

**An Exploration of the Factors Influencing
Practice Nurse Role Evolvement**

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Abstract

The aim of this study was to explore role evolvment and professional development in practice nursing in the UK. General practice is currently central to NHS reform, producing favourable conditions for the practice nurse role to strengthen and develop. However, the literature has continued to describe practice nurses as a disempowered, isolated group with many constraints reducing their ability to respond to opportunities. The rationale for conducting the study was therefore to provide a greater understanding about the constraining factors and their influence on practice nurses wishing to develop their role. The research was conducted in two parts; a survey to identify the range of issues and a case study to explore them in depth.

A combination of factors was found to contribute to the way the practice nurse role evolves. These are education, practice culture, practice nurse personal characteristics and empowerment. Empowerment holds the key to maximising the conditions favourable to role evolvment. This is not however a 'single' factor; it represents the combined synergistic effects of practice culture and practice nurse personal characteristics. The inter-relationship between these was captured in a set of 'empowering employment principles', which illustrate the features most conducive to role evolvment, providing a tool for nurses and their employers to enhance role development.

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Dedication

This thesis is dedicated to my parents.

Preface

This research study was carried out between 2006 and 2012, a period of considerable political change in the NHS with a particular impact in general practice. My interest in the topic stems primarily from my professional background and the combination of my clinical and educational roles in an environment that I found to be very responsive to change. I have a background in general practice nursing, nurse education and health services management and have maintained an interest in the social, political and environmental features that characterise general practice and influence the way that practice nurses work. Personal observations over many years raised a host of questions for me around why some nurses seemed to flourish in general practice while others appeared to find obstacles to their development that were too difficult to tackle. The focus of my interest has been in exploring the reasons behind these differences, to understand whether more nurses could influence their own role development, with potential benefits for their patients. I have previously completed research on the topic of practice nurse professional development and have published, mostly in nursing journals. I am currently employed as Chief Officer in a Clinical Commissioning Group (CCG).

The study was completed in two parts; a survey and a case study. The survey provided the context for the investigation, highlighting the major situational and professional challenges that are part and parcel of nursing in general practice. The case study explored how these challenges might affect the evolving role of the practice nurse. The methodology and findings for both parts are presented separately, followed by a discussion which draws on both. The conclusion and recommendations include the creation of set of 'empowering employment principles' as the outcome of the research.

This thesis is entirely my own work and no part of it has previously been submitted towards another degree. The length of the thesis is 99,082 words.

Chapter 1: The changing face of nursing in general practice

1.1 Introduction

Recent NHS reforms have focused on a shift in the provision of services from secondary to primary care and this has had a direct effect on the professionals working in this setting. Practice nurses are one group that has adapted their role to accommodate new policy (Rashid 2010). In the UK, doctors working in general practice usually employ their practice nurses directly, in contrast with other parts of the health system where doctors and nurses are usually employed by the same National Health Service (NHS) organisation in which they work. This means that general practitioners (GPs) directly influence the work undertaken by practice nurses in order to achieve the best outcomes for their registered patient population and to ensure the success of their business. This research study explores the particular effects that this arrangement has on the definition and development of the nurse's role in an area of nursing that is somewhat peripheral and isolated from more mainstream nursing specialties (Lovett-Clements 2010). This chapter describes the contextual setting for the research through a review of the literature on the emergence and growth of practice nursing during a period of significant health reforms.

1.2 Background

The last two decades saw a dramatic increase in the number of nurses working in general practice and the scope of their role has also broadened (Burns 2009, King's Fund 2009). The biggest rise followed implementation of the 1990 GP contract (DH 1990). Atkin and Lunt estimated a three-fold increase in the number of practice nurses between 1988 and 1993 to around 9,400 full-time equivalents (Atkin and Lunt 1993). Between 1995 and 2005 the number rose by 42% from 9,745 to 13,793 full-time equivalents (NHS Information Centre 2009) with the number of nurses employed in 2008 estimated at 25,000 (McGreggor 2008). The number of annual consultations in the average UK general practice has risen from 21,100 in 1995 to 34,200 in 2008 and the proportion of consultations undertaken by a nurse has risen from 21% in 1995 to 34% in 2006 (ibid). This pattern has largely been driven by policy changes to shift health services from secondary to primary care (DH 2008), improving access and choice for patients and reducing the costs of emergency hospital care (DH 2006a, Primary

Care Foundation 2009). These policies have been supported by contractual incentives for general practice to increase the services offered in a primary care setting particularly for health promotion (DH 1990) and long term conditions (Aldridge 2004). Much of this work has been undertaken by nurses, adding to a general increased delegation to nurses of work previously undertaken by GPs (Williams and Sibbald 1999, Griffiths et al 2004, Schum et al 2001).

As most nurses in UK general practice are privately employed by GPs they do not automatically have the standard employment terms and conditions that apply to NHS nurses. There are also differences in the way practice nurses are trained compared to NHS-employed nurses. In contrast to community nurses and health visitors, who have long established roles and educational programmes leading to specialist qualifications, practice nursing evolved separately with individual roles developing to suit the needs of general practices (Poulton 1997, King's Fund 2009). As a result there are wide variations in roles, employment conditions and qualifications among this group (Atkin and Lunt 1993, Longbottom et al 2006) and as they all work for different employers, there is no collective mechanism for monitoring the possible effects of this. There is no regulation about the level of educational preparation required for the role, which may have implications in terms of competency to practise (NMC 2011).

This chapter describes the emergence of practice nursing and outlines the political context within which the role evolved through a review of the literature. A literature search was carried out on commencing the study and continuously updated throughout the research, using CINAHL and Medline through the Athens database and also the search engine 'Google Scholar'. Key terms used for the searches included, 'practice' 'nurses' 'professional' 'development' 'support' 'role'. Some articles were found using the term 'office nurses' as this in an American listing for practice nurses. As many of the articles debated issues related to the nature of the relationship between nurses and doctors particularly around professional power, further searches included the terms 'professionalism' 'empowerment' and 'power'. Websites such as those of Department of Health, Royal College of Nursing, King's Fund and Audit Commission were also used, searching for documents pertinent to practice nursing.

This was supplemented by a hand search of recently published articles in 'Primary Health Care' and 'Practice Nursing'. Some of the literature has a local as opposed to national focus, using small geographical samples which are not, individually representative of the whole practice nursing population. However, the degree of consensus in research findings drawn from wide geographical areas over a long period of time provides confidence that the key issues arising from this body of literature are relevant across the professional group. Much of the literature on professionalism and power dates from the 1980s and 1990s, reflecting a time when these topics were a focus of active debate and emerging theory. These early works therefore form the basis of some founding principles for the topic of this research and they remain relevant today. The most recent papers in the field are from Canada, where professionalism seems to be a more current nursing debate. The literature review encompasses the historical background to the emergence of general practice nursing and the political changes that have shaped primary care. It concludes with a discussion of the effects of these events on the development of the practice nurse role.

1.3 The Origins of General Practice

Following the Beveridge Report in 1942 making sweeping recommendations to tackle inequitable social conditions in Britain and the subsequent creation of the NHS in 1947, GPs were charged with the task of controlling demand for the new free medical services. The arrangements for this were negotiated through a concordat whereby GPs remained independent from the NHS and agreed to provide general medical services (GMS) for a fee as opposed to a salary (Salter 1998). To achieve agreement from GPs the concordat had to include incentives and this created a medical bargaining approach to negotiation that has become well established politically (ibid.). The continued status of GPs as independent contractors with the NHS has had far reaching effects on the way that general practice has developed, including the employment of their staff.

There were disadvantages to the early general practice model, with no financial support available for premises or staff and GPs often working alone with little or no professional guidance or access to continuing education (Ham, 2004, Carey, 2000). This professional isolation resulted in services which varied considerably in scope and quality (Bolden and

Takle, 1989). The establishment of the College of General Practitioners in 1953 (to become the Royal College (RCGP) in 1966) created a body with responsibility for developing educational and professional support for GPs. Using the findings of a review of 'the work of the family doctor' (Gillie, 1963) the RCGP and the British Medical Association (BMA) negotiated with government to establish a new set of working conditions laid out in the 'GPs Charter' in 1966. The charter provided GPs with a financial contribution towards premises and staff, and this encouraged GPs to establish purpose-built surgeries, which in turn improved working conditions and the patients' experience. The charter also laid the foundations for a radical change in the remuneration system for GPs, with a structure that was to remain in place for almost forty years. This system, set out in the document held by all practices 'Statement of Fees and Allowances' (DHSS, 1974), commonly referred to as 'The Red Book', identified the basic allowances given to GPs and all the 'items of service' they could claim payment for.

During the 1950s and 1960s GPs began to group together in the same premises, sharing staff and on-call duties. By 1974 only one in six GPs was working alone (Ham, 2004). Community nursing staff at this time worked together in local authority health centres and clinics. Following the 1968 Health Service and Public Health Act (DHSS, 1968), which aimed to create closer collaboration in primary care, some local authorities began to attach district nursing staff to GP group practices and negotiated sharing premises. The success of this model prompted GPs to employ their own nurses, giving them freedom to decide how many nurses of what grade to employ and what duties to delegate to them. Thus a plurality of practice nurse team structures evolved according to the requirements and priorities of each practice.

1.4 The emergence of practice nursing

In the early years between the 1960s and 1980s there was only a gradual change in the numbers of practice nurses employed and their role, which was initially task orientated and often included reception and clerical duties, changed little (Bowling and Stilwell 1988, Poulton 1997, Carey 2000). There had however, been sufficient growth to create local Practice Nurse Associations, Royal College of Nursing (RCN) representation and the

emergence of journals and courses. Practice nurses were still very much a minority group though and in many ways they felt discriminated against (Carey, 2000). One of the reasons for this was that their employment by GPs excluded them from the NHS pension scheme, which disadvantaged them in comparison to other community nurses. This was addressed in 1997 following pressure from the RCN practice nurse association with support from the BMA (ibid.). Practice nurses were also disadvantaged in relation to education and training at this time, having no formally recognised training for the role (Winter 1994). The perceived professional isolation of practice nurses was not always viewed sympathetically by their community colleagues as there were also positive aspects associated with working in general practice, described in one survey as a 'jammy job' (Dent and Burtney 1997). These benefits included attractive working hours, a relative degree of autonomy and freedom from bureaucratic nursing structures (Bowling 1981).

During the 1980s and 1990s policy analysts and health commentators began to take a more active interest in practice nursing as a fast-growing branch of nursing. A review of community services in 1986 identified weaknesses in the organisation and management of nurses with duplication and gaps in the provision of care, rigid professional boundaries and ineffective team working (The Cumberlege Report 1986). The report recommended a reorganisation of community nursing into local 'neighbourhoods' within which all nurses working outside hospital would be managed. Recommendations were also made regarding a common training course for all community nurses and the introduction of nurse prescribing. With regard to general practice, some far-reaching recommendations were made about the employment of practice nurses. The report identified concerns about the cost-effectiveness and lack of financial control over GPs employing their own nurses and the risk of soaring uncontained costs to the NHS. Cumberlege warned that if all GPs used their maximum entitlement to employ nurses, the numbers could rise from 4,000 to 20,000 at a cost of more than £100 million a year to the NHS. The recommendation was therefore made that the general practice staff reimbursement scheme should be phased out and the estimated £10 million paid at that time each year to GPs should be redirected into the community nursing service, which would provide nursing cover for surgeries in 'neighbourhood teams'. The report recommended that one nurse practitioner should be employed in each neighbourhood,

managed by the nurse manager and responsible to a GP for carrying out services within general practice. This would allow for greater control of the deployment of staff, improved team-working and tighter financial control. The report also argued that the direct employment of practice nurses by GPs was divisive and could damage the cohesion of the new 'neighbourhood nursing service' proposed by the review and that on principle nurses should not be subject to control and direction by doctors (Cumberlege 1986:41). The view was expressed that GPs emphasis on diagnosis and treatment might pervade the holistic preventative approach that was so characteristic of nursing (Cumberlege 1986:48). This view resonates with a movement documented at that time to promote nursing as an independent profession with autonomy from medicine. In a similar vein, the report quotes the RCN as suggesting to the review team that doctors generally did not arrange appropriate training or professional support for nursing staff and that this had resulted in a fragmented, inadequate nursing service.

This report was not well received by practice nurses or GPs. The nurses defended their right to be employed by GPs and were offended by the lack of appreciation of the scope of their work as well as the implication that they were dominated by GPs and had no clear role (Damant 1994). GPs were also resistant to the idea that practice nurses should be employed and managed by the Health Authority (Nursing Times 1986) saying this would impede developments in patient care and role extension. Bowling (1987) discusses the response to the Cumberlege Report, stating that the recommendations angered many doctors and created a rift between practice nurses and the RCN. Despite some of these negative effects, the Cumberlege Report did raise the profile of practice nurses, by recognising that they were a significant group of nurses whose numbers were increasing and contribution to primary care nursing was valued by GPs.

The evidence base for the statements central to the Cumberlege Report, which was commissioned by the Secretary of State and therefore had the potential to influence high level health policy decision-making appears weak. The report uses comments from the participants as justification for change, despite no demonstrable evidence that there is an associated impact on health outcomes. It appears to have been an opinion poll, without any clear

identification of what was being measured and how. However, it remains a document that changed the shape of community nursing, and raised some contentious issues about the employment of practice nurses.

A further report that was influential in shaping the development of practice nursing was the Damant Report, commissioned by the English National Board for Nursing (Damant 1990). This report highlighted inadequacies and inconsistencies in practice nurses' training and recommended the introduction of a national framework, leading to a recordable professional qualification. This was a welcome recommendation, as the Cumberlege Report had excluded practice nurses from its recommendations on education (Cumberlege 1986:63) despite the fact that the provision of education for them was acknowledged as having been poor (Bolden and Takle 1984, Bentley 1991, Stilwell 1991).

The last influential study in this context was the Social Policy Research Unit (SPRU) Report, a national survey carried out by Atkin and Lunt (1993) at York University, which gave for the first time a detailed breakdown of the scope of the practice nursing role. The first stage of the report was a census entitled 'Nurses Count' which established a national profile of practice nurses, giving details of the work they undertook, their professional qualifications and their training needs. Overall, there were 15,183 practice nurse posts in England and Wales at the time, (representing 9,400 whole time equivalents) indicating a trebling of numbers over a five-year period and it was this huge increase that had prompted the Department of Health to commission the survey (Atkin and Lunt 1993). With such a rapid increase in expenditure on this nursing group, the Department of Health required information about the return for investment. The lack of restriction on access to funding for these posts was beginning to create exactly the scenario predicted by Cumberlege; huge increases in cost with little evidence of an increase in efficiency in the provision of patient care. The second stage of the report was a qualitative survey exploring the scope of the practice nurse role, future potential development and relationship to other primary care nursing services. This produced data from a number of different professional perspectives and highlighted a series of tensions related to GP expectations, practice nurse aspirations, tribalism between primary care providers and central government control of resources (Atkin and Lunt 1993:26).

The role of the practice nurse continued to be defined by the individual requirements of their employers, and there remain wide variations in this respect (Gray 2006, Rashid 2010). The term 'practice nurse' is an umbrella term used to describe any nurse employed in general practice but the actual role can vary from a generalist in the treatment room, giving general advice and nursing care to all ages, to a specialist nurse running clinics in areas such as family planning, travel health or long term conditions. In addition, there are now an increasing number of nurse practitioners employed with enhanced diagnostic, prescribing and referral skills. Many practices are also seeing the advantages of employing Health Care Assistants (HCAs) to carry out procedures such as phlebotomy and ECGs. Carey (2003) suggests that the practice-nursing role has not been shaped by the nurses themselves but moulded by other groups in an attempt to meet the demands placed upon general practice. This process was heavily influenced by the impact of changing government legislation and contractual conditions with general practice.

1.5 Political change in general practice

The backdrop for the years between 1987 and 2007 and the reports described earlier was a period of unprecedented political change in primary care. General practice became the focus for a programme of reform, with an emphasis on shifting investment into the primary care sector. A series of contractual changes in general practice each had an impact on practice nurses.

1.5.1 The 1990 GP contract and Health of the Nation

Following publication of the white papers 'Promoting Better Health' (DH, 1987) and 'Working for Patients' (DH, 1989), the main priorities were promotion of health and prevention of disease. As the first point of contact for most patients, primary care was therefore targeted as the focus for health promotion activity and attention turned to efficiency and standards of care in general practice.

These white papers paved the way for a new contract for GPs (DH, 1990), requiring them to provide screening health checks for the elderly and newly registered patients and more co-

ordinated care for those with long term conditions, with additional payment for health promotion activity. As previously described, GPs had historically been paid a fee for providing many services such as cervical smears and vaccinations. There was recognition that this system did not encourage related health promotion advice, that those most in need of preventative care may not present for treatment and there was no measure of uptake among patient populations. This was addressed by the 1990 contract with target payments for undertaking health promotion activity in a range of clinical areas. These changes to the provision of care were strengthened with the publication of the report 'The Health of the Nation' (DH 1992) which set targets based on the World Health Organisation's recommendations for five key areas: coronary heart disease, cancers, mental illness, HIV/AIDS and accidents.

The effects of these changes on practice nursing were dramatic. Firstly, GPs needed more nurses to run the clinics, set up registers and establish recall systems in order to maintain practice income (Mackereth 1995). As a result there was a sudden sharp increase in the number of practice nurses employed as described earlier from 3,480 full-time equivalents in England in 1988 to 9,605 in 1993 (Waller 2000, Ross and MacKenzie 1996). Secondly, the nurses were required to undertake a variety of new tasks. Prior to the 1990 contract, many practice nurses had been primarily 'treatment room' nurses, that is to say carrying out a wide range of nursing tasks such as injections, dressings and ear syringing. Suddenly, they were expected to develop a new set of skills (Ross et al 1994, Mackereth 1995). They were required to give in depth advice on aspects of health promotion including diet, exercise, smoking cessation, travel health, coronary heart disease prevention and women's health. There was also the introduction of chronic disease management clinics, which required specialist knowledge in asthma, diabetes and hypertension. The fact that all this happened rapidly with no coordinated training strategy for the nurses other than some distance learning material developed by the Department of Health (Carey 2000) gives another insight into the challenges practice nurses faced. However, there were benefits for practice nursing associated with this development in terms of job opportunities, and those nurses who chose to learn new skills proved most effective in the delivery of high level care and advice (Charlton 1991, Griffiths et al 2004). In a study of the health promotion activity of practice nurses,

Ochera et al (1993) criticize the basis upon which health promotion services were developed, suggesting that the practice nursing contribution may expand and contract according to health policy rather than the needs of the patient population. They recommended that effective outcome measures rather than politics should determine service provision. This appears to imply that practice nurses were providing a policy-driven service without clear evidence that there was a need for it, an argument which raises questions about how nurses in general practice assess patients' needs. However, Carey (2000) argues that practice nurses used the health promotion clinics as an opportunity to shape patient care, demonstrating their versatility and innovative skills, whilst motivating patients to take control of their own health, but she does concede that positive outcomes were difficult to identify.

1.5.2 GP Fund-Holding

Following the introduction of the NHS 'internal market' by the Thatcher government, which was a system designed to increase efficiency through competition by splitting the purchasing and providing functions of health organisations, this policy was extended to general practice. Whilst GPs were seen as 'providers' of care, it was felt that introducing a 'purchasing' function by giving them a budget and choices about which services they would use, would improve competition and quality in secondary care provision, offer greater consumer choice and reduce waiting lists (Carey 2000). GP Fund-Holding was therefore introduced in 1991, (DH 1991) giving GPs purchasing power and changing the face of general practice. Fund managers were employed to deal with the contracting, GP fund-holders became involved in strategic planning with health authorities and these practices evolved into mini NHS organisations. Not all GPs opted to become fund-holders and this created a two-tier system, as non fund-holding practices were seen as less influential and certainly less well off financially (Carey 2000).

1.5.3 The New NHS: Modern and Dependable

The New NHS: Modern and Dependable (DH 1997) outlined the Labour government's strategy for modernising the NHS. It aimed to tackle inequality in healthcare provision, inefficiency in management and bureaucratic hierarchies and to increase the influence of local clinicians and patients to shape their own health service. The legislation abolished the

previous Conservative government's GP Fund-holding scheme and introduced a local structure for the planning and management of primary care services. The introduction of Primary Care Groups (PCGs) and later Primary Care Trusts (PCTs) involved a gradual devolution of power and funding to a new executive committee, which included GPs (in the majority), primary care nurses, lay representatives and health authority staff. There was freedom to combine previously separate streams of funding and develop local health implementation plans (HImPs). This was promoted by government as a golden opportunity to cut waste on unnecessary red tape and spend money on real clinical priorities appropriate to the local population. The effect on practice nursing was to give them a direct opportunity to shape and influence the provision of care and to provide the potential for career progression as a PCT nurse. PCTs began to groom practice nurses by providing training in leadership, equipping them with skills to contribute to boardroom debate and decision-making.

This legislation, along with the Primary Care Act (DH 1996), the introduction of Private Medical Services (PMS) and the increasing trend for employing salaried GPs in place of independent contractors, allowed nurses the potential to create innovative practices. Funding could now be sought for new projects and initiatives and even new working arrangements, such as nurses employing each other, or even doctors. The potential for turning on its head the gender and power base upon which nursing is based was presented for the first time. There have been a few tentative steps in this direction, such as a Derbyshire practice nurse who set up a pilot site employing doctors in a nurse led practice (Baraniak 1998), but few seized the opportunity. This suggests that practice nurses need more than opportunity to make them break out of the traditional mould.

A report commissioned by the North West Anglia Health Authority (Thompson 1999) to assess the impact of PCGs on the primary care nursing profession identified tensions around the role of the PCG nurse and their relationship with GP colleagues on the executive board. There was a strong theme in the findings around nurses feeling undervalued. Respondents mentioned GP 'domination', commenting that the nursing contribution was rarely asked for. A commonly held view was that GPs find it difficult to work collaboratively, that they like to make unilateral decisions and find it hard to give control to others. Some nurses commented

that GPs seemed to have a strong paternalistic view about what nurses should do and how their role should develop, and that they did not like being challenged about this, particularly with reference to practice nursing. This model of GPs dictating nurses' roles and delegating their work is unlikely to provide practice nurses with a sense of empowerment over their professional development and a strong professional identity.

Political reforms continued to influence the development of the practice nurse role with the introduction of the new General Medical Services (GMS) contract in 2004 (Lilley, 2003)

1.5.4 The new GMS contract

The driving force for change that brought about the new GMS contract was GP engagement (Croxon 2003). GP morale was very low, recruitment was in crisis and the demands of the job were producing unacceptable levels of stress among many GPs (ibid). Doctors felt they had decreasing clinical freedom and an increasing burden of paperwork. Out of hours cover was a particularly contentious issue with increasing patient expectations and limited resources. There was a general lack of trust in both the government and the British Medical Association (Barnett 2003, Cameron 2003, McNulty 2003) who were negotiating on behalf of doctors and the predicted outcome of the national vote on accepting the contract was uncertain, with strong views expressed for and against (Balmer 2003). However, the final decision to accept the contract was supported by an overwhelming majority of 79% of GPs (Young 2003), with the promise of better pensions, more income, and the choice to drop out of hours work (Lilley 2003). The new contract gave doctors greater freedom and flexibility to determine the range of services they wished to provide, rewarded performance, invested in the modernisation of premises, IT and human resources and provided a more equitable system of funding allocation (ibid.).

Practices were able to decide what level of services they wished to provide, in terms of Additional and Enhanced Services over and above the Essential Services that had to be provided (Natpact 2003). This 'opting out' scheme meant that Primary Care Organisations (PCOs) had a responsibility to find another provider for these services for the practice population. This potentially opened up all sorts of opportunities for nurses in terms of role

development, including becoming primary providers of care for these patients (McGreggor et al 2008). Some of the services included in this group were family planning advice and immunisations, which are within the skill-set of many practice nurses. In addition, the decision by many GPs to opt out of providing Out-of-Hours care potentially increased the demand for first contact care from other providers, including A&E departments during the night and at weekends (Robinson 2003).

There was a new method of rewarding performance through the quality outcomes framework (QOF) (NHS Confederation 2003, Roland 2004, Bonsall and Cheater 2007). There were four domains; clinical, organisational, additional services and patient experience. Each domain had key indicators against which practices are measured and paid according to their level of achievement. Nursing staff remain key participants in practices' efforts to achieve these performance targets, particularly in the clinical domain (Rashid 2010).

1.5.5 Practice Based Commissioning

Shortly after the introduction of the new GMS contract, political changes in primary care focused on developing patient-led services by involving GPs in commissioning and on restructuring Strategic Health Authorities (SHAs) and PCTs. Following the publication of Sir Nigel Crisp's report on Practice Based Commissioning (DH 2005), a major reconfiguration of NHS services took place. There was a significant reduction in the number of PCTs and they were required to clearly show how their purchaser and provider functions were kept separate. In addition, future service provision would be open to competition from 'alternative providers', a move that created confusion and concern among managers and practitioners (Young 2005, Farrant 2005). This would allow non-NHS organisations to employ all staff currently employed by the PCT and potentially to attract Practice Nurses to join them. This potentially opened up a whole new horizon for Practice Nurses, with a mixture of opportunity and risk (Bonsall and Cheater 2007). The new arrangements also strengthened the opportunity for nurses themselves to form independent organisations that could provide a primary care service to the NHS. At the very least, it allowed Practice Nurses to consider what alternative options might be opening up for them, in terms of employment, development of specialist services and collaboration with other primary care practitioners.

A comprehensive consultation across the NHS in 2007 led by Lord Ara Darzi (DH 2008) recommended locally-led, clinically-driven quality should be at the heart of the NHS and established processes to achieve that goal. This strengthened the thrust for patient choice, increased quality and better integration of services across different providers of care. Subsequent papers in this review signalled intent to develop a process of accreditation for GP practices and to provide multi-professional education for staff to ensure they were well trained (DH 2008b, 2008c). These recommendations were further supported by targets set by the Chief Nursing Officer for England to ensure that the nursing workforce would have the capability to deliver the level of care required as a result of implementing the new health agenda (Chief Nursing Officer 2008). These targets provided practice nurses with strong support for negotiating any training and development they required.

1.5.6 Equity and Excellence: Liberating the NHS

This white paper set out the new coalition government's vision for the long term future of the NHS (DH 2010) building on the core values and principles of the NHS as set out in the NHS Constitution and putting patients at the heart of everything the NHS does (NHS 2009). The focus was on continual improvement in areas that really matter to patients such as the outcome of their healthcare and empowering and liberating clinicians to innovate with the freedom to focus on improving healthcare services. Patient choice and public consultation were core principles. The paper was controversial as it set out further major reforms to the structure of the NHS, giving GPs a significant role in designing services. It was therefore debated at length before becoming formalised through legislation.

1.5.7 Health and Social Care Act 2012

The Health and Social Care Bill introduced in January 2011 and passed by the House of Lords after many amendments in March 2012 took forward the areas of Equity and Excellence:

Liberating the NHS, covering five themes:

- Strengthening commissioning of NHS services
- Increasing democratic accountability and public voice
- Liberating provision of NHS services

- Strengthening public health services
- Reforming health and care's arm's-length bodies

The phrase frequently mentioned in the bill 'no decision about me without me' illustrated an increased emphasis on patient and public involvement in designing and delivering local health services. Patients were also able to choose which GP practice they registered with regardless of where they lived. This bill replaced PCTs with Clinical Commissioning Groups (CCGs) which gave GPs responsibility for commissioning the healthcare in their local communities, supported by Commissioning Support Units (CSUs) to provide administrative and contractual functions. PCTs and Strategic Health Authorities (SHAs) were abolished in April 2013 and the National Commissioning Board Authority set up local area teams which retained responsibility for commissioning Primary Care services from general practice and some very specialised high cost services.

This legislation signalled the continued drive for choice, equity and quality in the NHS and the growth and development of services in primary care. In theory, these principles should provide strong support for effective professional development resources for practice nursing. However, none of the policy documents referred directly to practice nurses as a group, and whilst it could be argued that the intention to make improvements for primary care staff must include them, this was implicit rather than explicit.

1.6 The effects of political change on practice nursing

The political reforms outlined in the previous section have encouraged and supported increasing diversity of nursing skills and expansion of responsibilities, calling for 'more nurse-led primary care services to improve accessibility and responsiveness' (DH 1999). The literature identifies opportunities and consequences for practice nurses as a result of policy implementation and subsequent changes in the organization of general practice affecting;

- Role and workload
- Employment terms
- Educational preparation
- Continuous professional development
- Professional identity

1.6.1 Role and workload

On the surface, the policy changes should have enhanced opportunities for practice nurses to innovate and develop their role. *Liberating the Talents* (DH, 2002) explicitly stated that nurses' roles should be expanded to include some work currently done by GPs and this builds on earlier recommendations by the previous government (Doulton 1995). This is supported by a literature review by York University, which suggested that between 30% and 70% of tasks performed by doctors in primary care could be carried out satisfactorily by nurses (Richardson 1995). The new GMS contract required practice nurses to work to maximum capacity and efficiency, support the drive to promote self-care, manage long-term conditions without hospital admission, achieve new GMS targets and provide quick access to first contact care (Cross 2006, McGreggor et al 2008). Within the literature just prior to the introduction of the new GMS contract, there is evidence of a general awareness that it would affect practice nurse workload and role (McQuarrie 2003, Chatterjee 2004). Certainly the Department of Health guidance on the subject (Natpact 2003) identified areas for increased nursing responsibilities, such as non-GP led chronic disease management, first contact care and new specialist nursing roles, including community matrons. However there was little exploration of the support and associated professional development that may be required to implement this (McGreggor et al 2008).

One survey (Crossman 2006) explored the effects of new GMS on the role and education needs of practice nurses. The findings provided evidence that the new contract had increased both the clinical and administrative workload of Practice Nurses. There were mixed views about the effects of this. Some participants expressed the view that new GMS restricts the scope of consultations and tends to focus on targets rather than patients' priorities. There was another view that new GMS improved the standard of care in General Practice. There was a strong consensus that Practice Nurses were working under considerable pressure, with little time to consider their own developmental needs. These findings were supported by a later survey on the same subject (McGreggor et al 2008). Both studies reported that a significant number of participants identified the potential for new nursing roles. There was a tentative willingness to engage in exploring these opportunities, but only if there was support to do so

and reassurance about security and employment conditions. The nurses seemed anxious about breaking new ground and sought a guide to lead the way. They were also reluctant to 'alienate' GPs. This suggests that the practice nurses were, on the whole, wary and insecure when it came to considering change, particularly if that involved stepping out of the traditional structure of general practice. They seemed willing to adapt their role, take extra responsibilities and work under considerable pressure, rather than lose the security and familiarity of working for GPs. This apparent lack of autonomy and choice suggests that despite political encouragement to be innovative in developing nurse-led care, practice nurses do not exhibit empowerment to act.

1.6.2 Employment terms

The literature suggests widespread variations between practices with regard to terms and conditions of employment, including contracts, pay, appraisal, induction, holiday entitlement and study leave (Corbett 2004, Gray 2006, Longbottom et al 2006) but few studies provide a complete national picture. Longbottom et al (2006), a team from Staffordshire University who carried out a comprehensive review of information available on the role, employment and professional development of practice nurses to inform the Working in Partnership Programme, (WiPP 2006) found that many nurses have never had an appraisal and do not have an up to date job description that adequately reflects their role. These findings come fifteen years after the RCN clearly identified that many practice nurses did not have job descriptions and that this made it difficult to identify their learning needs (RCN 1991). This failure to progress suggests a lack of impetus from those in a position to create change combined with low negotiating strength amongst the nurses affected. There is evidence of progress in some parts of the country but not on a national scale. In 2002, Torbay PCT undertook a local review in general practice (Phare 2002) and found a lack of equity in terms of service and, in some areas, low levels of education to support the nurse's role. They decided to tackle the problem by developing a framework for professional and educational support and recommending standardised terms and conditions across the PCT area (Torbay PCT and Teignbridge PCT 2005). Local initiatives such as this are not representative of the national picture (O'Donnell et al 2010).

Pay and pension arrangements for practice nurses also differed in comparison to other nurses working in NHS institutions. Until 1997 as non-NHS employees, practice nurses were not entitled to an NHS pension. Although they are now entitled to the pension, other employment conditions continue to be variable and inconsistent. A case in point is the NHS pay structure for nurses 'Agenda for Change' (Practice Nursing Forum 2003), which aims to reward nurses for their skills and the responsibilities of their post, not just their qualifications or years in service. Despite pressure from the Royal College of Nursing and PCTs, it seems unlikely that all GPs will conform to Agenda for Change (Benison 2005). As independent contractors, GPs retain the right to decide on levels of pay within their own practice. This demonstrates a 'regional pay' disparity between practice nurses and NHS colleagues (O'Donnell et al 2010).

