Defining the role of the General Practice Nurse Educator

Project Report to NHS England - December 2020

Contents

1. Introduction

The aim of this project was to explore the range of roles currently employed with the title of General Practice Nurse Educator (GPNE) and create a universal definition that can be applied to practice across primary care systems in England. There is a long history of nurses in General Practice having poorly coordinated access to education and variable employment conditions (Atkin and Lunt 1993, Crossman 2008, QNI 2016). The flexibility of their employment model in General Practice has attractions but also a down-side, as it limits their ability to negotiate minimum standards of professional development support if they are lacking. There is currently a recruitment and retention crisis impacting on General Practices across the UK (Napier and Clinch 2019). The increasing pressure in General Practice and the current changes in the structure of primary care puts GPNs in the spotlight as they help their GP colleagues to try and maintain excellent primary care, particularly during and following the Covid-19 pandemic. Finding time to devote to maintaining their continuous professional development and understanding the complex matrix of education on offer is therefore a real challenge, which poses a risk to ensuring quality of care and patient safety. The role of the General Practice Nurse Educator in supporting this process is therefore of vital importance.

2. Background

Due to the independent business model of General Practice, GPN recruitment is often inconsistently managed and job opportunities can be invisible to potentially suitable candidates. Some practices may be very proactive in planning recruitment and team development, others may recruit only in a crisis when nurses are leaving (Aston 2019). In addition to this, applicants for vacancies may be drawn from a wide range of clinical settings often with little or no primary care experience, resulting in a skills gap for working in General Practice, particularly if they are newly qualified. With a top-heavy workforce over the age of 50 years old (Innes 2019), as increasing numbers of experienced nurses retire, they will be replaced by less experienced colleagues (Ipsos Mori 2016). It is imperative that high quality education and learning opportunities are made freely available to these nurses new to General Practice, supported by mentors and educators (Health Education England (HEE) 2017). This is particularly important in small practices where there is a risk of professional isolation. Following the Care Quality Commission (CQC) report linking poorly performing practices with a lack of

training and supervision of staff (CQC 2015), General Practices must satisfy the requirements of 'Regulation 18', demonstrating the competence of their nursing staff in order to guard against poor quality care (CQC 2014, 2018). The role of the GPN Educator is pivotal to this and it was identified as a key priority (Action 2) in the GPN 10 Point Plan (NHS England 2017).

3. Literature review

A literature search on the title 'GPN Educator' yields very little and it is apparent that the role is variously interpreted across primary care and higher education organisations. To date, there is no clearly defined role and no uniform way of working, making it hard to quantify the benefits and establish the role on a national scale. Using the search terms 'GPN educator', 'General Practice Nurse education', and 'Practice nurse education' there was almost nothing published specifically on the topic, other than a series of policy documents created by either NHS England or Health Education England (NHS England 2017, HEE 2017). There is a plethora of publications outlining the training needs of GPNs and describing a variety of programmes to meet them (Queen's Nursing Institute (QNI) 2016, 2019, RCGP 2013, London-wide Local Medical Committee (LMC) 2010). However, the problems associated with accessing education, such as funding and competing practice priorities, are also well documented (Aston 2018) making it all the more important to ensure GPNs have locally available education support.

4. Purpose

The purpose of this project was to explore the range of roles currently employed with the title of GPN Educator (GPNE), and to determine how far these roles are meeting the goals articulated in the NHS England GPN 10 Point Plan. The goals were specified separately as 'NHS England deliverables' and 'Health Education England (HEE) deliverables'

NHS England goals:

- Through the four Regional GPN Delivery Boards ensure commissioners and general practice employers are aware of the evidence and benefits of the educator role on staff retention and recruitment.

HEE goals:

Develop GPN educator roles in each CCG area, in line with NMC requirements that:

- promote mentor training for all GPNs,
- support joint higher education and primary care initiatives to further develop mentorship programmes,
- support the development of a network of GPN educators and academics within Higher Education Institutions (HEIs).

The project therefore aimed to clarify what the role of the GPN Educator is, how it functions, where it works well, what support it needs and what tangible benefits it brings to GPNs, GP practices and patients in the primary care setting.

5. Method

The approach adopted was a qualitative survey, conducting structured telephone interviews followed by two focus groups to refine and further build on the data collected. The analytical framework employed was systematic text condensation, an approach used to analyse qualitative data into categories and themes (Malterud 2012).

The sample was purposively selected, to ensure all inclusion criteria were met and all characteristics included. As the NHS was under extreme duress during the Covid-19 pandemic, the project did not seek participants through social media or NHS platforms, using professional networks as the source of contacts instead. Participants were drawn from a range of geographical regions, GPN Educator roles and employer types. Participants were contacted initially by introductory email and those that expressed interest were sent a Participant Information Sheet and asked to complete the consent (Appendix 1). All data were anonymous and kept confidential.

6. Data collection

20 participants were interviewed by telephone and a further 5 were included in the Focus Groups. The geographical spread ranged from Wessex in the south to Bradford in the north, and from Suffolk on the east coast to Sefton on the west. The types of role included academic

GPN educator, practice educator, training hub education lead, lecturers in nursing, Primary Care Network (PCN) education lead, GP, and workforce development lead. Organisations represented included general practices, Training Hubs, PCNs, GP Federations, CCGs, Universities, a Local Medical Committee (LMC), the NMC, RCN, Queen's Nursing Institute (QNI) and HEE.

The structured interviews followed one of three formats, depending on the role of the participant. Those involved directly in supporting GPNs in practice were asked to comment on their role, including some of the challenges and enabling influences that have an impact (Appendix 2). Those in a role employing or supervising GPNEs were asked a modified form of the same questions (Appendix 3). And those in a more removed, strategic role were asked to comment on some of the emerging issues reported from the other two categories, particularly relating to the challenges and enablers that had been raised (Appendix 4).

