that is not available anywhere else. Many of the elements are known and recognised in certain places. However the totality, and how the elements fit together has been described in our work as a well-kept secret, a hidden gem. Realising it is there, and investing in its development, will be key to its future and the future success of the NHS.

The report gives a brief outline of the role, supported with some statistical analysis of the size and profile of the nursing workforce. It then develops a deeper qualitative examination of the value nurses bring in four arenas and identifies eight drivers of value, each of which are explained in detail. It draws out, in brief, some of the examples that illustrate that value - an aspect of the report that will be developed further in Phase Two. It then looks in brief - again to be developed further in Phase Two - at the factors which help and hinder the delivery of the value GPNs promise, before looking at the importance of GPNs in the changing face of Primary Care under the NHS Long Term Plan.

2. The role of general practice nurses (GPNs)

General Practice Nurses explained

General practice nurses work in general practices as part of the primary healthcare team, which might include doctors, pharmacists and other specialist healthcare professionals such as physiotherapists. The patterns of employment and the roles that nurses fulfil in general practice vary widely. In larger practices, a team of several practice nurses will share duties and responsibilities. Smaller practices may have just one or two GPNs who, as a consequence, may each hold broader sets of responsibilities. Some practices have developed such that nurses lead the practice overall.

For the purposes of this report, we use the terms 'GPN', 'general practice nurses' and 'nurses in general practice' interchangeably. We do not include healthcare assistants (HCAs), whose qualification and supervision routes are different. We do not include Nursing Associates as this role is relatively new to the practice setting.

GPNs are Registered Nurses working across range of roles and specialisms (including disease specialisms and may have the ability to prescribe) and are regulated by the Nursing and Midwifery Council. Routes into the profession vary, and it has been less common for nurses to enter general practice immediately on qualifying than it is for them to transfer from hospital or specialist settings, perhaps after a career break. A lack of general practice placements for undergraduate students as a standard part of training courses is believed to be one of several key contributors to this pattern.

Appendix 1 provides statistical analysis of this branch of the nursing profession, showing age, gender and other demographic trends and profiles for general practice nurses at various levels. It highlights a profession staffed largely by women and with a high number of older workers, with some 37% over 55 years old. GPNs constitute a significant proportion of the primary care workforce and are the second largest group after GPs. In the practices we spoke to in Phase One of our research between 20% and 70% of the staff were nurses (one practice was nurse-led). The average for England as a whole is 26%.

Since general practices operate as independent businesses providing contracted services to the NHS, and because GPNs are employed by the practices directly, there is a wide variation in pay, terms and conditions. Whilst most would like to be on the NHS Agenda for Change pay system, we understand that this is not yet the case everywhere. GPNs' pay (which can be viewed as the investment by the practice in their nursing team) is an important part of the assessment of the value they bring, and will be drawn into the investigations of the project's Phase Two work, as we develop the valuation model. .

Articulating the value of GPNs

This project has sought to build a framework through which the value of general practice nurses can be fully understood and articulated, whatever the size of the nursing team, or the specific duties of any one nurse. The following sections will discuss how we have analysed:

a) First, the arenas in which value is created, and

b) Second, the key drivers of that value – the things that nurses do, the approaches they take and the skills they bring which bring about positive outcomes.

As well as the care activities and services provided to patients, it is clear that part of that value lies in the nature of the professional nursing approach, and we are considering that essential approach alongside other value drivers.

Nurses are highly skilled and their degree level training and qualification is underpinned by a set of principles. Time and again in our research, these principles shine through as generating real and lasting value to patients, the practices and the wider community. The table below shows these 8 Principles of nursing practice, as published by the Royal College of Nursing.

Fig. 1 – Eight Principles of nursing practice: that apply to all nursing staff and nursing students in any care setting

Principle A
Nurses and nursing staff treat everyone in their care with dignity and humanity – they understand their individual needs, show compassion and sensitivity, and provide care in a way that respects all people equally.

Principle B
Nurses and nursing staff take responsibility for the care they provide and answer for their own judgments and actions – they carry out these actions in a way that is agreed with their patients, and the families and carers of their patients, and in a way that meets the requirements of their professional bodies and the law.

Principle C
Nurses and nursing staff manage risk, are vigilant about risk, and help to keep everyone safe in the places they receive health care.

Principle D
Nurses and nursing staff provide and promote care that puts people at the centre, involves patients, service users, their families and their carers in decisions and helps them make informed choices about their treatment and care.

Principle E
Nurses and nursing staff are at the heart of the communication process: they assess, record and report on treatment and care, handle information sensitively and confidentially, deal with complaints effectively, and are conscientious in reporting the things they are concerned about.

Principle F
Nurses and nursing staff have up-to-date knowledge and skills, and use these with intelligence, insight and understanding in line with the needs of each individual in their care

Principle H
Nurses and nursing staff lead by example, develop themselves and other staff, and influence the way care is given in a manner that is open and responds to individual needs.

Principle G
Nurses and nursing staff work closely with their own team and with other professionals, making sure patients' care and treatment is co-ordinated, is of a high standard and has the best possible outcome

3. Value analysis 1: Who benefits from GPNs?

Workshops with nurses working in general practice provided a rich seam of stories and examples of services, activities and initiatives led by nurses. Most of these examples focussed initially on the patient, but in probing more deeply, revealed that value 'ripples out' more widely than single patient health outcomes. As a first step we were able to determine four distinct arenas to which GPNs bring value – with the value itself responding directly to the needs of those arenas and the people within them:

- **In the practice** – which needs to provide quality care to patients, develop services to meet future needs of the local patient and population group and the wider strategic needs of the NHS, and be financially and operationally viable.
- **Amongst patients** – who need to receive timely and effective care, and to feel and be supported and enabled to make informed decisions regarding their health.
- **In the wider community** – which needs to enjoy better wellbeing contributing to illness prevention and, when needed, to be linked with or 'signposted to' all forms of health and social care.
- **Within the wider NHS and social care systems** – which need to develop, be accessible and be used efficiently in the delivery of high quality health and social care, supported by excellent primary care and developing self-care capabilities amongst patients and the wider community.

The diagram below shows how value builds in each of these areas.

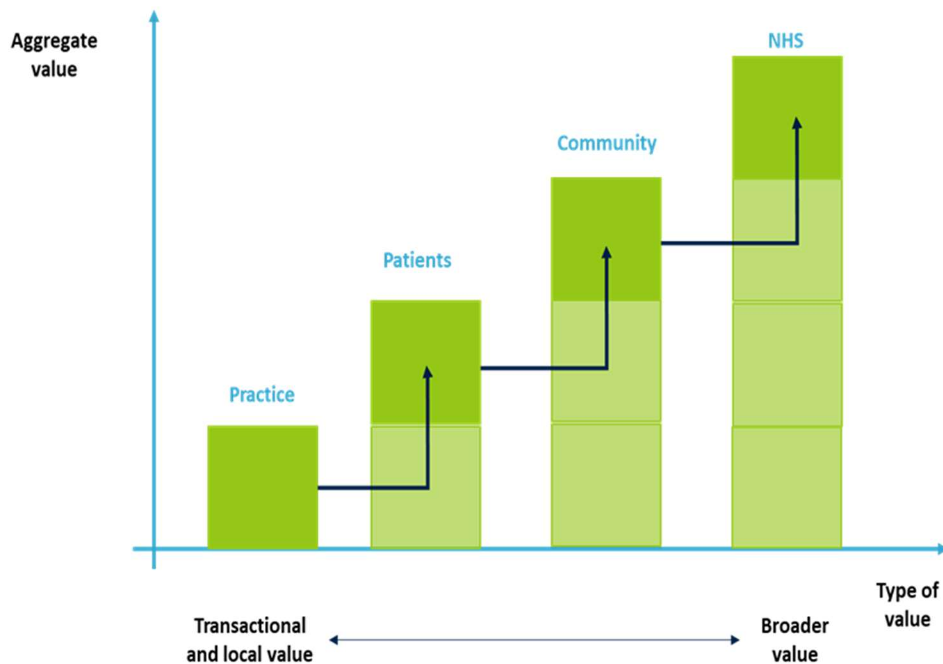


Fig. 2 - Four Arenas of Value Creation

The arrows describe the effects of nurses:

a) delivering ‘transactional’ and local value within the practice (such as seeing individual patients, and managing long-term condition clinics);

b) delivering a broader range of value to patients themselves – ranging from responsive care such as post-operative dressing management to preventative programmes and personalised health management advice;

c) leading activities responding to local area and health population needs, developing outreach and community support programmes that meet that need;

d) being key to effective and developing delivery of primary care within the wider NHS. This will be explored in detail in Section 8.