1.6.3 Educational programmes for practice nurses

The educational needs of practice nurses have historically been poorly met (Stilwell 1991), with courses often being provided in an uncoordinated way, varying considerably in content and quality from region to region (Prime 2003, Field 2011). In addition, since practice nurses have always been independently employed by General Practitioners they have planned their training in consultation with their employer, whose priorities will be dictated by the demands of his or her practice (Carey 1996, Stark et al 2001). Whilst this may result in nurses well trained for a particular role, it also carries the risk of disparity in educational standards and in opportunities for professional development amongst the group (Cross 2006). The lack of appropriate educational courses, along with difficulty in gaining funding and permission to attend (Lovett-Clements 2010) has created obstacles to professional development. During the 1980s it was quite common for practice nurses to fund their own training and attend in their own time (Bolden and Takle 1984). Courses available included English National Board (ENB) certificates in practice nursing and family planning but they did not lead to a recordable qualification. It was evident that preparation for the practice nursing role was both "limited and haphazard" (RCN 1991:2). The flaws to this situation were widely debated at the time (Bentley 1991, Peachey 1992, George 1993, Mayor 1997), which heightened awareness and created pressure for change. The frustration felt by practice nurses (Gupta 1994), was compounded when the UKCC introduced the new community specialist practitioner qualification. Practice nurses did not have their own route to the qualification, but were

included in a category for district nurses. Although this was later overturned after pressure from practice nurse groups, the transitional arrangements for conferring the qualification to those nurses with previous experience and training, (without having to undertake the three-year programme), discriminated against some practice nurses (Carey 2000). By stipulating that only those nurses with a recorded community qualification could gain the title, the UKCC excluded the majority of practice nurses. This was later resolved using the ENB A51 short practice nurse certificate as a standard, with a portfolio of supporting evidence, but the process served to illustrate the continued 'separateness' of practice nursing.

The specialist community practitioner title is a degree level qualification recorded on the NMC register, which in theory gives practice nurses parity with their community colleagues (NMC 2001). However, uptake of the course has been patchy due to the GP employer being required to release the nurse from work, pay her whilst she was absent from the practice as well as paying for a locum nurse to cover the work (Bell 2007). The NMC have confirmed that the number of nurses undertaking the qualification has declined from 196 in 2005 to just 33 in 2010 (Goldsmith 2010). Hawksley (1997) found in her study of GP perceptions of the practice nurse's role, that GPs placed more value on practical skills training rather than degree level studies, therefore nurses are not encouraged to attend such courses. This is supported by the findings of a practice nurse survey where only one out of 33 nurses had achieved the Specialist Practitioner qualification (Crossman 2006). However, a survey of the same group of practices ten years earlier (Thompson 1995) found that 50% were willing to attend a course to achieve the Specialist Practitioner qualification. This raises questions about barriers to access. Nurses were willing but apparently unable to attend, which could indicate a lack of their own commitment or barriers such as funding or permission to take time out of the practice. This cannot be generalised as a national trend but provides an indication of the difficulties in planning education provision for the group.

Courses currently available still seem to vary in content and length across the country, although there is no reliable database (Lovett-Clements 2010). The review carried out by Longbottom et al (2006) identified some excellent educational opportunities available but gaps in provision and wide variation across the country in access to courses. They also noted

variations between PCTs in terms of commitment to practice nurse education and stated that there were no educational requirements for nurses in general practice. Given that practice nurses' educational needs are diverse then if provision is patchy there is a risk that some nurses may be practising without adequate levels of training.

Almost two decades ago, recommendations were being made to reduce anomalies by making local health authority organisations responsible for the employment contracts and continuing education of practice nurses (Jewell 1994). Since the 2004 contract, staff training budgets for general practice are no longer held by PCTs but are directly given to practices as part of the 'global sum' (Lilley 2003), meaning that responsibility for funding nurse education lies, once again, firmly with GPs. Some have debated the wisdom of this, questioning how appropriate it is for one professional group to control the professional development of another (Crawford 2006). If there are barriers to education for this group due to their employment status, it seems unhelpful to return to a system where they also have to negotiate with that employer for education funding. It would appear that this area of policy, theoretically strengthened by the pledges in Darzi's 'High Quality Workforce' (DH 2008c), has failed to have an impact on practice nurse education.

1.6.4 Continuous professional development support in practice

Professional development is a commonly used term amongst professionals such as teachers and healthcare professionals but its definition is not always clear and precise (Happell 2004). It has been described as a process whereby the professional capabilities of staff are increased by providing access to training and educational opportunities (Management Sciences for Health 2001). The benefits of professional development are widely recognised, not just in terms of maintaining staff competence and achieving organisational and clinical standards, but also in boosting staff morale, recruiting and retaining high quality staff (Rafferty 2005, Hyde 2006).

All nurses are bound by the NMC code of conduct to maintain their competence (NMC 2008). A wide range of NHS policy documents stress the importance of appraisal, professional development plans, lifelong learning and clinical supervision for nurses, linking these with

improved competence and ability to apply evidence based research to practice thus improving quality (DH 1998, 1998b, 1999, 1999b, 2000, 2002, 2006b, 2008, 2008c). The NHS Modernisation Agency launched '10 high impact changes' following a review and meta-analysis of the literature on the relationship between good human resource practices and performance improvement (DH 2007). The team found that improved performance was associated with staff appraisal, staff involvement/partnership, good 'people management' and effective training and development, and these formed the basis of some of their recommendations. Supported by these findings and the requirements of Clinical Governance (DH 1999b) all nurses, including those in general practice should have access to a range of methods of support in practice such as appraisal, mentorship, continuous professional development and clinical supervision (NMC 2006). However, several studies identify low levels of appraisal and Professional Development Plans (PDPs) in practice nursing, even after the introduction of local frameworks and practical tools to aid implementation (Sherlock 2003, Corbett 2004, Gray 2006, Scottish Executive 2004, Bell 2007). This illustrates a trend of failure to embed continuous professional development in general practice, with potential consequences for competence and thus patient safety (Field 2011).

Practice nurses are vulnerable in terms of professional isolation due to working in an environment that is often physically and organisationally remote from others (O'Donnell et al 2010). There could be risks associated with this in terms of patient safety, particularly where nurses working alone lack support for clinical decision-making (Benison 2005b). This is difficult to defend at a time when the continuing political agenda is giving these nurses wider responsibilities. This issue of professional isolation appears to be a long-standing problem, as Atkin and Lunt (1995) found that GPs did not usually recognise the difficulties faced by a practice nurse when first taking up her post, a time when the nurse is particularly vulnerable to feeling isolated. Atkin and Lunt also found that the nurses recognized the importance of an induction programme because of the contrast between practice nursing and their previous employment, but that GPs had a limited understanding of the nurse's professional responsibilities in relation to competence (Atkin and Lunt 1995:28).

The implications of the situation are emphasised starkly by Martin (1996), who states that in law a practice nurse is expected to provide care to the standard of a typically skilled and experienced practice nurse, even on her first day in the job. Savage (2005) discusses the legal implications of practice nurse roles evolving in advance of approval by professional bodies and the tension between professional allegiance and allegiance to the workplace. This puts practice nurses in a difficult position, balancing service needs with legal and ethical constraints.

Professional support for practice nurses has been available historically through Family Health Services Authorities (FHSAs) and later, PCTs. At a time when this role was under threat, Paniagua (1995) voiced concern over the reduction in practice nurse advisors within FHSAs and the resultant loss of professional support for nurses in practice. The fact that the latest round of NHS reforms has resulted in a merging of PCTs and a re-definition of purchasing and providing functions, both of which will reduce the level of PCT support available to practice nurses, seems to indicate a circular pattern to these issues rather than progression.

The literature shows there has been little progress in achieving a minimum standard of employment conditions and professional development support, despite quality related incentives in the new GMS contract, requirements under clinical governance, and the availability of resources such as the Scottish Executive Framework. Perhaps the ‘voluntary’ nature of complying with best practice explains the continuation of such widespread variations. Alternatively, it may be a result of poor collective representation of practice nurses or a general lack of commitment by their employers in supporting professional development. Atkin and Lunt found that GPs “*generally favoured continuing training and education for practice nurses but took little active interest*” (Atkin and Lunt 1995:29).

Barriers to professional development cited by practice nurses include time, funding and employment status (Scottish Executive 2004, Crossman 2005, Bonsall and Cheater 2008). The fact that resources to support practices are available yet inequalities in access remain is worthy of analysis, otherwise there is a risk of investing in programmes that will have no effect.

1.6.5 Professional identity

Much of the literature discusses the view that practice nurses lack a clear sense of professional identity (Walsh and Huntington 2000, Dent and Burtney 1997, Williams and Sibbald 1999, Scottish Executive 2004, Bonsall and Cheater 2007). Gray (2006) identifies 13 different titles used in a survey of 61 nurses and she recommends harmonisation of titles and roles to improve clarity. Traynor (1991) discusses the ambiguity between role extension and medical delegation, which highlights the juxtaposition of practice nurse choice and GP control. Similarly, Dent and Burtney maintain that although the practice nurse role has expanded over recent years there has been little in the way of commensurate increased status (Dent and Burtney 1997:357). They cite the organisational subordination of nurses in a patriarchal environment as the main factor, suggesting that GPs have supported development of the practice nurse role in order better to fulfil government policy. Paniagua (2003) discusses the belief held by some that the expansion of the role could be regarded as exploitation rather than opportunity, as the work has become more complex and demanding with little or no increased financial reward. Some nurses have described the effects of political change on their priorities in practice, resulting in pressure to reach targets rather than give individualised holistic care (Harston 2005, Crossman 2006). An earlier description about the advantages of the practice nurse role from the RCN standards of care for practice nursing indicates more clinical freedom, stating:

“(The practice nurse) has a degree of autonomy because she is outside nursing structures and has the potential for initiating and regulating her work”
(RCN 1991:3)

This implies that practice nurses were assumed to exert some control over their scope of practice, whereas the more recent literature suggests this is not so much the case with work continuing to be defined by delegation from GPs and extended roles tending to produce uncertainty and intra-professional tensions (Bonsall and Cheater 2008). This appears contrary to the expectations articulated in policy that practice nurses could take more control of their work. This suggests either a missed opportunity for practice nurses to take more ownership of

the way their role develops or indicates that policy makers have misunderstood the motivating factors or barriers to this happening.

1.7 The policy response to support primary care

Following the confirmation of the new GMS contract requirements in 2004 the Department of Health recognised a need to support the workforce to achieve successful implementation. A project funded by the Department of Health entitled the ‘Working in Partnership Programme’ (WiPP), was designed to increase the capacity and capability of the general practice workforce (WiPP 2006).

1.7.1 The Working in Partnership Programme (WiPP)

This DH funded programme was intended to support the implementation of the new GMS contract at an organisational level by sponsoring, evaluating and spreading good practice (Martin 2008). The work-stream for general practice nurses produced a range of resources including employment standards, guidance on professional development and frameworks for education and career progression (WiPP 2008c). The programme acknowledged the trend of shifting workload from GPs to practice nurses and recognised concerns regarding capacity and capability in the workforce (Martin 2008). This was the rationale behind developing a web-based resource, approved by national nursing and medical bodies and readily accessible to all practice nurses, providing them with advice and approved standards to support the work they do. Implicit in this process is the assumption that developing such a resource would have an impact and that practice nurses would access and use it. These would seem quite reasonable assumptions to make, although there is no real supporting evidence for them. It would appear that the DH considered that given the right tools (through WiPP), practice nurses would not only effectively implement primary care policy but feel empowered to use the opportunities identified to develop new roles under initiatives such as ‘Social Enterprise’ and ‘Community Interest Companies’ (Young 2006, Bonsall and Cheater 2008). The message was that successful implementation of new GMS could be enhanced if practice nurses were willing and able to fill some of the gaps created by GPs ‘opting out’ of various additional services, and to support locally developed plans under PBC. Perhaps this may explain central government’s renewed interest in their development as demonstrated by the

funding of WiPP. The central tenet of the programme was the assertion that a developed and motivated General Practice Nursing workforce could support workload shifts and improve patient access to services (WiPP 2006b). However, based on the review of the literature on practice nurse development there is no evidence to date that providing practice nurses with external opportunities and readily available resources actually makes any difference to the inconsistencies in uptake of these. There appears to be something more complex creating a barrier to development.

1.8 Conclusion

The literature highlights variation in role definition and issues of continuing disparity around practice nurse employment conditions, education and professional development support across the UK, with some nurses having apparently inadequate levels of support for the work that they do. There has been a lack of progress in addressing these anomalies which are often inter-related and it appears that improvements in one area (for example, education) do not necessarily have a positive effect as long as other issues (such as study leave) remain unresolved (Bell 2007). Explanations for these anomalies vary, but it is likely that the employment of practice nurses by GPs, and the attitude of GPs towards professional development support have a direct bearing on nurses' access to whatever education and development resources may be available locally to them. Whilst provision of resources is undoubtedly an issue, this cannot be considered in isolation, as accessing them is still dependent on individual practice culture. The fact that such variation remains raises questions about the priority this is given by policy-makers and professional bodies that have published 'recommendations for good practice' rather than introduced effective measures for standardisation. It also raises questions about the level of empowerment amongst practice nurses, who when offered funded practical resources to support their development at a national level (Scottish executive 2004, WiPP 2006b) appear to lack the power to use these persuasively both at an individual and collective level.

The real nub of the problem would appear to be the lack of collective power and a representative voice that can articulate current priorities in an arena that influences national policy (Paniagua 2003). The political influence of practice nurses is weak in comparison to

GPs, which makes it easier for policy makers to continue not to pursue actively a collective agreement from GPs about minimum standards for employing practice nurses. However, there are undoubtedly disadvantages to both practice nurses and patients in neglecting to address these issues, with regard to ensuring safe high quality care. Historically, government has been reluctant to upset the balance of power held by GPs as they were the ‘gatekeepers’ in primary care and the NHS was dependent on their cooperation (Salter 1998). However, new medical regulation and revalidation procedures (RCGP 2012b) introduced since the Shipman Inquiry (DH 2007b) will also include Care Quality Commission (CQC) registration from April 2013. These developments balancing autonomy with responsibility may present a more favourable climate to lobby for centrally supported employment standards for practice nurses.

This chapter has highlighted the independent nature of practice nurse employment as a major factor in their access to role evolution support. It raises questions about the nature of regulation and supervision amongst this group and explores the effects that inconsistencies in standards may have on quality of care as well as implementation of policy. The wide variation in uptake of available development support also raises questions about motivation and empowerment amongst practice nurses and this is something about which there is sparse published research. Whilst the literature to date identifies many of the features in practice nursing associated with facilitating or obstructing role evolution, there is a paucity of literature exploring the underlying factors influencing these, particularly around practice nurses’ power to act. Given the political emphasis on increasing the role and responsibilities of this professional group, it is important to address this gap in understanding. These issues will be explored in more depth in the next chapter, in relation to the theories of power, professionalism and ‘segmentation theory’.

Chapter 2: Power and professionalism in nursing

2.1 Introduction

As discussed in Chapter 1, the model of direct employment of nurses by GPs is a departure from traditional organisational structures elsewhere in the NHS and this adds a twist to the power relationship between the two professions. This chapter examines power in nursing and its significance in relation to the general practice setting.

2.2 Professional power

The concept of professional power has its roots in the nineteenth century development of sociology as a science. It is not within the scope of this study to examine in depth the principles of sociological theories of power, but it is helpful to describe the main schools of thought. Power can be defined as *“the capacity to produce effects on others, change their behaviour or influence others”* (Daly et al 2004:58).

Wilkinson and Miers (1999) identify two basic forms of power, authority and coercion. Authority is considered to be legitimate power, accepted by those upon whom it is exerted, through status or knowledge. Coercion is the exercising of power that is not accepted as legitimate and does not therefore acknowledge the views or rights of others. Wilkinson and Miers refer to the concept of a ‘constant sum’ of power, where there is a finite amount to be shared and in order for one group to hold power, another must relinquish it. This was the view of Max Weber (1948), who also believed that power is held by people who use it to their own advantage, at the expense of others. Weber identified three types of authority in exercising power:

1. Charismatic, personal qualities which engender admiration
2. Traditional, based on ‘rightness’, maintained through loyalty and obligation
3. Rational-legal, according to a formal, impersonal framework

These categories have been developed and extended to include for example ‘expert’ (knowledge) and ‘referent’ (drawn from the strength of the relationship with followers) sources of power (French and Raven 1960) but most retain a link to these three principles.

In contrast to Weber, Talcott Parsons (1952) held the view that power was a ‘variable sum’ that fluctuates according to social and political change and is earned through merit. An extension of this theory was the basis for pluralism, which assumes that power is legitimately held by elites who have achieved their status through open competition. This is the system upon which western democracies are built and the central theme is participation in decision-making.

2.2.1 Power in nursing

Much of the literature on power in nursing tends to focus particularly on gender, medical domination and vocation. Oakley (1984) discusses the concept of power in relation to the dominance of groups. She explains that people who belong to subordinate groups tend to be socialised into a psychological pattern which emphasises dependency, passivity, subservience and thinking about others' welfare. Dominant groups on the other hand, develop qualities of independence, initiative, control, domination and putting their own welfare above others. The reinforcing effects of belonging to a powerless group make breaking out of it hard. Ponte et al (2007) discuss the abstract nature of power and the negative connotations associated with it for many nurses. They assert, however, that understanding power, seeking it and using it is critical if nurses are to shape their own practice and successfully influence the broader health environment.

During the period of early development in nursing in the late 19th century, power was a phenomenon associated with men. The suffragette struggle for political equality was not reflected in power sharing between nurses and doctors. In a description of the attempt to achieve recognition as a profession, Ruddy (1998) claims that the difficulties encountered were partly due to the majority of nurses being female. She discusses the late 19th century development of nursing knowledge and practice as distinguished by an “intuitive, experiential, silent knowledge” (ibid: 246) embedded in the approach that women of the time

brought to nursing. She asserts that the domination of nurses was total, depicting nurses as silent and powerless (Rutty 1998:246). The thought of nurses having any independence was dismissed by both doctors and politicians of the time. Indeed, during a House of Commons debate on the subject of the proposal for nurse registration in 1904, Sydney Holland, chairman of the London Hospital was scathing in his condemnation as it would lead nurses to consider themselves as belonging to a profession instead of simply carrying out doctors orders (Gamarnikow 1992:135)

This illustrates not only superior medical power but also the potential for nurses to pose a threat at some level, hence the need for control. Following the successful struggle by Bedford-Fenwick and her supporters (Nightingale not among them) the Nurses Act of 1919 resulted in the certification and registration of nurses in Britain through the General Nursing Council (Dingwall et al 1988). This was a significant development that allowed nursing to break away from medicine to an extent, determining its own educational requirements and standards for registration. However, the legacy of its roots were to dominate the culture and nursing developed in the early part of the 20th century as a military-style occupation, with rigid rules of conduct, discipline for misconduct and a religious moral code. Abel-Smith (1960) discusses the culture of fear in nursing in the 1920s where nurses' main ambition was to please their superiors. Autonomy and power were not even considered remotely relevant, as nurses were trained to be obedient. Jolley and Brykczynska (1995) and Gordon (1986) describe the early search for a nursing identity as characterised by servitude, male dominance and oppression. By the time the NHS was established nursing had assumed a traditionally subservient role to medicine and the concordat between doctors and the state ensured that it would remain so.

2.2.2 The road to 'professionalism'

Nursing accepted the pre-eminence of medicine without question and in return the government allowed it to develop a degree of autonomy and power within limits that did not threaten the medical establishment (Salter, 1998). Nurses were seen by government as the large group of workers who were responsible for supporting doctors in their task of maintaining the balance between demand and resource. As such, nurses were key

contributors to the success of the NHS but in a subordinate role. Whilst this status-quo remained unchallenged, the NHS established a career ladder of self-management for nurses in the Salmon management structure (Ministry of Health, 1966). Nurses were also granted self-regulating bodies controlling education, (the English National Board, (ENB), professional registration and conduct (the General Nursing Council (GNC), later replaced by the United Kingdom Central Council (UKCC) and in 2002, the Nursing and Midwifery Council (NMC)). However, this culture of political facilitation began to crumble with the emergence of a trend towards developing nursing independence and autonomy.

In the 1970s and 1980s when the feminist movement was at its height, nursing became increasingly preoccupied with shaking off the stereotypical image of the doctor's hand-maiden or 'angel' (Salvage 1982, Ehrenreich and English 1973) and developing a professional identity with more independence. Bridges (1990) discusses the perpetuity of these images in the media and the public mind, despite the rapidly changing role of the nurse. She explores the effect of these images on occupational reward, quoting Minghella (1983) as saying:

“The notion of vocation, self-sacrifice and philanthropic benevolence implicit in these stereotypes perpetuate the view that pay is irrelevant compared with the privilege and satisfaction of doing good for others. Any suffering which nurses experience actually adds to their virtue”. (Minghella 1983:46)

Kuokkanen (2000) suggests that the increasing range and complexity of nursing competencies and the expansion of the scope of practice can be seen as an exercise in promoting the position of women, contending that early protagonists of 'professionalism' were in fact feminists. Discussing the oppression of nurses, Kuokkanen describes medical power as being associated with status, control and authority. Many authors have noted the comparison made between nursing and 'women's work' (Salvage, 1985) and the predominance of supposedly maternal characteristics such as compassion and caring in describing the role. It was therefore inevitable that nursing would be strongly influenced by the feminist movement. Issues such as stereotyping and medical dominance became confused as feminist rather than professional issues, which was detrimental to the cause of professionalisation and did not

enhance its credibility. In contrast, Salter (1998) describes the subordinate status of nurses as simply being a direct result of their failure to establish a unique contribution to health.

Salter asserts that the attempt to shrug off this domination, to separate nursing from medicine and give it a pure identity and a professional power base was not welcomed by the state or the medical profession (Salter, 1998). He argues that equality of power could not be achieved in a health service in which doctors are legally responsible for care. As a result, he contends that this increasing pressure for independence had a significant impact on the relationship between nursing, medicine and the state. There was only room for one profession to be in control of the allocation of resources to patients and nursing could not be permitted to undermine the stability of the alliance between the state and medicine (ibid.). If nursing were to achieve an independent identity, separate from medicine, it would have a basis for negotiating a professional agreement with the state about the use of resources and the stability of the concordat between the state and medicine could be at risk. Government clearly would not support this. Salter's depiction of the division of professional power is stark but it does explain the political argument for appearing to protect the dominance of one professional group over another.

Nursing was therefore constrained in a variety of ways. Reforms following the Griffiths Report (DHSS, 1983) removed nurses from senior management and replaced them with non-clinical staff. This was followed by the dissolution of the ENB, with regulation of education standards passing to the UKCC and education funding passing directly from the Department of Health to Regional Education Consortia to purchase nurse training locally. This fragmentation of the national bodies diluted the institutional power base of nursing.

2.3 Power in organisations

Power is an aspect of management and leadership and derives from a variety of sources. Daly et al (2004) contend that those leaders who rely on expert or referent power where their staff also feel able to influence them have the most motivated and successful teams. Handy (1993) describes a range of 'style' theories in leadership and management ranging from autocratic to democratic, derived from categories coined in the 1960s as autocratic, paternalistic,

consultative and participative (Likert 1961, Harbison and Myers 1964). This spectrum identifies the degree to which leaders include their staff in decision-making and how much they delegate or hold onto it themselves. This is related to but distinct from culture, which involves a set of norms that govern the way an organisation operates. Handy (1993) describes four cultures:

- Power culture – often entrepreneurial with a strong central locus of power exercised by key individuals who communicate outwards
- Role culture – often referred to as a bureaucracy, with pillars of functional role determining how staff operate
- Task culture – adaptable flexible project-based approach with integration across individuals and teams
- Person culture – a group of individuals who work together because it serves their own interests but have an independent focus

Matching leadership style with organisational structure and culture creates an interplay that can enhance effectiveness or cause conflict if there is a mismatch. If, for example, a manager works in an organisation that has a role culture which is usually associated with a formal power hierarchy and their leadership style is consultative, staff may feel confused about how decisions are made. Similarly, a group of individuals used to working in a person culture would find it difficult to adjust to being employed by an organisation that is bureaucratic and requires vertical communication in a formal, centralised system.

2.3.1 Power and decision-making

Power and decision-making are closely linked and this is central to the relationship between nursing and medicine. In exercising professional power, decision-making is used as a form of asserting authority. Political scientists have identified several approaches to power-oriented decision-making. The approach most relevant to this research is ‘professionalism’ defined by Parsons (1995) as a process whereby “*professional elites acquire power in decision-making and the implementation of public policy*” (Parsons 1995:248)

2.3.2 Professionalism

Membership of a profession is considered to confer status and power (ibid). Despite strenuous efforts to define and refine the concept, it remains difficult to make an unambiguous assertion of what constitutes a profession. As Bilton et al (1987) and Traynor (1987) suggest, most people are fairly clear about which occupations they would consider to be a profession, but vague about the attributes that make them so.

Jolley (1989) describes two broad sociological approaches to the concept of professionalism; the 'trait' approach and the 'functionalist' approach. The trait approach defines professionalism in terms of a list of characteristics or attributes. The functionalist approach adopts the view that to be a profession, an occupation must have characteristics of functional relevance to the client or society. One of the earliest protagonists of the trait theory was Abraham Flexner. In his study of social work he identified six characteristics (Flexner 1915). He suggested that a profession is:

- basically intellectual, carrying with it high responsibility
- learned in nature, because it is based on a body of knowledge
- practical rather than theoretical
- in possession of a technique that can be taught through educational discipline
- well organised internally
- motivated by altruism

Flexner's trait theory was an example of the reductionist, scientific approach, reducing a concept to measurable component parts and he suggested that occupations could become a profession by developing those traits that they lacked. This theory has weaknesses and as Hugman (1991) points out, it is limiting and circular. Professionalism is far more than a checklist of traits devised by analysing acknowledged professions such as medicine, and this is a rather crude method of measuring something that has intuitive elements and is essentially experiential. Sociological factors including tradition, gender, power, education and role modelling all contribute to establishing a profession and each has an influence and relationship with each other. Hafferty (2006) defines medical professionalism as a

combination of these producing a 'self' that is in accordance with the values and contractual duties that medicine has with society.

Despite the limitations of Flexner's trait theory, it became the sociological standard for defining professionalism (Wuest 1994) and was refined and adapted by later theorists (Larson 1977, Freidson 1983). In a meta-analysis of the subject Moloney (1986) presents a matrix of characteristics suggested by some of them. Most identify the importance of a unique body of knowledge, control over their own education and autonomy in practice and these principles became central to the process of professionalisation in nursing.

More recent debates have focused on attitudes and behaviour, which represent "levels of identification with and commitment to a particular profession" (Wynd 2003:252). These behaviours are developed through a process that begins with formal entry-level education (Hafferty 2006) and continues through a socialisation process associated with work experience and role modelling (Traynor 1987, Castledine 1998, Ruddy 1998). Wynd (2003) measured levels of professionalism in nursing using the Professional Inventory Scale developed by Hall (1967), which identified five attitudinal attributes. These are: use of a professional organisation as a reference point for practice, belief in public service, autonomy, self-regulation and a sense of vocational calling and dedication. A Likert scale measured nurses' responses to a list of statements, with the highest score indicating a high level of professionalism. The highest scores were found in nurses who had most experience and belonged to a professional organisation. This contrasted with Hall's original findings where a high professionalism score was associated with belief in public service and a sense of calling. Wynd discusses these findings in the context of social and political change, commenting that belonging to professional organisations is central to professionalisation because they enhance the power of the group, which is important if legislative change is to be achieved.

This relationship between power and professionalism is a recurrent theme in the literature and one that Ponte et al discuss in depth.

“Having power allows nurses to guide nursing practice and function as professionals: when power is absent or not utilised, others are more likely to step in and decide what nursing is and what nurses do”. (Ponte et al 2007:1)

One of the effects of establishing nursing as a profession was therefore seen as increasing power and this was pursued in both the clinical and educational arenas. In order to achieve credibility in this quest, nursing first had to clarify its own unique contribution and identity.

2.3.3 Practice and professionalism

The role of the nurse was most clearly described by Virginia Henderson in her ‘definition of nursing’:

“The unique function of the nurse is to assist the individual, sick or well, in the performance of those activities contributing to health or its recovery (or a peaceful death) that he would perform unaided if he had the necessary strength, will or knowledge.” (Henderson 1966:15)

Henderson identified 14 activities of daily living, which were later adapted to 12 activities of living by Roper, Logan and Tierney (1983) and are used in the assessment of a patient’s nursing care needs. Assessment is the first step in the ‘Nursing Process’, an American system of care based on nursing assessment, diagnosis, planning, implementation and evaluation of treatment (Orlando 1961). This system has been widely used in nursing for decades, in conjunction with a variety of nursing models designed to allow for individualised, holistic nursing care (Pearson, Vaughan and Fitzgerald 2001).

Keogh (1997) asserts that the existence of these nursing theories fulfils the criterion of a unique body of knowledge, yet he concedes that other professions, including medicine, were not convinced. This reliance on external confirmation of the achievement of criteria is symptomatic of the power differential. The medical response to the introduction of nursing theories and models of care was not enthusiastic. While the Royal College of Nursing took the view that doctors and nurses must both recognise that their goals for a patient may differ or even conflict (RCN 1981), the view of one doctor expressed in the British Journal of

Medicine was that a nurse and a doctor could not both be 'in charge' of a patient (Mitchell 1984:219). There was resistance to the idea that nurses should be making an independent assessment of the patients' needs as it might conflict with a doctor's plan. The issue of being 'in charge' seems central. Degrees of autonomy and accountability are elements of practice that appear to be stumbling blocks for nurses in achieving credibility as a profession.

Expansion of the scope of nursing practice (UKCC 1992) as a response to changing healthcare needs, medical advances and economic priorities resulted in the development of roles such as nurse practitioner and the advent of nurse prescribing. Whilst expanding the expertise and knowledge base of nursing, these initiatives could, nevertheless, be considered cast-offs from medicine and therefore not unique to nursing. It has been argued (Chiarella 1998), that with advanced nursing practice there is a blurring between nursing and medical knowledge and practice. This trend continues with the increasing delegation of medical tasks to nurses and the creation of new roles such as nurse consultants, which would not appear to be helpful in defining a clear sphere of nursing practice in terms of developing recognition as a profession. This lack of clarity around the boundary between medical and nursing practice impedes progress in defining accountability for decision-making and autonomy. These are acknowledged elements of professionalism, yet it could be argued that the true exercising of nursing accountability and autonomy may be more achievable at the bedside, where nurses can make independent decisions about nursing care, based on experiential knowledge. This seems a perverse incentive for career progression and role development.

2.3.4 Education and professionalism

As previously mentioned, an obstacle in achieving professionalism has been the perception held by some that nursing shares much of its body of knowledge with medicine and cannot therefore claim to have unique knowledge, or a genuinely 'professional' status. However, as Lorentzon (1992) points out, this seems a rather spurious argument, as education programmes for all health professionals include much of the same knowledge drawn from biological and social sciences in varying degrees. It is in the area of technical skills that the professions differ and nursing has unique skills just as medicine does.

Nevertheless, nurse education was seen as a means of enhancing the process of professionalisation and there was a general acceptance that a reform of education programmes was long overdue (Spinks 1994). There was a view (Salvage 1985) that nurse training had remained essentially unchanged since the General Nursing Council held the first state final examinations in 1925 and there were concerns about whether the training was a meaningful preparation for the current role of the qualified nurse (Davies 1995). Salvage argued that the syllabus was dominated by medical knowledge and students' educational needs were secondary to their value as cheap labour. Whether this was a reflection of the general negativity felt by nurses about their profession is debatable, but it was clear that there was a growing groundswell of support to reform nurse education and move towards a graduate programme. The UKCC 'Project 2000' diploma programme (UKCC 1986) and subsequent graduate and post-graduate programmes have undoubtedly raised the educational standard of nurse preparation. However, some would argue that these programmes did not adequately resolve the issue of 'meaningful' preparation with commentators noting that students did not always seem to recognise the sum total of their knowledge and skills adding up to being a nurse (Jolley and Bryzyska 1995). Some were of the view that training had become too academic and that this detracted from the true essence of nursing. As McLeod (1996) lamented;

“Practical knowledge has a much lower value than formal knowledge. Knowledge which is practical, intuitive and experiential has lost ground in nursing to knowledge that is more scientific and theoretical.”