7. Data analysis

Each transcript was reviewed, and a detailed process of systematic text condensation was conducted, highlighting, and grouping responses into themes, then collating those across all participants, subsequently categorising and condensing them. This process gave rise to a summary of key themes raised by participants, generating a rich collection of data which were used to build a model for testing. These preliminary findings were then presented back to two small sub-groups of participants, which included five participants who were drawn from the same sample selection process but had not been interviewed, to introduce an element of objectivity in the analysis process, as a way to reduce bias. The focus groups were held remotely, due to Covid-19 in October and November 2020. Working in pairs, using the Nancy Kline 'Thinking Environment' approach, participants were asked key questions about the materials presented to them. The aim was to test these for authenticity, application to real-life practice, exploring barriers to effective adoption and generating recommended actions to ensure they are successfully embedded.

8. Results

There was considerable congruence between the major issues raised by participants. Many voiced the opinion that GPNE roles had evolved in a vacuum, because there was no guidance about where they fit into the new primary care organisational structures. This resulted in different interpretations of the GPNE role, who should employ them and how they connect. As they are now embedded in different ways, the view was that this needs to be worked around.

8.1 Part 1 – Interview data, key themes

- There is a range of employment settings
- Many different titles are used by GPNE participants
- Key responsibilities of the role were identified
- Benefits of the role were highlighted
- There were challenges that hindered the role being effective
- Enablers to support the role working well were suggested

The employment settings of GPNEs interviewed included General Practice, HEIs, Training Hubs, CCGs, Primary Care Networks (PCNs) and HEE. The job titles of those working in General Practice, HEIs and Training Hubs tended to include the word 'Educator', those working in PCNs or HEE were more likely to use the title 'Lead' for either education or workforce development. The responsibilities of each of the roles, partly drawn from job descriptions and partly from interviews, had some similarities and overlaps but were discernibly different. There were connections between them which allowed for valuable alignment of purpose and increased networks for sharing information for the benefit of GPNs. Their common collective functions were grouped and classified. The key responsibilities were summarised into generic statements, some of which applied to more than one role.

These titles, employers, and responsibilities were collated and used to compile a classification grid of 'Roles by Organisation' illustrated in Table 1 below. These were explored in detail in a series of Case Studies created to illustrate the roles in practice, which were presented and discussed in the focus groups.

Crossman Connections	Table 1 GPNE Roles by Organisation, Data analysis grid, October 2020		CROSSPATH CONSULTING / NHS England
Organisation	**GPNE Role outline**	**Key responsibilities**	**Suggested title**
HEI	Academic GPNE with formal teaching qualification and ideally the Specialist Practitioner Qualification in General Practice Nursing (GPN)	Ensuring that the learning environment is supportive. Making General Practice a 1st destination career choice by enhancing GP under-graduate placement opportunities and quality of learner experience	**Academic GPN Educator**
Training Hubs	GPNE is conduit between practices, PCNs and HEIs – commissioning the training that GPNs need and acting as resource for information and support	Sourcing and ensuring access to appropriate training; Ensuring (education) funding is equitably allocated; Making General Practice a 1st destination career choice by enhancing GP under-graduate placement opportunities and quality of learner experience; Supporting 'new to GP' transition of nurses into General Practice	**Locality GPN Educator**
General Practice	GPNE is supervisor/assessor, also gives pastoral support and career guidance	Developing a skilled workforce, that feels valued and supported; Raising the quality of patient care; Helping GPNs in practice to develop the skills to teach and support nurses in practice; Making General Practice a 1st destination career choice by enhancing GP under-graduate placement opportunities and quality of learner experience; Supporting 'new to GP' transition of nurses into General Practice	**Practice GPN Educator**
PCN/ Network of PCNs/ ICS	Education Lead identifies the workforce development priorities, based on local population needs and the changing shape of Primary Care roles	Developing a skilled workforce, that feels valued and supported; Raising the quality of patient care; Encouraging nurses to identify what patients need and getting the right skills in place, developing a culture of leadership; Increasing multi-professional integration; Supporting 'new to GP' transition of nurses into General Practice	**Multi-professional Educator/ Education Lead**
HEE	Primary Care workforce development lead to provide guidance on education standards, professional, quality and strategic issues	Developing GPNs within the educator role to create the future Advanced Care Practitioners and leaders – strengthening the workforce for the future; facilitating and supporting, identifying best practice, challenging poor practice and directing funds appropriately to stimulate innovation and promote future resilience	**Regional Primary Care workforce development/GPN Lead**
NHSE-I	Regional and National strategic leadership	Promoting GP Nursing, (fulfilling GPN 10 PP commitments), addressing key barriers to embedding the GPNE role and coordinating a national 'call to action' plan	**Primary Care Nursing Lead**

8.1.1 Benefits of the GPNE role

The benefits of the GPNE role were seen to be many and varied and not just confined to GPNs seeking professional development support. It became apparent that the role provides a 'golden thread' bringing together many positive features that enable nurses in general practice to perform to a high standard and to feel supported and fulfilled in their work. The nature of this support was captured in a poem (Appendix 5). Analysis of the interview transcripts provided an insight into the gap that exists when there is an absence of the GPNE role, particularly for GPNs working in isolation, which is still a common phenomenon. In settings where GPNs have little or no team around them and lack a strong local professional network, they can find it very difficult to know how to ensure their practice is safe and up to date and where to find information about training. The risks associated with this are obvious in terms of delivering safe, effective care to patients of all ages presenting with a wide range of conditions. The experiences shared by some of the participants illustrated examples of the predicament some nurses are facing.