Each of the four arenas of value– the practice, patients, communities and NHS as a whole – experience positive outcomes as a result of the work and activities of GPNs. The term ‘outcome’ is used to describe positive changes that meet a need in each of the arenas. The ‘impact’ is the extent to which these are caused by an intervention, activity, or service– for example, a childhood immunisation programme whose outcome is reduced numbers of measles cases and a resulting reduction in demand for primary or hospital care.

4. Value analysis 2: Where does the value come from?

Positive outcomes in our value arenas arise through a range of so-called 'value drivers'. Value drivers are the activities, approaches and capabilities that enable those outcomes to be delivered. Our research identified around 40 distinct value drivers, and further research will no doubt elicit more. Analysis of the growing list has revealed eight core thematic areas, into which the vast majority of drivers can be mapped. These are:

- Leadership – at multiple levels
- Networked approach
- Developing and enabling self-care
- Developing communities of support
- Skilled delivery of care
- Specialist areas of responsive care
- Strategic and system approaches for prevention
- Improving diversity of access and management

The diagram broadly groups these value drivers into two sets:

- Those arising from how nurses lead, work and engage (on the right hand side of the circle)
- Those arising from how they enable change for patients, their carers and communities (on the left hand side).

Fig. 3 - Eight Drivers of Value

The creation of value as described here, is not a series of isolated actions or 'transactions' taking place in the isolation of the surgery or clinic. Outcomes are needed and impacts are delivered in the context of people's real lives and social situations. With the focus being on how to help them manage treatments and conditions, and enhance their wellbeing in the longer term, it is important to recognise that:

1. In every arena there is a focus not just on the immediate or primary impact ('So what happened as a result…?') but also on the follow -on effects, or secondary impacts ('…and so this became possible'). This is important to note as it links directly to differences in treatment and preventative approaches and their long term outcomes.

2. The priority of needs for the patient is, in the same way, wider than the immediately-presenting difficulty. In this context, GPNs drop the priority of
   - 'What's the matter with you?' in favour of 'What matters to you?'
   - 'What treatment do you need today?' in favour of 'How can we help you manage the condition?'

   In each case, the former of these questions reflects short term and situation-specific thinking. It is not an approach that nurses described to us as being natural to them.

3. Delivery of support is holistic: GPNs' instinct and training is to think holistically about the patient, taking on board psycho social needs alongside physical needs, and their circumstances and to empower that patient to help themselves by the best means available. Listing a series of 'do's and don'ts' is of little value without an assessment of whether the patient is able and willing to stick to them (or properly understands them). The GPNs can motivate the patient to make real change, co-producing a plan of care for them, with them.

The better to understand how the value arises and where it goes, we can map the four arenas of value creation (from the graph on page 7) onto the eight drivers of value shown in the circle diagram above. The table in Figure 5 does exactly, that, showing how the eight value drivers enable GPNs to respond to the needs in the four value arenas, offering services that delivery positive outcomes in each arena. It identifies needs within each area of value and describes outcomes – or changes in the lives of patients, community, practice or wider NHS – that would be seen as these needs are met. It then indicates which of the eight value drivers appear to be driving towards the delivery of those outcomes.

Arena of Value	Needs	Outcomes	General Practice Nursing Value drivers
Practice	• To deliver quality care to their patients • To meet required targets and receive associated income • To meet CQC standards • To effectively and efficiently manage appointments and the delivery of responsive and preventative care • To employ good staff and support them to develop professionally • To embrace continuous improvement	➢ Practice maintains strong patient base ➢ Practice is financially sustainable ➢ Practice effectively reaches and delivers care to its patients ➢ Practice is a viewed as a leader – adopting innovative staff-led approaches and adapting to new models of care	❖ Leadership ❖ Networked approach ❖ Skills of nurses in delivery of care ❖ Specialist areas of responsive care ❖ Improving diversity of access and engagement
Patients	• To receive required care in a holistic model • To feel looked after • To be able to make informed choices about their health and be empowered to take a part in maintaining and improving it • To feel supported in times of poor health	➢ Patients receive holistic, joined up care ➢ Patients trust their doctors and nurses ➢ Patients are listened to, not just prescribed for ➢ Patients feel empowered over their treatment choices	❖ Developing and enabling self care ❖ Developing communities of support ❖ Skills of nurses in delivery of care ❖ Specialist areas of responsive care ❖ Improving diversity of access and engagement
Community	• To have links with local practices to benefit community health • To provide non-medical support to those experiencing health difficulties • To have healthy environments and be able to maintain their independence and ability to care for themselves for as long as possible • To have roles as carers appropriately supported	➢ Patients benefit from non-medical therapies ➢ Patients received joined-up care ➢ Support networks created	❖ Leadership ❖ Networked approach ❖ Developing and enabling self care ❖ Developing communities of support ❖ Skills of nurses in delivery of care ❖ Specialist areas of responsive care ❖ Strategic and system approaches for prevention ❖ Improving diversity of access and engagement
NHS	• Resources managed efficiently and used effectively • Patients to receive appropriate care • Early interventions for patients so conditions don't deteriorate, and may improve • To maintain and support a high quality workforce to deliver care	➢ NHS runs efficiently and on schedule ➢ It can shoulder the demands placed upon it ➢ The NHS and NHS-related organisations are viewed as a top employers	❖ Leadership ❖ Networked approach ❖ Developing and enabling self care ❖ Developing communities of support ❖ Skills of nurses in delivery of care ❖ Specialist areas of responsive care ❖ Strategic and system approaches for prevention

Fig. 4 – Value drivers mapped to arena needs and outcomes

The value drivers do not always work alone. It is the combination of them that is particularly valuable, and the fact that nurses have all eight at their disposal to combine as necessary…and know how to do that. Other health professionals undoubtedly can bring value in several of these areas, however it is the GPN team that brings value through all eight as an integrated whole. Nurse training develops individuals who are highly skilled generalists, albeit some have additional specialist areas of expertise. Nurses have a broad and comprehensive knowledge

base, meaning they can deal confidently and expertly with a wide variety of conditions and care needs ruling out conditions and making a differential diagnosis as well as coming up with a treatment plan. Their approach to patient care is a holistic one, embracing a number of diagnostic techniques with an ability to synthesise information in order to better understand a patient's needs. This role is very different to other nursing roles which may focus around a disease pathway.

The nursing team is not working in a bubble. Nurses work alongside other health professionals both within and beyond primary care, ensuring that care is appropriate and joined up. Appreciating the healthcare system as a whole allows us to properly assess how value is accrued through application of these value drivers - either individually or in combination. For example, a skilled nursing team able to support long-term condition management and proactively reaching out to particularly vulnerable groups in the community ultimately leads to fewer acute episodes of these conditions, freeing up time in the practice to offer additional services and more personalised care. This reduction in acute episodes presenting in primary care settings inevitably reduces demand on acute care beds as primary care responses are more timely and can prevent deterioration.

In the next section, each of the eight core drivers of value is discussed in more detail.

5. Value drivers explained

1. Leadership

Leadership – as distinct from management – is a key skill that is widely developed in nurses. Leadership can be defined as a process of social influence, which maximises the efforts of others towards achievement of a goal.

Given the high levels of self-direction and variability of work priorities that nurses have, leadership is a characteristic that enables much of what nurses achieve in general practice. Leadership demonstrated by GPNs embraces some or all of the following:

- Recognition of a need, which may mean spotting patterns of behaviour
- Analysis of need and initiating a response, both of which require original thought
- Research and design of that response, often in collaboration or consultation with others
- Facilitation to make it happen, including catalysing resources
- Putting in place guidance and support to enable it to continue, and improve

In the wake of the Covid-19 pandemic, and contextualised by an evolving NHS, leadership from GPNs now has an important additional overlay of emergent and strategic responses, demanding agility and flexibility to meet the fluid situations and needs encountered.

Leadership feeds from the insight that nurses gain from their work with patients both in treatment settings and in prevention, and sometimes in selected areas within the community. It benefits from the networks in which GPNs participate within and outside the practice. It can be seen in action within the practice, between practices, in the community, in the workplace , and within the wider NHS environment. Examples of leadership in action include:

- Development of new services and approaches within the practice
- Sharing ideas and approaches with other practices
- Teaming up for area-wide effect
- Solely managing and delivering certain areas of patient care
- Looking out for what has worked elsewhere – adopting and adapting
- Thinking independently, objectively and creatively rather than being constrained by group-think within their practices or roles
- Having a positive impact on the overall culture of the practice and its engagement with the community; creating balance of thought, insight and action.

A GPN-led initiative at Combe Down Surgery to create a risk stratification system for patients with long-term conditions, in particular diabetes, has been rolled out across the region. This new system schedules annual reviews in the month of each patient's birth and tailors responses and follow on actions based on individual patient risk profiles. The system has led to improvements in patient HbA1c levels (a measure of blood glucose) across the board.