(McLeod 1996:20)

Again, there seems to be a tension between advocates for professionalism and the values of 'traditional' bedside nurses. However, the very fact that education programmes are validated and approved by the NMC, a statutory body required to ensure programmes prepare nurses that are 'fit to practice' nursing in accordance with the Code of Conduct (NMC 2008), is significant in terms of defining nursing as a profession.

2.3.5 The argument against professionalism

Taking a patient centred approach, Rutty (1998) makes the point that the arguments put forward in support of professionalism often seem at odds with the philosophy of nursing. The

drive to achieve control over knowledge and practice and to increase autonomy is not, she suggests, necessarily in the best interests of patients' health. The eagerness to achieve power and recognition has created a purpose that seems rather removed from achieving clinical excellence. Salvage (1985) also identifies several problems with the concept of professionalism. She suggests that the quest for professionalism encourages nurses to focus on their status rather than the needs of their patients and relatives. Both of these arguments reveal an apparent confusion about the differences between professionalism and elitism, as the essence of being a professional should be about public service (Wynd 2003). Salvage (1985) claims that professionalism encourages nurses to have a uniform view and 'one voice', which may not be representative of the spectrum of roles in nursing. She also argues that it is a narrow approach, which does not challenge the status quo but merely tinkers at the edges.

Wuest (1994:365) claims that professionalism has failed to bring nursing the "power and prestige" that were anticipated by its protagonists. Wuest analyses professionalism from a feminist perspective, arguing that professionalism is a "patriarchal invention" that alienates women. She argues that in the quest for professionalism, elite educators and leaders who wielded the most power in nursing endorsed the dominant patriarchal structure of medicine rather than reflected the lived experience of bedside nurses. She suggests that feminism has much to offer nursing, as it challenges patriarchal systems and encourages women to take a more active role in altering social structure. It could, however, be argued that viewing nursing as a feminist struggle is to reduce it to exactly that which Salvage describes; a personal mandate rather than patient focused, thereby making the approach incompatible with professionalism.

2.3.6 The 'new' professional

Theories of professionalism have become less relevant as government has been advocating for a long time that health professionals should adopt a corporate approach to care that challenges the continuation of separate professional identities and enhances coordination and collaboration in care (DH 1990, DH 1997, DH 2000, Curry and Ham 2010). This is supported by Stacey (1992) who proposes a move towards a 'new professionalism', built on openness and co-operation between health professionals and patients. Stacey argues that the

control and power of doctors can be moderated by surrounding them with a collection of other players with decision-making powers. Richard Hugman's (1991) vision was for a 'democratic professionalism', which is based on a more equal relationship between professionals and service users and which challenges the boundaries between the caring professions. He argues that professional hierarchies and boundaries result in the caring professions being set in competition with each other to the disadvantage of themselves and their patients. Davies (1995) develops this theme by identifying characteristics of the 'new practitioner'. These include being inter-dependent rather than autonomous, being a reflective user of experience and being a creator of an active community in which a solution can be negotiated. These characteristics are a reflection of the shift in our society towards a community where people and professionals have shared rights and responsibilities. The relationship between this societal change and 'new professionalism' is still under debate (Scott 2008). However, it is clear that a society which promotes equality and collaboration as core values should empower nurses to negotiate and influence the way their work is defined and managed.

2.4 Empowerment

Empowerment is defined as a positive concept concerning power, associated with growth and development requiring critical introspection and changing patterns of activity as a consequence (Kuokkanen and Leino-Kilpi 2000). The literature on empowerment explores a range of foci. Foucault (1980) believed that power is not a fixed entity in itself but is manifest in every personal interaction and is strongly related to knowledge. Kuokkanen and Leino-Kilpi (2000) describe three distinct theoretical approaches to empowerment and these are considered in relation to this study.

2.4.1 Critical social theory

This approach holds that certain groups are subordinate in terms of power and are dominated and oppressed by those who hold power, being liberated only when others relinquish control over them (Fletcher 2006, Bradbury-Jones et al 2007). This theory has its roots in a Marxist philosophy of social deprivation and is often discussed in relation to disadvantaged minority groups linked to ethnicity, gender and social class. Litovitz (2000) describes another more

subtle domination in professional practice that is invisible and consensual. He discusses the concept of 'hegemony', a Greek term originally meaning the supremacy of one state over others. Litovitz presents Gramsci's development of hegemony theory whilst imprisoned for political activity (Hoare and Nowell 1971) as a process whereby a submissive group is dominated through the acceptance and internalization of a dominant group's doctrine. Gramsci articulated the two elements of this; force and submission, as a process of domination resulting in legitimate leadership. Critical social theory has been used to illustrate medical hegemony, with the predominantly male, middle-class medical domination of nurses and the horizontal bullying it can produce between nurses (Fletcher 2006).

2.4.2 Organisational and management theories

Kanter (1977) believed that structural elements of an organisation were important determinants of empowerment and that the necessary conditions included opportunity, resources, information and support. She identified two forms of structural power in an organisation:

- Formal – acquired through high performance and achievement
- Informal – gained through social networking and alliances

The degree of formal and informal power held will influence accessibility to the conditions (opportunity, resources, information and support). Studies conducted since have tested the application of Kanter's theory, demonstrating the positive effects of creating an empowering workplace (Laschinger et al 1997, Sarmiento et al 2004).

2.4.3 Social psychological theories

These theories hold that empowerment is generated at an individual level through personal behaviour and related to positive self-identity, beliefs and motivation to act.

Manojlovich (2007) proposed that 'relational theory' is the key to addressing powerlessness in nursing. She suggested that nurses need to control 'what' they do, 'how' they do it and the educational preparation to achieve competence in order to have power. This is strongly linked, she contended, to fostering reciprocal nurturing professional relationships in the workplace.

Knol and Van Linge (2009) examined the effects of structural and psychological empowerment on innovative behaviour and found that psychological empowerment is a mediator through which informal structural power could influence innovative behaviour; therefore the two elements are synergistic when both present.

Personality was also determined as having a bearing on how empowerment was developed. This was explored by Spreitzer (1996) who described the interaction between personality and environment as shaping four cognitive processes related to developing empowerment;

1. Congruence between beliefs, values and the purpose of the job – ‘meaning’
2. Ability to do the job well – ‘self-efficacy’
3. Control over one’s own job – ‘self-determination’
4. Impact of contribution to the organisation

Bradbury-Jones et al (2008) offered a fourth theoretical approach based on Foucault’s position (1980) that power is not fixed and can be transferred from different people according to conditions, such as knowledge held and this can be used to regulate their conduct. Bradbury-Jones et al described the ways in which nurses and other ‘disciplines’ can become normalised into believing that they have no power due to the position they hold but that this can be overturned through questioning the validity of ‘knowledge’ in certain contexts as being superior to truth. They postulated that in this way, nurses could challenge decision-making power by presenting facts rather than displaying knowledge.

2.5 Power and professionalism in general practice

In general practice, the dominance of doctors over nurses is more overt than in NHS organisations, as the traditional hierarchy, established through knowledge and legal accountability, is further emphasised by the status of the GP as employer. This gives the doctor direct responsibility for delegating, supervising and ensuring the competence of the practice nurses. By accepting this employment situation, practice nurses recognise that doctors are the holders of professional power. As previously argued, this professional use of

power seems at odds with cultural changes in the wider NHS and this may result in tension. This has important implications for the development of practice nursing as a career pathway.

Despite earlier suggestions that the professional partnership between GPs and practice nurses is not the best use of NHS resources (Cumberlege 1986) it has endured and seems to be a successful combination. Practice nurses appear to be comfortable being employed by doctors, accepting them as senior in terms of status and power. The culture has been described as paternalistic (Maslin-Prothero and Masterson 2002) with the GP delegating work to the nurse and providing her with rewards. However, there are mutual benefits with this arrangement. This close working creates a collaborative approach to providing a service, with a flat management structure and small team resulting in low waste and maximum efficiency. This allows general practice to be very responsive to the population's health needs. New initiatives can be set up very quickly, for the benefit of patients. The practice nurse generates income for the GPs and is rewarded with a working environment that has benefits such as attractive working hours, freedom from bureaucratic organisational structure and a degree of autonomy. The arrangement works well for both parties. The evolution of nursing and its relationship to medicine are complex processes, which have resulted in a firmly established tradition of hierarchy, a deep-rooted tradition that has heavily influenced the dynamics of the GP, practice nurse relationship. Practice nurses seem willing constantly to adapt their role to accommodate new policies and structures. The question is, whether their employment within general practice is sustainable and appropriate in the NHS of today and the future, which is increasingly focused on cost-effectiveness and quality. It could be argued that the current employment arrangements cannot reliably provide nurses that are competent and deliver high standards of care.

2.5.1 The policy perspective

As a publicly funded organisation, the NHS has a duty in terms of probity and quality of service (DH 1997). Public safety must be a priority and therefore all contracts the NHS enters into with providers of service must specify the standards required and their monitoring process. General practitioners are contracted to the NHS and must therefore demonstrate that the service they provide meets the required standards, and this should include staff in their

employment. Whilst there are many methods in place for rewarding good performance in general practice, including the new GMS Quality Outcomes Framework and clinical governance, few of these relate to conditions of staff employment and this area remains one that is difficult to monitor and influence.

In terms of service provision, it could be argued that there may be overlaps and duplication in care provision between practice nurses and other primary care staff, which is perpetuated by their separate employment and is not the most efficient skill mix. Similarly, restricting nursing staff to working in very small teams within one practice is not the most cost-effective model.

In terms of political risk, if practice nurses are becoming increasingly central to the implementation of NHS primary care policy, it may be imprudent to leave them working outside NHS organisations where they cannot be directly influenced and managed. However, altering this arrangement would necessitate government challenging the GP power-base, something which carries an element of risk in terms of potential consequences, as GPs remain the major gatekeeper to the NHS.

2.5.2 The professional perspective

From the practice nurses' position, questions arise about how far they can develop whilst employed by GPs who will only require developments that support their business plans. This is always going to be an issue for the nurses, as their own ambition must be compatible with the priorities of the practice where they work. All NHS organisations require nurses to plan their continuing professional development in conjunction with service need (DH 2002), but the scope and opportunities for this will be greater in a larger organisation than in general practice.

Another professional issue is how firmly established practice nursing is in terms of retaining a clear 'nursing' identity in a medically driven practice. As previously discussed, services are developed primarily by GPs and they delegate work to the practice nurses, which raises questions about how influential nurses are in shaping and 'owning' their professional role.

Models of care in general practice tend to focus around medical ‘consultation’ models such as the Calgary-Cambridge model (Munson 2007), which was specifically written for doctors.

Practice nurses have been adaptable and flexible in their role, accommodating change even though it sometimes creates tension for them between their employers’ requirements and their philosophy of care (Harston 2005). It would seem plausible that at some point the positive aspects of working in general practice might be outweighed by constraints. If practice nurses are required to make changes in their work that result in disadvantages rather than benefits, or begin to conflict with their core nursing values it could produce considerable tension between them and GPs. If this were to happen, practice nurses might feel motivated to explore alternative employment choices where they have more influence.

Various alternative models have been explored in pushing the boundaries of development (Cook 2005, Young 2006, Duffin 2006):

1. Practice nurses become partners in general practice, sharing responsibility for business planning and financial management.
2. Practice nurses work for Alternative Providers of Care, private health organisations, which may cover a large geographical area. There would be more emphasis on multi-disciplinary working, and practice nurses would have to adapt to a different culture, which would be very much unknown territory.
3. Practice nurses work independently or in teams and directly provide services under contract to the PCT. This could be on the basis of an Alternative Personal Medical Services (APMS) agreement running a nurse-led service or under Social Enterprise or Community Interest Companies, (Young 2006) where staff own the organisation and all profits are reinvested in the development of the company. There is more risk involved in this model and less job security but also autonomy to design and deliver their own service and potential for the development of leaders.

These proposals represent options potentially available to practice nurses, depending on their level of motivation and empowerment. Practice nurses seem to be facing a dilemma: the consequences of either remaining in their traditional role, or of embracing the challenge of

new roles, possibly outside General Practice. In order to transform this dilemma into an opportunity practice nurses would need to feel empowered. Supporting and facilitating that process would require a deep understanding of what influences their decision-making and of what would be necessary to liberate them to make free choices about their professional future.

One factor in their interpretation of potential opportunities is practice nurses' individual personality characteristics. In order to gain deeper insight into their responses to these opportunities and to understand their ability to influence any of them, the concept of 'segmentation theory' (Dent and Burtney 1997) will be explored as a way of making distinctions between different 'types' of practice nurse.

2.6 Segmentation Theory

Professional segmentation was a concept introduced by Bucher and Stelling (1977) which was further developed and refined by several later theorists. The essence of the concept was that within all professional groups there are 'segments' or sub-groups made up of members who share particular characteristics distinct from other 'segments'. This theory was further developed by Carpenter (1977), whose work explored the effects of the Salmon Report (Ministry of Health 1966) on nurses' career progression and management hierarchy. Carpenter discussed the introduction of a management system that was radically different from the traditional role of the matron and resulted in the development of a new career pathway where the rewards grew greater the further the managers became removed from clinical contact. This in turn resulted in frustration in the clinical environment, with senior staff resentful of managers who were "*ignorant of the complexities of the ward situation*". Carpenter (1977:185)

There was therefore growing support for the creation of more senior clinical roles, with the advent of nurse consultants or specialists who had advanced education and clinical expertise. Carpenter was critical of this development and saw it as divisive, providing reward and job satisfaction for a minority of senior clinicians and managers, with the rest of the workforce left to do the more menial tasks. However, this could be seen as devaluing the role of the bedside nurse, which remains the focus of meaningful patient interaction upon which the

whole philosophy of nursing is based. Carpenter (1977) identified three segments within nursing: basic nursing which he termed 'rank and file', clinical specialists he termed 'new professionals' and professional managers who were the 'ex-nurses' he termed 'new managers'.

Melia (1987) further developed the theory of segmentation but had a very different perspective. It was her belief that the removal of nurse training from the hospital environment into colleges of education following the Briggs Report (Ministry of Health 1972) created a sharp division between pragmatic nurses in the clinical environment and ideologists in education. She explored the difficulties faced by student nurses who straddled both cultures and had to learn how to behave differently in each. Melia (1987) therefore proposed that there were two major segments in nursing: education and clinical. Within the clinical segment she placed Carpenter's three categories and added a fourth under the education segment, which she termed the 'academic professionalisers'.

Dent and Burtney (1997) describe how these categories related to nursing roles. New managers arose out of the Salmon Report (Ministry of Health 1966), which created a management structure for senior nursing staff. New professionals are based on the American model of clinical nurse specialists and nurse consultants, and generally have an enhanced clinical role. The rank and file nurses are the vast majority of nursing staff who are happy to accept delegated work from medical staff and have no particular professional ambitions. The academic professionalisers are nurses who sought autonomy for nursing through an educational route based on nursing theory. Dent and Burtney argue that these divisions remain relevant as distinctions between various nursing roles and aspirations within both primary and secondary care settings.

Dent and Burtney carried out a study in general practice (1997), interviewing primary care staff about the role of the practice nurse, the effects of political change on their work and on nurse professionalism, their education needs and their views on the future of practice nursing. They found that the role, responsibilities and aspirations of practice nurses fell broadly into

four categories that closely matched the segmentation groups, and they termed these the ‘rank and file’, ‘extended role’, ‘enhanced role’ and ‘coordinator role’.

Extended role (practice nurse 1)

These nurses show an interest in expanding their role, taking on more delegated work from the GP and actively engaging in a process of professional development that could more clearly define their role and lead towards more autonomous practice.

Rank and file (practice nurse 11)

The nurses in this segment are described as practice nurses who passively accept the doctors’ definition of their role and are not interested in actively engaging in a process to pursue a distinct professional identity. They are interested in maintaining a traditional role and have no real interest in concepts such as autonomy.

Enhanced role (nurse practitioner)

This segment is characterised by nurses who have undertaken post-graduate study to achieve autonomous practice typified by the nurse practitioner role. They will be working at the top of the clinical ladder, in a senior position with a clear clinical role.

Coordinator role (manager)

This is described as a managerial role, where the nurse enjoys the challenge of managing teams and influencing strategic planning rather than advancing clinical skills.

There is currently a confusing array of nursing job titles and it is not always immediately obvious how they translate into working practice. Definitions such as ‘specialist’ and ‘advanced’ have different connotations in different settings (Bartlett 2004) and whilst the governing bodies may be close to agreeing definitions, job titles do not always accurately reflect this. Does a ‘specialist’ nurse necessarily have a specialist practitioner qualification? Terms such as ‘nurse consultant’ and ‘maxi-nurse’ (RCN 2005) are also less than clear and even nurse practitioners do not all have a common level of education (Carr et al 2005).

Segmentation theory focuses on role rather than titles, which makes it easier to transfer to different settings and it seems to describe the range of roles in general practice well.

2.7 Using segmentation to explore practice nurse motivation

The literature has shown a great variability in resources available to practice nurses but also suggests that even when access is good, practice nurses as a whole do not always use opportunities for development and they tend to be compliant, adaptable and reluctant to alter the status quo. This would suggest that the majority of nurses fall into Dent and Burtney's (1997) rank and file category and are therefore unlikely to respond to new opportunities for progression. If this is the case, then these nurses are not likely to be influenced particularly by further enhanced opportunities but they do need to engage with support to maintain their competence and ensure safe practice. This should therefore be reflected in the design of professional development programmes for this group, whose professional priorities are just as legitimate as those with more ambitious goals.

For those nurses that fall in the category of extended role, a robust education and career framework within general practice should be available, to enable their progression. If they are interested in actively engaging in acquiring qualifications and experience to extend their scope of practice, opportunities for this should not be dependent on either geographical location or GP attitude, but should be a choice available to all practice nurses.

Nurse practitioners have been a feature of general practice for 20 years (Harston 2006) and although the definition of their role is continually being refined, they have become a valuable asset in primary care. Their determination to achieve an enhanced role in nursing may make them more assertive and articulate in voicing their professional development needs and there is a view expressed by some nurses that nurse practitioners are seen as more important (Carr et al 2005). The blurring between nursing and medical roles at this level of practice should be guarded against, with support for nurse practitioners to retain a patient-focused nursing identity.

Nurse managers, in the 'coordinator role', are likely to have increased in number as the size of nursing teams has grown. These nurses should have access to appropriate management training to make them effective in the role. As there is no universal nursing structure within general practice, it will be up to individual nurse managers to negotiate the boundaries of their role and adequate preparation and support to carry it out effectively.

In addition, there is a very small group who are quite entrepreneurial in spirit and enrol on leadership programmes, set up nurse-led initiatives or become nurse partners (Cook 2005). As this group of nurses has evolved due to political change creating new opportunities for primary care nurses, a new segment could be added, entitled 'entrepreneurial role'.

If one accepts the premise that these 'types' of nurses exist and are stable representations of the practice-nursing workforce, then planning for education and career frameworks can be designed with this in mind, to optimise performance at all levels. The overriding concern must be to ensure that whatever 'types' of nurses are employed within a practice, public safety is maintained and standards of care are up to date and of a high quality. These things should not be dependent on nurses' attitudes to their own development.

2.8 Conclusion

The first two chapters have described the emergence and subsequent development of practice nursing, which encompasses a broad spectrum of nursing activities and a diverse range of roles or 'segments' (Dent and Burtney 1997). These segments describe different categories of nurses whose attitudes towards professional development and engagement in opportunities for career progression vary. Questions are raised about the level of empowerment amongst practice nurses. The literature highlights widespread disparities in the provision of resources to support practice nurses but the reasons for these anomalies, their effects on practice nurse career development and standards of care remain largely unexplained. This study explores these issues by examining the various roles in general practice nursing, highlighting the availability of professional development to support them and seeking possible explanations for the disparities. The next chapter outlines the methodological approach used to conduct the research, which has two parts; a survey and a case study.

Chapter 3 - Methodology Part 1: The Survey

3.1 Introduction

The previous two chapters described the context and theoretical framework within which the study is set and gave some preliminary signposts to the professional challenges and opportunities for practice nurses, particularly around issues of empowerment to shape the development of their role. This chapter introduces the methodological framework for the study, firstly from a theoretical perspective and then as applied to the two stages of the research project.

3.1.1 Definition of terms

For the purposes of this study, the term ‘professional development’ will refer to the active process undertaken to enhance skills and knowledge to ensure that professional practice is informed by sound, current evidence. The term ‘resources’ will refer to any medium that provides learning opportunities such as educational materials, research based evidence, conferences, clinical guidelines, frameworks and standards. ‘Support’ denotes facilitation to access development, whether financial or practical.

3.2 The Research study

3.2.1 Rationale

The literature highlights many unresolved issues of inequality in relation to the employment and professional development of practice nurses and provides no solutions as to how these can be tackled. There is recognition that professional development is a crucial aspect of maintaining the status and credibility of nursing as a profession (Happell 2004, Whyte et al 2000). There is widespread agreement about the need for effective professional development support as a way of maintaining competence and therefore ensuring the highest standards of care (UKCC 1996, DH 1998, DH 1999b, RCN 2005b, Happell 2004, Hyde et al 2006, DH 2007, Sheikh et al 2007). This is the professional responsibility of all registered nurses (NMC 2008). However, there is evidence of poor access to the support required to maintain professional development and barriers such as financial and organisational issues have been

identified (Sherlock 2003, Longbottom et al 2006, Happell 2004). The underlying reasons for these persistent inequalities warrant investigation, as there may be implications for the quality of patient care. Despite the fact that NHS primary care policy has promoted the professional development of nurses in general practice and local and national frameworks providing recommendations on appropriate support for professional development have been introduced, there are persistent problems around access and equity (Bell 2007, Corbett 2004, Gray 2006). This raises questions about the factors that may be contributing to these problems.

It seems clear that organisational factors within general practice are likely to have an effect on whether or not nurses access professional development support. However, there may also be more subtle factors that are equally influential but less easy to identify. If resources are in place but nurses do not use them, it is possible there may be behavioural features associated with access. The variability in access to resources may be attributable to the attitude of the GP employers, but it could also be due in part to the attitude of the nurses. The literature suggests reluctance amongst practice nurses to seize development opportunities, particularly if they perceive a risk to maintaining the status quo with their GP employers (Paniagua 2003, Thompson 1999, Crossman 2006). This suggests a lack of motivation and empowerment in some nurses. If there is an attitudinal component related to accessing professional development resources, this may improve our understanding of the factors affecting uptake of opportunities. Taking this into account may help to enhance the design and success of professional development programmes by making them appeal more to those nurses reluctant to engage with role development opportunities. This in turn may contribute to maintaining high levels of professional competence, thereby enhancing quality and safety in patient care.

3.2.2 Aim

The aim of this study was to explore role definition and evolvment in practice nursing in the UK. Two research questions were posed:

- What factors affect practice nurse role evolvment?
- How do these factors affect practice nurse role evolvment?

3.2.3 Research Objectives

In order to answer the research question, the over-arching objectives of this study were to:

1. Investigate how practice nurses, GPs and managers view the practice-nursing role;
2. Explore the availability of appropriate professional development support for the various practice-nursing roles;
3. Investigate the factors perceived by practice nurses, GPs and managers as influencing practice nurse access to professional development resources;
4. Explore any relationships between ‘types’ of nurse such as those identified by Dent and Burtney (1997) and access to professional development resources.

Decisions about research design were made following consideration of the data being sought to achieve the research objectives. Careful consideration of about methodology is a critical step in the research process as *“The quality of the data is only as good as the quality of the measurement process”* (Bowling and Ebrahim 2005:422)

The data collection requirement to meet these objectives necessitated two distinct approaches. The choice of methodology for the first stage of the research process was based on the fact that preliminary information about the topic was required to provide evidence for the investigation. This was an important starting point, to identify the fullest possible range of issues associated with role development support and to highlight predominant themes giving a focus for further inquiry. The literature review established that at the commencement of the research there was no current comprehensive information available on practice nursing roles and the availability of professional development to support them, and it was therefore necessary to obtain this as a first step. To achieve objectives one and two, data were required across a broad spectrum of different employment situations, to include variations in role and qualifications: practice type; location and size; employment conditions; and the availability of resources across different parts of the country. These requirements for wide, varied and factual data from a large dispersed population were well met by conducting a survey. The data would highlight predominant themes and provide information about factors related to professional development, giving a focus for further investigation.

The purpose of the second stage of the research was to discover factors that might be related to role evolution, explore possible relationships between them and seek explanations about them. The second stage therefore had a different emphasis from the first and was only possible after the first stage provided the framework for investigation. The two separate stages were therefore closely inter-related. Both were necessary to answer the research question as the second built upon the foundations laid by the first.

The second stage of the research process required data of a complex and detailed nature from a variety of perspectives about a discrete set of phenomena relating to one professional group. This stage was characterised by a need to seek deeper understanding using multiple data sources, with the potential to create a diversity of interpretations and explanations, thereby providing a full exploration of the issues. Participants of this stage of the research process would be asked to comment on the findings of stage one, giving possible explanations that could provide a deeper insight, providing their interpretation of the issues identified and the influences affecting them. The data requirements for this stage fit well within the case study methodology and this was the approach used.

The methodological framework for the first stage is discussed below, before being applied to the implementation of the survey. The methodology for the second stage will be discussed in Chapter 5 after the presentation of the survey results.

3.3 The Survey

3.3.1 Introduction

The survey is a research method used to describe characteristics of a section of the population at a particular time (McQueen and Knussen 2002, Fowler 2009). Robson (2011) defines a survey as

“A collection of standardised information from a specific population...with no attempt to manipulate variables or control conditions or introduce change”

(Robson 2011: 49)

The typical survey is passive in that it seeks to capture a picture of ‘how it is’ rather than to introduce change and it provides descriptive information at one point in time. It is an effective tool for providing a ‘marker’ or gauging levels of occurrence of a particular phenomenon (Robson 2011). The data it provides are, however, restricted to the issues covered by the questions asked and are therefore comparatively superficial in nature and not adequate for developing explanations and building theories (Yin 2008, Robson 2011).

In designing a survey, the researcher needs to have a clear idea about what they are looking for, in order to ask the right questions. It is therefore crucial that the research question is clearly articulated. There should be a sound understanding of the contextual issues and decisions must be made about the range of topics to be included, the type of questions and ways in which participants will be able to respond (McQueen and Knussen 2002). Sapsford (1999) describes the process of survey design as very structured, involving a clear understanding of the type of answers needed from the sample to address the problem or question under investigation. He argues that whilst this may seem as if the researcher is anticipating the results before carrying out the research, it is in fact essential if the data collected is to have any value as evidence. Whilst being a comprehensive method in its own right, the survey can be a useful precursor to more detailed research, by confirming whether or not certain characteristics are in fact present and providing evidence to justify further investigation (Fowler 2009).

3.3.2 A brief history of the survey

The survey evolved as a means of gathering information from a population during the industrialisation of society in the late eighteenth and nineteenth centuries, at a time when the population became a potential resource as a workforce (Sapsford 1999). The earliest type of survey is the census, a systematic effort to count an entire population usually for the purposes of taxation (Groves et al 2009). The British Census, probably the best known use of survey in this country, has been carried out every 10 years since 1801 and has provided complete national descriptive data on age, gender and occupation which have been used to analyse societal trends and inform planning for housing, health and education (Sapsford 1999). Nineteenth century British surveys such as those conducted by Booth between 1892 and 1902

(Booth 1902) and Rowntree (1901), focused on social conditions and the effects of poverty. These surveys tended to resemble the census as they usually covered a systematic list of topics with house-to-house coverage across London. They produced huge volumes of data, which were analysed by a team of mathematicians.

During the early part of the twentieth century, the approach to survey began to change. This was due to the influences of market research, electoral polls and journalism and led to the development of survey methodology as a credible academic research discipline. The market research survey model was based on the approach used in psychophysical laboratory testing, where the assumption was made that any grouping of individuals was as valid as any other grouping, due to the fact that the processes being tested were common to all people (Rossi et al 1983). In market research, consumers, who either volunteered in response to newspaper advertisements or were canvassed in the street, were asked their opinion about a product and their views were taken as representative of the general public.

Early political polls during the 1930s needed to achieve greater certainty that their interviewed sample closely represented the general public as their data were used as an indicator of election outcomes. As a result, there was considerable investment by journalists and governments in refining the instrument to enhance accuracy (Miller 1983, Rossi et al 1983). Statisticians, economists and demographers began to develop probability sampling methods that allowed for statistically significant assertions to be drawn from data and these techniques enhanced the credibility of surveys in terms of academic rigour (Rossi et al 1983). Miller (1983) describes the 'Gallup norm' developed by Dr George Gallup and used by the American Institute of Public Opinion he established in the 1930s, as the basic model upon which the modern survey is based. Gallup's greatest success was the prediction in 1935 that Roosevelt would win the election and his method was celebrated as reliable and accurate. However, his poll in 1948 failed to predict the election of Truman and his method was scrutinised by the Social Science Research Council, which identified errors in sampling (quota) and failure to predict last minute behaviour in undecided voters. As a result of this, Gallup abandoned quota sampling in favour of probability sampling and the Gallup Organisation established a global reputation for conducting survey research (Miller 1983).

Over the past two decades a set of theories and principles has been developed that offer a framework for the design, conduct and evaluation of surveys. Groves et al (2009) discuss the tendency for some textbooks to focus on a recipe-like list of instructions on how to conduct a survey whilst neglecting the science underlying the framework. They argue that a sound understanding of the principles is essential to allow for a survey to be conducted in a unique way to fit a particular purpose for a particular population.

3.4 Survey methodology

Survey methodology is the study of survey methods, and the sources of error that affect the accuracy of results. This field of research has led to the ‘total survey error paradigm’, a framework that guides the design and evaluates the quality of surveys (Groves et al 2009). The application of this framework to survey research draws on principles from several disciplines, primarily mathematics, statistics and psychology. The study of sampling methods to achieve estimates that can be expressed as probability values and allow for inferences to be made about the total population is firmly rooted in mathematical principles. In addition, because social surveys often involve asking questions about human attitude or behaviour, psychology provides a framework for understanding the effects on respondents of design, question wording, and interviewer behaviour. This mixture of academic disciplines has affected the reputation of survey methodology as a scientific field and much of the early significant advances and theoretical developments took place outside the academic environment in large government or commercial organisations. However, survey methodology is now generally regarded as both a science and a profession, with a unique body of knowledge and a set of guiding ethical principles (Groves et al 2009).

Surveys are conducted in a real world environment, affected by many uncontrollable factors and this makes it impossible to conduct the perfect piece of survey research. Compromises have to be made in the attempt to measure aspects of a microcosm of the whole population and the effects of those compromises have to be weighed in the decision-making process about design. Each step of the survey has the ability to affect the quality of the final results. The total survey error approach means taking an holistic view of the whole process to ensure

that no single aspect undermines the quality and ability of the survey to achieve its purpose. An experienced survey researcher will have the knowledge to make appropriate decisions about design and implementation and will understand the implications and effects of those decisions on quality (Groves et al 2009).

Miller (1983) identifies nine characteristics of the 'survey norm' based on earlier work by Hyman (1973) who listed five essential features. Miller also highlights acceptable variations to the norm and some commonly made errors:

Geographical scope – The sample must include coverage of all regions relevant to the survey. Regional variations can have a considerable effect on results and must therefore be represented. The fit between the sample and the survey purpose must be appropriate so that a rural survey only samples rural communities and a national survey includes all regions in the country. A national survey has two functions. It provides information about the whole country and also a benchmark for comparing sub-groups against. However, selecting a sub-group from a sample of 2,000 may have too few respondents to yield reliable data. This can be improved by either a vast initial sample (10-20,000) or by geographically 'boosting', by over-sampling in an area where sub-groups are strongly represented.

Population scope – All elements in the population that are eligible should be included. Reaching all of those eligible is not always easy depending on access to the particular population and the accuracy of lists and databases. An acceptable variation in reaching elusive sub-groups is to approach them directly to ensure they are represented. A frequent criticism is that sample selection criteria produce a biased sample that does not resemble the population and cannot therefore allow for conclusions to be drawn about it, so it is important to be aware of sub-groups that might be missed.

Timing – Data should be collected as closely as possible to events related to the survey. People can change their minds about opinions in the run up to an election and can forget how they felt about an event in the past. Similarly, if data is collected over a long period of time, early data may not be reliably compared to later data as contextual conditions may have changed.