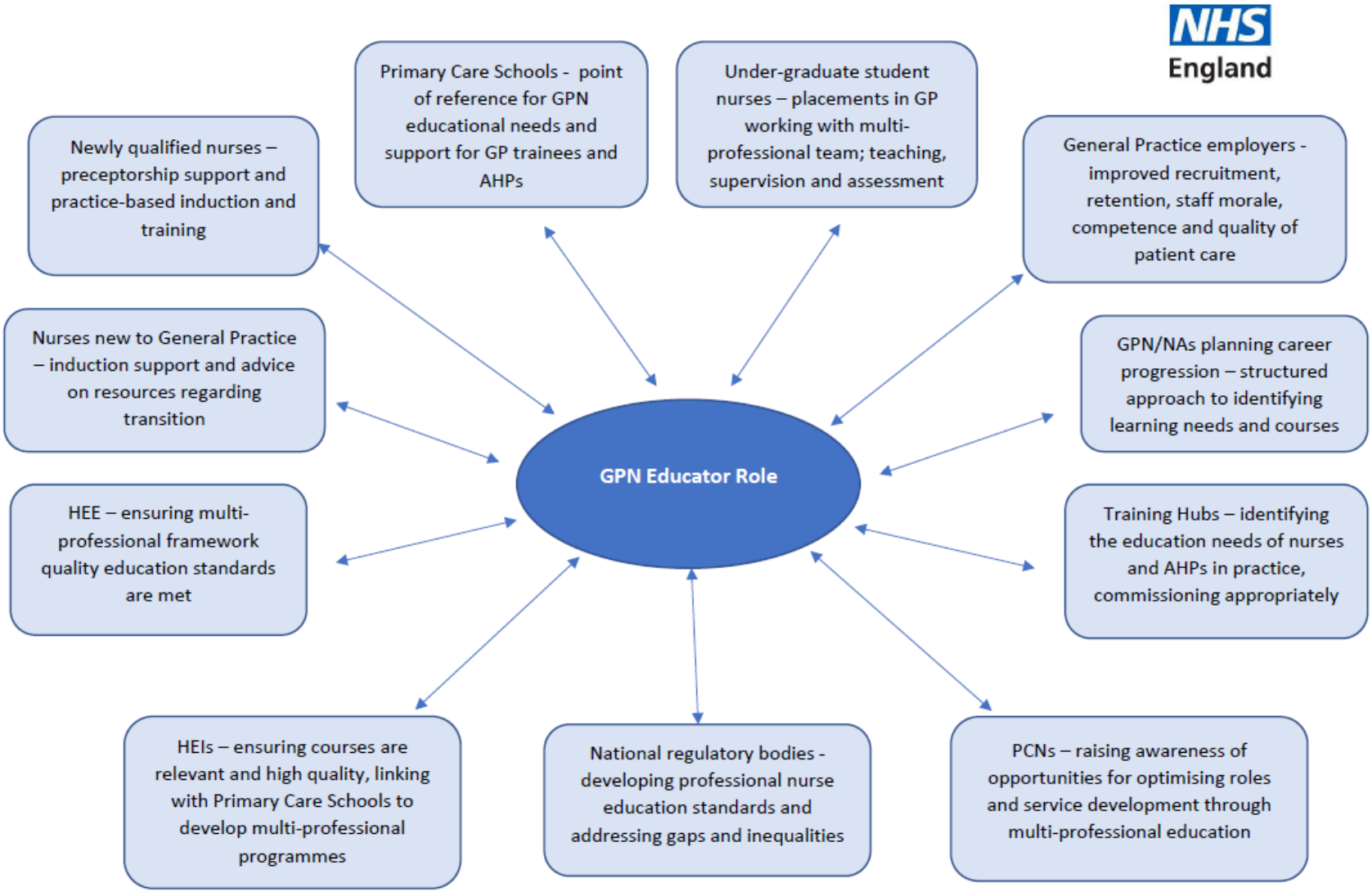
Participant 6: *"nurses not valued and training not important"*
Participant 12: *"disrespect for their educational needs, in some cases the learners are simply abandoned in practice"*

The GPNE was seen as an advocate, adapting to individual nurses' needs, connecting them to education and supporting them in their practice. The benefits are summarised below.

- Providing support for 'new to GP' nurses making the transition into General Practice
- Raising the quality of patient care through mutual learning, with the GPN Educator challenging poor practice and supporting GPNs to make improvements
- Supporting supervisors and assessors in practice to increase the number of student placements in GP
- Providing a structured approach to career development planning for existing GPNs
- Improved recruitment, retention, staff morale and competence
- Feedback to Universities so that courses remain relevant to current practice
- Developing the workforce to create Advanced Care Practitioners and leaders for the future

The full range of benefits were captured and mapped across the range of relevant stakeholders, illustrated overleaf in Figure 1.

Figure 1 – Mapping the benefits of the GPNE roles across the wider system



8.1.2 Challenges to the GPNE role working effectively

The fifth of the key themes concerned challenges and barriers to the effectiveness of the role, linked to particular organisations or professional groups. Some of these could be resolved directly by the organisations. Others are less easily addressed and relate to complex multi-system issues, which nonetheless need to be resolved if GPN Education is to be equitably accessed in a consistent and sustainable way across England. The issues are summarised below.