The common factor in all of these examples is that they are largely self-initiated. The GPN recognises a need and responds to it, sharing results with colleagues to enable better and more widespread outcomes. Many of the nurses we spoke to reported that they did not overtly seek permission to make necessary changes – they simply worked out the best way to address a need and 'got on with it'. This ability to lead (oneself and others) is particularly important when jobs or initiatives are mandated at a high level, without detailed instructions on how to mobilise the response (for example, organising the Covid-19 vaccination programme at a practice level).

Leadership from the GPNs within practices is key to that practice delivering effectively. It feeds from the unique insights of the GPNs, looks holistically at how positive outcomes may be delivered for patients and community, and recognises readily how networks inside and outside the practice may help that to happen. It can be supported, helped and enabled by others such as GPs, but cannot be delivered well without the GPNs themselves. Interestingly, whilst providing us with examples of good leadership, many of the nurses we consulted did not recognise themselves as leaders – what they did was 'just part of the job'.

2. Networked approach

Nurses, with an open style of working practices and high levels of mutual support, engage with and develop networks at multiple levels. Within the practice nurses network amongst each other, with GPs and other professionals. Outside the practice networks exist with community bodies and organisations and with nurses and other professionals within other areas of the NHS. Being a 'super-connector' is an important part of the role of nurses in general practice.

Networks are not only fundamental to the effective delivery of NHS services, but also for the engagement of the NHS with other providers of community health and wellbeing. They are envisaged as key to the effective delivery of primary care under the NHS Long Term Plan. In particular, the future model of Integrated Care Systems (ICSs) sees NHS teams working in partnership with non-NHS professionals and other providers. Whilst the ICS provides the financial and resource management angle of this, there is a need for a pragmatic 'let's make this work' approach at the delivery end, and much of this will come through nurse-led networks. Networking within the practice nursing team is demonstrated by nurses:

- Sharing workloads fluidly and effectively amongst the nursing team
- Having a joint focus on what is best for the patient and their family
- Understanding and making good use of each other's skills and specialisms.

With GPs and other professionals, the network has a different character:

- Forming one of the core segments of practice delivery, with a strong focus on prevention
- Offering a more consistent, permanent team alongside others that may include significant numbers of locums, or part-time workers
- Reciprocating advice on medication and case management with GPs in areas of respective specialism.

Networks with community bodies and organisations take many forms, including a diverse range of organisations, systems and individuals involved in providing or enabling care. Some of those most frequently cited are:

- District nursing
- Social prescribing
- Schools (eg, through the Private Schools Wellbeing Council)
- Care homes
- Charity and private sector support providers
- Local religious groups
- Universities, colleges and training providers
- Communities with limited access to care (eg, homeless people, refugees).

The nature of such networks is complex and dynamic, drawing on a range of skills, principles and attitudes including coordination, intelligence sharing, and education. Networking in this way is fundamental to being able to support patients in getting the help they need – be that from the practice or elsewhere. It relies on common understanding of the needs of patients and patient groups and a shared desire to meet that need.

Integrated Care Systems (which are planned to replace Clinical Commissioning Groups) are a step on from the often informal networks of which nurses are frequently a part. They are predicated on a widespread capability to draw value from networks and place them at the heart of service delivery. As such they need the relationships that nurses build with other professionals and in the community as well as nurses' insight into the social, psychosocial and systems contexts in which care is being delivered.

The nurses participating in our research were keen to share details too of other networks which they saw as critical to their professional contribution. These reflect a desire for continual improvement and pragmatic problem-solving which characterises the GPN role:

- Other general practices within the PCN (sharing best practice and innovative ideas)
- Other primary care staff (following up or advocating on behalf of patients)
- Specialist primary care and secondary care providers (on multi-disciplinary care teams, for example, or in informing hospital specialists of patients situations and practical needs)

A local nursing federation employed two GPNs as lead nurses to visit all GP surgeries in Southwark (18) and speak to their GPNs. The lead nurses asked whether the GPNs felt supported at work and what their training needs were. They discovered that many of the GPNs worked alone or did not know their colleagues as they worked different shifts. Some felt unsupported by their GPs and felt they had no one to talk to. Stemming from this, a WhatsApp group was created where local GPNs could chat and ask questions as well as a monthly forum to share knowledge and offer training.

- Mental Health professionals and providers (liaising on appropriate support for patients)
- Professional Bodies and National Leadership (contributing to research and professional development).

3. Strategic and system approaches for prevention

GPNs regularly take the lead in designing and implementing approaches to care that focus on prevention and condition management. Built on a deep understanding of how conditions progress or heal over longer periods, and how they are affected by the social and psychosocial contexts of the patients themselves, GPNs tailor their advice to meet individual needs, however this prevention approach is rooted in a wider public health prevention strategy.

Much of this work is informed by knowledge around area and patient needs, that is built up over time by the nursing team and supported by a treatment and care approach which includes time to help the person understand and manage their condition.

Wherever possible a strategy will be developed that includes care plans that will work for the individual and are understood and manageable by them, their family or anyone else involved in their care. Where multiple patients share care and advice needs, nurses take the lead in education and health management (e.g. healthy eating groups), rolling out programmes or designing new ones where gaps in provision are identified.

Systemic approaches to recalls, and observation of indicators of escalating need, help to ensure that the wider patient base is managed effectively, and that income generated by effective and proactive practice can be applied. 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 key public health programmes such as seasonal 'flu vaccinations have an impact on the wider health system, improving outcomes for whole communities and health populations.

An ANP in Nottingham described working at a clinic called POW (Prostitute Outreach Workers), which provides a safe space for sex workers in the city. The clinic offered Hepatitis B vaccinations and check-ups for women who found it difficult to communicate their circumstances and lifestyle to their GP and felt more understood in a specialist clinic.

4. Improving diversity of access and engagement

A key focus of the nurses in general practice is to ensure that the practice reaches the whole community and is visible and accessible to all. People are not all the same, and the situations in which they find themselves and in which healthcare is delivered do not stay the same. GPNs' preferred or default approach to engagement with patients complements that of doctors, and it is only by being able to offer the best of both that the general practices can achieve the best possible engagement, and impact.

A pertinent example of this has been in evidence throughout the Covid-19 pandemic, during which nurses have continued face-to-

face contact with patients throughout the lockdown period – even in situations where GPs have been consulting by telephone only. This in-person contact with nurses has been acknowledged as a deeply comforting and vital element of care delivery in difficult times. Indeed, it is largely nurses who are administering the vaccines, in the biggest vaccination programme the NHS has ever undertaken.

Exemplified by a nursing approach that works 'with' patients, not 'on' them, GPNs provide a mix of forms of engagement that complement those of the GPs and other healthcare professionals, including different ways to reach and treat people:

- Longer-term relationships – such as a 'named nurse'
- Often working within a care management context unique to a patient's circumstances
- Appointment times can vary (e.g. longer sessions for those newly diagnosed with diabetes)
- Conversations with nurses often cited as being 'on a level' with patients (not too remote or medicalised)
- Active management of getting patients to attend appointments and follow-ups – developing recall systems and forms of contact
- Delivering clinics or 'outreach' services in places where patients are likely to be (e.g. prostate checks at a local football ground).

Liaison and networking with other care providers in the community can help promote better and more effective care for patients. This is often predicated on an understanding and relationship with patients that:

- is built up over time – and, indeed, over generations
- acknowledges and works with the patient's situation and how it compromises or helps treatment or management (the psychosocial and systems aspects of care management)
- takes into account any knowledge of the wider family.

Patients report that nurses can be easier to talk to than GPs when it comes to more intimate conversations. In such situations nurses speak frankly, engender trust and find ways of broaching medically intimate or embarrassing realities. Conversations have been described as 'straightforward', 'no nonsense', and non-judgmental.' GPNs report that there appears to be a widespread belief amongst patients that nurses may have more time than GPs (regardless of whether that is always true), and patients often feel more able to bring up additional concerns in the course of a consultation than they would in a 10 minute, single condition consultation with a GP. These are known as 'door handle' conversations[1] and recognised as an important point at which patients disclose the one thing that is really worrying them. GPNs need always to be alert to these as that point of disclosure may be the only hint that a patient gives that something may be seriously wrong.

[1] It is recognised that 'door handle' conversations are also a part of the consulting work of GPs, and other healthcare professionals. However, for GPNs, they perhaps happen as part of broader discussions, prompted and enabled by the wide context in which the GPN often knows the patient, and being held alongside the information exchange relating directly to the treatment or advice being provided at the time.