Sample size – Huge samples are no more accurate than a sample of 2,000-3,000. A randomly selected sample of 2,000 produces a result with a 95% chance of providing an estimate within 3% of the result that would be obtained from the total population (Miller 1983). It is therefore adequate for the estimation of attributes throughout the population as a whole. This size of sample is not however, adequate for extracting sub-samples of the population as the reduced numbers result in an increased sample error.

Sampling criterion – A true random sample of the UK population would be scattered across wide regions and therefore be expensive and practically difficult to access for interview. Where there are high rates of non-contact or refusal it is not uncommon for researchers to interview whoever is available to top up the selected sample and this will clearly alter the nature of the data and increase the margin of error.

Data collection setting – Data collection is affected by the context and setting. There should be a ‘neutral’ environment without any factors that may influence attitude and responses. The interviewer should refrain from showing any reaction to the responses and there should be no one else present.

Data collection method – Ideally a personal face-to-face interview allows for natural conversational progression.

Data collection measures - fixed-choice questions produce more standardised data but have disadvantages regarding restricting freedom of thought.

Data structure – ‘Atomism’ refers to the practice of treating each respondent as an individual rather than part of a group in the analysis of data.

Other theorists describe essential components of survey research as being based on the four cornerstones of coverage, sampling, response and measurement (Salant and Dillman 1994) and these are discussed in detail below. All of these must be meticulously attended to in order to enable high quality data that can be used for analysis (Leeuw et al 2008). Total survey error will be affected by error in any of these four areas and the literature focuses heavily on mechanisms for reducing the risks of error. The challenges of achieving this are discussed below.

3.5 Challenges in survey research

The quality of a survey is often judged by its fitness for purpose and this can be determined by its accuracy, timeliness and accessibility (Leeuw et al 2008). Different theorists classify threats to survey quality in different ways, with some taking an approach based on errors of non-observation (e.g. design, non-response) and errors of observation (e.g. data collection), (Groves 2004) and others differentiating between sampling and non-sampling errors (Biemer and Lyberg 2003). Dooley (2001) highlights common errors including inadequate sample size, bias in sample selection and errors in data collection including bias in question wording. The risks of errors in any of these areas affecting the total survey quality must be acknowledged and addressed at each stage of the survey process to allow others to make a judgement about the value of the findings. Suggestions for addressing this are discussed below.

3.5.1 Sampling

Whilst a census gives comprehensive data and avoids problems of error arising from measuring a subset, the volume of responses from a large population is usually impractical. As a result, various methods of selecting a sample from the population have evolved. The key to good sampling, according to Fowler (2009), is to find a way to give all population members a non-zero chance of being selected, and to use probability methods for choosing the sample, ensuring that they are selected at random. The sampling frame is the set of people within the total population that has a chance to be selected and the comprehensiveness and accuracy of data will depend on the sampling frame bearing a close resemblance to the population as a whole. If the population as a whole is quite small, then the sample may be drawn directly from it rather than a sampling frame. Coverage error occurs when some members of the population have a zero chance of being selected and this may result in the sampling frame failing to cover all elements in the population to which the results are to be generalised (Leeuw et al 2008).

The sampling strategy is the method by which the sample is selected from the sampling frame and the quality of this selection is crucial in producing reliable data. Two types of sampling are generally used in surveys: probability and quota. Probability sampling is the only method

that produces statistically significant data, as the chance of being selected can be calculated using a formula, and the sample is genuinely random, thereby reducing errors of bias and omission (Fowler 2009). The likelihood of probability samples representing their parent population if they are randomly taken from it follows a normal distribution (Sapsford 1999). The mean of the sample should therefore closely match the mean of the population, and this can be calculated using mathematical formulae to demonstrate the confidence level of this happening through chance, giving a probability value.

In large populations it is common to employ the techniques of stratification and clustering to produce a probability sample that is manageable both in size and geographical distribution. This involves separating the population into mutually exclusive groups or strata, then taking random samples from each group. Multi-stage stratification involves doing this repeatedly. Clustering is commonly applied in the final stage of stratification by randomly selecting from a particular locality, to achieve a geographically compact sample that is still probability-based. However, no system is 100% foolproof and clustering can result in a skewed sample if, for example, there were a non-representative sub-set of the population prevalent in the area selected. Even a truly random sample may be non-representative if there is a poor response rate that omits a significant proportion of the sample.

Sampling error is defined as a measure of how closely the results from a sample can reproduce the results that would be obtained from a complete count or census (Hansen et al 1953). Leeuw et al (2008) describe sampling error as occurring when only a sub-set of all elements of the population is surveyed. Fowler (2009) discusses the effects of sampling error on quality of data and advises that the credibility of any non-probability sampling method relies on the researcher presenting convincing arguments regarding the close fit between the total population and the sample. The effects of omission on the completeness of data should be considered, as should the possibility of chance errors occurring. If probability sampling is not possible or appropriate, then efforts must be made to counteract the risks of sampling errors. Selecting an adequate sample size and being aware of the distribution of characteristics being measured can reduce these risks and guard against important omissions (Fowler 2009). Lohr (2004) suggests comparing demographic estimates of the non-

probability sample with the general public in an attempt to test the quality of the sample, but cautions that unknown characteristics may still be unrepresentative in the sample.

Robson (2011) reinforces the need to be able to convince others that the non-probability selected sample is representative of the whole population, but acknowledges difficulties associated with this because it cannot be proved or measured. He suggests some sampling techniques that can help to achieve a sample that closely resembles the total population in a survey:

- Quota sampling – data collection continues until all the known elemental types of the total population are present in approximately representative proportions;
- Dimensional sampling – at least one representative of every combination of different known characteristics from the total population is included;
- Purposive sampling – the researcher uses their judgement to ensure that the sample includes issues of typicality and/or interest and will provide the information needed to answer the specific research question.

Whilst these measures offer no guarantee of comprehensiveness, as there may be elements the researcher is unaware of omitting, they nonetheless demonstrate efforts to achieve as close a resemblance as possible to the population, which is particularly important where sample size is small.

Rea and Parker (2005) identify some situations where non-probability sampling may be particularly appropriate and useful. Where the purpose of the research does not require an analysis that allows accurate statistical generalisation to the total population, probability sampling is unnecessary. Non-probability sampling is also much less costly and time-consuming to perform. The main advantage of non-probability sampling is its usefulness in the preliminary stages of a research project, to generate an understanding of some of the key issues underlying the research (Rea and Parker 2005).

3.5.2 Sample size

The size of the survey sample will be dictated by the type of analysis to be undertaken. In a statistical analysis of survey data it is essential to have a sample size that provides an

acceptable level of confidence, achieved through calculating the standard error and adjusting the sample size until it produces the required margin (Sapsford, 1999). However, if the analytical approach to data is descriptive rather than statistical, then this calculation is not relevant, although the sample size is still an important factor in determining the quality of data. Fowler (2009) asserts that in qualitative analysis, there is no particular sample size that guarantees a large enough amount of data to guarantee accuracy, and this is particularly true where the distribution of variables is complex and unknown. Depending on the quality of the sampling process, the purpose and design of the research, a small sample may provide a very good or a very bad representation of the total population. Estimates of an adequate percentage or an acceptable number of respondents are not good indicators of comprehensiveness. A better guide is the close fit between the total population and the sample (Fowler 2009). This can be achieved by ensuring that known variable characteristics in the total population are represented as closely as possible in the sample (Robson 2011).

3.5.3 Response rates

One of the factors contributing to a small sample size is a low response rate, the concern being that those who did not respond may differ significantly from those who did, thereby representing views that are absent from the data (Robson 2011). This is particularly so when a sample is carefully selected in order to represent all the characteristics of the total population. If the response rate from this selected sample is very low, then the final sample will not bear a relationship to the total population (Fowler 2009). The key problem is that the degree of bias produced through non-response cannot be accurately measured. If non-response is completely at random, then although the sample is smaller there should be no bias effect on results. If however, non-response is selective because the non-responders differ from the responders in important ways, then certain groups may be under-represented, causing bias (Leeuw et al 2008).

A high response rate from a well-defined and selected population minimises the effects of this and therefore enhances reliability. Maximising response rates is therefore an important factor in reducing survey error. Lynn (2008) suggests that willingness to respond may be affected by the relevance of the topic and the burden associated with it regarding time, cognitive

effort, risk and sensitivity. Potential respondents will weigh the risks and drawbacks and a well-trained interviewer will tailor their approach to individuals' concerns (ibid.).

Hewson et al (2003) suggest several ways to maximise response rates. They advise that issue salience should be ensured, i.e. the topic must be engaging and important to participants. Postal and Internet surveys are more likely to be returned if there is respondent interest and perceived benefit as a result of participation (Thompson 1995, Fowler 2009). Other recommendations for increasing response rates include affiliation with a respected official organisation, providing preliminary notification of the survey, using a short clear layout, sending reminders to encourage response and ensuring that confidentiality and anonymity is explicit (Hewson et al 2003, Fowler 2009).

Whilst non-response error can only be calculated in probability samples, its effects should be discussed in a non-probability sample and the reasons for non-response such as contact difficulties or refusal should be documented.

Robson (2011) highlights the pre-test as an essential tool to help maximise response rates. He also suggests that pre-testing a questionnaire enhances the reliability of data from a survey by ensuring that standard questions used for all participants mean the same thing to different respondents. A pilot study highlights issues of clarity and ambiguity in question design as well as giving the researcher a preview of the types of answers to expect. Over-familiarity with the questionnaire design often blinds the researcher to weaknesses, so having a 'dry run' with a group seeing it for the first time can produce helpful feedback about layout, length and ease of use, as well as ambiguity and accuracy of questions.

Where a low response rate has occurred Robson (2011) advises making a determined effort to turn a small group of non-responders into respondents, by contacting them individually and asking them to participate, then comparing their responses with original respondents. Other 'palliative' measures he recommends include comparing early responses with late ones for similarities, suggesting consistency in data and checking which known characteristics about the population are present in the sample, looking for evidence of a close match. These

measures are a way of determining whether a small sample size has affected the reliability of the data through bias.

Sapsford (1999) advises survey researchers to compare their sample with any available population statistics or other surveys of the same population. If samples can be shown to be reasonably representative on known variables, this gives greater confidence in the sample when it comes to unknown variables (ibid.).

3.6 Data collection methods

The data collection method is just as important as the sampling strategy in determining how well the data describe a population. There are two commonly used methods of data collection for a survey, interviews and questionnaires. Observation of participants is sometimes used as a form of triangulation, to provide evidence that supports or refutes some of the findings from questionnaires or interviews. This can provide a useful check against what participants report and what happens in reality.

The process of data collection must produce data that address the purpose of the survey. There are many opportunities for getting this wrong. With pre-set questioning the researcher determines the topic and it may in some sense be wrong in terms of the respondents' views. This could result in missed opportunities:

“Surveys may take a picture but they certainly do not have a wide-angled lens.

The view is narrow and the lens may be pointing at an unimportant part of the scene”

(Miller 1983:75)

3.6.1 Interviews

The interview, either structured or semi-structured, is a valuable data collection method as it can potentially provide fuller information than a self-completed questionnaire. The researcher has the opportunity to clarify any areas of ambiguity and to follow up with subsidiary questions according to the response. When semi-structured interviews are used the researcher can also assess the attitude and behaviour of the participant and use it as a prompt to guide

questioning, or record it as data (Groves et al 2009). The interviewer can also tailor their approach according to the participant's concerns (Lynn 2008). However, interviews are time-consuming and are therefore limiting in terms of the numbers of participants that can be included. As a method of data collection it was therefore not considered appropriate for this survey, which aimed to gather information from as large a sample as possible, using one researcher. Interviews will be discussed in more depth in relation to data collection for the case study.

3.6.2 Questionnaires

Self-completed questionnaires can yield a lot of information about what people do, think or believe and are therefore efficient in terms of time and effort (McQueen and Knussen 2002). Large numbers of questionnaires can be administered simultaneously and providing questions are carefully constructed, data can be collated quickly.

However, the data they produce are superficial in nature and there is no check on honesty or seriousness of the responses. There is a risk of response error, where the responses are faulty or inaccurate or interviewers interpret their meaning (Miller 1983). Robson (2011) discusses the often perfunctory nature of responses made by participants and questions how much meaning can be attached to them. McQueen and Knussen (2002) caution against putting too much emphasis on what people say they do as opposed to what they actually do and warn that asking people for their views invites a great deal of bias in reporting, therefore limiting the usefulness of data. However, Maxwell (2002) argues that the inclusion of conscious or unconscious manipulation of answers by participants to allow them to address their own agenda does not detract from the validity of the data as it reflects a true picture of views and influences in the real world. He also asserts that there are no known absolute truths about populations with which to compare data from the sample so there is little point in excessive concern about the honesty of responses. Maxwell maintains that rigorous design and an accurate account of the recorded data are more important and that faithful description is vital in producing authentic data.

It is essential that the questionnaire design be fit for purpose. Just as the research question will determine the approach to analysis, it also determines the instrument necessary for measuring responses to questions, to ensure the right type of data is obtained. The questionnaire must provide an accurate and appropriate framework for this purpose. If the purpose of the questionnaire is to produce quantifiable data that can be precisely measured, then the design must make this achievable. A project that aims to provide statistically significant evidence will require a specific sample size, statistically determined, and will use closed questions, often with a scaled measurement of responses. Open questions on the other hand, allow respondents great freedom to express their answer using their own terms of reference and this can reveal unanticipated information about the terms in which people think about the subject (Weisberg and Bowen 1977, Fowler 2009). Robson (2011) warns against using open-ended questions, which are time-consuming and complex to analyse, recommending using forced choice options or scales measuring intensity of beliefs instead. Forced choice guards against ‘acquiescence response set’ or the tendency for respondents to agree, which can be exacerbated by giving the ‘agree/disagree’ option (Robson 2011). However, despite being an advocate for closed questions, Robson does concede that open questions can be valuable where not enough is known about an issue to write appropriate response categories without the danger of omitting important information, or when measuring particularly sensitive issues. Miller (1983) is of the view that asking respondents to choose from a pre-set list of responses may at best restrict their freedom of thought and at worst prompt thoughts they would otherwise not have had. However, he also concedes there can be value in reminding respondents of the possible range of answers. Iarossi (2006) claims that open questions achieve higher accuracy because respondents get the opportunity to say exactly what they mean in their own words.

Robson (2011) emphasises the importance of a painstakingly careful process to ensure clear and unambiguous questions, which are pre-tested with a small sample. Weisberg and Bowen (1977) reinforce the need to ensure questions are reliable (evoking a consistent response), valid (measuring what they are designed to do) and free from bias. They strongly advise avoiding the use of double-barrelled questions, leading statements and assumptions about the respondents. Fowler (2009) stresses the importance of ensuring there is consistent meaning to

all respondents. Questions should be brief, objective, simple and specific, to enhance clarity (Iarossi 2006). Leeuw et al (2008) add another dimension to clarity and meaning, arguing that there are two forms of meaning, semantic and pragmatic. Semantic meaning is inadequate as it is a literal interpretation of the question being asked. The question “How big is the practice where you work?” could have several literal meanings such as the physical size of the building or the patient list size. Pragmatic meaning includes knowledge of inference or intention, and this is affected by the information given to respondents about the focus and purpose of the survey.

The sequence of questions can also affect the quality of responses. Varying the type of question and the response required can increase reliability and validity. This is because participants can tend to lose concentration if questions all require the same response, unless they are stimulated to think about another type of response, or unless there is a variety in whether “yes” is a positive or negative response (Weisberg and Bowen 1997). The tendency to be acquiescent and answer in the positive on each question can produce a ‘response set’, which results in an unbalanced and inaccurate measurement (Weisberg and Bowen 1977: 47). There are differing opinions about the importance of the order of questions such as giving personal details, but questions of a sensitive nature should not appear at the beginning of the questionnaire until the respondent is engaged with it, and the first question should capture their interest and be related to the study subject as this will enhance the likelihood of their continuing to complete the questionnaire (Iarossi 2006, Robson 2011).

Memory recall also has an effect on responses and several things can influence this (Schwarz 2008). The intensity of an experience will influence how it is remembered, as will the frequency of the experience and how recent it was. The order of response options can also influence the responses through memory recall. If the first response option is ‘no’ this can prompt negative memory recall, which then affects judgement, as it is the most readily available example. If the first option is positive, the opposite can occur. Similarly, if the response to one question is positive, it can influence the way in which the next question is approached as the respondent is still recalling the event that prompted their response.

The literature agrees that a pre-test or pilot is an essential step in testing out whether the design of the questionnaire will do the job it was designed for in the real world. The feedback from this gives the researcher valuable information about misinterpretations, problems with language and question clarity, as well as reactions from the sample to sensitive questions.

3.7 Internet surveys

The internet is becoming an increasingly popular medium for gathering data as it provides access to very large populations. Speed, low cost, improved accuracy in encoding data using software programmes and a wide reaching population are obvious advantages to internet research (Coomber 1997, Wang and Doong 2007). Anonymity is easily guaranteed with internet research and this enhances honesty in responses, particularly when researching sensitive topics (Fricker and Schonlau 2003). Hewson et al (2003) caution that a negative aspect of anonymity is that the researcher is unable to judge the sincerity of participants but this would appear to be a risk with any response other than face-to-face.

The first internet tool used for research was email, with respondents simply using the email reply to participate (Schaefer and Dillman 1998). This had drawbacks in terms of confidentiality and anonymity, as the source of the response was easily identified. More recently, websites have been used to host surveys, with visitors to the website being invited to complete them. Coomber (1997) describes this as insufficient as a means of targeting a population and recommends using a more direct approach. A combination approach uses email to contact the sample and then provides a link to the web page (Truell 2003). Andrews et al (2003) describe email as a “push” technology, where researchers can communicate directly with the participants and also track whether the email was delivered, opened or deleted. However, email data is not as secure as web-based surveys, as they can be altered subsequently and they have been found to be more confusing and less visually appealing than web surveys (Andrews et al 2003). One disadvantage of web surveys is that ‘pop-ups’ may be blocked by some computer software configurations, and as a result the intended recipient may not read them. Similarly, some potential participants may find email surveys filtered by their software as ‘SPAM’ messages. These may present obstacles to data collection and could be addressed by alerting the potential participants to the problem and reassuring them that it is

safe to open an email attachment or access a website. Ideally, the design should avoid any technological features that may create any security concerns, as they may raise concerns in potential respondents about participating (Truell 2003).

3.7.1 Quality of internet data

Wide debate continues about methodological advantages and disadvantages of email and web surveys compared to postal surveys, particularly concerning the effects of sampling methods, completeness of data collection and response rates (Fricker and Schonlau 2003, Coomber 1997, Dillman 2000, Truell 2003, Wang and Doong 2007). The following issues are important considerations in reducing errors.

Coverage

The literature on internet research raises the issue of the ‘unknown population’ (Wang and Doong 2007) meaning that if technologies such as pop-up windows and banners on the internet are used to recruit the sample, the respondents come from an unknown population pool and cannot therefore be considered in any way representative of a wider group. They may have characteristics in common, such as an interest in the topic or a familiarity with the web site, but there is no way of knowing whether they are in any way representative of the population being targeted by the survey. Manfreda (2008) discusses the issue of coverage error being a concern if using the general public as the population, as internet usage denotes certain social attributes linked to affluence and skills. However, in the case of a discrete professional group or organisation where all members have internet access as part of their work, this is not a relevant concern. Dillman (2000) suggests that coverage error will exist if the sample frame fails to contain all of the characteristics present in the population of interest. With a web-based survey, the sample may be restricted to those members who visit the web site unless an additional form of notification is used. With an email survey, the sample frame may be incomplete due to incorrect email lists. However, Coomber (1997) suggests that the benefits associated with drawing a self-selected sample from the web outweigh the drawbacks. Despite the problems of only attracting internet users, this method allows a very broad sample to be included, specifically allowing the inclusion of hard to access groups who may provide valuable information on sensitive subjects (Coomber 1997).

Sampling method

As previously discussed, the degree of sample error in the selected sample will be determined by the quality of the sample frame. If the sample frame is incomplete and therefore biased, this affects how representative the final sample will be. Using the internet as a medium restricts the ability to 'select' a sample and this immediately creates a methodological weakness. Voluntarily self-selected samples are open to many types of bias, which could potentially affect the quality of data. When using a non-probability sample drawn from an incomplete sample frame, the researcher has a responsibility to provide evidence about the sample composition compared to the total population (Wang and Doong 2007).

Completeness of data

Truell (2003) discusses the importance of demonstrating that internet data is equivalent to postal questionnaires in terms of completeness as one way of assessing the quality of data. He claims that the literature supports the observation that internet surveys tend to produce a higher completeness than other survey methods. Truell et al (2002) carried out a comparison of response completeness between internet and postal surveys and found that the internet surveys were significantly more complete than the postal ones. They do not suggest an explanation for this, but it is possible that there is an advantage to the respondent only being able to see one page at a time in an internet survey, thereby being less aware of its length. It is also more likely that completion of a hand-written questionnaire may be interrupted with the risk that it will then be forgotten, whereas an internet survey may not allow the respondent to log on again, so they may be more likely to complete it without a break. Fricker and Schonlau (2003) found that internet surveys also tend to yield longer answers to open questions and they suggest that this enhances the quality of data.

Response rates

In internet surveys without a defined sample frame, response rates are hard to define and therefore the effects are equally hard to assess. However, the researcher has an obligation to discuss the impact that a low response rate may have on their findings.

Measurement validation

In common with a postal survey, unless using a previously validated questionnaire internet researchers are encouraged to conduct a pilot study to test and revise the accuracy of the instrument they are using to gather data. Wang and Doong (2007) report that this is an area neglected in many published internet studies.

Survey Process errors

Non-sampling errors during data collection can occur as a result of misinterpretation of questions, transcription and reporting mistakes. The accuracy of data transcription and classification is enhanced in computer-based research due to software programmes storing data accurately and logic checks ensuring that answers are entered in the correct format. It is therefore arguably easier to track and retrieve data stored in this way than to do it manually. However, there is a risk in the open-system web-based questionnaire of multiple responses being submitted from one individual or responses from people outside the sample frame (Wang and Doong 2007). Whilst this would be avoided by using an email questionnaire, anonymity would be compromised and this could affect the honesty of responses. Some studies have overcome this problem by registering participants with a member ID and password, which prevents duplicating a response (Wang and Doong 2007). However, this may again be perceived to compromise anonymity and therefore have a negative effect on respondents participating.

3.7.2 Rationale for using the internet for data collection

The decision to use the internet in this study was based on the practicalities of gathering data from a large group spread over a wide geographical area. The total practice nurse population in the UK is estimated at around 25,000 (McGreggor 2008). Sending a postal questionnaire to the total population could potentially result in the return of thousands of paper responses for analysis, which would be unmanageable for one researcher. In addition, the topic being investigated could be perceived as sensitive and a postal survey might not actually reach those nurses who might wish to express problems experienced within their working environment, due to their post being opened by colleagues, managers or GPs. A direct, private medium was

therefore preferable. The internet was considered a viable option but posed a problem with access, as there is no national database of practice nurses or their email addresses. The decision was therefore made to approach an existing organisation, the Working in Partnership Programme (WiPP) as this website was available to all practice nurses in the UK, had been endorsed by the NHS and was relevant to the survey topic. The national project leader for the WiPP Nursing Initiative was approached and asked if they would be interested in sponsoring and hosting the survey on their website and this was agreed.

The issues raised above in relation to internet research will be addressed in the discussion that follows about how this study was carried out.

3.8 Conducting the Survey

The specific research objectives being addressed by the survey were to explore the range of practice nursing roles and availability of appropriate resources to support role evolution. The survey was used as a preliminary scoping exercise to provide data that would inform and shape the rest of the study. A ‘snapshot’ was required to capture the range, nature and extent of the issues, to identify the focus and emphasis for deeper investigation in the case study.

3.8.1 Understanding of contextual issues

As a result of previous research and long-term working relationship with practice nurses, my awareness of some of the issues being investigated gave me a good idea of the sort of data I would need to address the objectives of the study. This gave me a degree of ‘insider’ perspective in identifying contextual issues such as the employment environment and professional relationships, which helped to bring clarity and focus to the design (McQueen and Knussen 2002). The possibility that my knowledge of the context may lead me to empathise and ask specific questions was difficult to avoid and should therefore be declared and acknowledged as an inevitable feature of the study. This is not necessarily a problem, but it can produce bias in the interpretation of data making it vital to ensure transparency and rigour in the process. The risks that this ‘insider’ perspective can pose to the research process will be discussed in depth in a later chapter.

3.8.2 Design issues

The design of the survey produced challenges, some of which related to combining an academic study with a sponsored survey. Academic rigour was important in both instances; however, the demands of the sponsor were not always matched by the demands of completing a higher degree. Despite this tension, sponsorship did not affect impartiality as control over design, implementation and analysis rested wholly with me. The WiPP programme board naturally required assurance and their advisory panel duly approved each stage of the survey as the mechanism for ensuring probity in the use of public funds. The panel comprised members at senior manager level from WiPP, the Royal College of Nursing (RCN), the Royal College of General Practitioners (RCGP) and the Department of Health. The WiPP project leader approved the title ‘SNAPSHOT Survey’ (Crossman 2008), design, timescale and advertising. From an academic perspective, the methodology was presented to research colleagues for critical comment and the questionnaire design was retrospectively reviewed by a senior primary care academic at Manchester University after circulation. Although this process would have been more valuable if done during the pilot phase, it was still useful as a learning exercise and provided some insight into the importance of clarity in question wording and the weaknesses associated with using numerical categories (e.g. 20-29) rather than exact numbers.

In the development of the questionnaire (appendix 4) the focus for the questions was guided by a set of ‘good practice’ standards summarised from the WiPP General Practice Nursing (GPN) Toolkit (see appendix 1). This Toolkit had been developed by a working party following an extensive review of existing national frameworks and examples of good practice (Longbottom et al 2006), circulated for wide consultation and finally approved by the WiPP advisory panel and endorsed by the RCN. The standards taken from this toolkit represent terms and conditions of employment that should be in place to ensure adequate preparation and support for practice nurses, including access to appropriate training and supervision. These have since been published as an employment guidance document (WiPP 2008b) and circulated to Strategic Health Authorities, but at the time they represented a framework for good practice. This provided a structure to guide questions about the conditions practice nurses experience in their work situation. Other questions were designed to determine the

nature of their role, qualifications and size of practice in which they worked. Data were collected using mostly closed questions to determine the prevalence of issues and to assess whether they bore any relationship to each other. Three open questions were used to ask participants to identify topics they felt they needed training in, to identify any consequences of refusing to do a task they judged they were not competent to perform and to make any comments about the support they received. The latter question was designed to allow participants the freedom to express any issues that were not covered by the main questionnaire and may not have been recognised as relevant during the design of the study. If this question had not been included, potentially important data might have been absent because it was not asked for.

3.8.3 Ethical considerations

Ethical approval was discussed with the local research ethics committee, who decided that the survey came under the category of ‘service evaluation’ or ‘audit’, did not propose any new intervention and did not therefore require an application for approval. Nevertheless, the National Research Ethics Service (NRES) guidelines were adhered to as good practice to ensure participants gave informed consent and had confidentiality assured. This was achieved using a Participant Information Sheet (appendix 7) followed by a consent button to commence the survey. Access to the results was restricted to the researcher and the computer company, and all responses were anonymous and listed numerically, thereby providing excellent levels of confidentiality.

3.8.4 Sampling strategy

The sampling strategy was based on the data requirements, which were:

- A comprehensive description of roles and professional development availability;
- A national scope, to avoid sampling error due to local and regional differences;
- A large sample in order to obtain as many elements as possible present in the total population.

As the research objective did not include a statistical generalisation to the total population a non-probability sampling method was chosen. Probability sampling would not in any case

have been possible, due to the incomplete database of practice nurses in the UK, making it impossible to give the whole population a non-zero chance of selection. The aim of the sampling strategy was to minimise sampling error by attempting to give as many practice nurses as possible an opportunity to be in the sampling frame and hoping for a large enough number of respondents to give a good chance of achieving a distribution of characteristics bearing a close resemblance to the total population. The sampling method used a combined approach whereby participants self-selected either through visiting the website independently or being directed to the questionnaire through reading a Practice Nursing journal editorial (Martin 2007) or a mail-shot. Every general practice in England was sent a colourful flyer inviting the practice nurses to participate in the survey, with details of the web site (appendix 2). The other UK countries could not be included in the mail-shot as addresses were unavailable. The goal was to achieve maximum coverage over a short space of time, with the aim of retrospectively demonstrating a resemblance to 'quota sampling' (Robson 2011). The only inclusion criterion for the sample was that all participants should be nurses working in general practice in the UK. This was deliberately wide so as to include the views of any nurses currently working in the field. In the unlikely event that this strategy might produce a sample too big to manage, a sub-sample would have been selected using systematic sampling. This involves dividing the desired sample number by the number of responses received and using the resultant figure as the frequency for picking out the sample (Fowler 2009). For example, if 8,000 responses had been received and a sample of 1,000 was considered adequate, then every eighth person on the list would be selected. This only produces a random selection if there is no order to the list, i.e. no grouping of characteristics being measured. In this study, the responses were simply recorded in order of receipt so this could have been a feasible method of selection. However, the numbers received were not unmanageable and were therefore all included.

The lack of a comprehensive database of UK practice nurses posed difficulties for sample selection in terms of available information about the population. All that was available was a list of postal addresses for general practices in England. The risk of nurses not receiving a postal invitation to participate could seriously reduce the response rates and this risk could not be reliably calculated.

Quota sampling would require pre-determined characteristics to be included in the sample and might exclude some important unknown ones. Cluster sampling might over-represent some characteristics found in a geographical area or type of practice. Blanket coverage of the whole population was therefore decided as the option most likely to give the best chance of including all the important variables. It could be argued that this created an element of random selection in that there was no researcher control over who would respond. However, this lack of a 'selected' sample posed some of the threats to data quality previously raised and these are discussed below.

3.9 Addressing the methodological weaknesses of internet surveys

3.9.1 Coverage

With regard to the difficulty in achieving a complete sample frame, strenuous efforts were made to give all the population an equal chance to participate, by sending a promotional postcard to every practice in England, advertising in the nursing press, promoting at primary care conferences, through practice nursing journal editorials and on the WiPP website. In England theoretically only nurses who do not receive post addressed to 'The Practice Nurses' at work, or do not read nursing journals, use the internet or attend conferences should have been at risk of exclusion from the sampling frame. Those nurses who were not comfortable using the internet were invited to complete and return a paper version of the questionnaire. Some may have rejected the opportunity to participate through lack of interest and this group may represent absent data about what motivates nurses to engage in their professional development. However, this is not what was being investigated by the survey and was therefore not considered a threat to the validity of data. The issue of personal motivation is something that may be explored in the case study during the second stage of the research study. Nurses in Scotland, Northern Ireland and Wales had less chance of participating due to the postcard mail-shot only being to practices in England. This was unavoidable due to the practice lists in these countries not being available to the WiPP personnel who conducted the mail-shot. However, the eventual responses did include comments that revealed that some of

the nurses were from Scotland and Wales, which suggests that the mail-shot was not the sole method of recruiting participants.

3.9.2 Sample ‘fit’ to population

The closeness of ‘fit’ between the sample and the total population cannot be accurately measured, as the current distribution of known variables in the total population is not known. However, the nature of those variables is known, such as size and geographical location of practice, age, qualifications and hours of employment of the nurses. A good range of these variables was represented in the sample and when compared to previous census data, (Atkin and Lunt 1993), the profile was very similar, suggesting a sample that bore a resemblance to the total population. According to Sapsford (1999), if samples can be shown to be reasonably representative on known variables, this gives greater confidence in the sample when it comes to unknown variables. In addition, the data were monitored weekly to assess variations as the number of responses increased. Variations were noted in the first 120 responses but thereafter the data pattern became consistent with very little change between the initial 120 and the final 1,161 responses. This retrospective assessment of the credibility of the sample would not be acceptable if the data were required to demonstrate statistical significance. However, in this study the emphasis was on including as wide and diverse a sample as possible from the total population of 20,000 nurses, to record the whole range of issues for consideration. It is possible that due to the sample being a small proportion of the total population, some non-respondents may have had views that do not support the findings, resulting in bias. It is more likely however that those non-respondents that were unaware of the survey would have been isolated and unconnected to professional networks and therefore reflected the situations described by the data, thereby supporting the findings.