HEI communications
Programmes: • HEIs and lecturers don't always understand what training GPNs need • The credibility of who is actually doing the teaching is crucial, they need to be GPNs • There is variation in course content and quality across institutions **Relationships:** • It is sometimes difficult for practices to get information about programmes/ placements • Training Hubs are not always included in the relationships between HEIs and the placement partners
GP employment factors
Organisational culture & education ethos: • Paternalistic, inconsistent Terms & Conditions, focus on money and productivity • Not supporting development - failing to release nurses for training, disrespecting the need for education, resulting in attrition and resignations **Conflicting professional models:** • Lack of understanding of roles - GPs and Practice Managers not familiar with NMC regulatory framework, asking GPNs to do things they're not competent to do **Access to learners in practice:** • Low numbers of educators in practice to support GPNs, difficult for HEIs to link with learners and get suitable dates/times to visit **Independent business model:** • Conflict of 'colleague and employee' status, concerned with business sustainability rather than people, not preparing the future GPN workforce

Professional nursing issues

Attitude:

- Resistance and apathy from GPNs to taking students, fear of exposing own weaknesses

Regulation:

- Different professions more prepared to take some risk – nurses very risk averse
- Nurses breaking the NMC code every day because practices don't support their education
- We are promoting a role that is not even recognised by the profession itself

Isolation:

- Those who come from acute care find it hard to work independently without a nurse hierarchy.
- GPNs are accepting that it's the norm rather than demonstrating leadership and trying to bring about change

Primary Care structures

- Top-down priorities from STP and NHSE - I don't always reflect what's needed or already in place on the ground
- Too many layers of people involved (competing forces and priorities)
- GPN workforce is under threat - PCN contract created a 'perfect storm' - new roles in GP have Agenda for Change Terms & Conditions and some of their work could have been done by GPNs
- The GPN educator is never just an educator role and this warrants further enquiry
- The post is not adequately funded for the role to be political/strategi

National Barriers

- Inadequate placement funding (tariff) impacts negatively on GP placement numbers
- No national GPN education support infrastructure to mirror GP Deanery
- No nationally mandated minimum training programme
- No national guidance on pay, terms, and conditions

8.2 Part 2 – Synthesis phase, Focus Groups exploration

8.2.1. Testing the 'Roles by Organisation' framework (Table 1, page 8)

There was a high level of agreement in the focus groups that a clear definition of the GPNE role is urgently needed and that the current local variation in interpretation is very confusing. There was a view that it would have been helpful to have the role clearly articulated much earlier to avoid this inconsistency.

Participant 11: *"If we'd been more prescriptive about the role, we'd be in a different place now."*

Participants felt it important to use titles and terminology that will stand the test of time and not become obsolete or irrelevant when the NHS structures change. Also, that there should be flexibility about which of the 4 GPNE roles are established in different localities with different resources, they should not be fixed and prescriptive, as 'one size doesn't fit all'.

Participant 17: *"No issue with the roles and responsibilities but we're not starting with a blank sheet - there are roles out there already and they're fragmented and inconsistent. Localities need to map roles against the framework and determine which are appropriate for them."*

However, there was a strong feeling that consistency was urgently needed to provide clear guidance and support.

Participant 8: *"Really important to balance the benefits of standardisation with the need for local flexibility".*

There was general consensus that the titles were good descriptors of each role and that the framework provides clarity and consistency. One participant was uncertain about how the model links with non-nursing roles, but others felt it is easily adaptable to encompass them.

Participant 13: *"Very authentic, brilliant framework, I can put all the roles I know into it. Prevents silo working, shows how they all fit together. The relationships between the roles allows us to live with uncertainty and provides flexibility for the future."*

There were some concerns about who would fund the roles and whether there will be enough funding for them all. There was a view that not all the roles needed to be filled by nurses, just professionals with an excellent understanding of primary care education and how it is organised. This was particularly the case in PCN/ICS roles which have a more multi-professional workforce development dimension.

8.2.2 Case Studies

The factors identified by participants as enabling the GPNE role to be most effective, along with examples of best practice, were used to develop case studies to illustrate the ideal features of each of the roles. It was clear from the case studies that there is potential overlap and synergy between these roles. Some participants saw this as a weakness, others found it useful because it meant that one post in a locality could be flexible and adaptable, in order to meet the needs of the GPNs. It also provides a safety net so that the GPNEs are all working towards the same goals and the risks of GPNs not being picked up is reduced.

Participant 19: *"'All the roles need to work together, to join up and ensure there are no gaps."*

The case studies were discussed at the two focus groups, testing them for authenticity and stimulating debate about how to embed them and make them most effective. The case studies and group comments are presented on the following pages.

Case Study 1 – HEI Academic GPN Educator

A registered nurse new to general practice has applied for the GPN 'Fundamentals' programme run by a university. The practice has a history of a high turnover of nursing staff and does not offer placements for students. There is no senior nurse in the practice with responsibility for GPN induction and supervision. The applicant feels under pressure to complete the course urgently, to develop the competencies for their new role. The university has an academic GPN Educator (lecturer in GP nursing) who oversees the clinical component of all GPN learners, and links with a network of practice educators. The educator arranges to meet with the leaner and her GP sponsor in the practice, to draw up an agreement detailing the tripartite responsibilities of each party in relation to the learner's education programme. This agreement forms a contract to ensure the learning environment is supportive, there is effective communication between the university and the practice, and the commitments are upheld. It also establishes who will be the lead/associate supervisor within the practice, co-ordinating the clinical experience aligned to the programme to enable the student to apply theoretical learning to practice in the most beneficial way, assessing and signing off their competencies. When the programme is completed, the academic GPNE visits the learner, to gather feedback from them and their practice about how well the programme met their needs and how it could be improved. Whilst on the practice visit, the academic GPNE takes the opportunity to discuss the benefits of practices providing placements for 3rd year nursing students, as they have valuable skills to offer and are often influenced to apply for posts in general practice as a result of a positive placement experience. The practice team agrees to consider this as a future option.