GPNs are seen to take the lead in pioneering different modes of consultation and engagement, including:

- Short, urgent appointments, but taking an holistic view
- Longer discussions
- Group consultations
- Online and video consultations

5. Developing and enabling self-care

Whether for patients managing a long-term condition, for prevention, or for broader development of wellness, self-care is key. It demands that the patient understands the need for self-care and how to do it, that they want to do it - for reasons which make sense to them over the longer term - and that they believe it is possible. Self-care support draws heavily on a GPN's knowledge of the patients' circumstances (allowing them to select practical solutions), and their ability to pinpoint and help to marshal support from family and friends.

Developing and enabling self-care is about understanding people in their social and human context, and enabling them to develop strategies that keep them healthy, including support to manage long-term conditions. Key elements include:

- Taking time to discuss the impact of the patient's conditions on their lives, and ways of dealing with that impact
- Spotting areas where patients need additional help
- Advocating for patients in obtaining additional support.

Self-care is a key component in the arena of public health management, and GPNs have an important role to play here - both in helping to identify health concerns that are common across health populations and in delivering preventative and enabling support to drive down demand at an early stage. 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 that are preventable. The economic implication here is important, but so too is the wellbeing of the individuals and communities that nurses support in this way.

One interviewee told us that someone with diabetes needs to spend around 1,000 hours each year actively managing their condition. Only three of these hours is spent in the company of a healthcare professional (usually a nurse), so that nurse needs to be skilled in both assessing the self-care capability of the patient and equipping them with additional advice and resources to effectively improve that capability.

With this in mind, key skills employed by GPNs are:

1. **Influence** – to get messages across convincingly, and to persuade the patient to act
2. **Problem-solving** – to find ways of overcoming the challenges in self-care posed by everyday realities
3. **Planning** – both for engagement by the patient with formal care settings, and in how the individual can plan to make the self-care happen

4. **Monitoring** – so that recalls happen when needed, and conditions are holistically monitored with an eye to what might emerge and not just what has emerged, and involving the patient and their carers in the monitoring
5. **Forward thinking** - both an awareness of what may emerge (as problems) and a prevention-focussed vision of how to change lifestyles and other factors to head off risks in a practical, holistic way.

6. Developing Communities of Support

Communities of support are important for individual wellbeing. Combining the empathy of those with shared experience, the support of carers as well as those with similar conditions, and the encouragement to persevere, they are a powerful force. Related to their support for self-care, nursing teams often initiate, design, facilitate and support the continuation of communities of support for various diseases and health conditions. Some of the examples we have heard about are:

- ‘Club’ settings such as a Leg Club, or ‘It’s Good to Talk’ online loneliness support sessions
- COPD clinics developing support between people who live with this condition
- Working with patients and family members to extend effective care into the home environment and empower that source of support
- Enabling development of support groups for carers, so that they can support each other (providing an ‘official’ identity for an often hidden cohort).

Communities of support are extremely valuable, but often under-appreciated. Nurses are skilled at recognising when group settings or activities will be helpful for patients. The Covid-19 pandemic, for example, has revealed a need in many people for connection with others who are struggling with similar issues – a need to know they are not alone in their struggle, and to share support and tips for getting through it.

Group consultations are being rolled out more widely in general practice, in many cases instigated by GPNs, and feedback from many nurses who have been trained to facilitate these suggests that patients often take advice more readily from others in the group than from the healthcare professional. This demonstrates the importance of shared experience and mutual support that comes from such groups. As a secondary outcome, patients often build lasting and trusting relationships over time with others in the consultation group, to whom they turn directly for support at times when they would otherwise be booking a GP or a nurse appointment to discuss a worry or concern.

A practice in Southwark ran (pre-Covid-19) a reminiscence group within the surgery for patients experiencing bereavement and loneliness. The group provided a reason for patients to leave their house and enabled them to socialise in a familiar setting. This worked very successfully and led to the formation of friendships and bonds between patients who might otherwise not have met. During the pandemic that group has continued online.

7. Skilled delivery of care

Nurses working in general practice bring a set of existing skills and experience enabling them to immediately benefit patients and practice through treatment, advice and condition management. In addition, many will build on existing specialisms and knowledge in response to patient and practice needs. The skillset is a broad one. Nurses are trained in a variety of technical skills and engagement models, and in how to identify the most appropriate of these to use in any given situation. In general practice this skillset is often broader than in acute or specialist settings, as nurses will need to respond appropriately to any problem presented by the patient. The nursing skillset is flexible and can be 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)
- Deploying skills through service provision which attracts income to the practice.

In Tower Hamlets GPNs noticed that many patients from the local care home were coming in with urinary tract infections as a result of poor hydration. They decided to organise a coffee morning at the care home with staff, residents and their families to address this. As a result of the positive atmosphere created, residents who would ordinarily refuse to drink anything were drinking beverages. Following the success of this, the GPNs delivered training to the care home staff on hydration and nutrition over 18 months.

The level of academic qualification required to practice as a nurse is high (degree level) but also encompasses the skills needed to deliver care with a high degree of competence, and those necessary to operate in a general practice environment (such as risk management, autonomous working, safe delivery of care, additional knowledge of immunisations, cervical cytology, wound care and much more besides).

In addition to using their skills directly with patients, nurses actively support the training of younger or more junior nurses within the practice and beyond. This is important as there are no universally-adopted general practice standards of training or nurse continuing development. In some practices training relies heavily on peer supervision, support and development.

Skilled delivery of care by the GPN teams is strongly rooted in the professional standards of nurses as individuals, underpinned by the eight principles of nursing. This includes an inherent duty:

- Not to do what they are not skilled to do
- Always to act in the best interests of patients
- In practice to go ‘the extra mile’ for patients and colleagues

8. Specialist areas of responsive care

There is a commonly-held belief that 'doctors diagnose and nurses support', however this could not be further from the truth. The role of GPNs includes a wide variety of specialisms, with considerable academic training and practical professional skill 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 reduce demand on secondary care facilities.

Other areas which commonly see nurses specialising within primary practice (often leading treatment and condition management clinics) include:

- Chronic disease or long-term condition (LTC) support, empowering patients in self-care
- COPD, Asthma, Diabetes and hypertension reviews
- Childhood immunisations and adult vaccination programmes
- Family planning
- Cervical screening
- Comprehensive well-woman, well-man and 40+ health checks.

The choice of specialist care offered by GPNs is often closely related to the specific needs of the community supported by the practice, with opportunities for leading local approaches to care delivery being closely linked to population health management.

6. Great ideas: innovation and leadership in healthcare and wider wellbeing

The conversations we have had with GPNs and others have revealed numerous examples of innovation and leadership in healthcare and wider wellbeing, all driven by GPNs. The callout boxes in the previous section highlighted a few of these. A more extensive list is shown below, and this will be built-upon and the examples expanded in Phase Two.

The examples below may or may not be unique: it is perhaps likely and indeed preferable that they are not. They are, however, important illustrations of the eight value drivers in action, creating real GPN-led, and GPN-enabled impact and value.

More effective care

- A GPN-led initiative at Combe Down Surgery near Bath, designed to better manage patients with long-term condition diabetes, has been rolled out across the wider BANES[2] region. It involves risk-stratifying all patients with diabetes into five tiers according to need and type of support required. From this the practice is able to:
    - Plan which professional should see whom based on need, so using staff more efficiently
    - Schedule visits at appropriate intervals to spread the workload and maintain a regular consultation and support pattern
    - Schedule annual review visits in the month of each patient's birth so spreading them efficiently through the year
    - Involve not just GPNs, GPs, and HCAs more effectively in patient support, but also the administrative staff, who know the protocols by which that support can be delivered, and are empowered to deliver more as a result.

  The system built in liaison with the consultant in secondary care, enabling him to visit the practices and gain insight to the more practical manifestation of the patients' situations and presenting health needs, which enabled him more effectively to refine and deliver secondary support. The roll-out across twenty-two other practices was led by the GPN who had developed the programme in the first place. That enabled not just a wider effectiveness of provision at scale, but also an interchangeability of staff and expertise, and an opportunity for wider collective learning and peer support.