3.9.3 Maximising response rates

In an attempt to reduce bias due to low response rates I followed recommendations from the literature about measures to maximise responses when designing the survey (Hewson et al 2003, Robson 2011, Fowler 2009). My regular contact with practice nurses meant I was confident that the subject of professional development support was a salient issue to them and the literature clearly highlighted the fact that there were unresolved problems in this area. I

also had affiliation with a respected organisation, the Working in Partnership Programme, although this may not have been widely known among nurses who do not read practice-nursing journals or attend primary care conferences. Preliminary notification was fulfilled by advertising and a mail-shot to each practice, including an explicit statement ensuring anonymity and confidentiality. The questionnaire was pre-tested in a pilot study to identify weaknesses in design and the feedback was incorporated in modifications. This is discussed further in chapter 4. The layout of the questionnaire was colourful and professional in appearance and questions were short and clear. It was not possible to follow up non-responders with a view to converting them to responders (Robson 2011), due to the anonymity of replies preventing their identification and the lack of funding to send out reminder letters to every practice in England. The effects that non-responders may have had on the data cannot be measured as previously discussed, but the stability of results once 120 responses were received suggests a saturation of issues had been reached. However, there remains a possibility that a significant group of non-responders may have had either additional or opposing views that were not included in this survey. The chances of this appear low, but it remains a potential risk to the validity of the data.

3.9.4 Process errors

Any research project is always a learning exercise and this one was no exception. Unfamiliarity with computer software was a limitation, as was the experience of being primary investigator in a sponsored project. As a result, several weaknesses became apparent which could have been predicted if I had been more experienced.

Firstly, author authenticity could not be guaranteed due to there being no mechanism in the software for registering and restricting the completion of the questionnaire. The likelihood of people outside the sample frame, i.e. non-practice nurses, completing the survey, or people feeling strongly enough to make multiple responses appears low but was possible. There were no identical responses and all seemed convincingly genuine. The risks associated with author identification and multiple entries were weighed against the advantages of using the internet and considered unlikely to pose a significant threat to the validity of data.

Completeness of data was a potential problem, as the software did not prevent people from exiting the questionnaire before completion. Some data were therefore inevitably lost and these could present a similar threat to the validity of data as those absent through non-response. However, partial data was saved from those who discontinued, so their contribution was not lost. It could also be argued that participants are likely to exit the questionnaire only after they have made the responses they feel are most important to them, but this cannot be measured and the possible effects of incomplete questionnaires must be acknowledged as a small but potential threat to the quality of data.

Accuracy of recording and storing data was an advantage of conducting an internet survey and the software included mechanisms to ensure that responses could not be entered incorrectly thereby helping to reduce any potential ambiguity in answers.

The advantage of using a computer to record text responses to open questions as opposed to a postal survey also reduced errors due to poor legibility or lack of space.

In addition, using software packages to organise and code the data can greatly help the researcher in data analysis. In this survey, as I was not familiar with such programmes and the amount of qualitative data was not unmanageable, data were organised using Microsoft 'Excel' and 'Word'.

3.10 Conclusion

This chapter has described the methodological framework for the survey and its application in the design and implementation of data collection. The approach to data analysis was descriptive and interpretive, exploring the scope of issues and factors influencing them. This is described in full in the next chapter, where the results of the survey are presented. The methodology for the second stage of the research, the case study, is introduced after the analysis of the survey, which sets up questions for further exploration.

Chapter 4: The Survey

4.1 Introduction

The previous chapter outlined the methodological approach used to explore the research question. This chapter will discuss the first stage of data collection, the survey and present the interpretation and analysis of findings. The purpose of the survey was to provide data about the role, employment conditions, access and barriers to professional development support for practice nurses, through administering a questionnaire.

4.2 Pilot study

The questionnaire design was pre-tested in a pilot study to check for clarity and accuracy of measurement. 28 practice nurses, one from each practice across one PCT, were approached because they were the 'lead' nurses from their practice with an interest in professional development. They were invited to participate in a pilot study to test the questionnaire, which was sent electronically by email. 12 of the 28 nurses completed the questionnaire and returned it with comments. Several said they were not accustomed to using email or making amendments to attached documents and felt this might put respondents off participating. As the final version was to be on-line rather than sent by email, this was considered not to be a concern. A meeting was then held to discuss the design of the questionnaire further and seven of the nurses attended. These nurses raised some additional issues they felt should be included in the survey. These were:

- Protected study time
- Pressure to achieve 'targets'
- Opportunity to voice in-house problems
- Exclusion from decision-making
- System for addressing grievances
- Lines of accountability
- Funding for training
- Nurses generate income but GP gets reward

These issues were incorporated into the questionnaire, apart from the comment about nurses generating income but not being rewarded, as this did not seem relevant to the purpose of the survey and would be difficult to word in a way that was not leading. Amendments including typographical errors and issues of clarity were then made and the revised questionnaire was sent back to these nurses for comment, as well as to three clinicians with a management role in primary care. These were a GP/PCT executive chair, a Nurse Practitioner/chair of a National Nurse Practitioner Association, and a Specialist Community Nurse (general practice)/Practice Based Commissioning board member. Inviting their comments was an attempt to provide another perspective and guard against bias, as all other input had been from practice nurses (including myself as an ex-practice nurse). Asking clinicians with a role both inside and outside general practice for their view would hopefully provide a more objective scrutiny.

Comments made about the final draft were supportive, with very few suggested corrections and amendments. The view expressed was that the questions were user-friendly, clear, and appropriate and that they highlighted issues of support and supervision.

4.3 Data collection

Once the questions had been tested and confirmed they were sent to an external computer company to set up the on-line survey. This company provided the website, collected all the electronic responses using the software programme 'iSalient' and presented it in table form. This service also included establishing associations between the quantitative findings by cross tabulating responses to more than one question. These analyses were driven totally by me.

Data were collected over a 3-month period from May to July 2007 via the WiPP website (appendix 2). Participants were invited to complete the survey after reading the 'participant information sheet' (appendix 3) and consenting to taking part by clicking the 'Consent and start survey' button. The sample was therefore self-selected and anonymity was guaranteed, as the only identifier was a reference number. A 'pdf' paper version was available to print off and post (appendix 4), and paper copies were also distributed at several practice nursing conferences. The survey was widely publicised, with a postcard mail-shot to every practice in

England (appendix 5), notices and editorials in practice nursing journals, as well as a press release in some women's magazines. The survey was also promoted in WiPP newsletters, and was accessed by visiting the survey site directly or via the homepage of the WiPP website.

4.3.1 Responses

The number of responses was 1,161, representing approximately 6% of the estimated total population of 20,000 practice nurses in the UK. During data collection, results were monitored at frequent intervals and variability in data between each monitoring was noted. Early variations decreased as the numbers of respondents rose and patterns established with the first 120 respondents remained unchanged throughout the duration of data collection, indicating adequate saturation across a broad spectrum of issues and practice types. The response rate peaked following promotional initiatives and began to tail off after two months. To protect anonymity, and to avoid inhibiting their responses, participants were not asked to provide information about their geographical location. However, some volunteered their location in the text comments. Areas mentioned included Dagenham, Wales, Manchester, Tayside (Scotland), London, Derby, Suffolk, Essex, Bristol and Exeter, suggesting a broad geographical spread.

4.3.2 Data management

Whilst much of the data collected through the questionnaire was quantitative in nature, the purpose of collecting the data was not to provide statistical evidence about the frequency of phenomena occurring, rather to establish their range, give an indication of how common they were and the factors linked to their occurrence. However, where associations were made between results a Chi Square test was carried out on the cross-tabulations to determine their significance (appendix 15). This provided greater assurance that these findings were not just due to chance and were therefore valid and worthy of deeper analysis.

Ritchie and Lewis (2003) discuss the benefits of combining qualitative and quantitative methods in contextual research, and suggest that using both in tandem can allow for a deeper exploration of both the 'process' (how a phenomenon occurs) and 'outcome' (how many

times it happened), where a statistical enquiry might not fully capture the complex or delicate nature of a phenomenon. Ritchie and Lewis expand by stating it is often important to know something about the incidence and frequency of a phenomenon to determine the extent to which it exists, whilst also needing to understand it at a deeper level. Some researchers have claimed that this approach to data collection provides a form of triangulation, which enhances the validity of the study (Goodwin and Goodwin 1984, Corner 1991). Proponents of this view assert that the benefit derived from a combination of methods lies in providing a fuller picture with added depth and breadth to the data (Fielding and Fielding 1986). However, the opposing view is that as all qualitative research is unique to time, context and sample, validity cannot be achieved by combining different forms of qualitative and quantitative data. Generally, there seems to be agreement that there are benefits rather than disadvantages to using mixing qualitative and quantitative methods of data collection, providing it is done rigorously and made explicit (Ritchie and Lewis 2003).

4.4 Analysis strategy

According to Sapsford and Abbott (1992), early data interpretation is the opportunity for initial impressions to be formed as the data is fresh and the researcher may be surprised by some responses and have creative thoughts and ideas about links and relationships. Sapsford and Abbott stress the importance of capturing these early impressions, as they may be lost once the data has been read and re-read several times. This was achieved by identifying themes as the survey responses came in and were read, rather than leaving it until the end of the 3-month data collection period. Keeping a log during the analysis process also helped to record early impressions.

Clifford (1997) describes qualitative data analysis in five stages:

1. Making the data accessible.
2. Reducing the data.
3. Organising the data by coding.
4. Combining ideas and themes.
5. Drawing conclusions from the data.

Other frameworks to guide the process (Ritchie and Lewis 2003, Pope et al, 2000) use different terminology for the stages, but the purpose of them all is to provide a means of imposing order upon the data by systematically grouping and labelling them so that interpretations can be made.

Data from the survey questionnaire were quite readily accessible, and no transcription was required. Although the numerical data were presented in table form, there were several questions that had text responses and this led to a large quantity of qualitative data to reduce and organise. The analysis strategy used for this was qualitative content analysis to interpret meaning from the content of text data using a systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon 2005).

Ritchie and Lewis (2003) discuss the importance of initial reading, reviewing and becoming totally familiar with the data to ensure that the full range of characteristics within it are known. This leads on to the next stage termed by Ritchie and Lewis as ‘descriptive analysis’ where the data is revisited and the analysis process begins. This involves:

1. Detection – determining what characteristics are present in the data, labelling the data appropriately.
2. Categorisation – labeled data is ordered under the index categories and they are refined if necessary to accommodate new information.
3. Classification – groups of categories are given a higher classification together.

This process moves the raw data to a higher more abstract labeled state, making it easier to analyse and draw inference from. For example, a comment like “I am only a workhorse” becomes labeled and grouped under the classification of ‘lack of empowerment’. Ritchie and Lewis stress the importance of this process in all qualitative data management, regardless of the method of data collection, to demonstrate a rigorous approach.

Labelling of the free text comments was carried out using a coloured highlighter to group similar comments together and assigning codes. This proved to be very time-consuming and limiting, and the process also created many different files and folders, which were unwieldy.

However, the process necessitated much going back and forth through the data, which had the advantage of increasing familiarity with it, and much was learnt from the experience.

In addition to being coded the qualitative data were also assigned to one of three over-arching categories:

- a) 'positive' - meaning they expressed satisfaction with the professional support received, e.g. "I am very well supported by the Practice" (S343)
- b) 'negative' - meaning they expressed dissatisfaction, e.g. "very little support is offered by any of the GPs" (S380)
- c) 'neutral' - meaning they made comments unrelated to levels of support, e.g. "I am fairly new in post here and still developing and considering my role" (S293).

These terms do not carry any value judgement, but are used throughout the analysis with the meaning described above.

The next stage in the analysis process involved looking for meaning, searching for links and associations in the data to explain the phenomena. This is arguably the whole purpose of qualitative research and therefore a crucial step. The term used by Ritchie and Lewis (2003) is the 'explanatory account' and they describe a process of looking for connections between phenomena. Occasionally these may be overtly expressed by participants, or suggested by the literature or a hypothesis. More often, they have to be searched for by sifting through the data again, counting how often phenomena occur in association and what factors are related to their absence, what patterns emerge in relation to these associations and which cases 'fit' the pattern or not. Richards (2005) describes exploring the data and distilling commonality or contrast as a starting point for looking for explanations for phenomena.

This exploration was initiated through the process of going back to original questionnaires and looking for common features associated with individual phenomena. For example, examining the questionnaires of respondents who had a negative reaction from their employer when they refused to undertake a task they were not trained to perform, it emerged that a common feature between them was that their development needs were determined by the practice and not by their professional development plan.

This method of content analysis is widely used in the interpretation of qualitative data (Denscombe 2003). Its strength is that it remains faithful to the original data as it draws on the material and uses it as a basis for classification. However, the method is at risk of researcher bias as it is their impression that determines the criteria. The risk of bias in the interpretation of results was minimised in two ways. Firstly, the findings were reviewed by the WiPP advisory panel, which critiqued the design of the questions, the research process and the conclusions drawn from the findings, by asking questions about evidence. Secondly, a consultation exercise was carried out, holding a series of meetings with representatives from stakeholder organisations including the Royal College of Nursing, Royal College of General Practitioners, Department of Health and Queen's Nursing Institute. A summary of the research was presented at these meetings and then feedback on the process and outcomes was invited. The representatives did not see the primary data and therefore this process did not conform fully to peer-debriefing (Lincoln and Guba 1985:308). Nevertheless, being exposed to searching questions by experienced protagonists 'playing devil's advocate' provided a valuable opportunity to test the emerging analysis. This resulted in some of the early statements being reconsidered in terms of accuracy and clarity.

The data presented in this chapter are organised in the order of questions as they appeared in the survey, under the theme headings that emerged during analysis. Quantitative and qualitative data are therefore presented side by side, to provide as much depth to each issue as possible.

4.5 Results

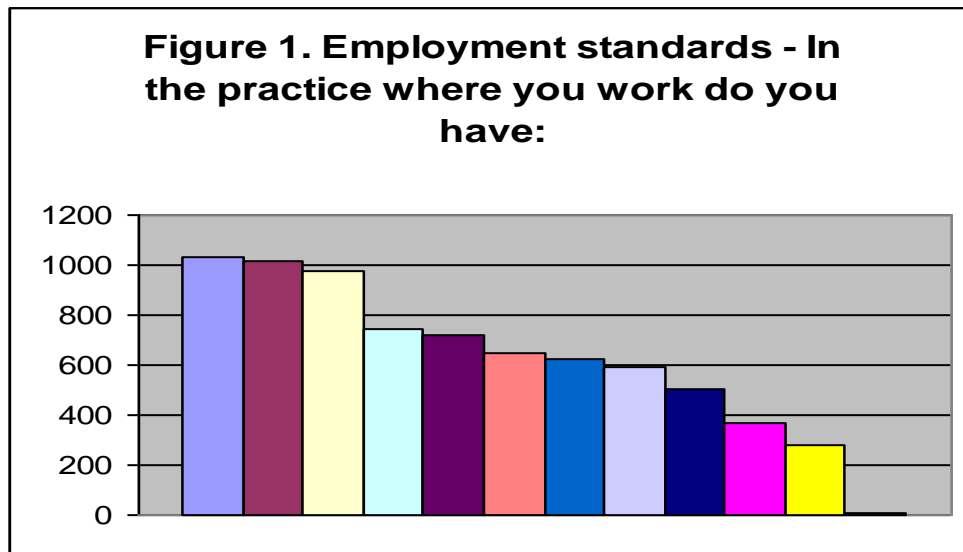
There were 1,161 responses to the survey. 427 of the respondents (37% of the total sample) used the opportunity to answer the final question inviting them to make comments about support they receive and this was the main source of qualitative data. 163 of those (38%) made 'positive' comments, 211 (49%) made 'negative' comments and 54 (13%) made comments that were 'neutral'.

4.5.1 Demographics

Most nurses were over 40 years old, with almost half the sample (48%) aged between 41 and 50 and 30% between 51 and 60 years. The nurses in the group of positive respondents were older (58% aged over 50years) than the negative respondents (13% aged over 50years). This age profile is similar to the SPRU Report findings (Atkin and Lunt 1993) where most nurses were aged between 40 and 49. In this survey over half of the participants had been in practice nursing for more than 10 years and 22% between five and 10 years. Only 13% had been in practice nursing less than three years, indicating an increasingly stable population, which contrasts with the SPRU Report (ibid.) where only one out of 10 nurses had been in practice nursing for over 10 years. This change may be due to the sharp rise in practice nurse employment following the 1990 GP contract. About half the nurses in this survey (45%) worked more than 30 hours a week, compared to the earlier average being 18 hours a week in 1993 (ibid.), indicating an increase in working hours. Only 7% of nurses worked for a single-handed GP, but 12% worked as the only nurse. Although 33% worked in practices with 6-10 GPs, only 14% worked in teams of 6-10 nurses. The most common numbers of nurses in the practice were 2 (25%) and 3 (21%). The large majority of nurses were 1st level Registered Nurses (97%) with 7% holding the Enrolled Nurse qualification. This suggests that 4% had done the conversion course from EN to RN. A very small proportion had additional primary care nursing qualifications other than practice nursing: 4% were community nurses and 2% were health visitors. In 1993 (Atkin and Lunt) there were 92% RGN, 10% EN (suggesting 2% had done the conversion to registered nurse), 12% community nurses and 3% health visitors, illustrating a decrease in qualified community nurses moving into general practice.

4.5.2 Employment standards

The recommendations for employment standards made in the GPN Toolkit were used to design this question (see Fig.1). These represent terms and conditions of service that are considered indicators of 'good employment practice' (WiPP 2008). Participants were asked which of these employment standards were available to them in their practice.



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

Standards being met for a high proportion of respondents who answered this question included a comprehensive employment contract (91%; n=1,034) and annual mandatory updates such as anaphylaxis training (90%; n=1,020). Whilst this represents a high proportion of nurses, the fact remains that almost one out of 10 nurses in the sample reported being without an employment contract or mandatory training. Although annual appraisal was received by a high proportion of nurses (85%; n=974), it would appear that follow up support was not always given, as only 44% (n=502) reported having received help in achieving their professional development plan (PDP) targets following the appraisal.

When cross-tabulated with the number of GPs in the practice some variations on these findings emerged, showing a relationship between size of practice and standards (see appendix 15). In single-handed practices, particularly notable differences were that nurses were less likely to have the benefit of an appraisal ($\chi^2 = 27.77$, $p < 0.001$) or a clear line of managerial responsibility ($\chi^2 = 26.34$, $p < 0.001$). Generally, the percentage of nurses benefiting from these employment standards increased as practices got bigger, the only exception being the use of Agenda for Change pay scales (Practice Nursing Forum 2003), which were lower in practices with more than 10 GPs at 15%, compared to 28% in single-handed practices. Pay emerged as a prominent theme, with Agenda for Change being mentioned as a specific problem. Some GPs seemed to have adopted various aspects of it, such as holiday entitlement, but most were not willing to sign up to the whole package.

Respondent 99

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

Sick leave was also an area specifically mentioned by six respondents as lacking in their employment terms.

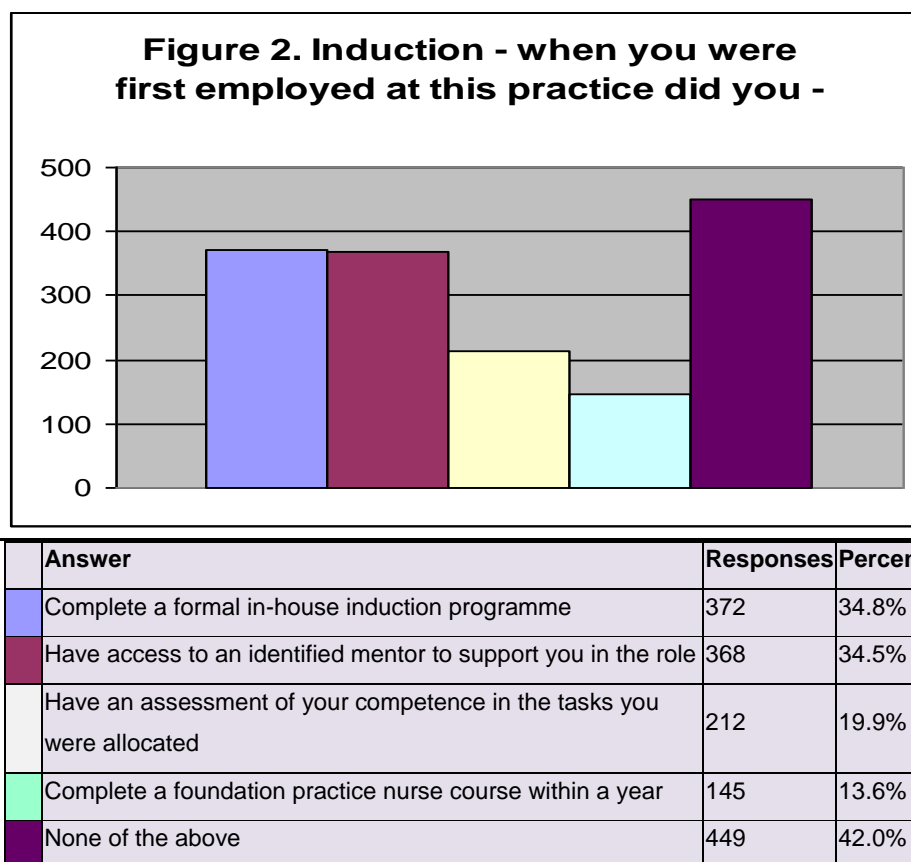
Respondent 946

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

There was a strong link between positive comments in the final free text question and a high score in employment standards, with 92% of positive respondents reporting having seven or more of the employment standards in their practice. This contrasted with those making negative comments, where only 13% reported having seven or more of the employment standards.

4.5.3 Induction

The WiPP recommended standards for induction support when employing a new nurse in practice were also used to frame the second question (Figure 2).



Most nurses who answered this question seemed to gain support from within the practice when newly employed, with 35% receiving a formal in-house induction programme and 34% having a mentor. Only 13% attended a foundation course for practice nursing within their first year in post, although 39% of respondents had a local university running a practice nurse induction programme. Only 20% said they were assessed in-house as competent when undertaking new tasks. A considerable number of the sample (42%) had none of the induction support listed at all. It is possible that some of these may have had previous experience or already completed a foundation programme during another employment. Again, size of practice was a factor, with formal in-house induction programmes more available in practices with more than 10 GPs (51%) than in practices with one GP (21%) ($\chi^2 = 45.29$, $p < 0.001$). This pattern was emphasised further when looking at the number of nurses in a

practice (appendix 15). Formal in-house induction was offered to 70% of those in practices with more than 10 nurses and to 21% of nurses who were the single nurse in the practice ($\chi^2 = 84.51$, $p < 0.001$). Fewer nurses in practices with a large nursing team undertook a foundation course in practice nursing within their first year ($\chi^2 = 26.09$, $p < 0.001$), possibly as a result of them doing more in-house induction than smaller practices. There was little difference between positive and negative respondents in their experience of levels of induction support when newly appointed, which suggests that receiving induction is not an indicator of overall satisfaction.

4.5.4 Role

The respondents' clinical roles covered a broad spectrum of work areas with the top four including health promotion, chronic disease management, immunisation and women's health, being part of the role for around 90% of respondents (see Fig. 3).

Figure 3. What does your role involve?

Answer	Responses	Percent
Health Promotion	1091	94.0%
Chronic disease management	1084	93.4%
Immunisation	1021	87.9%
Women's' health	1021	87.9%
'Treatment room' work	882	76.0%
Minor injury management	711	61.2%
Minor illness management	681	58.7%
Managing other staff	607	52.3%
Triage	515	44.4%
Nurse prescribing	359	30.9%
Other	1	0.1%

This shows that these are 'core' functions such as health promotion common to most practice nurses. Although 76% carried out general treatment room work, only about 60% were involved in minor illness or minor injury management. Less than a third had prescribing as part of their role. In response to the free text question at the end of the questionnaire inviting any other comments, seven nurses commented on the broad spectrum of activities

encompassed by their role, which is “*constantly changing and developing.*” (Respondent 640)

Respondent 207

“I have been a Practice Nurse for five years. (The) role has developed immensely, knowledge and current research and target for GPs has created an unbelievable demand on role of PNs.”

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

Respondent 274

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

Respondent 329

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

Respondent 363

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

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

Respondent 489

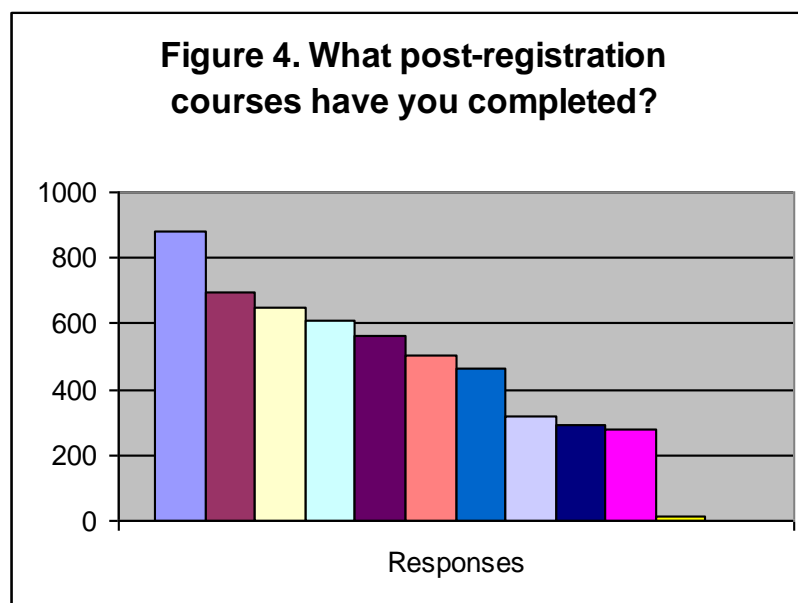
“Generally the nurse’s role is in support of the GP, working to the GP’s agenda. Not always able to give adequate nursing care due to this.”

Respondent 213

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

4.5.5 Qualifications and training

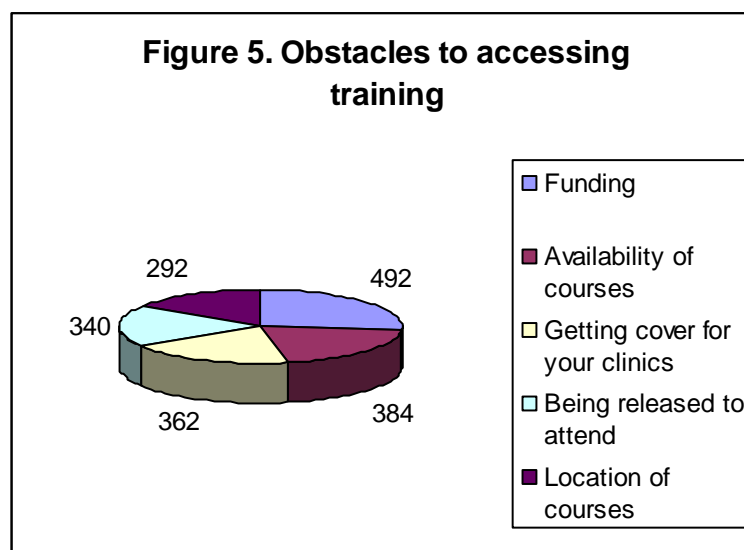
The participants were asked about the post-registration training they had in preparation for their role (Fig. 4). The question listed accredited courses commonly available at HEIs covering topics related to the main areas of clinical responsibility.



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

Looking at the relationship between what the nurses do and what they are trained to do revealed some variations. These could not be accurately described as the training topics did

not exactly match the roles described in Fig. 3. This was a flaw in the questionnaire design, which became immediately apparent when exploring the questions in relation to each other. However, there were several observations possible from the data. Cross-tabulating the nurses who prescribe with those who have acquired the necessary educational qualification, revealed that 13% of those prescribing did not have the non-medical prescribing qualification, which is a cause for concern. 88% had ‘women’s health’ as part of their role and 87% of these had the cervical cytology certificate but only 51% had the family planning certificate. This suggests that up to 49% of those carrying out ‘women’s health may have been required to give contraceptive advice without having a formal training in the subject. 93% of the nurses provided ‘chronic disease management’; 57% had the asthma diploma, 52% were diabetes trained and 43% had done a coronary vascular disease course. Whilst the category ‘chronic disease management’ did not indicate specific conditions, the figures could indicate that a considerable proportion of nurses were giving advice on managing chronic conditions without having a recognised qualification. With regard to professional qualifications and job title, 12.7% had the Nurse Practitioner qualification, but a higher number (15.4%) were using the title. 15.5% had the Specialist Practitioner Practice Nursing qualification, the practice nurse equivalent of the community nurse or health visitor qualification. 48% were trained assessors of pre-registration students and could therefore potentially teach nursing students in general practice. 700 nurses said they experienced obstacles to accessing training and 492 of those said funding was an obstacle (Fig. 5).



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

Respondent 930

“For the last two years training and support has been sadly lacking, getting worse, from outside the surgery. I gather one out of the two more local universities... have stopped courses and the other seems to have reduced relevant ones... it has taken seven months to put our new nurse on a training course for cervical smears... even mandatory updates are difficult to access.”

Respondent 231

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

Some identified the negative effect this could have on recruiting nurses into general practice.

Respondent 330

“I still think the biggest barrier to recruitment into General Practice Nursing is the lack of a nationally recognised educational pathway.”

4.5.6 Professional Isolation/ Risks regarding safety

Concerns were expressed regarding nurses undertaking tasks and roles they felt unprepared for and the potential risks that inadequate access to training could present to patient safety. The language used included words like ‘unsafe’ (respondent 879) and 21 respondents mentioned ‘isolation’.

Respondent 613:

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

Respondent 60

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

Respondent 879

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

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

Respondent 356

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

Respondent 1355

“I worked as an isolated nurse in a rural practice without a mentor or clinical supervision... having qualified just two months previously.”

Respondent 179

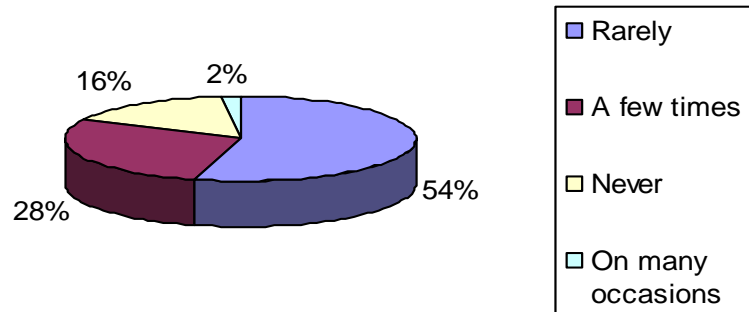
“The lead practice nurse said that she did everything when she first became a practice nurse without any supervision. She just taught herself. She thinks that I should be the same.”

Respondent 346

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

The issue of adequate preparation leading to competence to carry out their role was explored further by asking participants whether they had been asked to undertake tasks they did not feel competent to perform (Fig 6).

Figure 6. Have you ever been asked to undertake a task you were not competent to perform?



Whilst very few nurses reported having been asked on many occasions to undertake a task they did not feel competent to perform, over one in four nurses did report this happening ‘a few times’ and only 16% said it had never happened. This suggests that there is either poor preparation for the role or unrealistic expectations by those delegating tasks, both of which could be avoided by assessing the competence levels of new staff. Five nurses expressed the view that GPs seem to assume that general nurse training was adequate preparation for all aspects of the role of the practice nurse. In the group that had the Nurse Practitioner qualification, this seemed less of a problem, with a higher percentage (24%) reporting they had never had been asked to undertake a task they did not feel competent to perform, compared to 16% of the total respondents, which may be due to their enhanced skills. When asked what action they had taken when faced with a task they did not feel competent to perform, 548 respondents (53%) refused to do the task, 545 (53%) requested further training, 352 (34%) asked for supervision and 114 (11%) sought advice from a mentor or PCT advisor. Out of the 413 respondents who explained the consequences of their refusal to carry out the task, very few had experienced a problem. 37 (9%) experienced a variety of negative consequences such as an angry GP (respondent 381) or redundancy (respondent 410).

Respondent 192

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

Respondent 194

“This happened soon after becoming a PN. I was pressured to say yes but held my ground and refused as I felt it was not safe practice.”

Respondent 249

“A feeling that I was a nuisance for "having standards too high for general practice" as I was once described.”