Focus group feedback on Case study 1

- HEI role is about formal teaching
- HEI role needs to capture provision of Fundamentals programme in modular form and Introduction to GPN
- Big difference between academic GPNE and practice educator. HEI GPNEs need to be practising/past GPNs
- Fundamentals programme not available in Bristol area
- HEI illustration needs to include visiting learners in their practice and liaising and also that they provide pre and post registration courses

Case Study 2 – Training Hub Locality GPN Educator

A senior GPN has recently recruited two new nurses to the team and although they both have experience working in General Practice, they have some urgent training needs. The senior GPN has discussed this with the lead GP and Practice Manager, who asked her to investigate the options available, but she is having difficulty sourcing information about local programmes that meet their differing requirements. She contacts the Training Hub Locality GPN Educator for advice and information. At the same time, the senior GPN has asked the practice if they will consider providing a practice placement to a 3rd year student, but the practice feels this is too much to take on at once. The Locality GPNE in the Training Hub has developed a database with a wide range of programmes available locally and online, for GPNs of all levels of experience. She commissions a regular rolling programme of training and can advise on when there are places available. She is also able to support the application process, provide information about funding, liaise between the education provider and the practice, and connect the new nurses to a local GPN support network. The GPNE can also provide professional support to the practice, offering advice about frameworks and tools to facilitate GPN career/professional development, linking the process to appraisal and quality improvement. The senior GPN and the two new GPNs feel reassured and well supported and the practice is appreciative of the practical help provided by the Training Hub.

Focus group feedback on Case Study 2

- Training Hubs are still trying to work out the role
- Training Hubs are all about facilitation, liaison, and workforce support
- Training Hub leads don't have to be nurses but do need expertise in education and the new NMC standards for supervision and assessment framework
- Engagement between Training Hubs and PCN Clinical Directors is key

Case Study 3 – GPN Practice Educator

A GPN is looking for a job in a new practice because he feels he is not progressing his career development in his current practice and wants to look for new opportunities. He has found the GPs' and Practice Manager's expectations of what he should be able to do, coupled with their unwillingness to provide training very disheartening. The only other nurse in the practice mostly works opposite shifts to him and he has had very little in the way of discussion about his professional development needs. He joins an online GPN Forum, where he is connected to a senior GPN who has a role as a practice educator in the same locality and she invites him to visit her practice to shadow her in clinic. When he visits her practice, he is amazed by the contrast and feels inspired by the work she is doing. The practice educator spends her lunch break asking him about his aspirations in GP and mapping the skills and competencies he has currently and those he would like to acquire in order to fulfil his role. She shows him the GPN roles and competencies framework, and together they identify the competencies that are expected of a nurse at his level and where there are gaps that represent training needs. She then gives him the contact details of the Training Hub Locality GPNE, who will be able to support him in finding appropriate courses to meet his needs. She also explains that in her practice, there is a structured team of nurses, all of whom provide placement supervision to under-graduate and post-graduate students of a variety of health disciplines. She leads the team and provides the assessment component for the education, induction and preceptorship support for new nurses, as well as coaching and supervision for the whole GPN team.

The GPN returns to his practice and explains that he has identified the training he requires and that it is funded by the Training Hub. The practice is unable to provide internal supervision and study leave to support his learning and when a vacancy arises at the practice where the practice educator works, he applies for it and is successful. When he commences a GPN programme at the local HEI and his academic GPNE asks the cohort whether they can recommend a practice that provides a supportive learning environment for students and newly qualified nurses, he has no hesitation in encouraging them to approach his new practice.

Focus group feedback on Case Study 3

- Practice Educator provides face-to-face support and practical teaching
- Practice role is specific, direct support, others have wider remit
- GPNE in practice needs to be a trained educator with expertise in career development guidance
- Not enough GPNs to free them up to fill the practice educator roles.
- We need to support nurses to develop into this role whilst staying in clinical practice.
- Value in supporting the roles part-time to retain clinical practice.

Case study 4 – PCN/ICS Multi-professional Educator/Education Lead

Health Education England has tasked Locality Training Hubs with identifying the learning needs of the staff in Primary Care at STP/ICS level and allocating the funding equitably across each PCN and professional group, commissioning appropriate education. The Training Hub has no data about the training needs of the local workforce and emails each PCN Clinical Director asking them to gather it at practice level and submit a return. The Clinical Director requests the Multi-professional Educator to pick this up and coordinate a response to HEE.

The Multi-professional Educator has a background in nursing and has a PG Cert in Education. She is well versed in the latest primary care developments and well connected with her neighbouring PCN education leads, STP workforce development lead and local Training Hub. She has established a strong education network of GPNs and AHPs from each practice in the PCN and has developed a newsletter which she circulates to them all individually. She contacts the senior GPN and Practice Manager in each practice within the PCN, asking them to share any recent Training Needs Analysis information they may have collated from appraisals. As the response is poor, she adapts a TNA survey used by a neighbouring PCN with their permission and sends it to every GPN and AHP in the PCN, then collates the information and summarises it anonymously. The information she is able to submit to the PCN Board and Training Hub provides a valuable picture of current roles, responsibilities and qualifications as well as a profile of potential future leaders, clinical specialists and advanced practitioners. This is a valuable resource to underpin locality workforce development planning and collaboration across practices and PCNs.