  The system has led to improvements in patient HbA1c levels (a measure of blood glucose) across the board. The consultant reports changed secondary responses informed by the GPN teams which have improved patient outcomes. *(Becky Wych, Combe Down Surgery)*.
- A lead nurse In Plymouth ran group consultations for diabetic patients alongside GPs. Eight patients took part in these on a regular basis and were highly engaged. The sessions benefitted the patients and the practice by avoiding the need for individual consultations, and in enabling consistency of advice and mutual support across the patient group. *(Lynda Carter, Beacon Medical)*
- Group consultations for diabetics in London led to improvements in patient HbA1c levels (a measure of blood glucose) across the board. It also led to the creation of communities and, in a few instances, old friendships being rekindled after meeting again. These groups have allowed patients to experience the

[2] Bath and North East Somerset

practice and its staff in a different, positive way and has improved their trust and confidence in the medical care they are receiving. *(Linda Aldous, Bromley by Bow Health)*

Sharing best practice

- The GPNs in our Nottingham workshop described how they often used the Royal College of Nursing Facebook group for practice nurses as a networking tool and source of information. GPNs can read questions and responses from other nurses and can also post questions and get responses and advice from other GPNs on where to find information on specific topics, and how to deal with certain difficult situations. *(Fiona Angyal, locum in Notts area)*
- A local nursing federation employed two GPNs as lead nurses to visit all 18 GP surgeries in Southwark and speak to their GPNs. The lead nurses asked whether the GPNs felt supported at work and what their training needs were. They discovered that many of the GPNs worked alone or did not know their colleagues as they worked different shifts. Some felt unsupported by their GPs and felt they had no one to talk to. Stemming from this, a WhatsApp group was created which local GPNs can use to chat and ask each other questions. A monthly forum to share knowledge and offer training was also established. *(Cathy Thomas, Elm Lodge Surgery)*
- In Devon, the lead nurses from 16 practices in the Primary Care Network use a WhatsApp group to keep in touch and share information. The group also meets online every fortnight and is joined by the lead nurse from the Clinical Commission Group (CCG), who acts as a liaison between the group and the CCG. *(Lynda Carter, Beacon Medical)*
- A practice in Plymouth has just launched a skills swap scheme for its nursing team. This has involved creating a database of competencies where each nurse or health worker can list a skill in which they are competent enough to train someone else. Skills listed range from clinical work to computer skills (e.g. using programmes such as MS Teams). The database allows colleagues to book time with each other for training across six sites. This leads to both upskilling and networking between staff who might have not otherwise met. *(Lynda Carter, Beacon Medical)*

Innovation enabling wellbeing

- Before the Covid-19 pandemic a practice in Southwark ran a reminiscence group within the surgery for patients experiencing bereavement and loneliness. The group provided a reason for patients to leave their house and enabled them to socialise in a familiar setting. This worked very successfully and led to the formation of friendships and bonds between patients who might otherwise not have met. *(Cathy Thomas, Elm Lodge Surgery)*
- A practice in Croydon ran social prescribing programmes with Zumba, yoga, and Park Run groups. These proved very popular with patients. During the pandemic lockdown, members of the Zumba group moved on to start an online knitting group and knitted rainbows to decorate the local High Street and a special heart-shaped rainbow for the practice as a 'thank you' to the NHS. *(Jo Yanzu, Parchmore Medical Centre)*
- In Tower Hamlets GPNs noticed that many patients from the local care home were presenting with urinary tract infections as a result of poor hydration. The nurses decided to organise a coffee morning at the care home to address this, inviting staff, residents and their families. As a result of the positive

atmosphere created, residents who would ordinarily refuse to drink anything were drinking beverages. Following this success, the GPNs delivered training to the care home staff on hydration and nutrition over a period of 18 months. In addition, care home staff were trained on checking blood glucose and monitoring oximeter, blood pressure and peak flow. The training proved incredibly effective with no residents needing to come into the surgery during lockdown for issues relating to poor hydration or nutrition. *(Lola Soloye, Bromley by Bow Health)*

Investing in the future of the profession

- Driven by the efforts of its lead practice nurse, Parchmore is one of the first practices in London to be involved in a pilot scheme to get student nurses placed into GP surgeries. This has led to two student nurses joining the practice upon registering. In addition, other student nurses that were placed at the practice have gone on to become GPNs in other surgeries. *(Jo Yanzu, Parchmore Medical Centre)*

Improving access to care

- An ANP (Advanced Nurse Practitioner) in Nottingham described working at a clinic called POW (Prostitute Outreach Workers), which provides a safe space for sex workers. The clinic offers Hepatitis B vaccinations and check-ups for women who found it difficult to communicate their circumstances and lifestyle to their GP and felt more understood and less judged in this specialist clinic setting in the heart of the city. *(Fiona Angyal, locum in Notts area)*

7. Harnessing the value: Risks, barriers and enablers

The research in Phase One has highlighted a number of areas that bear consideration alongside a discussion of the value that GPNs bring. These fall into the three categories of risks, barriers and enablers. Whilst the following list is by no means exhaustive, it does suggest that structured support for and development of the GPN role may need to be improved if the full value of the profession is to be realised. As Section 1 explains, this is an area to be expanded in Phase Two, which will also include a more detailed explanation of how education and skills contribute to the value delivered by GPNs.

Risks

The risks brought to our attention stem mainly from the structural nature of GPN employment in practices that are – at one and the same time - part of the NHS and self-contained independent businesses.

1. Variation in terms and conditions of employment, expectations, and career opportunities has implications on perceptions of the GPN profession and increases the difficulty in recruiting new and younger nurses to general practice. It points also to a need to enhance training programmes better to equip nurses to work more effectively in general practice, and to bring this with a national consistency of standards and cover. In a setting which operates as a business, nurses are far more accountable for negotiating their own pay, conditions and responsibilities than their peers in other settings. Recognition and reward for additional work undertaken does not come automatically – a nurse will need to learn to stand up for themselves and forge their own path.

2. Training and development opportunities also vary widely, influencing not only how nurses feel about taking up a general practice role, but also how patients experience care (apparently at odds with NHS-wide campaigns to reduce variability in care). Some aspects of this include:
   - Line management of GPNs that is inconsistent: many report to Practice Managers, but worry that they are not sufficiently clinically experienced to be able to develop and get the best out of the nursing resource.
   - In smaller practices with only one or two nurses, there is a lack of supervision and training 'sign-off' resource. Whilst nurses may be confident in self-reliance and self-leadership, the responsibility for training someone else 'on the job' is one that many decline to take on. Skills transfer techniques may be another useful addition to core nurse training programmes, since peer-to-peer working in practice is an integral part of the current training model – and something that is at particular risk in light of historical low numbers of nurses being attracted into general practice.
   - Peer support is delivered effectively through networking (physical and social) but this is often compensating for the lack of a structured and system-wide continuing development expectation.
   - A shift of training and communications online (both in response to the pandemic lockdown restrictions and as part of a pre-existing trend) removes a vital opportunity for nurses to network and exchange best practice informally 'in the margins' of a training event. If a significant amount of training moves to online delivery it may be necessary to create alternative mechanisms for nurses to network informally – we have

seen that this is a crucial skill for keeping up to date.

3. There is a 'buck stops here' reality experienced by GPNs that affects their ability to deliver quality outcomes to some patients, and in so doing has a knock-on effect on time available for other patients. This is apparent in cases where patients waiting for specialist care are deemed to be 'safe' in the care of the practice so continue to be seen by nurses, despite the practice nursing team not having the skills to deliver the actual care needed and regardless of whether the practice has capacity to deliver against such addition care demands. In such cases patients can pay for private treatment but often simply remain on specialist waiting lists until their condition worsens sufficiently to pass the specialist service threshold criteria.

Barriers

Barriers to the value of GPNs being widely acknowledged and effectively realised lie largely in the struggle to reverse or update existing perceptions.

4. Most of the nurses we have spoken to believe that others (patients, the general public, some GPs and other healthcare professionals) regard them as 'only' a nurse – by implication, something less valuable than other professionals. In light of this 'what you bring' in terms of nurse performance and patient experience is more important than the GPN job title (which doesn't in itself lead to a known expectation). In one recent recruitment round applicants were asked to describe what they thought the role entailed and 5 out of 6 described an HCA role.

   Practices themselves sometimes exacerbate this perception by failing to confer an appropriate status on nurses in comparison to GPs or other professionals. One example of this is can be found on practice websites, on which we frequently see doctors listed with title and surname but nurses referred to only by their first name. This may be intended to imply friendliness and approachability but has the side-effect – and presumably unintended consequence - of suggesting a lower status or value.

5. Responsibility for changing this perception lies not only within the NHS, but also outside. Most media portrayals of nurses are stereotypical and outdated; even the most recent TV public health adverts urge patients to 'talk to their GP', subliminally by-passing the nursing team.

6. There were some suggestions that nurses perceive themselves as (the least valued?) professionals compared to occupational therapists, physiotherapists, pharmacists, and paramedics, all of whom will be working out of general practices as the NHS model evolves, potentially worsening the relative perceived status of GPNs. In reality, these other professionals have relatively narrow (albeit deep) specialisms and are not routinely able to work across the breadth of services that nurses do, nor to draw on the 8 Drivers of Value that are essential for effective, efficient and cost-effective primary care.

7. Some of the nurses we spoke to tended to take for granted and so downplay the full range and depth of their achievements until challenged and presented with them. They do celebrate what is being achieved, but the instinct to confer success on the wider team could be masking individual potential. There is some suggestion that, in a workforce that is predominantly female (see Appendix 1 for demographic data), this could be a

gendered response. If this is true – and the question is beyond the scope of this research – then that will have implications on how future cohorts of nurses must be trained. The non-clinical elements of the nursing skillset are becoming increasingly critical to the role and need to be properly recognised, included in perceptions of what nurses do, and rewarded appropriately.