Respondent 372

*“I was told by one of the GPs that I was being '**** neurotic' and that she was really disappointed at my lack of team spirit.”*

Despite the fact that the experience of these nurses is apparently rare and they are in a small minority within this sample, this experience is a cause for concern, particularly as practice nurses often work on their own which may make them vulnerable in this situation. Upon further examination of the group that experienced negative consequences after refusing to carry out the task, 30 of these 37 nurses (81%) reported that their role development was determined solely by the needs of the practice. This contrasts with the total survey sample, where 71% reported that their professional development was determined by a combination of their own and the practice's needs. This suggests that the influence of the small group was not strong within the practice, for whatever reason.

The vast majority (81%) of the 413 who described the consequences of their refusal to carry out the task due their lack of competence stated that their refusal was accepted and they either received training or supervision. This suggests that overall, when nurses are confident enough to assert themselves on professional grounds they are usually treated with respect.

4.5.7 Training topics requested

699 (65.5%) nurses said they required further training to carry out their role. 668 of those identified specific topics (Figure 7).

Figure 7 Training topics

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

The highest training priorities reflected the most common areas of clinical responsibility, i.e. management of long-term conditions, travel health and women's health. 89 nurses requested prescribing training, which suggests that although a minority have this role (31%), many more

are interested in taking it on. The highest training priority of all was ‘locally held updates on all clinical topics’. This was not reflected in education curricula, with only 44% saying their local university provided such study days. The number of different topics totalled 52, with 24 of the topics being requested by less than five nurses. This illustrates the broad spectrum of training required by often small numbers of nurses which is a challenge for Higher Education Institutions (HEIs) in the design of training programmes, as it is not financially viable to put on courses for very small numbers. Five respondents highlighted the dangers of a lack of continued updates and support following prescribing training.

Respondent 248

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

Respondent 352

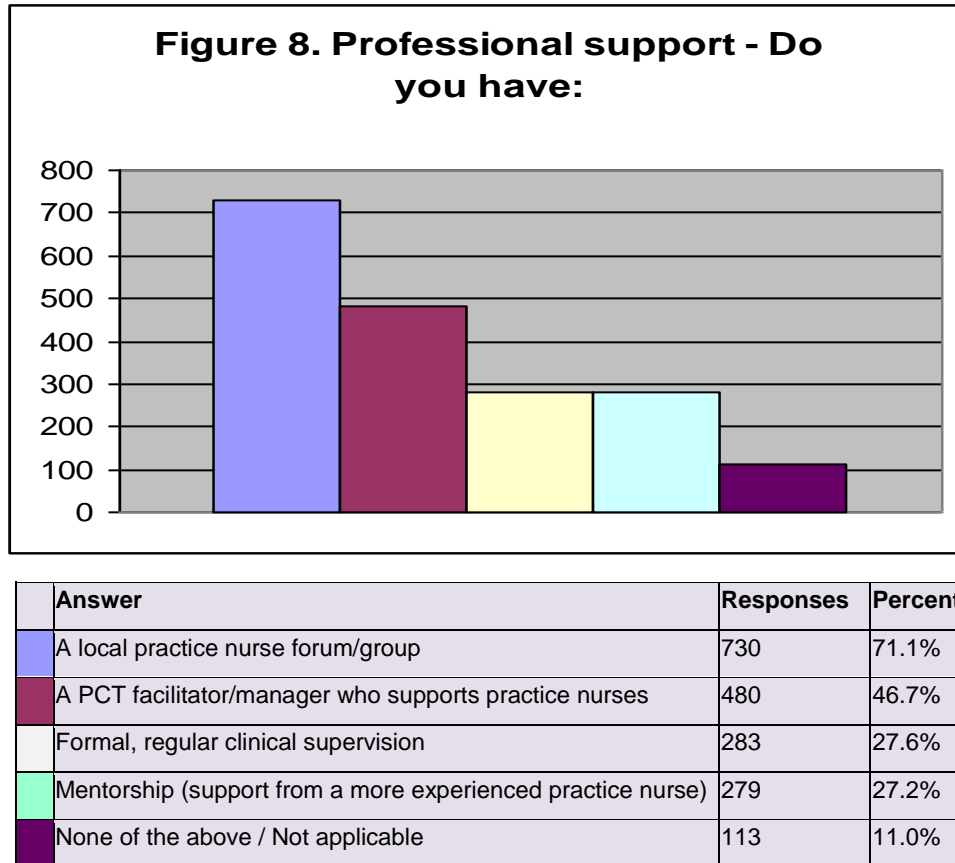
“All the fuss over prescribing, I got trained and then...nothing. I struggle to keep up to date and daily fear that I have no support (unless I arrange it myself). At present, it does not exist. It is disgraceful that we can just be left to prescribe with no support.”

These comments indicate a lack of follow-up study days on the topic but also suggest that nurse prescribers see it as someone else’s responsibility to keep them up to date after their training.

4.5.8 Professional support

Recommendations for professional support looked at access to on-going resources to support the nurses in practice. The responses to this question (see Figure 8) identified local practice nurse groups as the most commonly available resource (71%). Less than half of the respondents (47%) had access to a PCT facilitator and 30 nurses expressed concerns about the lack of support from the PCT, particularly since the recent reorganisations and changes in

PCT function. Just over a quarter of the respondents had access to regular formal clinical supervision (28%) and/or a practice nurse mentor (27%). Considerably higher numbers of positive respondents received clinical supervision (36%) compared to negative respondents (5%). Perhaps surprisingly, mentorship was not more available to those working in bigger nursing teams.



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

PCT Issues

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

Respondent 353

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

Respondent 1289

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

Respondent 692

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

Respondent 1310

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

Some of these comments illustrated a lack of understanding about the PCT reorganisations. It was not funding cuts that reduced PCT support, but the inclusion of training monies in the new GMS Global Sum allocated directly to GPs, resulting in PCTs having no primary care training budget and having competing priorities for funding. In addition, the change in PCT role from provider to commissioner has exacerbated this issue, meaning that they no longer have a responsibility to provide services to support primary care. However, from the nurses' point of view, they were acutely aware of a reduction in available resources.

Another small group of respondents reported that being employed by the PCT as a nurse in general practice had advantages. Six out of the 11 PCT employed nurses reported favourable terms such as study leave and management support.

Respondent 399

“As I am employed by the PCT I find it easier to attend study days and diploma courses.”

Respondent 417

“Employment by PCT rather than GP's ensures equal opportunities and access to annual mandatory training, and increased pay and holidays. Being employed by a larger organization is superior to being employed by GPs.”

4.5.9 New GMS Issues

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

Two respondents felt this system had benefits:

Respondent 165

“I believe that QOF and nurse management are integral to delivering patient care.”

Respondent 801

“Since the introduction of QOF it has improved standards and raised the GPs awareness of the clinical needs of the nurses.”

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

Respondent 1188

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

Respondent 66

“We are overworked and sometimes feel that we are dangerous due to pressure of work- we often omit to do things correctly or record what we have done accurately due to time pressures. We have met with the GP partners to express our concern to no apparent avail to date.”

Respondent 1096

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

Respondent 808

“I feel that the GPs I work for are only interested in meeting their QOF targets and in being remunerated for locally enhanced services.”

Respondent 840

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

Nine of the respondents expressed dissatisfaction that they were generating extra income for the GPs through QOF but were not rewarded for doing so. This is interesting to note as it seems to conflict with their criticism that general practice has become too money-orientated, and it indicates that they too are financially motivated.

Respondent 187

“I feel that our GP's are committed to their patients but with the advent of the Quality and Outcomes Framework they have seen their income rise enormously but seem to think this is "their" money and do not even say Thank you to the nurses or Reception staff.”

Respondent 11

“Morale is low and the all-important QOF points appear to be all that counts in our practice. We see no financial benefit from this activity and I have had my annual cost of living pay rise frozen for the past two years.”

Respondent 808

“I am not rewarded for meeting targets (even though my employers are doing very well) and am constantly being put under pressure to take on more QOF commitment.”

This seems to suggest that there are tensions in the relationship between GPs and some nursing staff around reward, the value of their contribution and a shared perception of ‘reality’ and expectations in the business of general practice. Two respondents linked QOF with deterioration in the working relationship between GPs and GPNs.

Respondent 1211

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

Respondent 1236

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

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

4.5.10 Indicators of positive support - GP/Nurse relationship

163 of the 427 respondents (38%) who answered the free text question about support expressed satisfaction with the support and preparation they received for their role. These respondents were usually older (58% aged over 50) than those who made negative comments about support (13% aged over 50) and they used general terms such as ‘supportive’, ‘fair’, ‘development encouraged’, ‘approachable’ and ‘excellent’ to describe their practice. The respondents who gave fuller answers specifically identified having meetings (n=12), mentorship (n=3), clinical supervision (n=5) and good relationships (n=7) as being additional key factors contributing to feeling well supported. A recurrent theme was that the respondents felt they were part of a strong team (n=17).

Respondent 316

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

Respondent 823

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

Respondent 859

“Very well supported and appreciated within my practice, no problems experienced. You need to have a good relationship with the GPs.”

36 of the 163 positive respondents (22%) stated that they felt either ‘lucky’ or ‘fortunate’ to have good professional support, indicating that they did not see this as the ‘norm’. Positive

comments included words such as ‘trust’, ‘respect’ and ‘valued’. Some identified mutual respect and assertiveness as aspects of a successful team.

Respondent 600

“I feel I am valued and trusted by the partners and practice manager...”

Respondent 335

“Very lucky in this excellent practice which is run by GPs who highly value their staff and development of staff to enhance the quality of care we provide our patients.”

Respondent 477

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

Respondent 177

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

Respondent 543

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

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

Respondent 333

“I much, much prefer working for a GP practice than for the PCT!! (which was overly bureaucratic and inefficient). At least now there is an easy and accessible chain of

command and I feel respected and my training needs are met. This was NEVER the case in the five years I spent as a District Nurse. GP's are, in my experience, very good employers."

Respondent 448

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

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

Respondent 680

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

Respondent 1194

"I am only a "workhorse"."

Respondent 761

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

Respondent 468

"GPs refuse to have meetings as they deem them pointless and say that we may start to discuss issues other than clinical."

Respondent 840

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

Respondent 1265

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

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

Respondent 1291

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

This respondent demonstrates a sense of recognising the rights of nurses to assess their own development needs, but stops short of articulating the ways in which this should be achieved. This apparent impotence was further illustrated by one nurse who claimed to have no opportunity to develop her potential in general practice.

Respondent 1349

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

4.5.11 Sharing Responsibility for professional development

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

Respondent 786

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

Respondent 834

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

Respondent 1267

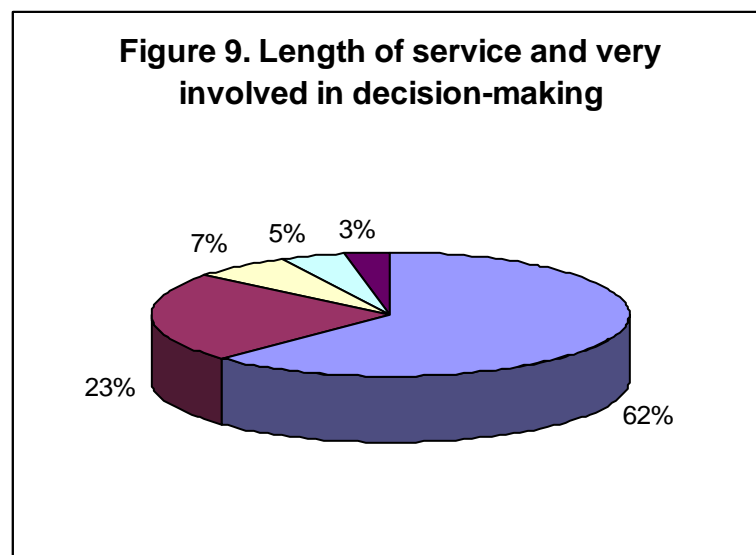
“My GPs have been happy to encourage and support, but also required a commitment from myself e.g. I had to pay my own fees for my Adv NP course, and substantial travel expenses (200 mile round trip once weekly for three years), and the first year do in my own time, with 4.5 hours paid weekly leave the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

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

4.5.12 Decision-making

It could be argued that throughout the data the theme of empowerment emerges as an issue in relation to the lack of influence practice nurses perceive they have in practice. The question

about decision-making explored the extent to which nurses felt involved in decisions about nursing developments within their practice. In the group of ‘positive’ respondents who felt well supported by their practice, 70% of the nurses stated they were ‘very involved’ in decision-making. This contrasted with the group who made negative comments about support, where only 5% reported being ‘very involved’ in decisions. There was a relationship between length of service and level of involvement in decision making ($\chi^2 = 65.92$, $p < 0.001$). Of those nurses who said they were very involved, 63% had been in practice nursing for over 10 years (see Figure 9).



	Answer	Responses	Percent
	More than 10 years	233	62.6%
	Between 5 and 10 years	86	23.1%
	Between 3 and 5 years	25	6.7%
	Between 1 and 3 years	17	4.6%
	Less than a year	11	3%

4.5.13 Size of Practice

Despite individual comments to the contrary, there was no apparent relationship between size of practice, measured by number of GPs, and levels of actual professional development support received. Some nurses attributed aspects of good support to the size of the practice, for example, small practices making communication easier, or large practices affording more opportunities for development but the data did not support these assumptions. Bigger practices did have better employment conditions and there was a link between this and positive comments from the respondents but there was no evidence that this led to better induction, training or support. It could be argued that nurses who feel positive are more likely to have high levels of self-esteem and therefore actively seek out opportunities for development but there is no direct evidence that this is more common in bigger practices.

4.6 Limitations of this survey

One of the key criteria used in making a judgement about the value of a study is whether the conclusions derived from the study have any relationship to the wider setting and can therefore be generalised (Ritchie and Lewis 2003). The quantitative use of terminology such as ‘representative sample’ is often used inappropriately to determine this. As qualitative research cannot be generalised on a statistical basis, quantitative principles should not be used to attempt this. It is not the prevalence of phenomena that determines whether inference can be drawn, rather the range of content and the factors that influence them. Ritchie and Lewis (2003) suggest that establishing whether a sample is ‘representational’ depends on two main issues:

- The accuracy of the phenomena being captured and interpreted.
- The degree to which the sample represents the parent population in terms of inclusivity, by containing the diversity of issues central to the parent population.

These factors affect the credibility and therefore reliability and validity of the research.

The extent to which this study achieves representation can be partly determined by assessing whether the sample allowed for inclusion of all the issues of importance to the practice nursing population. This is reflected in the consistency of repetition of themes by respondents

and the fact that once a critical number had been collected (120 responses), no further themes were introduced thereafter.

The accuracy of phenomena being investigated may have been affected by the quality of some of the questions. The question “Have you ever been asked to undertake a task you did not feel competent to perform?” lacks specificity to time and place. Therefore, although the respondents all referred to issues within their employment in general practice, there is no indication whether this occurred recently or necessarily within this current post. These responses cannot therefore be related to other findings regarding practice characteristics.

A form of inferential generalisation described by Lincoln and Guba (1985) as ‘naturalistic generalisation’ involves interpretation based on the researcher’s own thoughts and views. In order to assess the quality of this, it is important to give adequately detailed information or ‘thick description’ (Geertz 1993) about the data collected and their context to allow for inferences to be made to a wider setting. This was achieved by giving a detailed account of the individual respondent’s comments, the process of thematic analysis and the factors associated with working in general practice.

4.7 Discussion

The results of the survey were consistent with the literature and extended it by updating national information about practice nurse employment conditions. Many of the issues regarding practice nurse professional development highlighted in the earlier literature (Longbottom et al 2006) remained unresolved and neither professional guidance documents (UKCC 1996, DH 1998, DH 1999b, RCN 2005b), nor local and national frameworks (Torbay and Teignbridge PCT 2005, Scottish Executive 2004, WiPP 2008) seemed to have had a significant impact on them over time.

The findings of this survey provided data about employment factors associated with nurses having a positive attitude. Human resources literature describes a link between good employment practice, a positive attitude amongst staff and the likelihood of those staff taking an active role in seeking professional development opportunities (Rafferty et al 2005). This in

turn can enhance performance (Hyde et al 2006, DH 2007) and have a positive effect on patient outcomes (Sheikh et al 2007). Factors that contribute to a positive approach should therefore be shared with nurses to empower them and increase their ability to influence their own working conditions. The nurses in this survey identified effective teamwork, good relationships with GPs, shared decision-making, mentorship and clinical supervision as important factors in feeling positive about the support they received at work. This is supported by the literature, which demonstrates the role played by these factors in achieving improved competence, ability and performance (DH 2007, Keller and Price 2010). This survey also found that provision of these resources was inadequate in places, thereby making nurses and patients vulnerable and jeopardising safe practice. The reasons for this patchy provision are worthy of further investigation.

Survey respondents reported that education provided did not always meet their needs and this again is supported by the literature (Longbottom et al 2006, Tinson 2011). Even where appropriate courses were available, barriers to access included funding and being released from work to attend. The biggest demand was for regular study days to update their knowledge across a broad spectrum of topics and these were locally available for less than half of the survey sample. The mechanism for gathering data on training needs, the decision-making process leading to nurses attending courses and the development of curricula for practice nurses therefore requires fuller exploration.

There is evidence from the survey that some practice nurses were being asked to carry out tasks that they were not trained to perform, and this has implications for public safety (Goldsmith 2011), as well as being in breach of nurses' professional code of practice (NMC 2008). There is evidence that this is not an isolated finding. A survey of primary care respiratory nurses roles and training (Upton et al 2007) reported that 52% of the nurses providing advanced level COPD care and 22% providing asthma care had no appropriate training, suggesting that a large group of patients may be at risk of receiving sub-optimal care. Upton et al recommend addressing this through local clinical governance measures. This could be explored further by reviewing methods of quality assurance at local and national level.

In addition to organisational factors, the survey findings indicated that nurses' own attitudes had an influence on how they viewed opportunities for professional development. This relates to the discussion in chapter 2 about power and professionalism in general practice. The paternalistic culture described in the literature (Cumberlege 1986, Carey 2000) undoubtedly gives GPs greater professional power than nurses. Individual nurses can respond to this in different ways, depending on their attitude and aspirations.

'Segmentation Theory' (Dent and Burtney 1997) is relevant here as a means of explaining how intrinsic as well as extrinsic factors influence role development in practice. It would be interesting to explore whether Dent and Burtney's categories do in fact have a bearing on practice nurses attitudes and aspirations, and therefore professional development needs.

The survey identified organisational resources linked to nurses feeling positive about their professional development. It is possible that putting such elements in place when they are absent could influence nursing staff, making them feel more positive. However, this in itself is too superficial an approach, as the presence of these factors does not demonstrate a causal relationship. The positive work environment may be the result of the nurse's attitude rather than the cause of it. A deeper analysis of what creates the positive attitude is therefore necessary in order to understand whether it can be influenced. The negativity displayed by some of the respondents in the survey appears to encompass a perceived low level of influence, a feeling of being undervalued and, crucially, a lack of empowerment to take any action. A deeper understanding of what creates this disempowerment will enable the building of explanations (Ritchie and Lewis 2003).

4.8 Issues for further exploration in next stage of research

The issues highlighted above lead to several questions for further exploration to provide greater depth and clarity of understanding about the processes involved, influencing factors and possible solutions. This helped to frame the design of the second stage of the research project, the case study. Many of the issues are complex and inter-related involving multiple

political and professional perspectives, making the case study an appropriate methodological approach.

The next stage of the research project will draw on themes identified in the survey and empirical data collected by interviewing a selected sample of practitioners, managers and educationalists.

4.9 Conclusion

This survey uncovered a wide variability in employment standards within practice nursing and inequitable access to external resources to maintain the nurses' clinical competence. This is supported by existing literature. The main themes to emerge from the survey data were:

- Employment standards
- Induction
- Role definition
- Qualifications and training
- Professional isolation
- Professional support
- The new GMS contract
- The GP/Nurse relationship
- Decision-making and empowerment

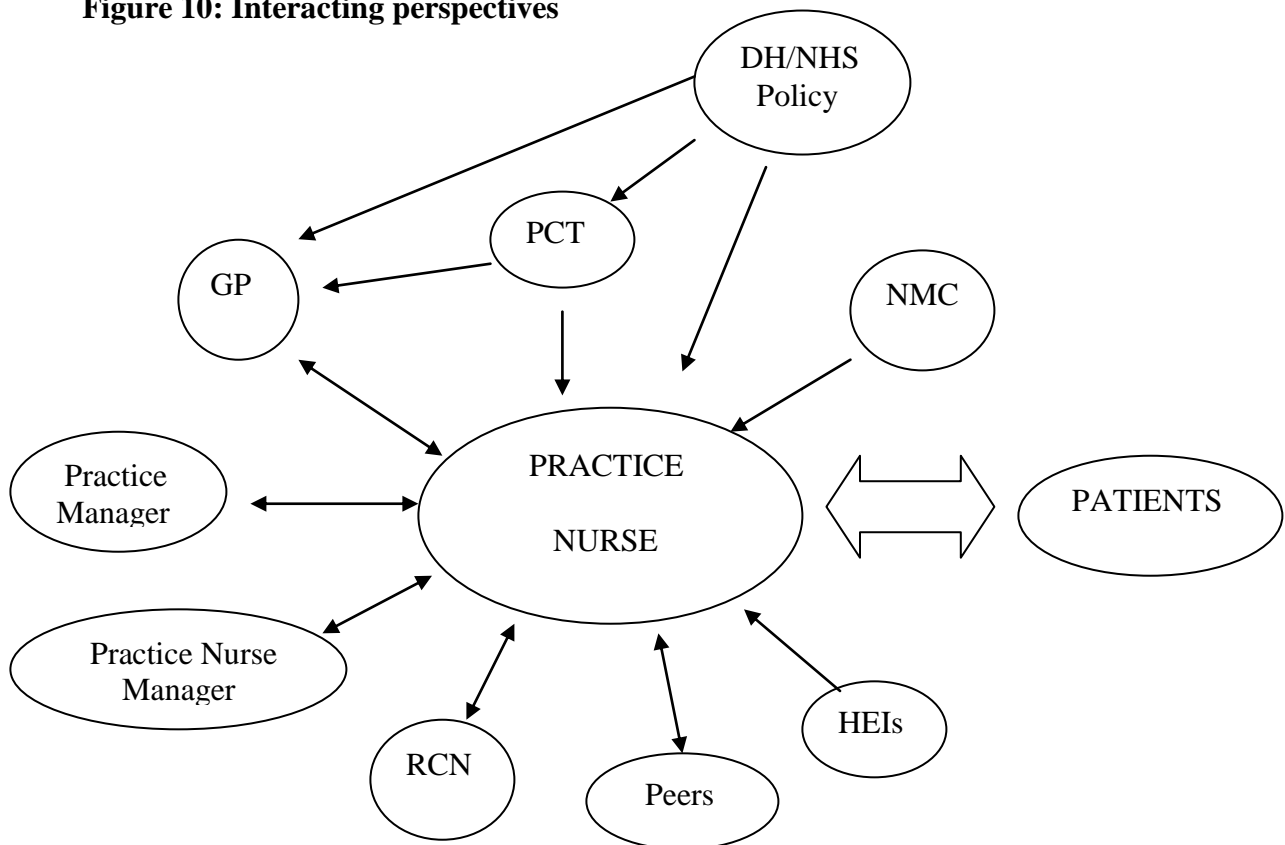
The survey highlighted a broad range of roles, experience and attitudes among the sample and suggested that there may be links between some nurses' individual characteristics and the way their role develops and the support they receive. This has implications for employers - in the recruitment and training of practice nurses, nurses - in understanding how to progress in their careers, education providers – in developing appropriate professional development support, and the NHS – in ensuring the quality of patient care in general practice. The survey provided data purely from a practice nursing perspective but provided insight into the central themes they saw as relevant to developing their role. These data were therefore used to identify the focus for deeper investigation from several perspectives in the next stage of the project, the case study. The methodology for the case study is outlined in the next chapter.

Chapter 5: Stage Two -The Case Study

5.1 Introduction

This chapter introduces the methodology for the second stage of the project and its application to the study. The results from the survey lead to several questions for further exploration to provide greater depth and clarity of understanding about the processes involved in role development, influencing factors and possible solutions. The data gathered so far was from the sole perspective of the practice nurse, providing only one professional viewpoint. However, many of the issues raised from the survey, such as the lack of educational courses, were concerned with forces outside the control of the practice nurse, which could not be explored adequately or explained simply by gathering practice nurse opinion. These forces are complex and inter-related, involving multiple political and professional perspectives (see Figure 10).

Figure 10: Interacting perspectives



Individuals from each of these groups have some degree of influence over the development of the practice nurse role and will all have their own perspective. The next stage of the research project drew on the themes identified in the survey, documentary information and empirical data collected from sources in Figure 10.

5.2 Methodology

The results from the survey highlighted the fact that there were apparently persistent and unresolved problems for practice nurses around control over shaping their own role and access to the resources required to achieve this. The aim of this second stage of the research process was to discover factors that might influence this, to explore possible relationships between them and seek explanations about them. Although the second stage had a different emphasis from the first, the two stages are closely connected, as the first set of data provided the scope of issues for further exploration. The second stage was characterised by a need to seek deeper understanding using multiple data sources, with the potential to create a diversity of interpretations and explanations, thereby providing a full exploration of the phenomena.

Aim

To recap, the overarching aim of the research project as a whole was to explore UK practice-nursing role definition and evolution, the processes involved and how they may be influenced. Two questions were posed in relation to this:

- What factors affect practice nurse role evolution?
- How do these factors affect practice nurse role evolution?

The survey addressed the ‘what’ part of this investigation, providing information about what practice nurses understood their role to be and what resources were available to help define and develop it. The second stage of the research addressed the ‘how’ by investigating the underlying reasons for the lack of empowerment described by practice nurses to influence their role.

Objectives

The objectives of this second stage of the project were to:

1. Investigate how the practice nursing role is viewed by practice nurses, GPs and practice managers as well as representatives from a PCT, higher education institution and national practice nurse forum.
2. Investigate the factors perceived by participants as influencing practice nurse role evolution.
3. Explore any relationships between ‘types’ of nurse such as those identified by Dent and Burtney (1997) and role evolution.

These objectives represent an extension and further development of the first stage objectives, by seeking to explore the underlying causes for the phenomena identified through the survey.

5.3 Selection of research strategy

Yin (2008) discusses the importance of recognising the advantages and disadvantages of different research strategies when making a choice about which to use. An essential consideration in this process is the type of research question being explored (Robson 2011). Yin uses a comparison between the features of survey, archival analysis, history and case study as a means of illustrating how to select the appropriate strategy to answer the research question (Yin 2008:5). Questions that focus on ‘what, who or where’ are most usefully served by a survey or archival analysis, providing descriptive evidence about prevalence and sometimes, in the case of political polls, predicting outcomes. This was the case for the first part of this research study. Questions that focus on ‘how and why’ require a more explanatory strategy to provide links and relationships. The questions being asked in the second stage of this research relate to how practice nurse roles are defined and developed, who influences the process and in what way, and why wide disparities relating to employment conditions and access to educational resources persist. These questions are exploratory in nature and therefore require a strategy that can provide data leading to possible explanations.

The second important consideration in selecting a research strategy is the degree of control over the behaviour of the population being investigated (Yin 2008). Unlike experimental

research, a case study requires no control or manipulation of variables and uses contextual contemporary data to help answer the ‘how and why’ questions. These features of case study research were particularly pertinent in relation to the group under investigation in this study, where it was not possible to control the behaviour of the participants. On the contrary, the complex variables influencing their professional behaviour formed a central part of the investigation. The contextual information relating to their work environment was potentially highly pertinent and a variety of data sources was necessary to answer the questions being investigated. These data requirements and contextual variations made case study an ideal research strategy and this was the methodology chosen for this study.

5.4 Case study research

Case study as a methodology has its roots in social anthropology where the focus of investigation was a family or ethnic group and later, psychoanalysis, where individual subjects were intensively observed and analysed (Gerring 2007). The methodology is said to have been developed by Frederick Le Play, a French nineteenth century sociologist who collected data on hundreds of working class families across Europe in an examination of families in society (McQueen and Knussen 2002). The strength of a case study approach lies in the flexibility to use a wide variety of evidence, including documents, interviews and observations, the goal being to deepen understanding and build explanations (Yin 2008). Case studies are valuable where broad questions have to be addressed in complex circumstances, and where no single method will capture all the salient information (Keen and Packwood 1995). In this case, the research questions required a combination of methods, including interviews and documentary searches, to gather data that will help to deepen understanding of the forces that influence practice nurse role development and build explanations about why disparities persist for this group.

5.4.1 Definition

McQueen and Knussen (2002:66) define a case study as research that involves “the detailed analysis of a single unit of interest which could be an individual, group or organisation”. Yin provides a fuller definition, describing case study research as:

1. *“An empirical inquiry that investigates a contemporary phenomenon within its real life context, especially when the boundaries between the phenomenon and context are not clearly evident, but are highly pertinent.*
2. *An approach that copes with the technically distinctive situation in which there are many more variables of interest than data points, hence the reliance on multiple sources of evidence converging in a triangulation fashion.”*

(Yin 2003:13)

Case studies could therefore be seen as an attempt to “*understand the dynamics present within a single setting*” and a helpful strategy to use when exploring something which is essentially unquantifiable in nature and hard to define, such as an individual’s views or attitudes (Eisenhardt 2002:8).

Gerring (2007:17) discusses the “*definitional morass*” relating to case study research and the confusion surrounding a methodology that embraces so many approaches in one term. However, this should not be taken as implying that case study research is weak, nor that it has no structure and identity of its own. The case study provides a way of thinking about complex situations that takes real life conditions into account but is nevertheless rigorous and facilitates informed and balanced judgements (Keen and Packwood 1995). Case studies can be based on any mix of qualitative and quantitative evidence so long as it helps to answer the research question (Yin 2008). A combination of methods such as qualitative interviews and quantitative archive data is in fact recommended by some as a means of increasing validity through triangulation (Keen and Packwood 1995). Again, this is an advantage of the methodology rather than a weakness as it facilitates the capturing of all relevant data in whichever format is most meaningful, providing multiple sources of information to explore questions. Providing there is a clearly defined theoretical, philosophical and methodological framework, the researcher can argue the rigour of utilising multiple methods in case study research (Luck et al 2006).

Yin (2008) considers that case studies benefit from the prior development of theoretical propositions to guide data collection and analysis and this is particularly helpful if the process

is intended to build theory (Eisenhardt 2002). This is not to say that the case study purports to be an experimental type of research, where a hypothesis is tested in a tightly controlled environment. In fact, the two methods are at opposite ends of the spectrum as the case study deals with uncontrollable contextual data. However, the case study does allow for a proposition to be investigated by gathering and thoroughly exploring the relevant data and then deciding whether or not they provide evidence to support or reject the propositions, or perhaps provide totally unexpected explanations (Yin 2008). Luck et al (2006:106) discuss the “*paradigmatic flexibility*” of case study, suggesting that it is an approach that bridges the gap between different methodologies.

In this study, the case study approach allowed for a broad investigation where participants from a variety of professional, managerial and policy making positions were free to contribute what they considered to be relevant information, which might not have been captured by another methodology. For example, a practice nurse or manager may be primarily concerned with internal organisational reasons affecting the development of their role, whereas a representative from a Primary Care Trust (PCT) or the Royal College of General Practitioners (RCGP) may have an awareness of political or professional influences that shed a different light on the subject. Capturing the range of perspectives allows a deeper, more comprehensive understanding.

5.4.2 Case study design

Within case study research a case may be an individual, group, organisation or event, and this case is the focus for the research and the unit for analysis. A case study may be characterised as being of single or multiple design (Yin 2008).

Single case designs provide data about only one case and are particularly useful when the case is chosen because of one of the following reasons:

1. The purpose is to use it as a ‘critical case’ i.e. to test out a clearly defined theory. This would require a situation where variables were known and could be minimised or controlled in order to prove or disprove the hypothesis.

2. The characteristics of that single case are either extreme or typical. This would allow for an exploration of the particular circumstances associated with the extreme or typical characteristics.
3. There is only one opportunity to capture unique data, or
4. The single case is to be followed longitudinally over time.

However, there are disadvantages to only using one case, as the context may be so idiosyncratic that conclusions drawn from the data may only have any meaning in that one situation and be of limited use elsewhere.

Multiple case designs are generally preferable, as they are less vulnerable in terms of rigour, due to providing some variation in contextual conditions between cases and therefore strengthening the transferability of findings. Gerring (2007) makes the distinction between an intensive study of one or more cases, and a cross-case study where many individuals have a much less intensive level of investigation, more like a conventional sample than cases. In addition, case study design may be holistic, where the total environment is considered, or embedded, where a particular form such as a function or a service is the unit of analysis (Yin 2008). The design for this study will be a multiple-case holistic case study, as it explores cases in several different contexts and includes all relevant environmental factors.