Focus group feedback on Case Study 4

- PCN is a strategic role, workforce development, conducting multi-professional TNAs
- PCN Clinical Directors not really ready to engage on workforce development
- PCN level might be too small to have a GPNE in each as they are sometimes only 4 practices - maybe needs to be at slighted higher network level/ICS
- PCN role needs expanding to allow them to have relationships across the organisations
- PCNs vary across the areas, very GP focused
- New PCN roles increase the risks of practitioners working outside their sphere of competence

Case Study 5 – HEE Primary Care Workforce Development Lead

Health Education England is conducting a strategic regional mapping exercise, to identify Primary Care leadership potential and models of collaborative practice in education and professional development across practices and PCNs. The Regional PC Workforce Lead is tasked with presenting this to HEE to provide evidence of progress against the HEE multi-professional quality framework targets. There is a Primary Care School, newly established in the region. The Associate Dean has a key role in supporting the commissioning, transformation and quality management of multi-professional primary care education in accordance with the standards set by HEE and regulators. The HEE PC Workforce Lead has been working closely with the Associate Dean, to ensure that there is a clear focus on strengthening the primary care workforce for the future. He has asked the Associate Dean and PCN workforce leads to do some 'talent spotting' in the practices across the region, identifying practitioners demonstrating leadership potential, interested in developing their role further. The Associate Dean is also asked to ensure that Training Hubs are investing adequately in education programmes to support this. He is also asked to identify how the GPN Educators in Training Hubs and PCNs are promoting multi-professional education and to collect examples of innovative models of collaborative training programmes.

As part of this exercise, the PC Workforce Lead is made aware of a university in his patch which is reportedly not supporting learners to achieve their clinical competencies and failing to provide clear information to the employing practice. He arranges a meeting between the HEI, Training Hub and Primary Care School Associate Dean to raise the quality concerns and require the HEI to provide a quality improvement plan which aligns to the HEE quality framework.

Focus group feedback on Case Study 5

- HEE role should have enough power to influence as well as professional credibility
- Roles as laid out could be used as a career framework. Needs to show everyone working collaboratively to have the biggest impact.
- How will the roles be quality assured? HEE developing a new QA system at PCN level to include Care Homes.

Case Study 6 – NHSE-I Primary Care Nursing Strategic Lead

The NHSE Strategic Lead for PC Nursing receives a series of recommendations for action arising from projects commissioned under the GPN 10 Point Plan, highlighting critical barriers that will prevent successful achievement of the 'deliverables' stated within the plan. Specifically, these relate to the non-medical clinical placement tariff, the lack of a nationally mandated training programme, no national guidance on pay and employment terms, as well as the lack of a national GPN education infrastructure to ensure equitable access to consistent educational preparation for the role. A joint letter from the RCN, NMC and the Council of Deans emphasises the need to address key barriers and calls for NHSE-I to coordinate a 'call to action' round table forum with representation from all the relevant bodies, in order to develop a strategic plan to formally resolve the issues.

Focus group feedback on Case Study 6

- NHSE role difficult to define, should be strategic shaper
- Priority must be given to raising the profile of GP Nursing
- Needs to be 'bigger' than the GPN 10 Point Plan!
- Emphasis on strategic leadership – addressing the national barriers to success

9. Discussion

There was a general consensus that the case studies were a realistic and authentic depiction of how the roles would work in practice and they generated much debate.

Participant 9: *"Are they drawn from real examples? They seemed so realistic."*

Discussion confirmed the view that the roles provide a valuable framework with universal application to practice but it needs to be used in a flexible way because responsibility for GPN education sits within a variety of posts across different systems and regions. It is particularly important in an ever-changing health service, that models can provide continuity throughout change, providing guidance that is flexible enough to remain relevant

over time. For example, the role of CCGs in system workforce development is gradually being superseded by the new Integrated Care Systems (ICS) which have a broader remit. Similarly, some PCNs are too small to have a post dedicated to education, so it may sit within the ICS. However, the distinction between the academic, practice and Training Hub Educator roles seemed to be clear and whilst there was a lack of clarity about whether there is funding available for each role, they were all unique and important.

It was also clear that the case studies describe the 'ideal' scenario, where each GPNE has a clearly defined, properly supported role and works in collaboration across the primary care education structures, drawing together partners in order to facilitate and support GPN learning. There were concerns expressed about how some local systems can transition from the present situation to a more ideal set up, with participants questioning who will provide the leadership and funding to support it. In reality, as we heard in the interviews, there are deep-seated obstacles that prevent this happening in a smooth and consistent way across regions. These were explored in the focus groups in a number of exercises. Some of the obstacles related to entrenched negative assumptions that could be challenged and changed into positive statements that create a 'can do' attitude and make use of existing resources and connections. This is where leadership and positive role modelling can exert a powerful influence. However, some of the barriers to successful implementation of the GPNE role stem from long established cultural and structural factors which limit the extent of positive impact that any innovation promoting GPN development can have. Participants were asked what single action would be most powerful in progressing the successful adoption of the GPNE framework of roles. These are illustrated in Figure 2 overleaf. It would appear that the success of embedding the GPNE role as a resource which brings a wide range of benefits across the primary care system, hinges on addressing these barriers in a systematic concerted effort.

Figure 2 - What single most important action would have the biggest impact on successfully embedding the GPNE role?

Participants in the focus groups were asked how these actions should be taken forward and by whom. The results of this were captured as a series of actions by organisation, presented in Figure 3 below.

Figure 3 - Actions recommended by project participants

HEE Actions

Clearly define the GPNE role emphasising the need for consistency across England, reducing variation.