Enablers

Enablers to value realisation stem mainly from the aspiration of nurses looking to innovate and take the lead in delivering new services in new ways. In discussion around this topic, a number of skills gaps were identified:

8. Facilitation skills, which is increasingly important as group consultations become more widely available. Facilitation is a distinct skill that runs counter to a nurse's natural calling to provide advice.

9. Consultation skills, which are needed when dealing more holistically with patients and their circumstances. We heard, for example, that some nurses were being encouraged and supported to progress to Advanced Level Practice with prescribing capabilities, but that a training module on consultation and 'history taking' was neither a part of nor a pre-requisite for the prescribing course. Of course, there are many ways in which nurses can progress through developing specialisms, and many would benefit from consulting level practice.

10. Better and more current awareness of the wider systems in which patients and communities sit, which create the context for NHS primary care operations, and which support or limit care and wider wellbeing outcomes. This is not a formal requirement for nurses – it's something they 'pick up' as they work, but in future operational models will be key to effective delivery. In particular, nurses reported that it was difficult to 'keep up with' the ever-changing wellbeing provision commissioned on short term contracts from third parties.

11. Better and more current awareness of the roles of nurses in other parts of the system. One example we were given was that of a hospital nursing team referring a patient back to the GPN for a treatment not provided by that practice. This situation is exacerbated by the nursing role in both general practice and hospital settings evolving quickly.

8. Forward thinking: A developing model of nursing in primary care

Since nurses were introduced formally into general practices with a role in the broader delivery of primary care, their role and contribution has grown considerably. The previous pages have described the current position which stands in contrast to the original ‘traditional’ one in which nurses were viewed largely as additional resource and support to GPs.

In our current model the eight drivers of value have emerged as recognisable and widely replicated elements that help us to define and articulate the role and contribution of GPNs, and their value. General practice has developed to span:

- Diagnosis, prescription and referral
- Treatment of a variety of types, including access to social prescribing, delivered with a view to systems and social context
- Selected areas of work in prevention and promotion of wellbeing in certain parts of the community, or focused on particular needs
- Outreach, coordination and leadership in the operation of primary care across wider areas.

The NHS Long Term Plan proposes a further development of the scope and responsibilities of primary care as it seeks to address demand in more appropriate settings than the current model can support. In the new operating model, general practice will include:

- 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 wellbeing
- Broader education of the general population and specific groups within it to seek and improve their own wellbeing individually and collectively
- Leading and running of Integrated Care Systems across all areas of England.

An analysis of the Long Term Plan and related strategies for transforming the NHS reveals three major factors that drive the change towards a new target operating model. These factors, shown in the green box in Figure 5, and explained below are:

1. A changing pattern of demand and supply
2. A changing operational and funding context
3. A foundational role for primary care

Taken in combination, we can see that the demand for quality nursing provision in primary practice is a fundamental requirement for the effective management of health and care needs over the longer term.

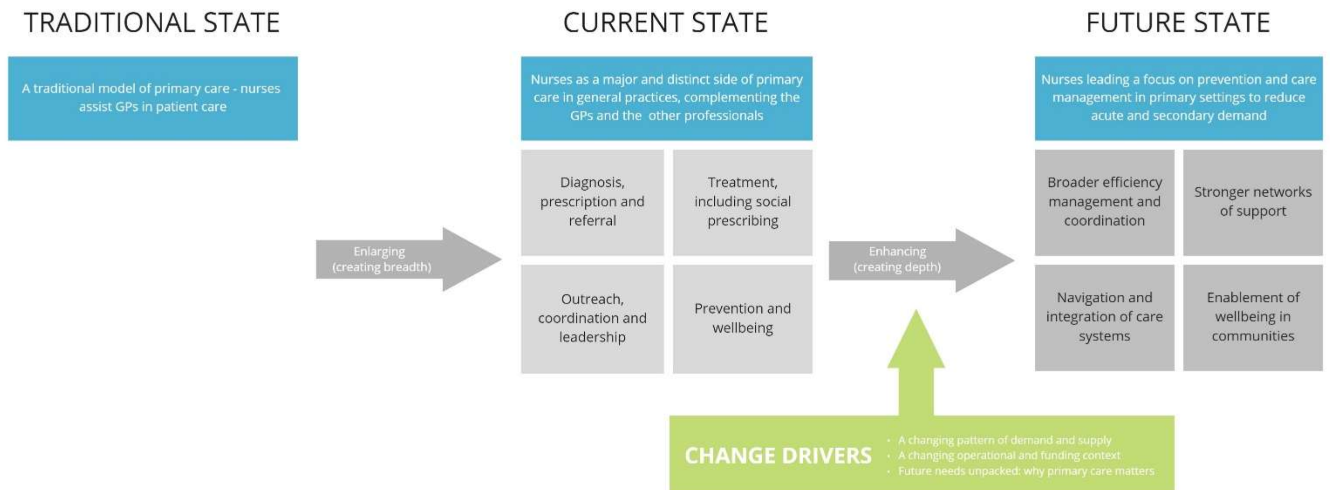


Fig. 5 – A developing model of nursing in primary care

A changing pattern of demand and supply

The NHS was designed to manage ill health – to deal with episodes of illness and accidents, providing quality care at the point of need. Today's NHS is doing much more than that, and the demands placed on it – largely arising from changing population demographics and public health trends – necessitate a new understanding of the service as a whole, and the role of primary care within that whole.

The NHS Long Term Plan describes a re-designed NHS, in which resources and expertise are focussed where they are needed and used effectively and efficiently. To meet the support needs of growing numbers of older people and those living with long-term conditions (LTCs), more needs to be delivered through primary care settings. Older people and those with LTCs are not acutely *ill* (albeit they can have acute episodes). Rather, they have *conditions* which need careful management, and most have some capacity for managing their own conditions well – with the right support available from the general practice and the wider community. Much of this support is delivered by GPNs, and we have examined via the eight drivers of value why this makes sense.

All of this means that the focus is on health and public health outcomes – diagnosing and treating illness when it occurs, certainly, but emphasising prevention and enabling wellness. Re-doubled efforts in screening and prevention services (including social prescribing and health management) mean more demand is being channelled into primary care. The Covid-19 pandemic has underlined this by relying on GPNs to manage not only winter 'flu vaccinations but also to prepare for and deliver an adult vaccination programme of unprecedented scale and complexity at very short notice.

As a result in this change of context and priorities, things are beginning to look different in general practices: larger and more autonomous nursing teams, including advanced nurse practitioners; prescribing pharmacists;

allied healthcare professionals forming part of an extended delivery team. Many of the GPN skills and capabilities we have encountered in our research are well-suited to this new delivery context – in particular the emphasis on person-centric, holistic and socially-contextualised care.

A changing operational and funding context

Funding and resource management is changing too. The creation of Integrated Care Systems (ICSs) - and within those, Primary Care Networks serving neighbourhoods Integrated Care Partnerships serving places - demonstrate a very different operating landscape from the one we are used to. Primary Care Networks, in particular, are viewed as a fundamental building block that will enable the development of ICSs. As the Kings Fund observes:

> *' Over time, they will be required to deliver a set of seven national service specifications, provide a wider range of services in primary care, use the skills of a greater range of professionals and work closely with other services in the community through multidisciplinary teams.'*

The new GP contract is designed to enable this new philosophy from a funding perspective. As the Kings Fund explains:

> *'Just as changes to the GP contract in the 1960s and 1990s saw significant investment in practice nurses who became a core part of the service, this investment will mean patients attending their general practice in years to come may also see a pharmacist, paramedic or physiotherapist, with advanced training in diagnosis and treatment in their specialist areas. This signals a fundamental change in how patients will experience general practice, expanding general practice to much more of a 'team sport' that is better suited to meeting patient need.'*

This highly networked, system-based model of delivery will provide new and expanded opportunities for GPNs to bring their skills to the fore, shifting the nursing team's role within the practice. Nurses will be more involved in networking, sharing best practice, facilitating and convening MDTs, enabling self-care and advocating for patients within a complex delivery system. The eight drivers of value demonstrate that the skills and aptitudes characteristic of nurses are well-placed to support the shift in operational environment described here - the ability to seek out and share best practice, to act as a 'node' in professional networks and to continually and cost-effectively improve service design and patient outcomes, to name but a few.