Design types

Yin (2008) describes three main types of case study design, exploratory, explanatory and descriptive. The type used depends on the sort of questions being posed by the research. A descriptive case study is likely to be used in addressing questions that are concerned with identifying the scope of phenomena or describing previously little known characteristics of a group. As such, there will be no hypothesis or prior theory to test and no predictions about outcome. An exploratory case study deals with questions about how and why phenomena exist, but without the development of a prior theory, thereby simply seeking information about the topic under exploration. This type of case study is open and wide-ranging in approach but must still have a clearly articulated purpose to guide its process. An explanatory case study seeks definitive answers to the questions under investigation and attempts to build

theory or explanations. This study employed an exploratory design as it was wide-ranging in approach, seeking new information on a subject about which it would have been premature to conjecture hypotheses or prior theories. There are however, several variables relating to employment conditions and nurse characteristics that were explored in relation to the subject under investigation.

Whilst the three designs above are useful broad classifications for developing the case study, they are limited in terms of guiding the precise requirements for case selection. This requires a very clear definition of the research questions (Robson 2011).

5.5 Developing research questions

As case study research is broad and encompasses a variety of designs, it is essential that the process of developing research questions is clearly articulated and well structured, to give a framework to guide the study (Keen and Packwood 1995). The questions should drive the data collection process and only data relevant to answering the questions should be sought (Robson 2011). A ‘conceptual framework’ can be a useful starting point as this forces the researcher to be explicit about the purpose and important features of the study (ibid.). The conceptual framework consists of a narrative or diagrammatic illustration of the issues under investigation and any possible links or relationships between them. This helps to define the questions that need to be asked and therefore the appropriate types of data collection, method and sampling strategy.

Whilst this study did not propose a prior theory to test in the case study, the first stage results and literature review did identify features linked to the subject under investigation, which guided the design. Figure 10 (page 117) illustrates a range of individuals and organisations with differing perspectives and degrees of influence over the development of the practice nursing role. In addition, the literature documents a range of structures and processes within individual employment settings and organisations that will also have a bearing. These are illustrated in the conceptual framework below (Figure 11) and they can be collectively considered under the broad headings of structural and psychological empowerment as they relate to organisational features on the one hand, individual’s behaviour on the other, and

interactions between the two (Kanter 1977, Spreitzer 1996). Tentative links are made between the features, illustrating possible influencing forces based on comments made by the survey respondents and the literature. Prior specification of these possible links allows constructs drawn from the literature to be tested out in the real world to see if they emerge as bearing a relationship to the process being examined, i.e. the ways in which practice nurses negotiate their role evolution and access to professional development resources. This provides firmer ground for explanations emerging from the results (Eisenhardt 2002).

Figure 11: Conceptual framework – processes and structures influencing role evolution

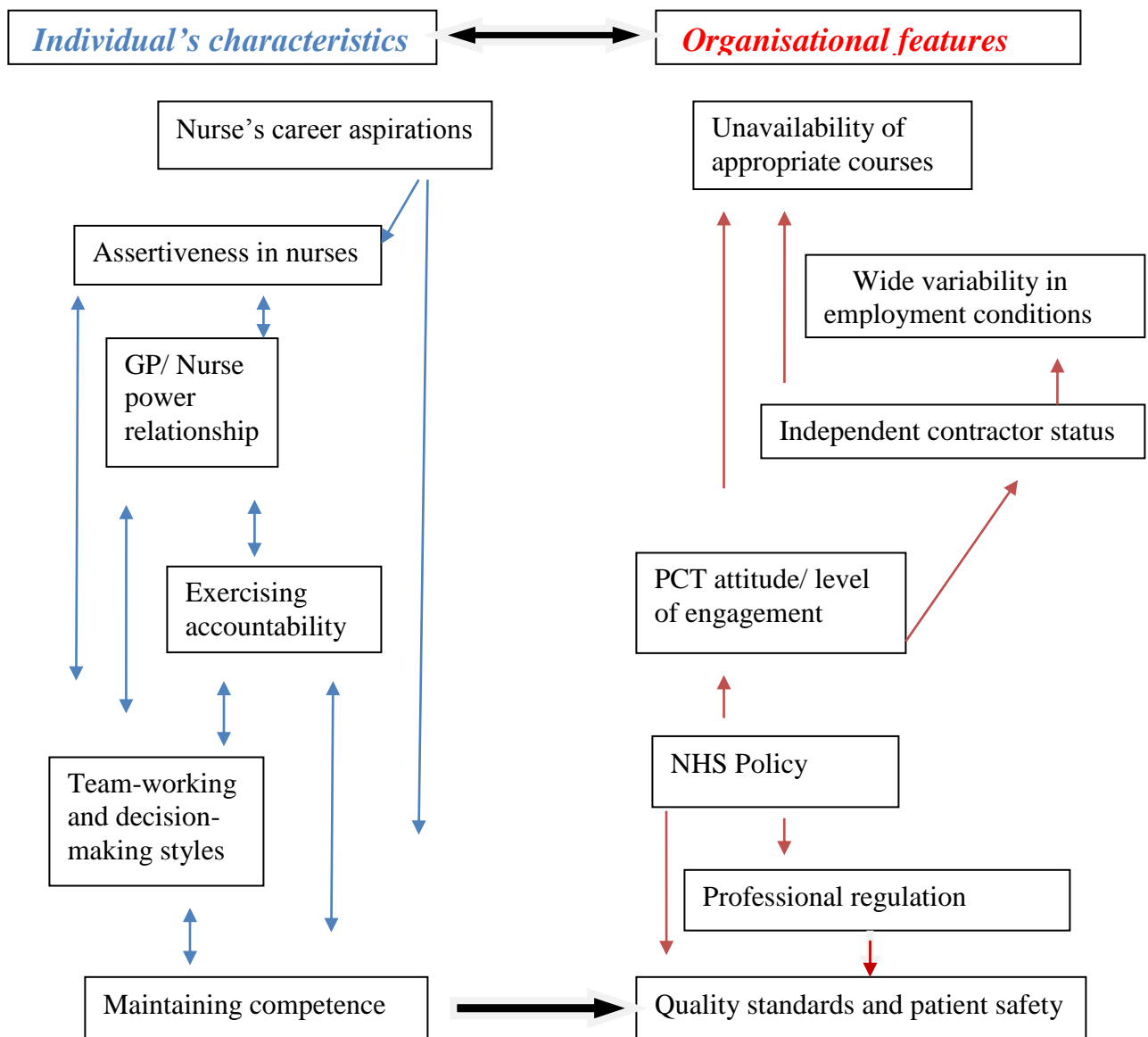


Figure 11 highlights the complexity and number of structures and processes and there will inevitably be inter-relationships between many of them. In order to include data about these, the interview questions were framed in a way that allowed for participants to explain possible links and relationships between them, without asking leading or directive questions. This was done by using comments from the survey respondents and sources from the literature that were used to build the model illustrated in Figure 11 as starting points for interview questions. In this way, participants drew their own conclusions about what factors are involved and how they influence role definition and involvement.

5.6 Sampling strategy and case selection

Decisions about sample selection for cases should be based on the type of data being sought and the distribution of the characteristics being investigated in the population (Robson 2011). In an exploratory case study the objective is to collect the greatest possible amount of information on a given problem or phenomenon, therefore a random selection is neither necessary nor preferable (Flyvberg 2004, Eisenhardt 2002). This is because the typical or average case may not yield the richest information about the phenomenon and valuable data may be omitted. Various strategies can be used to ensure that good quality data is obtained and they rely on theoretical rather than statistical sampling (Glaser and Strauss 1967). This means the cases may be chosen to explore or extend emergent theory, fill theoretical categories or illustrate polar types, rather than to demonstrate statistically significant relationships with the total population (Eisenhardt 2002).

Flyvberg (2004) terms this ‘information-oriented’ selection as opposed to random selection, and gives the following examples as types. Extreme case sampling selects cases that are deviant or unusual and demonstrate a point dramatically. These cases allow for the observation of polar types and may yield rich information about the effects of conditions on outcome. Critical case sampling selects cases that permit deduction about other similar cases, by demonstrating that a clear set of circumstances can produce a predictable outcome. Maximum variation cases are selected to provide information about the effects of differences in one feature between several individuals, such as size or location (Flyvberg 2004).

Other types of non-probability sampling used in case studies include ‘purposive sampling’, where individuals are selected due to their particular characteristics and relationship to the subject under investigation (Robson 2011). This allows the researcher to ensure that the sample will yield enough information to achieve the research objectives. Within this type of sampling, individuals can be selected according to principles such as homogenous or heterogynous characteristics, at different times and in different settings, to fulfil the research purpose (Robson 2011). Purposive sampling was used in this study to select individuals with varied but relevant characteristics.

Gerring (2007) provides a comprehensive summary of approaches to case selection with specific guidance about the applicability of each. The case selection for this study followed the approach termed by Gerring as a ‘diverse’ case, whereby cases display the full range of variation on the variables of interest. Selecting cases where these variables are present or absent allows for possible inference about their effect, by comparing data obtained in each context. If there are multiple variables, then each should be combined differently in every case, in order to determine whether particular combinations are of any relevance. Gerring claims that diverse case selection also provides the best chance of total population representation, as all variables are present in both high and low quantities. Whilst this may not represent typical distribution, it provides good coverage (Gerring 2007).

To overcome the risk of missing useful ‘peripheral’ data Robson (2011) recommends including people who are not central to the phenomenon but related to it, as they may provide a different perspective. These people can provide valuable contextual information and are referred to in this study as ‘key commentators’.

5.6.1 The cases

The main focus of the overall investigation was the practice nurse, what influences the way her role develops and how it is supported. The unit or case was the practice in which each nurse was employed, thereby using a multiple case study design. The data points within each case were the practice nurse, a GP and manager who were able to provide highly pertinent

contextual information to each case. Each nurse was from a different employing practice and therefore had different circumstances as well as personal characteristics that related to their role involvement. Treating each practice as an individual case allowed the opportunity to vary some of these characteristics and explore whether or not their presence or absence bore any relationship to the subject under investigation. This would have been lost to some extent if all cases had been considered together and information gathered more collectively.

In order to be included in the case study each nurse had to;

- be a Registered General Nurse employed by a General Practitioner in the PCT area,
- fit the selection criteria,
- volunteer to participate.

Locum or agency nurses, or any nurse not employed by one specific practice could not be selected for inclusion. Based on these inclusion and exclusion criteria the study comprised six cases, i.e. six practices, selected to represent varied individual and practice characteristics (see Table 1).

Table 1: Case variables

4 or more full time GPs	Nurse practitioner
4 or more full time GPs	'New' practice nurse (<2 years in post)
4 or more full time GPs	Experienced practice nurse (>5 years in post)
2 or less full time GPs	Nurse practitioner
2 or less full time GPs	'New' practice nurse (<2 years in post)
2 or less full time GPs	Experienced practice nurse (>5 years in post)

The justification for using these variables in the case selection was as follows:

1. The survey findings indicated that the size of the practice, measured in number of full time GPs, appeared to be linked to the employment conditions offered to practice nurses.

2. Selecting nurses with a variety of roles was expected to provide data about nurses working at different points of progress in terms of career development.
3. From the survey findings, length of time in post appeared to have a positive effect on the empowerment of practice nurses and their involvement in decision-making within the practice.

Once the six cases were selected, each case had a profile of further characteristics compiled to include:

- the total Quality Outcomes Framework (QOF) practice score, which may provide information about whether there is a link between practice nurse role evolution and practice performance;
- whether or not the practice was a GP training practice, to explore whether a willingness to train GPs influences the level of practice nurse professional development support.

These characteristics provided a fuller profile of each case for comparison purposes. They were not included as selection variables because they were either unquantifiable or considered too sensitive to use as selection criteria.

Each case included two participants in addition to the nurse with direct or indirect involvement in the professional development of practice nurses. These were the practice manager and a GP, who would each provide a different perspective on what practice nurses do and how they should be supported. They were also likely to have played a role in facilitating or impeding practice nurse role evolution. Beyond the six practices, three key commentators were interviewed to provide the broader perspective. These included the PCT primary care practice nurse lead who had an overview of nursing in general practice across the whole county and was influential in shaping local education provision. A nurse educationalist from the relevant higher education provider was also interviewed as universities have a vital role to play in assessing the educational needs of practice nurses and providing appropriate programmes for them. A national and strategic perspective was provided by interviewing a Professor of Primary Care who was also a Local Medical

Committee (LMC) practice nurse advisor, who was well informed about national professional and political considerations that influence the subject under investigation.

5.6.2 Generating and recruiting the sample

The population from which the sample was drawn included all the practice nurses working in one PCT area. A list of potential cases that fulfil the selection criteria was identified through discussion with the Practice Based Commissioning (PBC) Consortium and Primary Care Trust (PCT) Nurses. Access was an issue as the nurses' contact details could not be divulged to the researcher and they had to have the opportunity to volunteer of their own free will.

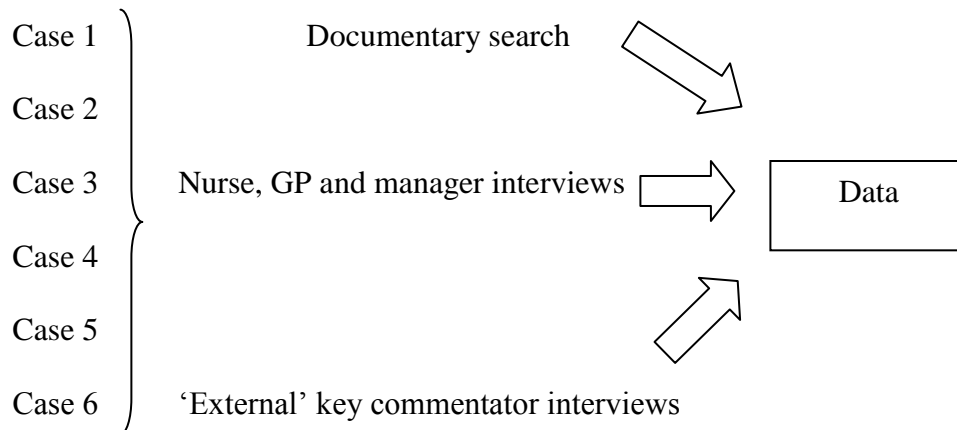
The potential participants were approached initially by letter (appendix 6), enclosing an information pack including a Participant Information Sheet (appendix 7) sent out by the PCT to protect the confidentiality of their personal details. They were invited to indicate their interest in taking part by completing and returning a reply slip signed by the three potential participants in their practice (appendix 8). The first reply that met the criteria for a case was selected, until all six cases were identified. The researcher contacted each case by telephone, confirming that they had been selected and arranging a date for the interviews. The practices that returned a reply slip but were not selected were also telephoned by the researcher and thanked for their interest. At the interview the Participation Information Sheet was discussed and any remaining questions were answered. Written consent was confirmed before the interviews commenced (appendix 9).

5.7 Data collection methods

As previously discussed, case studies benefit from a variety of different data sources and collection methods. Typically, they might include audio-recorded interviews, either structured or semi-structured, observations, and secondary sources such as archive documents or previous research (Eisenhardt 2002). The range of sources used will depend on an assessment of the best information to address the questions being posed. In this study data collection took the form of semi-structured interviews as illustrated in Figure 12.

Observations were not considered an appropriate method as the data required was not about what the nurses did per se; it was about how that was defined, developed and supported.

Figure 12: Data collection sources



5.7.1 Interviews

Semi-structured interviews were chosen as the main source of data collection to allow the participants to provide full information in their own words, thereby providing a large volume of data and minimising problems of data omission bias due to limited, structured questions (Robson 2011). Whilst obtaining large volumes of data is useful in that it provides a better chance of finding answers, there is also the danger that the bigger the volume, the more susceptible the data may be to the vagaries of the particular data collection situation and the researcher must be aware of this risk (Groves et al 2009). Nonetheless, interviewing allows the researcher to clarify questions and probe responses to obtain full and accurate information. Questioning can be adapted according to non-verbal cues such as confusion or reluctance (Groves et al 2009). In addition, interviews allow the researcher to follow up unexpected avenues that emerge thus providing data that could not have been anticipated. Privacy must be considered, as it may well have an effect on the willingness of the participant to be open and answer questions fully. These factors were all carefully considered in the interview process of the case study.

Audio-recorded interviews lasting approximately one hour were conducted with the selected sample. Each participant was interviewed once by the researcher. Participants were offered a choice of being interviewed at their workplace or in a university room.

The interviews followed a semi-structured schedule (see appendix 10) to ensure that all topics of interest identified from the survey findings and the literature were covered and an open questioning style was used to allow the participants to raise relevant additional topics. All interview transcripts were sent to participants after the interview, for them to check the accuracy and make any amendments (appendix 11). This participant corroboration is one method of enhancing the trustworthiness and accuracy of data (Yin 2008, Lincoln and Guba 1985).

5.7.2 Document search

A review of available documents in the public domain that provide information about practice nursing roles and professional development was carried out. Sources included the Department of Health, National Audit Office, King's Fund, Care Quality Commission, RCN, NMC, RCGP, local PCT and SHA. This provided information about the position adopted by various organisations with a responsibility to provide clear guidance to primary care about standards concerning employment and training of staff and accountability for quality of patient care delivered. It also provided a picture of where practice nursing fits into the national workforce and how some of the consequences of the national workforce trends might impact on practice nursing. This provided a different perspective with which to compare the primary data collected through interviews.

Each step of the data collection process was carefully and thoroughly documented, using the software programme 'nVIVO' to enable accurate storing, retrieval and comparison of all data. This was an essential part of ensuring that an assessment of rigour can be made as part of a critique of the research.

5.8 Analysis strategy

Choosing the strategy for analysing data before commencing a research study helps to ensure that the correct sample is chosen and data are collected in the correct way (Yin 2008). In case study research, if there is to be 'cross-case' comparison then careful thought needs to be given to obtaining data that is in a similar enough format to allow for meaningful comparison (Gerring 2007). This was achieved in this study by using a semi-structured interview schedule, ensuring that all areas were addressed in the data collection and were recorded in consistent manner.

Stake (2006) describes the main activity of cross-case analysis as reading the case reports or transcripts and applying the findings of each situated experience to the research questions. The expectation is to create and modify general understanding on the basis of the cases' experiences. He developed a highly organised process for analysing each case and generating 'theme-based assertions' using a matrix worksheet to record the prominence of themes in each case, sorting and ranking them. A range of software packages provides the means to do this electronically, through a coding system that identifies the frequency and spread of the themes across all participants. This study used such a programme to record the occurrence of themes at case and individual participant level and then analysed them by grouping them in a variety of different ways to look for any emerging associations between the data.

The analysis strategy for text data used throughout this research was qualitative content analysis, an approach used to interpret meaning from the content of text data using a systematic classification process of coding and identifying themes or patterns (Hsieh and Shannon 2005). Content analysis is a flexible research method that incorporates a range of approaches across a spectrum from intuitive qualitative to statistical quantitative analyses. It was used quantitatively in the early 20th century, defined by Bernard Berelson (1952) as a research technique to quantify the presence of certain words, phrases or concepts in a systematic and objective manner, by counting and measuring them. Quantitative content analysis is therefore used as a tool for reducing complex texts and drawing conclusions about their meaning through counting the frequency of appearance of words or phrases. However,

this provides little information about the context of these words and phrases and is therefore of limited value in research that is focused on exploring the contextual meaning of communication and the relationship between different elements of a text. Qualitative content analysis explores concepts that relate to what the text is 'about' rather than how much is said, making connections between contextual elements rather than just noting each group of words in isolation. The richness of the analysis using this approach has to be balanced with the associated risks of subjective interpretation made by the researcher discussing the meaning of the text. It is inevitable that any text will have a number of possible interpretations depending on the experience and beliefs of the person reading it. It is therefore essential in establishing the trustworthiness of the analysis that findings are presented in such a way that allows for others to make their own interpretation (Lincoln and Guba 1985, Graneheim and Lundman 2004).

Three distinct approaches to qualitative content analysis have evolved: conventional, directed and summative (Hsieh and Shannon 2005). In conventional content analysis coding categories derive directly from the data with no preconceived template as to what they should be. This inductive bottom-up approach is ideal for exploratory research that is seeking deeper understanding where there is a paucity of literature or under-developed theories. The directed approach starts with a theory or proposal and this directs the coding process. This approach is used for explanatory types of research, where some prior knowledge about the subject under investigation directs the type of questions asked and will test out or extend current explanations. Summative analysis involves counting of key words or phrases and a subsequent analysis of the associated contextual factors. This provides less depth about the subtle nuances at play as it is primarily driven from a quantitative position that subsequently examines the conditions of numerically predominant data.

The approach adopted in this case study was conventional content analysis because the purpose was primarily exploratory. Although the survey in stage one had provided information about factors that practice nurses felt were related to their role development, there was insufficient evidence about any inter-relationships to be able to develop a preliminary explanatory theory. It would therefore have been inappropriate to formulate a pre-determined

theory and focus the data collection and analysis on testing it as this would constrain and limit the amount of potential new knowledge to be gained.

Selection of the unit of analysis is an essential first step in content analysis, providing the researcher with a concept of a unit that is whole and represents the context for the material within it to be coded (Graneheim and Lundman 2004). The unit of analysis in this study was each interview transcript as they all had individual characteristics associated with the participant and this had a bearing on the way questions were answered.

Many different terms exist for the process of reducing and coding texts which can cause confusion for readers of research reports (Burnard 1991, Clifford 1997, Ritchie and Lewis 2003, Hsieh and Shannon 2005). For clarity, in this study data were first classified by a group of words or statements that related to the same central meaning and were assigned a code that described them. This condensed large amounts of text into a phrase that described the essence of the content. These codes were then grouped according to similarities and differences into themes that provided a broader concept of meaning, providing a term that conveyed the main focus of a large body of text.

Braun and Clarke (2006) describe a theme as capturing something important about the data in relation to the research question and being used to represent some level of patterned response or meaning. However, the interpretation of what qualifies as 'important' is subjective and therefore needs to be supported by clear and explicit links between the data sources, the themes identified and the way in which they directly address the research question and are therefore central to achieving the study outcomes.

The process of content analysis coding creates data in a format that allows comparison with previous research findings and the literature, thus producing triangulation to strengthen trustworthiness. Any claim made about the data must be supported by documentation that reflects a truthful representation of the phenomena through systematically gathered and analysed data (Fielding and Fielding 1986, Pope et al 2000, Lincoln and Guba 1985). The

particular challenges in achieving this posed by case study research are discussed in depth below.

Because this case study used multiple cases with deliberate variations between them regarding context and participants, the amount of data generated were considerable and the process of comparison across and within cases was complex. Gerring (2007) describes this as ‘variable-orientated comparative analysis’ because once coded and themed, the focus turns to the variable characteristics associated with each case, mapping and interpreting any relationships between them. In this case study, this involved looking at the frequency, context and emphasis of themes raised in individual interviews, then charting or mapping each case to explore the patterns that emerged between cases in relation to variables such as the length of nurses’ experience or size of practice. This process is described in more detail in the next chapter where the results of the case study are presented.

5.9 Limitations of case study research

Case study research has a tendency to be viewed as one of the weaker methodologies in terms of objective rigour (Yin 2008). This is partly due to the historical development of the approach and ambiguities surrounding the use of the term ‘case study’ in a variety of professional and educational contexts, resulting in a rather loose general understanding. As previously discussed, there is no rule about which methods must be employed in case study research, neither does it have to be exclusively quantitative or qualitative (McQueen and Knussen 2002, Gerring 2007, Eisenhardt 2002). This allows the flexibility to use appropriate methods but also makes it a strategy vulnerable in terms of ensuring rigour. Case study research must therefore be seen to be conducted according to systematic procedures (Yin 2008).

It has been suggested that case study research permits a bias towards verification, where the study confirms the researcher’s pre-conceived notions because it allows more room for subjective interpretation and judgement, and this would make it have less scientific value (Yin 2008). Flyvberg (2004) asserts that most case study research actually results in the rejection of previously conceived notions and therefore has a bias towards falsification rather than

verification. This, he contends, is due to the real-life testing of views in relation to the phenomena as they unfold in practice. Flyvberg argues that verification is a natural human tendency and has to be constantly guarded against in all methodologies, including quantitative, where the choice of research question and control conditions may all have a subjective element. Quantitative methodologies have less opportunity for the correction of researcher bias towards verification whereas case study creates such close-up detail and participant “talk-back” that it is hard to escape challenges to subjective perceptions (Flyvberg 2004:429). Having preconceived notions is clearly an integral part of using prior propositions to guide the data collection and although this is undoubtedly a subjective process on the part of the researcher, there is nothing inherently wrong with that, as it will be rigorously tested out in the field. It is vital, however, that there is sufficient documentation of the process to allow an external observer to judge the soundness of any decisions made and conclusions drawn (Yin 2008, Lincoln and Guba 1985).

Case study research has also been criticised as a methodology because of its focus on context-dependent data and experiential interpretation. Flyvberg (2004) contends that the conventional classification of the case study is oversimplified and misleading. He argues that social science cannot be explained through context-independent theoretical methodologies as it is about exploring meaning and relationships between complex features that cannot be predicted. Flyvberg compares social research to human learning, and asserts that this occurs most effectively through cumulative knowledge derived from individual cases or experiences rather than from theoretical principles. It can be argued that case study research has its own form of rigour in that it focuses on real life situations and tests understanding directly in relation to phenomena as they occur in practice rather than in an abstract sense.

5.9.1 Measures to ensure rigour

Providing that a systematic approach is used, the interpretation and analysis process are transparent and detailed and checks are used to establish rigour, then the case study methodology stands up to academic scrutiny as well as any other (Yin 2008, Flyvberg 2004, Ruddin 2006, Luck et al 2006). Lincoln and Guba (1985) are still regarded as having defined

the gold standard model for assessing rigour in qualitative research (Pope et al 2000). Their criteria are:

- credibility or (truth value)
- transferability or (applicability)
- dependability or (consistency)
- confirmability or (neutrality)

Credibility

Also termed by some as validity, this refers to the accuracy and transparency of data and whether it correctly represents what it describes (Ritchie and Lewis 2003). The nature of the account; its accuracy and transparency is therefore of vital importance (Ritchie and Lewis 2003, Yin 2008, Lincoln and Guba 1985). In this case study, credibility was achieved in the capturing of data by giving participants a choice about where they were interviewed, by using a pre-determined set of prompts to guide the interview and collecting accurately by audio-recording. Systematic labelling of the data to ensure transparent and consistent meaning was achieved by using a software programme and using codes that were simple and descriptive. Yin (2008) calls this construct validity. There must be sufficient evidence to support any interpretation and the findings must be displayed in such a way that the path to analytical explanations is clearly visible. This creates a detailed 'thick description' of data referred to by Lincoln and Guba (1985) and Geertz (1993), which allows others to make a judgement about the quality of the research by providing full details of the analysis of data that lead to conclusions being drawn. Respondent validation, triangulation and peer de-briefing can all be used as measures to strengthen credibility and confirm the truth value of the account. Peer-debriefing involves using a critical outsider to ask searching questions and play 'devil's advocate' in an attempt to probe any biases, clarify the basis for interpretations and expose any weaknesses that may require further consideration. The measures used in the case study included respondent checking of transcript accuracy, triangulation of more than one source of data and peer-debriefing with academic supervisors and two research colleagues.

Ritchie and Lewis (2003) identify two further aspects of internal validity that form an essential part of developing descriptive and explanatory accounts and should therefore be

transparently displayed. These are firstly, the ‘constant comparative method’ coined by Silverman (2000), which involves deriving a hypothesis from one part of the data and testing it out across variable features such as different times, respondents etc. and secondly, ‘deviant case analysis’, where outliers are examined as an important part of the data to determine whether they highlight weaknesses in the hypothesis, or show common features or differences that shed light on the findings. Both of these methods were employed by using a multiple case study design and conducting cross-case analysis.

Transferability

Transferability in qualitative research is a contentious issue but one of the criteria by which the value of a study will be judged. It relies on demonstrating that meaning derived from one study has relevance in the wider setting (Pope et al 2000, Lincoln and Guba 1985, Ritchie and Lewis 2003). Others refer to this as generalisability, but this can be a misleading term as it suggests the application of findings to the wider population. Whilst it is widely accepted that case study findings cannot necessarily be applied to the wider population, it is true to say that they can be used to generate new knowledge and theories, which can then be used by the wider population (Yin 2008, Pope et al 2000). Views differ on this subject, with some contending that ‘critical’ case studies are specifically designed to test the generalisability of case study findings in the wider population (Ruddin 2006, Flyvberg 2004).

Yin (2003) is of the opinion that it is important to demonstrate generalisability but makes a clear distinction between what he calls ‘analytical generalisation’ and statistical generalisation which has no place in qualitative research. Analytical generalisation involves testing out and developing theory in the real world context using evidence drawn from the data and comparing it to previous propositions or theory. In other words, it seeks deeper understanding of phenomena but does not attempt to ‘prove’ their existence or prevalence in the total population. Analytical generalisation is about developing theory to explain the very existence of those phenomena and testing them out in a microcosm that is the real life context. Prior theory formulation in case study research is therefore useful not only to shape the design, but also to provide a template with which the results can be compared, thereby contributing to analytical generalisation which should be the goal (Yin 2008, Eisenhardt 2002).

(Flyvberg 2004) describes the ‘black swan’ theory used to test the theory that all swans are white. This test is termed ‘falsification theory’ and is used in the process of testing the general applicability of case study findings. If one piece of data does not fit the theory i.e. one swan is not white, then the theory is rejected (ibid.). This allows further case studies using different samples and settings to be tested against the theory. Yin (2008) compares this type of generalisation to that used in experimental research, where each experiment can be used to test a theoretical concept. If several repetitions of this process are completed, through for example multiple case studies, the results may be accepted as providing strong evidence in support of the theory.

Any generalisability claims made within case study research must be viewed with caution, as the case study includes, by definition, only a small number of cases of a more general phenomenon (Gerring 2007). It may therefore be more helpful to avoid using the term generalisation at all as there appears to be a continuing debate about how it can be applied in case study (Ruddin 2006, Luck et al 2006). Instead, the term transferability provides a mechanism to allow the use of newly-found evidence beyond the individual case study. Lincoln and Guba (1985) assert that in establishing transferability, it is not the responsibility of the social science researcher to provide a measure or index of this, but to provide enough information for others to make transferability judgments for themselves. Beyond providing exhaustive information about the study and the circumstances in which it took place, Stake (2006) contends that the number of case studies in a multiple case study is critical. Fewer than four will not demonstrate interactivity between phenomena whereas more than fifteen will show more than the researcher or reader can interpret and make judgements on. The important reason for doing multiple cases is to examine how the phenomena manifest in different settings and this requires a great deal of focus and depth (Stake 2006).

Dependability

The goal in achieving dependability is to minimise errors and bias in the case study by providing such accurate and detailed information about the process that would allow it to be repeated in the same way and produce the same results. This requires a very comprehensive documentation of the process, representing a complete audit trail. Lincoln and Guba (1985)

discuss the difficulties in demonstrating dependability of data in qualitative research. This is largely because each case is unique, both in terms of context and the individual interaction between researcher and participants, meaning that reproducibility of the same results on another occasion would be very difficult to guarantee. Others have conventionally used the term reliability, defining it as the need to demonstrate that the findings are not just a quirk of one particular group or location, and assert this as key to appraising soundness (Ritchie and Lewis 2003). However, as it would appear to be difficult, if not impossible, to prove this beyond question, the success in achieving this is often measured by judging how realistic the findings are when compared to other studies in similar contexts using similar methods. This is a form of external triangulation, which enhances the likelihood of the findings not being due to chance and therefore having meaning.

Dooley (2001) advises checking the dependability of data by testing reproducibility with another researcher, but as Lincoln and Guba (1985:317) point out in discussing the weaknesses of their own technique ‘stepwise-replication’, in a naturalistic inquiry two researchers could end up following divergent paths, thereby making replication a “dubious procedure”. However, they also argue that a good analysis will attempt to reduce the problems of bias associated with a low degree of dependability due to variation by providing very detailed ‘thick description’ of the research process to provide transparency in the analysis of data (Lincoln and Guba 1985, Yin 2008, Geertz 1993).