Confirm what the GPNE role is and is not, clarify how the role fits with preceptorship and supervision

Officially endorse the GPNE roles

Ensure appropriate qualifications and QA systems are put in place

Require multi-professional training of GPNs alongside GPs and other practitioners

Make confirmation of the GPNE role a 'parting gift' from Regional GPN Delivery Boards

Lobby the Council of Deans to join forces for a 'call to action' to address barriers identified

NHSE-I Actions

Disseminate results, roll out model, identify funding streams for implementation

Provide clear definition of the GPNE role and a contractual requirement to ensure equality in access for GPNs to a GPNE

Build in evaluation from the start – baseline and chart evidence of impact

Provide clarity about what happens post-GPN 10 Point Plan

Coordinate a round table summit between professional bodies and regulators, to tackle the on-going national barriers to effective GPN education, recruitment and retention:

1. Placement funding tariff
2. Agenda for Change inequalities between GPNs and PCN additional primary care roles
3. Minimum mandated GPN training programme & competences
4. Consistent education infrastructure across England

Joint NHSE-I and HEE Actions

Develop a collaborative plan for successful implementation of key actions jointly between both parties - not the 'left' and 'right' hand as now…

Professional Bodies – NMC, RCN, RCGP

Come together with HEE and NHSE-I and work collaboratively to resolve the long term barriers

PCN/ICS Workforce Lead Actions

Strengthen links with HEIs
Identify the GPN population in locality and raise profile of the GPNE role within new primary care structures

Primary Care Schools/Training Hubs

GPNEs should be established within the emerging Primary Care Schools, initially should be part of the current infrastructure in every Training Hub.

10. Conclusion and recommendations

This project has fulfilled its aim, which was to clarify what the role of the GPN Educator is, how it functions, what support enables it to work most effectively and what tangible benefits it brings to GPNs, GP practices and patients in the primary care setting. The focus of the project was clearly felt by participants to be relevant and important, due to their expressed lack of consistent guidance on the role. A Framework was developed using the data collected, outlining the various GPNE roles. This was tested with participants, who confirmed their support for it. A series of case studies illustrated these roles in practice and again these were endorsed by participants as being authentic and practically useful. The benefits to all partners linked to the GPNE role were mapped to illustrate connectivity and justify investment. The conclusion drawn from this work is that the Roles Framework, Stakeholder Benefits Map and Case Studies are valid outputs providing much needed clarity for those working in the field. It is recommended that these tools are widely disseminated to those organisations directly and indirectly involved in GPN education, to promote an effective model of facilitation and create a point of consistent reference. There remain some significant outstanding issues that have a reported adverse effect on the effectiveness of the GPNE role and these have been captured as a series of recommended actions for relevant bodies. Addressing these actions will enhance the likelihood of systemic, sustainable improvement in GPN access to appropriate consistent education, thereby safeguarding high standards of care in General Practice.

Authors:

Sue Crossman, RN, MA(Ed), PhD

Gill Rogers, BA, RN, MSc

References

1. Aston, J (2018) *The future of nursing in primary care*, British Journal of General Practice, pp312-3, July 2018; DOI: https://doi.org/10.3399/bjgp18X697577
2. Atkin K and C Lunt (1993) *Nurses Count, A national census of practice nurses*, Social Policy Research Unit, The University of York
3. Care Quality Commission (2015) *The state of health care and adult social care in England* http://www.cqc.org.uk/sites/default/files/20151103_state_of_care_web_accessible_4.pdf
4. Care Quality Commission (2014) *Guidance for providers, Regulation 18*, https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-18-staffing
5. Care Quality Commission (2018) *High level guidance to support a shared view of quality in general practice*, March 2018 https://www.cqc.org.uk/category/keywords/general-practice
6. Crossman, S (2008) *Survey shows need for better access to training,* Practice Nursing 2008; 19(5):249-253
7. Health Education England (2017) *The General Practice Nursing workforce development plan*, https://www.hee.nhs.uk/sites/default/files/documents/The general practice nursing workforce development plan.pdf
8. Innes, L (2019) *General Practice Nurse education in Scotland – now and in the future*, Education for Primary Care https://doi.org/10.1080/14739879.2019.1626771
9. Ipsos Mori (2017) *The recruitment, retention and return of nurses to General Practice Nursing In NHS England* https://www.england.nhs.uk/publication/the-recruitment-retention-and-return-of-nurses-to-general-practice-nursing-in-england/
10. London-wide LMC (2010) *General Practice Nurse Training Programme*, (cited July 2nd 2020), available from https://www.lmc.org.uk/practice-nurse-training.html
11. Malterud, K (2012) *Systematic text condensation: A strategy for qualitative analysis*, https://journals.sagepub.com/doi/abs/10.1177/1403494812465030?journalCode=sjpc&
12. Napier J, and Clinch M, (2019) *Job strain and retirement decisions in UK general practice,* Occupational Medicine 2019;69:336–341 Advance Access publication 17 June 2019 doi:10.1093/occmed/kqz075 (cited August 10th), available from https://academic.oup.com/occmed/article/69/5/336/5516045
13. NHS England (2017) *General practice — developing confidence, capability and capacity. A ten-point action plan for general practice nursing* https://www.england.nhs.uk/wp-content/uploads/2018/01/general-practice-nursing-tenpoint-plan-v17.pdf
14. 14. QNI (Queen's Nursing Institute) (2016) *General Practice Nursing in the 21st century: a time of opportunity*, London, (cited July 2nd 2020), available from https://www.qni.org.uk/wpcontent/uploads/2016/09/gpn_c21_report.pdf
15. 15. QNI (2019) *Transition to General Practice Nursing*, (cited July 2nd, 2020), available from https://www.qni.org.uk/wp-content/uploads/2017/01/Transition-to-General-Practice-Nursing.pdf
16. RCGP (2013) *'The 2022 GP A Vision for General Practice in the future NHS'*, (cited August 10th 2020), available from https://www.rcgp.org.uk/~/media/Files/Policy/A-Z%20policy/The-2022-GP-A-Vision-for-General-Practice-in-the-Future-NHS.ashx

Appendix 1

Defining the role of the GPN Educator

Participant Information Sheet, March 2020

The purpose of this project is to clarify and define the role of the GPN Educator. The project will explore the range of roles currently employed with the title of GPN Educator (GPNE) and determine how far these are meeting the goals articulated in the GPN 10 Point Plan to facilitate GPN access to education and training. To date, there is no clearly defined role and no uniform way of working, making it hard for GPNs to know how to access an educator and what to expect.