A foundational role for primary care

The structural changes being made to the NHS under the Long Term Plan re-visits the hierarchy of care settings, with hospital and emergency care being at the top of the pyramid. This kind of care setting is scarce and expensive and quite rightly needs to be used only when necessary, yet the current model is struggling to manage demand in these settings. List quotas, treatment thresholds and sheer weight of demand means that patient care is too often delayed or misplaced, such that conditions worsen and urgent or more extensive care is necessary.

The overall intention of the Plan is to successfully manage patients in lower tiers such that they remain well for longer and manage their long-term conditions (LTCs) with minimal intervention needed. With additional capacity for specialist clinical or healthcare support available through primary care practices, fewer instances of 'failure

demand' (conditions left to worsen whilst waiting for appropriate treatment) will be driven up the care hierarchy into hospital admissions. Better preventative approaches mean more time and resource available for other forms of demand outside of LTCs.

9. Future needs unpacked: why primary care matters

The evolving NHS model implies that primary care settings will truly become 'primary' in both senses of the word: they will be both the *first* point of care and the *main* point of care. This is fundamental – if primary care fails to live up to this role, then the whole system fails.

Such an expansion in service and role for primary care is simply not possible in what many still think of as a 'traditional' structure of a general practice, with nurses and HCAs perceived to be supporting the work of doctors. GPNs, GPs and other professionals will need to work together in MDTs – each specialism bringing their own skills and capabilities into the mix, and each needing to proactively and flexibly lead and manage both the design and the delivery of the service they provide, responding to the needs of their communities and neighbourhoods. Much of the evidence we've heard around innovation and leadership from GPNs is testament to early moves into this space.

NHS target operating model (inferred from NHS Long Term Plan)

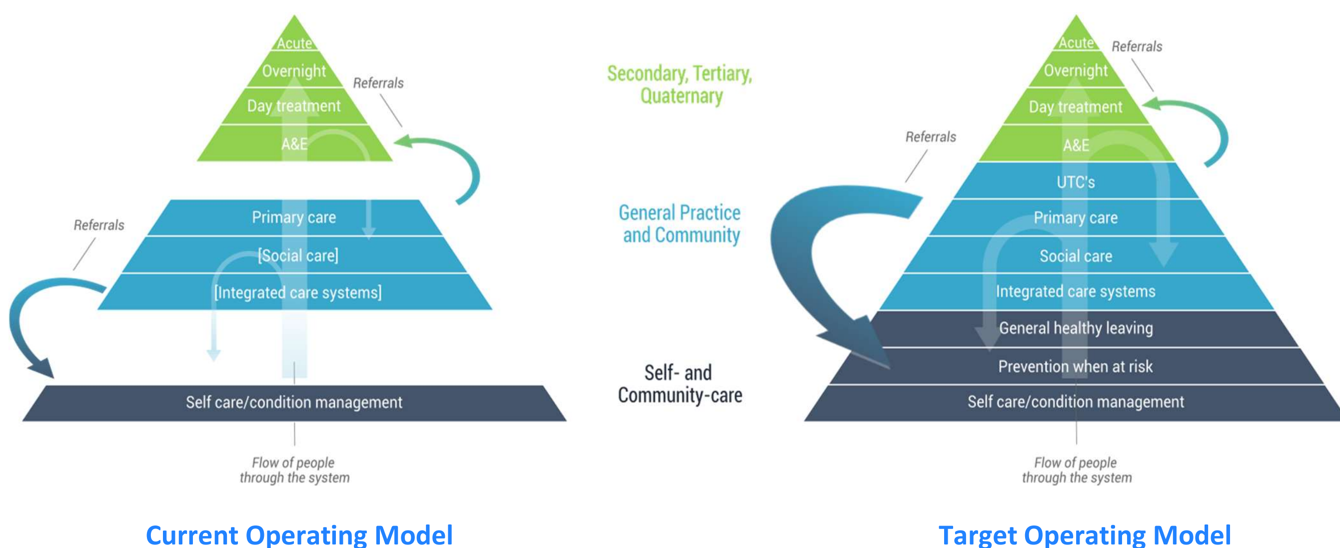
Generally speaking, in the current profile of the NHS healthcare provision, (shown on the left hand side in Figure 6, below) general practice and formal community health care sit at the base of a pyramid of healthcare provision. They reach into the arena of supporting self-care, enabling the individual patient and their carers to manage long-term and chronic conditions for themselves.

Primary care, and general practices in particular, are responsible for referral to secondary, tertiary, and occasionally quaternary care, as well as wider engagement with others who provide care and support for their patients. GPN nursing teams have a significant role in most areas of the practice, and often have leadership roles in designing, delivering and coordinating provision.

In the new Target Operating Model (shown on the right hand side in Figure 6) a number of significant changes become apparent:

- The remit of primary care is 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 are further enhanced by the wide 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 are able to expand their capacity a little and refine it as investment in digital technology supports its functions.
- The expansion of responsibility and scale of primary care includes wider and explicit responsibility for harnessing and developing the self- and community-care arena, so that the level of burden placed on the formal healthcare systems is reduced. This is to counter, substantially, factors such as population growth, an ageing demographic bringing complexity and co-morbidities, and lifestyle health risks arising from environmental and behavioural factors.

The new model, whilst being driven by a combination of economic and demographic factors, results in a healthcare system that is predicated on enabling and supporting wellness for a wider proportion of the population, and that is efficient and effective at coordinating care at all levels without generating 'failure' demand in acute settings. Critical to this is the primary care layer. If this layer fails, the whole pyramid will once again find that demand is squeezed 'upwards' as conditions are poorly managed, treatment is delayed and staff are hard to recruit and retain.



Current Operating Model **Target Operating Model**

Fig. 6 – Illustration of the evolving NHS operating model

In the new Target Operating Model, the role of the nursing teams is key. They bring value from all of the eight value drivers, but particularly:

- Their Leadership, Networked approach, and in Strategic and systems approaches for prevention in delivering Efficiency in management of all elements;
- Their Leadership, Networked approach and Improving diversity of access and engagement with patients in delivering Stronger networks of support;
- Their Leadership, Networked approach, Strategic and systems approaches for prevention, and Developing communities of support in delivering Integrated care systems;
- Their Leadership, Developing and enabling of self-care, Developing communities of support, and Improving diversity of access and engagement in delivering Broader education of wellbeing and how the population can achieve it for themselves.

Given this understanding, it becomes clear that some of the risks and barriers to value creation that we have discovered are already causes for genuine concern. If the role that GPNs play in providing primary care is expanding then their role will need to be properly resourced in terms of, for example:

- Refreshed training programmes, incorporating new skills as standard (e.g. facilitation, consultation)
- Attractive and well-understood routes into and across the profession
- Updated public understanding of what nurses actually *do*, that reflects reality and not outdated or mythical stereotypes.

Phase Two of this project will support that need by developing a valuation model that supports the value hypothesis outlined in this report.

10. Conclusions and next steps

Phase One of this important project has revealed a wealth of information regarding the role that nurses play in general practice, the difference they make and the value they bring.

Analysis has revealed four main arenas in which that value is felt (practices, patients, the community and the wider NHS) and nurses have demonstrated a keen awareness of the importance of their work to each of these arenas. That said, the understanding is, in many cases, implicit. Nurses in general practice cannot point to an approved, well-publicised explanation of what they do and why it matters – they simply know, and see, that their work is both vital and worthwhile.

Within those four arenas we have seen outcomes that GPNs deliver, and eight factors that drive that value. It is the totality of the eight, and the way that they interact, that show why GPNs are a key facet of their practices' delivery. This are not a group for which there is a ready range of alternatives, even with new additional healthcare roles coming into general practices and wider primary care. Representing between 20% and 70% of the healthcare professionals in the practices we consulted in Phase One, and averaging 26% across all general practices in England, GPNs are a substantial part of the workforce. The value drivers they bring and the role that is being described makes GPNs key to delivering what is currently demanded of primary care.

This is not a passive workforce, responsive to others' leadership, but one that brings its own strength, leadership, insight and vision to the benefit of the whole practice - when enabled and empowered to do so. This aspect is set to prove even more important as the role of primary care expands under the NHS Long Term Plan.

In light of both the evolving shape of the NHS and the demographic and economic challenges faced by us as a society, the role of GPNs demands to be better understood – by nurses, by other healthcare professionals, by the general public (patients) and by decision makers in Government. Without a full acknowledgement of how important GPNs are, and the extent of their potential value to the wider system, we risk both de-valuing the profession and actively reducing the extent to which GPNs can bring about positive value to society (a significant opportunity cost). In contrast, if policy makers recognise this and we are enabled to invest in this profession we stand to gain a considerable return on that investment with dividends in community health and wellbeing.

The general practice nursing workforce is an ageing one, and general practice is not yet viewed as an exciting and rewarding first career step, meaning staff shortages are anticipated in coming years, and subsequent vulnerabilities in ongoing skills development in the form of peer-to-peer supervision. This position must be reversed if we are to staff the primary care sector sufficiently well to both meet future demand and support the future NHS operating model.

Phase Two of this project commenced in January 2021 and seeks further to test the emerging findings presented in this report through a combination of workshops and questionnaires. These will be carried out in three NHS regions that are demographically and geographically different to the three we have been working with so far, and

will serve to test the applicability of our hypotheses. Phase Two will also pick up the valuation work that must sit behind the narrative if we are to build a compelling argument to stakeholders. This will entail the analysis of selected data and modelling assumptions, such that we can begin to see financial value alongside health and social care value.

Feedback and reactions to this interim report would be very welcome. If you would like to contribute through feedback, please do so using the contact details provided on the cover of this report, or through the contact details in the publication notice on page 1.

Jim Clifford OBE FRSA
Katie Barnes FRSA
Roshni Arora
Sami Raouf

Appendix 1: General practice nurses: analysis of numbers

The following data, graphs and tables are drawn from information in the NHS England General Practice Workforce dataset for 2020.

Numbers – Whole of England

In 2020, there were around 190,000 employees (up 5% from 2015) working in 6,650 practices in England and providing care for an average of 9,081 patients per practice. These employee figures include GPs, nurses, other direct patient care professionals and administrative staff.

The number of nurses working in general practice has risen by 5% since 2015, from around 22,000 to 24,000 in 2020. Practice nurses represent the majority of the nursing staff within general practice in England. Advanced Nurse Practitioners are the second largest role representing 21% of the general practice nursing workforce in 2020, with much lower numbers of both Nursing Partners and Nurse Dispensers.

Staff profile of GP practices in England	2019	2018	2017	2016	2015	2020 Total	2020 Practice average	2020 Proportion
GPs	25%	25%	24%	24%	24%	**46,857**	**7**	**25%**
Nurses	13%	13%	13%	13%	13%	**23,952**	**4**	**13%**
Direct Patient Care staff	11%	10%	10%	10%	10%	**20,980**	**3**	**11%**
Administrative staff	52%	52%	53%	53%	53%	**96,476**	**14**	**51%**

Table 1: Staff working in general practice (England)

Totals	2015	2020	% change 2015 - 2020
Advanced Nurse Practitioner	3,359	**5,054**	50%
Nurse Specialist	877	**739**	-16%
Extended Role Practice Nurse	541	**981**	81%
Practice Nurse	17,854	**16,932**	-5%
Trainee Nurse	134	**223**	66%
Nursing Partner	21	**53**	152%
Nurse Dispenser	19	**44**	132%
Total Nurses	22,805	**24,026**	5%

Table 2: Changes in number of nurses by general practice job role (England)

Demographics - Whole of England

Gender: Approximately 82% of general practice staff identify as female, with an imbalance across job roles. Whilst 43% of GPs identify as male, this number reduces to 3% for nurses (compared to 2% in 2015). The majority of male nurses are in Practice Nurse or Advanced Nurse Practitioner roles.

Age: The majority of the nursing staff (79%) are aged 40-64 – indeed the workforce is often described as 'ageing' population. One contributory factor for this could be that pathways into the profession often involve nurses training and working in secondary care first before moving into general practice for the rest of their career. The small increase in younger nurses in recent years may be a result of increased focus on trainee recruitment.

Age band	2015	2016	2017	2018	2019	2020
Under 25	0%	0%	0%	1%	1%	**1%**
25-29	2%	3%	3%	3%	4%	**4%**
30-34	4%	5%	5%	5%	6%	**6%**
35-39	7%	8%	8%	8%	8%	**8%**
40-44	11%	11%	11%	11%	11%	**11%**
45-49	16%	16%	15%	14%	14%	**14%**
50-54	22%	23%	22%	21%	19%	**18%**
55-59	18%	19%	20%	20%	20%	**20%**
60-64	8%	9%	10%	11%	11%	**12%**
65 and over	3%	3%	3%	3%	4%	**4%**

Table 3: Nurse proportions by age band, 2015 to 2020 (England)

Ethnicity: Across England the majority of general practice nurses who disclosed their ethnicity are white. The table below shows ethnicity profiles for all CCGs in each region of England, showing some variations in ethnic diversity – most notably in London, where 19% of nurses are black, compared with 44% who are white (and still the majority group). Population ethnicity is clearly not reflected in the diversity of nurses working in general practice.

Area	Asian/ Asian British	Black/ African/ Caribbean/ Black British	Mixed/ Multiple ethnic groups	White	Other ethnic group	Not recorded
London	12%	19%	2%	44%	4%	19%
South West	0.3%	0.3%	0.1%	86%	0%	13%
South East	2%	2%	0.3%	84%	1%	11%
Midlands	4%	2%	1%	83%	1%	10%
East of England	2%	3%	1%	80%	1%	14%
North West	2%	1%	1%	85%	1%	11%
North East and Yorkshire	2%	1%	0.4%	86%	0.4%	11%

Table 4: Nurse proportions by ethnicity and geographic area, 2020

Staff profiles of participating practices (Phase One)

Those practices participating in Phase One of the research were drawn from broadly similar urban areas, however their size and staffing profiles showed some variability, with nurses making up between 9% and 38% of the practice employees. Correcting for the Cuckoo Lane Practice, which is nurse-led, the upper limit of this range is still 30%, although this practice (Elm Lodge Surgery) had noticeably fewer additional staff involved with Direct Patient Care, which implies a greater reliance on the nursing team for certain services.

Participating Practice (Phase One Research)	Number of Nurses	% Nurses	% GP	% Direct Patient Care staff	% Admin staff
Rivergreen Medical Centre	**4**	15%	30%	11%	44%
Tudor House Medical Practice	**3**	20%	27%	7%	47%
Family Medical Centre	**5**	12%	35%	12%	42%
Beacon Medical Group	**18**	10%	24%	12%	54%
St Austell Heath	**16**	12%	17%	19%	51%
Combe Down Surgery	**6**	15%	22%	15%	49%
Elm Lodge Surgery	**6**	30%	25%	5%	40%
The Cuckoo Lane Practice	**8**	38%	14%	10%	38%
Parchmore Medical Centre	**5**	9%	23%	11%	57%

Table 4: Nurses as a proportions of the workforce in participating practices, 2020

Compared to the national picture in 2020 our participating practices employ almost twice as many nurses than the average (just below 8 per practice, compared to a national average of 4).

Appendix 2: List of Participants

London practices	Elm Lodge Surgery:	Edward Drake; Practice Manager Cathy Thomas; Lead General Practice Nurse Claire Goldie; Elderly care nurse
	Parchmore Medical Centre:	Dr Agnelo Fernandes MBE; GP Sr. Partner Jo Yanzu; Lead Practice Nurse
	Bromley by Bow Health:	Linda Aldous; Director of Nursing and Partner Lola Soloye; Senior Practice Nurse Natalie Brown; Practice Nurse
Nottinghamshire practices	Family Medical Centre:	Dr Naresh Sood; GP partner Elizabeth Pain; Practice Manager Leah Hennessy; Practice Nurae
	Tudor House Medical Practice:	Dr Jonathan Lloyd; GP partner Patricia Gibbons; Practice Manager Nichola Pearce; Nurse Practitioner
	Rivergreen Medical Centre:	Sarah Braun; Senior Practice Nurse
	Locum:	Fiona Angyal; Advanced Nurse Practitioner
South West practices	Combe Down Surgery:	Andrew Smith; GP partner Becky Wych; Advanced practice nurse partner
	Beacon Medical Group:	Lynda Carter; Nurse Manager
	The Adam Practice:	Clare Mechen: Nurse Manager

Additional interviewees:

Georgina Craig - ELC Works
Vanessa Anthony – Nursing student, University of Greenwich
Sarah O'Donnell – Lead General Practice Nurse, Rooley Lane Medical Centre
Claire Carmichael – Practice Nurse, Gudgeheath Lane Surgery
Jag Mundra – NAPC
Clare Simpson – NAPC
Dr. Mark Atkin – Consultant Diabetes & Endocrinology, Royal United Hospital
Cathy McMahon – Public Health Development and Commissioning Manager, Bath & NE Somerset

Steering Group members:

Paul Vaughan – Head of Perceptions and General Practice Nursing, NHS England & NHS Improvement
Karen Storey – Primary Care Nursing Lead, NHS England & NHS Improvement
Helen Irvine – Nurse Advisor, Wessex Local Medical Committees Ltd
Mitzi Wyman – Director, Wyman Associates
Dr Hilary Piercy – Professor, Sheffield Hallam University
Elaine Biscoe – National Clinical Advisor, Primary Medical Services, CQC
Gill Rogers – Director, Cross Path Consulting
Marie Therese Massey – Professional Lead, General Practice Nursing, Royal College of Nursing

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