If you are willing to participate in this project, please mark X in the 'yes' or 'no' boxes below.

	Yes, I am willing to do this	No, I am not willing to do this
Sharing a copy of your job description if you are a GPNE and willing to do so		
Having a brief structured telephone interview to answer questions about the GPNE role, its benefits and what could make it work more effectively		
Attending a Focus Group to refine and create a standard GPNE role description for NHS England to endorse		

Consent:

Please complete your name, role and contact details below, save the document in word and email to sue.crossman1@nhs.net This will register your consent to participate. Your data will be anonymous and nothing in the report will be attributable to you. The interview transcript will be sent to you to verify accuracy.

Name:	Role:	Email address:	Telephone no.

Thank you.

Appendix 2

Structured interview questions for GPN Educator project

Group A – GPNEs

1. What is your job title?
2. Who is your employer?
3. Have you ever worked as a GPN?
4. Have you ever worked in a Higher Education Institution teaching nurses?
5. Do you have a teaching qualification?
6. How would you describe your role?
7. What challenges have an adverse effect on you doing your job well?
8. What enables you to be effective in your role? (people or processes)
9. How do you know if you're having a positive impact on GPN's access to education and training?
10. What would you change that would allow to be even more successful?
11. Can GPNs access you directly?
12. How do GPNs know how to contact you and what you offer?
13. Do you provide face-to-face support to GPNs?
14. Are you willing to share your job description?
15. Are you willing to attend a focus group to explore the range of GPN Educator roles?
16. Would you be interested in joining a community of practice network?
17. Do you have contact with HEI link lecturers?
18. Anything else you'd like to add?

Interview Date:
Interviewer:
Participant number and contact details:
Transcription verified by participant:

Appendix 3

Structured interview questions for GPN Educator project

Group B – GPNE Employers

1. What type of organisation do you work in?
2. How did your organisation determine what they wanted a GPN Educator to do?
3. How would you describe their key responsibilities?
4. What value do they add?
5. Where should they be situated for best effect? (T-Hub/GP/PCN etc)s
6. What challenges do you think adversely affect their ability to do their job?
7. What enables them to be effective?
8. What could your organisation do to help them to be even more successful?
9. How do you measure whether they have a positive impact on GPNs access to education and training?
10. Are you willing to share your organisation's GPN Educator job description?
11. Are you willing to attend a focus group to explore the range of GPN Educator roles?
12. Does your workforce lead meet with HEIs to determine whether the needs of GPNs are being met and gather feedback on the programmes?
13. Anything else you'd like to add?
14. Can you recommend any other participants? – either GPNE or their employer?

Interview date:
Interviewer:
Participant number and contact details:
Transcription reviewed by participant:

Appendix 4

Defining the role of the GPN Educator, June 2020

Questions for 2nd round of interviews

We are exploring the range of General Practice Nurse Educator (GPNE) roles, employment models and factors that affect how well they function. Your organisation's perspective adds a valuable strategic layer to the analysis.

1. What would you say is the greatest benefit from having a GPNE in place?

2. In your experience, are there different types of GPNE that could be grouped according to common features?

3. Do we need more than one type of GPNE in different places in the primary care structure? If yes, where should they sit and why?

4. How important is it that a GPNE has a teaching qualification?

5. Does it matter if a Training Hub Lead is not a nurse?

6. What support should there be in a PCN for GPN Education?

7. Regardless of the employment model, there are some factors that adversely affect the professional development of GPNs, such as;
   - Specialist training not being mandated and standardised as it is for GP trainees
   - GPN placement tariff being a tenth of the GP trainee tariff (£80pw vs £800pw)
   - The lack of concordance between national regulation of nurses and independent contractor status, regarding accountability for ensuring nurses are competent.

   These issues have always impeded progress. What are your thoughts about how to tackle these in the new primary care structure?

Participant number:
Interviewer:
Date:
Transcript verified by participant:

Appendix 5

The GPNE Gardening Compendium

A new nurse in General Practice is like the promise of a beautiful garden.
All they can offer yet to be discovered and vulnerable to wilting in the wrong conditions.
New GPN plants need nurturing and supporting, holding them till they're strong,
Feeding them just enough at the right time, to get their roots established.

The experienced gardener will recognise when a GPN plant is not thriving
And will investigate the problem.
It could be they're not in the right position, too crowded, not a good fit for the soil type.
Neglect or over-watering can both be disastrous, the root cause must be unearthed.

Spotting the flowering potential is key to success.
Moving them at the right time but not too often,
Seeing when they need to be left alone or given help and encouragement,
Allowing them to establish and settle, then burst into full bloom!

Eventually, the old GPN plants will fall away, so be ready to seed for the next wave.
Don't dead-head too soon or there will be a big empty space with nothing there.
Best to let them self-seed all around themselves, providing ground cover and continuity.
More effective than setting new annuals every year that flower brightly but don't last.

So, choose your GPN plants wisely, treat them well and you'll see years of outstanding results!

Inspired by a conversation with a very colourful GPN Educator

July 2020