Ritchie and Lewis (2003) recommend using the following five guiding principles with regard to assessing reliability. Firstly the sample selection must be without bias and inclusive of all known constituents. Consideration must also be given to the effects of non-response or attrition. Secondly, fieldwork must be comprehensive enough to achieve coverage of all the issues. Thirdly, analysis must be systematic and classifications confirmed by multiple assessments of the data. Fourthly, interpretation must be well supported by the evidence. Lastly, the process must allow equal opportunity for all perspectives to be captured. An accurate audit trail is paramount to be able to demonstrate the measures taken to provide dependable data.

Confirmability

This final consideration of the trustworthiness of data refers to the extent to which the results are directly drawn from the participants, providing convincing evidence that there was no manipulation of the findings on the part of the researcher or any other form of bias (Pope et al 2000). This is particularly relevant where inferences are made, when evidence points strongly towards a causal relationship between phenomena (Yin 2008). Inference must be thoroughly tested against all other rival explanations to exclude them as possible causes. Pattern matching against previously conducted studies can be helpful by showing the similarities in findings between two closely matched cases (Yin 2008). This is one of the advantages of multiple as opposed to single case study design. This study took the form of an exploratory case study and did not therefore attempt to show causal links between phenomena. It was however possible to make some inference about the findings, in terms of relationships between variables and outcomes, but great care had to be taken to demonstrate clearly the basis for any such statements. Confirmability was established through the triangulation of different sources of data, providing interpretation from more than one source (Stake 2006), the process of reflexivity between the researcher and participants as well as peer de-briefing by academic supervisors.

5.10 Ethical approval

The National Research and Ethics Committee approval process was followed. The case study protocol was submitted to the local Research Ethics Committee and approval was granted on January 29th 2010 (Ref: 09/H0310/99). Participants were given information about the study including the scope and potential consequences of their involvement before being asked to sign a consent form (appendix 9).

5.10.1 Confidentiality

Assigning participant numbers to each transcript helped to ensure confidentiality as far as possible. However, due to the small sample size and the geographical distribution of some key players, complete anonymity could not be guaranteed. Quotations were anonymous and individuals who made comments that could be seen as controversial or could be identified as attributed to them individually were consulted before quotations were used in the thesis. The

only personally identifiable data were the signed consent forms and these are held in a locked filing cabinet in the researcher's home to which only she has access. Audio interview recordings were destroyed once the interviews were fully transcribed. Computer held data will be kept for a period of five years on a secure password-accessed computer at the home of the researcher.

5.11 Data collection

The proposed six cases were successfully recruited to the study by the method described above. A total of nine nurses expressed interest in participating, two dropped out once they realised that their GP and manager would also be interviewed and one was not selected due to the sample being complete. The profile of the six cases selected met the inclusion and sampling criteria fully. There was a mix of experienced and new practice nurses and nurse practitioners, the practices were of varying sizes and rurality and half were GP training practices (see Table 2 below).

Table 2 - Practice profile

QOF Score (2009/10)									
	Patient Popul'n	No. of Dr's	GP TP?	No. of nurses	clinical	org	Patient satisfac'n	Nurse interv'd*	Rural/urban
Case 1	5,450	3	no	4 (p/t)	100%	100%	Average	Exp	Urban
Case 2	12,786	9	yes	5	98%	96%	High	NP	Urban
Case 3	22,049	13	yes	30 (p/t)	100%	98%	Low	New	Urban
Case 4	8,358	6	yes	5	100%	100%	Low	NP	Rural
Case 5	4,694	3	no	3	96%	90%	Very low	Exp	Rural
Case 6	8,700	7	no	9	99%	96%	High	New	Rural

*experienced = >5 years, new = <2 years, NP = nurse practitioner

The mix of practice profiles provided a good range of combined variable features of general practice. This reduced the risk of findings being attributable to an atypical grouping of practice characteristics and created the potential for linking results to common variables across different practice types.

In addition to the nurse, GP and manager from each practice there were three other participants. These were the local PCT nurse advisor, a Local Medical Committee Practice Nurse Advisor (who was also a Professor of Primary Care Nursing and a member of the RCGP foundation) plus a senior lecturer in primary care nursing at the local university. These 'key commentators' provided a broader and more senior nursing perspective with which to compare the case findings.

5.11.1 The interviews

A total of twenty-one face-to-face interviews were conducted. Sixteen of these were completed between April and July 2010, the remaining five were very difficult to arrange and were carried out between October 2010 and March 2011. Reasons for this included one practice experiencing severe disruption as the practice was being taken over by new GPs and delays due to geography, availability and non-response to emails and phone-calls.

The interviews were all held in the workplace, with the exception of the PCT nurse who was interviewed at home due to the time of the interview. Where possible, all three interviews for each case were conducted on the same day, but this was not easy to achieve and in the last three cases they were spread over a period of weeks. Although this meant that where there was a gap between interviews and therefore limited recall of the others within the same case, this had no discernable detrimental effect as each interview was a discrete set of data which did not rely on any prior knowledge of the other participant's contribution. The interviews lasted between twenty minutes and one hour and the number of coded text sections in each interview transcript ranged from 33 to 107. In general, the earlier interviews lasted longer but yielded less data and it is likely that time was used more efficiently in the later interviews as experience was gained. This could imply a degree of complacency about what might come up, with a temptation to direct the participant. However, the fact that new codes were highlighted right up to the last interview shows that there was no pre-determined template for the responses to fit. Certainly, confidence increased as the interviews progressed due to familiarity with the questions and being more relaxed about letting the participant determine the direction of the interview.

All interviews were transcribed verbatim using the 'nVivo' software programme. Initially, a secretary was employed to do this as the task was time-consuming. However, these transcriptions required a fair amount of editing to correct typing errors, so the last six were transcribed by the researcher. Each transcript was sent to the participant for corroboration and all except three participants responded to confirm their transcription was an accurate reflection of the interview. A second email was sent to those who had not responded, but to no avail. Every reasonable effort had therefore been made to confirm transcript accuracy.

This chapter described the methodology for the case study, outlining how the conceptual framework was developed and used as a basis for designing the exploratory interview questions. The rationale for choosing case study as a design was explained and the process of case selection was described in detail, providing transparency about the quality of the sample. The choice of analysis strategy was justified in relation to the data collection methods and overall case study design. Potential weaknesses of case study research were discussed and measures employed to counteract them were described. The analysis of the case study data is presented in Chapter 6.

Chapter 6: Case Study Findings

6.1 Introduction

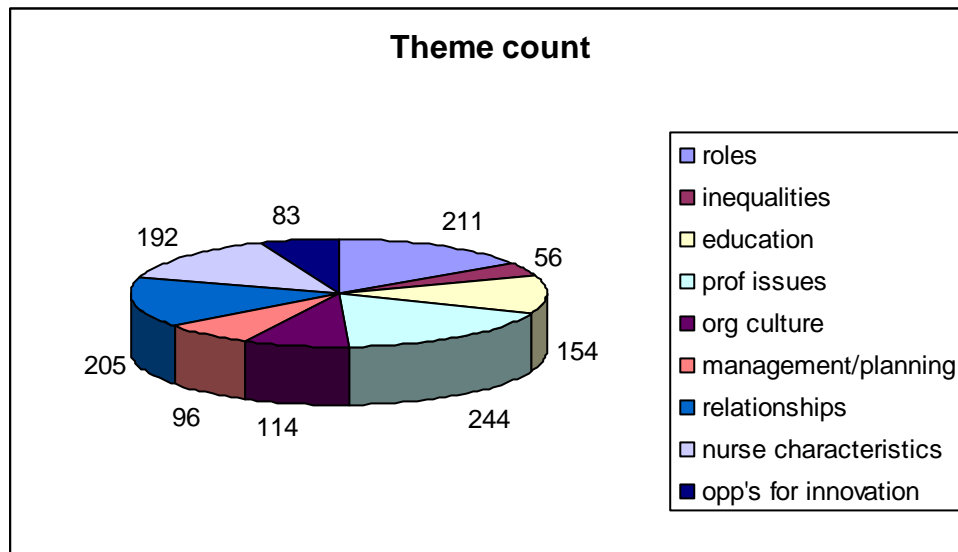
The following chapter presents the data from the case study interviews, describing the process through which they were coded and labeled. The results are presented under theme titles, using illustrative extracts to demonstrate how they arose.

6.2 Data analysis

Data were analysed in several stages using the qualitative content analysis approach described in Chapter 5 to include the key elements; familiarisation with the data, annotating it with codes, grouping together codes into higher order categories or themes, looking for patterns and interpreting their contextual meaning and finally drawing conclusions or developing theory (Clifford 1997, Hsieh and Shannon 2005). This approach starts from an inductive or ‘bottom-up’ position, where analysis is data-driven and the process of coding results in themes that are rooted in the data with no attempt made to fit them into a pre-existing framework (Braun and Clarke 2006). This means that themes are strongly linked to the original data and therefore have a high ‘truth value’ (Lincoln and Guba 1985).

The interview transcripts provided a large amount of text to be coded. An audit trail of the coding process, which generated 1,355 labelled pieces of text, is included at appendix 12. The codes assigned to these pieces of text were too many to manage and interpret, so these were further categorised into nine higher themes, illustrated in the table at appendix 13. Some of these themes were more predominant than others both in terms of frequency within texts and emphasis. The frequency of theme occurrence is illustrated in Figure 13 below, showing that four themes predominated; professional issues, roles, relationships and nurses’ characteristics. The number of times a theme was mentioned in transcripts was not necessarily an indicator of importance to the participant as use of language and emphasis were the aspects that provided real insights into what participants were expressing. However, it did provide an initial illustration of predominance as a ‘way-in’ to accessing the data and getting a feel for what was important.

Figure 13: Frequency of theme occurrence in transcripts



6.2.1 Coding the data

The first step in the analysis process was to read all the transcripts, identifying data-rich text and ignoring material that was obviously irrelevant. All transcripts were then read again and a careful line by line analysis comprehensively highlighted the text and coded the data. The process of assigning codes was built up by reading a phrase and reducing it in length by trying to find a term that accurately captured its meaning. For example, the following phrase from Practice Nurse 5 made important points about the pressure nurses can be put under to perform tasks.

PN5: "So when that person says "I'm paying you your wages, I want you to do [x]" you have to be quite firm about your parameters coz from the NMC, you're accountable so that's the main problem I felt."

The content of this text was labelled with the code 'accountability' identifying the main subject matter of the extract but the first part of it was also labelled with the code 'GP dominance'. The participant therefore had a count in both the 'relationships' and the 'professional issues' themes for this extract (see appendix 13). This process was diligently followed through all 21 interviews, building a list of codes that described those sections of text that contained comments relevant to the research questions being explored. As this

process progressed, new codes emerged in each transcript building up to the eventual total list. This meant that the later-read transcripts were analysed with an awareness of many more codes than the earlier transcripts. It was therefore important to re-code all the transcripts comparing the texts to the full list of codes. This exercise yielded some fresh codes from the early texts and very little from the most recently completed ones.

Once all the transcripts were coded twice the resultant text excerpts in each code were examined to ensure that there was consistency between them in interpretation and that they all fitted the code. The codes were then grouped into nine higher themes to allow for interrogation of the data in a manageable form. The themes were not pre-determined but arose from aligning the codes together in natural groups. The decision to assign codes to the higher themes was based on the codes' similarities in nature and this was discussed with the researcher's supervisor. It was also confirmed by peer-debriefing with two other research colleagues. The process through which codes were assigned to themes involved copying the data onto an 'Excel' spreadsheet, going through the list of codes and highlighting with colour those that seemed to belong together. Some of the codes had natural groupings and very close similarities, and some were less easy to assign. For example 'autonomy' was grouped with a large number of other comments that all described the way the work is carried out, under the theme 'role' and this seemed a very clear grouping. However, as an example of a less obvious grouping, texts coded 'no career framework' were grouped with other comments that related to elements of the job that differentiated practice nursing from other branches of nursing by their absence, under the theme 'inequalities'. Taken in isolation, this might not seem an obvious categorisation but it was driven by the fact that the context of the comment related directly to aspects of employment available to nurses in other areas of nursing than general practice. In this way the coding attempted to accurately reflect the meaning of the text, thereby providing a high degree of 'truth value' or credibility essential in ensuring rigour (Lincoln and Guba 1985).

Inevitably, the coding process is a subjective exercise and one that will have a bearing on the quality of the analysis. If codes had been assigned inappropriately to a theme and then conclusions drawn about their importance, this would have produced a result that was not

faithful to the original data. This was carefully considered during the coding process. The largest groupings of codes under the themes such as 'professional issues' and 'roles' were generally the ones with the strongest similarities, providing a good degree of confidence that these were appropriate and accurately represented under those themes. The codes that had weaker connections were few in number and not central to participants' comments. However, this does not necessarily mean they were less important in terms of addressing the research questions. It is perfectly possible that participants might find it easy to talk at length about insignificant issues and more difficult to articulate things they have strong views or feelings about. The two themes that were most difficult to categorise codes to were 'inequalities' and 'opportunities for innovation'. Inequalities comprised a grouping that included generally negative comments regarding the practice nurses' situation especially in comparison to other groups. Opportunities for innovation included positive and negative comments that could be interpreted as identifying a potential opportunity to bring about change.

6.3 Results - description of themes

The themes generated from the coding process are presented below, giving an early flavour to create a broad sense of the way in which the data began to take shape and to give some context upon which to 'hang' the subsequent comparisons across and within professional groups and cases in the analysis that follows. Although the frequency of occurrence of themes was not necessarily indicative of importance, it is reasonable to assume that a frequently mentioned theme is likely to be one that most participants relate to, so the themes are described in order of predominance below.

- Professional issues
- Roles
- Relationships
- Nurse characteristics
- Education
- Culture
- Management and planning
- Opportunities for innovation
- Perceived inequalities

6.3.1 Professional Issues

The data in this theme covered a range of issues that could broadly be described as relating to the professional code of conduct to which all registered nurses must adhere (NMC 2008). Participants described the variable nature of the practice nursing role and lack of clearly defined limits to it as creating dilemmas and tensions for nurses because it caused uncertainty about their clinical responsibilities. This had the potential to impact on standards of care, because if the nurses were not clear about what they should be doing care may not have been delivered correctly, which may in turn have posed risks to patient safety. Examples of this were nurses undertaking tasks they were not wholly competent to perform which resulted in a breach of their code and potential harm to patients. This included situations where GPs asked nurses to perform tasks without training or where nurses were ‘unconsciously incompetent’ through not being aware they were providing incorrect or incomplete treatment. This demonstrated hazards around the scope of practice and accountability associated with professional isolation for some nurses in small teams with no mentorship or supervision available. There was universal concern expressed across each case and between professional groups regarding this. Nurses commented that without a nationally recognised set of standards for general practice, it was not clear what should be expected of them in their role or how to access guidance if they were unsure whether they were practising safely. A lot of emphasis was put on the unpredictable nature of practice nursing work by all professional groups and the difficulties in preparing for this.

PCT Nurse – “If you've got a doctor saying well I taught you how to do that and that should be enough and actually you're feeling no it doesn't feel safe...”

Some nurses expressed surprise and concern at the lack of a structured process to assess competence and allocate work accordingly, saying this resulted in nurses being thrown into situations where they had inadequate skills and didn't know what action to take. Some employers recognised they were taking a risk by relying on nurses' individual professionalism to recognise their limitations and protect patients, illustrated by one GP:

GP3- “Well we have to trust our nursing colleagues implicitly. We have to trust them to be safe and also to know what their limits are.”

Guidelines and protocols were considered by some to provide protection to both the nurse and the patient by articulating best practice in performing procedures. However, some nurses considered this reliance on protocols to be flawed as it assumed that the nurse was practically capable of performing the task safely, which may not be the case. Conversely, as the lecturer observed, the nurse may be able to perform the task but be unaware of the underpinning knowledge necessary to make a sound clinical judgement from what they observed. In addition, it was noted by some that protocols were not always comprehensive or up-to-date and following them slavishly may result in nurses failing to provide 'best practice', as they may tend towards protocol-driven as opposed to patient-centred care. Some nurses found protocols unhelpful as on occasion they restricted their role development and practice enhancement.

The lack of a mandatory set of standards around the training and employment of practice nurses was emphasised across all groups. Words such as 'indefensible', 'should be enforced' and 'compulsory' were used and most participants were puzzled by the fact that this situation was not regulated in some way. Several participants recommended that practices should be assessed against a set of good practice criteria to include training and employment conditions, suggesting that the Care Quality Commission accreditation would be an ideal tool to motivate and incentivise GPs. Comments relating to accountability and scope of practice were particularly illustrative of the effect that being employed in general practice can have on nurses' work. Practice nurses described a very variable level of delegation from GPs, which was at times inconsistent with the competence or experience of the nurse. This posed potential risks to patient safety when nurses were asked by GPs to do something they felt was not safe and some GPs expressed concern that junior nurses found it difficult to refuse to do so. This related partly to the fact that the GPs paid their wages but also to a lack of assertiveness to challenge them. In some cases this led to nurses leaving a practice and looking for another job. Two GPs expressed surprise and concern at the scope of practice some nurses were undertaking and felt it was inappropriate, with one saying she felt the nurse should not be examining a child. Being able to admit what they didn't know was stressed by some as very important, but participants recognised there were varying degrees of individual insight into this.

6.3.2 Roles

This theme concerned the definition and functions of practice nurse work, including descriptions of how work was delegated, how it was shared between nursing teams, whether there was clarity about who did what and the level of specialisation and seniority. The delegation and distribution of work varied in different settings from patients having direct access to nurses with triage, diagnostic and prescribing skills, to clinics with clearly defined activities such as immunisation. Treatment room roles were generally described as less senior than those in specialist clinics and therefore conferred a lower status, with this tending to be the first role for nurses new to general practice. However, there was always an unpredictable element to this role due to the nature of primary care consultations, which required an adaptable approach and a wide range of skills. Job titles did not correlate with a consistent role across different settings, which was difficult for new nurses to understand. Some roles were clearly identified and others were blurred, with a lack of distinction between practice nurse and HCA functions and sometimes between nurse practitioners and GPs.

There were two different types of engagement with this subject unrelated to profession. Finding it hard to describe, one group simply listed the tasks that a practice nurse does without taking this further, while others made lots of connections between role and other situational factors such as practice size and culture.

Many comments were confined to describing the types of roles in terms of being generalist or specialist and how elements of the work were allocated. In this context team skill-mix featured quite strongly, with the emphasis being on job title rather than the skills level associated with that role. Typically, participants talked about what the HCA or the nurse practitioner in their practice did, rather than linking the roles to specific skills or competencies. There were some concerns expressed about the lack of clarity associated with that distinction, a blurring of roles between different professionals and the confusion that can cause for patients. For some, this focused on the difference between a nurse and an HCA, where patients may well be unaware of the difference in training and levels of competence, seeing them both as a 'nurse'. One practice manager felt there was a general trend emerging whereby routine practice nurse tasks were being delegated to HCAs without the same level of training.

PM1: "It is leading to a general kind of pushing of traditional nurse duties to non-nursing staff. I think that's a really dangerous precedent if that's the case. I'm not sure the public are completely aware of the level of training sometimes behind some of the staff".

Similar comments were made about nurses taking over roles previously performed by GPs such as management of long-term conditions, triage and prescribing. Some GPs expressed the view that they were becoming de-skilled in some areas, and therefore less confident and competent. One GP, who admitted feeling quite threatened by this trend, saw it as an encroachment by nurses into medical territory.

GP2 – "I think nurses themselves then need to think whether they really want to be doctors or whether they want to stay being nurses."

Interestingly, the nurse practitioner in the same practice had concerns about the blurring between the roles and felt that GPs do not always fully understand the limits to the practice nursing role and can delegate inappropriately on occasion. There was a wide range in attitude amongst GPs describing what practice nurses do. Some used paternalistic phraseology, demonstrating a clear sense of responsibility for deciding what should be delegated and within what limits. At the other end of the spectrum were some who seemed resigned to their perception that nurses' roles are evolving and GPs' roles are shrinking, and they do not have much choice about it. One GP saw this as having an impact on his role both in focus and workload.


GP3 – "I think that the biggest issue for the doctors is that they're now working harder, coz they're seeing more complicated stuff on a more regular basis, very few UTIs or pill checks or blood pressure checks coming through the door, it's more people with significant illness so I feel I'm working harder, I feel I'm working more appropriately too."

The two nurse practitioners had advanced roles and a different position in the practice from the other nurses. In both cases, the GP and practice manager held the nurse practitioner in high regard and this seemed to extend beyond their advanced clinical skill set, incorporating

their personal characteristics and contribution to building a successful practice. Both nurse practitioners had an aura of self-confidence and appeared comfortable in their position. Both of them talked about practice nursing in a wider context than just their own practice and both were involved in teaching and mentoring nurses and doctors. They were viewed as providing positive role models within their practice.

As previously described, Dent and Burtney (1997) found that the role, responsibilities and aspirations of practice nurses fell broadly into four categories that closely matched those established by Carpenter's (1977) segmentation theory. Dent and Burtney termed these the 'extended role' (which they labelled practice nurse 1), 'rank and file' (practice nurse 2), 'enhanced role' (nurse practitioner) and 'coordinator role' (nurse manager). For the purposes of the case study interviews, the 1997 categories were renamed to align more closely with current nursing developments (see Figure 18).

Figure 18: Dent and Burtney's re-named segmentation categories:

Description of role	Original title		New title
Additional clinical responsibilities (Practice Nurse 1)	Extended		Specialist
Passive assisting role (Practice Nurse 2)	Rank and File		Generalist
High professional development (Nurse Practitioner)	Enhanced		Academic
Nurse manager	Coordinator		Manager

The re-named categories were intended to be more applicable and meaningful in the current general practice setting and to avoid any associated value judgement. The term 'generalist' was considered a less negative expression than 'rank and file' and would therefore be more readily accepted by nurses working at this level as well as their co-workers.

All participants recognised the Dent and Burtney (1997) segmentation of roles in general practice to a greater or lesser degree, with some seeing the roles as synonymous with actual job titles and others seeing them combined in some cases, where nurse practitioners are generalists but also run specialist clinics.

GP4 – “Well, there’s obviously an overlap isn’t there?”

While the participants readily identified a 'generalist' group of nurses they also described what they considered to be a separate category, where nurses 'just do the job' without any real career development plan or aspiration.

GP6 – “Happy just to come to work, do the job 9-5 but they’re not aspirational.”

PCT Nurse – “Bit of a ‘jobs worth’ – it fitted into their life and they were happy just to turn up and do their bit.”

GP6: “There are those that are just happy with where they’re at and what they’re doing, they don't want to be pushed, they don't want to be challenged, they don't want to take on a new skill set.”

This new group matched aspects of Dent and Burtney's 'rank and file' category. The fact that many participants spontaneously distinguished the low ambition 'rank and file' group from a 'generalist' nurse, as having a wide-range but lower level of skills and less aspiration, further demonstrates the strength and applicability of this classification when applied to practice nursing. This application does, however, require great care, as a number of underlying issues appeared to influence how participants understood and applied the segmentation categories. There were four different approaches to the interpretation of categories related to task, job title, personality and life-stage.

1. Task related

Some participants felt that the segmentation categories simply described different aspects of practice nursing tasks and could therefore all apply to one nurse.

GP 4: "I think they've all got bits of everything."

This was particularly the case when describing experienced nurses and nurse practitioners who may have a combination of advanced generalist roles, such as triage, in addition to specialist roles such as sexual health, and may also have a management role. This interpretation indicates that some participants viewed the categories as purely functional, in other words, literally representing what the nurses did.

PM4: "No I think they are roles almost."

As it is well established that practice nursing encompasses a wide range of roles (Atkin and Lunt 1995, Williams and Sibbald 1999, O'Donnell et al 2010) it is not surprising that participants who viewed the categories as functional task descriptions would feel that one nurse with many roles may fit into several categories.

2. Job title related

Another group of participants were clear that nurses did have a tendency towards one category as opposed to the others, and this was linked to the job title and the perception of the role associated with that title. For example, they described treatment room nurses as generalists, because of the broad range of tasks they perform and they described nurses running travel health or other single-focus clinics as specialists because they had in-depth topic knowledge and expertise. This distinction is seemingly clear and unambiguous. However, a minority also described nurse practitioners as generalists, although they clearly had a very different role and level of responsibility from treatment room nurses. This created some ambiguity about the categories, indicating that the terms 'generalist' and 'specialist' do not denote a level of expertise, merely the focus. This departed from the original concept of these two categories, where the rank and file (generalist) was characterised specifically by low ambition and the extended (specialist) by an active interest in extending their role, suggesting that the role held by a practice nurse was linked to personal aspiration (Dent and Burtney 1997). The relationship between job title, associated role and personal aspiration makes it difficult to assert distinct differentiation of categories and this was reflected in the findings of the case study.

GP3; “And I think most of the generalists, some of them aspire to be clinical specialists as well.”

As well as focusing on what the nurses did some of the job title related descriptions included references to the ‘type’ of person they were, where personal qualities reflected a natural tendency to be ‘a manager’ or ‘an academic’.

NP4; “Specialist Nurses they’re full of ambition, academically a little bit more enthusiastic.”

This tendency to ascribe the segmentation categories to personality traits was further developed in the third category.

3. Personality related

Some participants could clearly identify nurses that had an affinity with one category and their statements referred specifically to the nurse’s personality traits. This was illustrated by descriptions such as ‘career minded’ or ‘not ambitious’, which were seen as determining the roles that nurses would seek. This suggests that practice nurses will be drawn to certain roles on the basis of how well they fit their personality. This resonates with Rovezzi-Carroll and Leavitt’s (1984) linking of Myers-Briggs’ personality characteristics (Myers 1962) with professional career choices. Rovezzi-Carroll and Leavitt found that clinicians with an ambition for a specialist role were adaptive problem-solvers whereas clinicians who aspired to a generalist role were routine-orientated and comfortable with procedure and stability.

PM6 – “I think people’s personalities lead them that way, I see specialists who almost come with that pre-determined.”

4. Life-stage related

Other characteristics identified by participants that determined which category nurses fitted into were the individual’s life-stage and domestic situation.

NP2: “Lots of people are attracted to practice nursing because of the hours, you know because they’ve got young families or had their families so are older nurses who don’t want to do shifts or whatever anymore.”

PCT Nurse: “I think...there are some nurses that literally it fitted in with family life, but it’s actually not being the clinical specialist that drives them it’s actually a job that fits in with their other commitments. It’s not the passion for asthma they have, it’s the fact that asthma clinics run on a Thursday afternoon.”

PM1: “I think a lot of it is also to do with where that particular nurse is within her career as well so for example a nurse coming maybe towards the end of her career is not particularly interested in development opportunities that come along.”

Career interruption to have children is well documented and Weitzman (1994) describes the over-optimism amongst many women in planning how to manage both family and career roles. Age and parenting responsibilities were mentioned by many participants as placing nurses in a temporary category that might not be in line with their natural tendency.

Whilst confirming that the Dent and Burtney segmentation categories are present in general practice, participants were clear that each category carried no particular status or judgment and all practice nurses should have equal access to the support and training necessary for their role, regardless of their level of ambition or aspiration.

Overall, the data collected from participants illustrated the complex nature of practice nursing work and the diversity of roles and responsibilities within different practices.

6.3.3 Relationships

The topic of relationships was a key theme in terms of emphasis, with participants stressing the importance of strong relationships in general practice and giving examples of the consequences when this was absent. There were some features mentioned as essential for good relationships including respect, communication and trust. This encompassed the way in which participants interacted with each other on a professional and personal level, with personality differences being a feature but also the level of familiarity and ‘friendliness’ as well as the degree of caring and support shown to each other. An interest in each others’ well-being had a big impact on the way they worked together. Examples of this included enquiring about each other’s family and nurses supporting each other after bereavement by doing extra shifts. Respect was often described in terms of GPs acknowledging a nurse’s

expertise and this was one of the ways that nurses felt valued by GPs. Where there was a particularly strong relationship, trust was often mentioned as being fundamental. Trust was described as having confidence that a nurse would perform to a high standard and from the nurses' perspective that they could 'own-up' to a mistake and be treated fairly. There was a focus on how key the nurse GP relationship was to effective working and that this took time to develop, building trust and respect. In practices with very good communication and strong relationships the nurses perceived they had support for role development and they felt able to request it. Some GPs were reported to be much more approachable than others and this was often mentioned by nurses as influencing whom they would consult for advice. Feeling dominated by a GP had a very negative effect on nurses' views about their sphere of influence, which produced apathy towards interacting with the GPs generally.

PN6 – "I know all three of us really do struggle with approaching the GPs"

PN3 - "Some doctors...I'm very wary of...I don't do well being shouted at and I think if at any point I've heard him...been particularly sharp with anybody it's made me very wary that I don't then approach or seek them out."

Power was referred to by nurses who felt it was exerted to exclude them from decision-making and therefore reduced their influence. This was inextricably linked to the stereotypical medical/nursing power culture, which seemed a dominant feature in practices with an autocratic management style. Some nurses transcended this, demonstrating a high degree of personal power and this was associated with more highly developed roles within the practice. Some GPs were quite sensitive to the power imbalance and uncomfortable about the barriers it produced to collaborative team working. Others exerted that power deliberately by asserting their position and this created a very different dynamic. Some nurses seemed to hold more power than others and this was generally found in practices with a large nursing team with high levels of confidence and experience. Two participants commented on stereotypical gender roles affecting power relationships, expressing the view that medicine has always had superior power to nursing and this is rooted in gender difference which is exemplified in general practice. One participant felt this is changing with the increasing

numbers of female GPs, but the other was clear that female GPs can take on a 'male persona' because of the tradition and this reinforces the stereotype.

Confidence and assertiveness were recurring themes in the nurse interviews, with many recognising that a deficiency in either put them at a disadvantage in the professional relationship with their GP. This was more of a problem for the new nurses, both of whom were younger than the rest but very experienced and well qualified in their previous roles. Unfamiliarity with the general practice setting and working systems had reduced their confidence level and they were unsure how to address issues that needed resolving, being unclear about communication channels and line management. This was in direct contrast to GPs and managers in these practices who asserted that they had very clear processes in place. This is explored further in the 'in-case' analysis. Empathy between GPs and staff varied across the patch. Where this was high, there was evidence of a unified team spirit with the nurse, GP and practice manager all demonstrating high levels of commitment to the practice and support for each other. This tended to be a feature in practices that were more democratic in culture, where the nurses had a high degree of influence.

The position of independent contractors seemed to heighten some GPs perceived need to cement a firm working relationship with nurses as if it was more fragile and needed to be nurtured more than the traditional NHS system, where nursing staff are part of a separate management structure from doctors. Some GPs struggled with the dual role of colleague and employer, finding it a difficult balance to get right.

GP6 – “We'll see patients together, we'll do things together but then we also have to step out of that and look at the bigger picture and sometimes be the mean boss that says no and that can create tensions and I think its about communication. Maybe it's difficult for them to understand that sometimes when we say no we're rejecting the idea not the individual.”

6.3.4 Nurse Characteristics

Discussion around the part that an individual nurse's attitude or personal characteristics might influence the way their role evolves and is supported generated a lot of data which were unavoidably subjective but nevertheless provided insight into different participants' perspectives. Many made reference to nurses' personality traits and how these affected the way they engaged with their work.

GP2 – “ She’s in a sense very good in a sort of pastoral way, I think she sort of does give a bit of support to everybody and actually... is somebody that probably I suspect everybody can open up to.”

Some made general observations about career or life stage and how this might affect motivation and freedom to take up development opportunities. However, a few made statements about the degree of positive influence a particular nurse can exert according to her individual personality with regard to role modelling and pushing boundaries in development. These were chiefly related to the nurse practitioner role and the value this brought to the practice in terms of leadership and clinical excellence but focused particularly on their personality.

Positive characteristics described were high levels of motivation, aspiration, confidence and assertiveness, and actively using opportunities to develop skills with an interest in how this contributed to the changing demands on the practice. The expressed evidence of these characteristics included a willingness to take on new tasks, and ‘going the extra mile’ for the practice by working late to see patients rather than ‘clocking-off’. It also included nurses recognising and using opportunities to expand the scope of their work. Practical illustrations of this included seeking training opportunities and negotiating permission to attend; observing the way care was delivered and suggesting improvements; supporting other team members and working to enhance practice performance. Specific characteristics that had a positive effect were commitment and teamwork. One of the common agreements across all professional groups was that if nurses can appreciate what it is like for the GPs running their business and really get on-side with making that a success, they will be viewed very positively. Negative characteristics included being resistant to change because adaptability and flexibility were seen as essential in practice nurse work. Some GPs commented that older

nurses who had been in post a long time tended to be less flexible and more set in their ways and this could be difficult to work around. If nurses came across as adversarial or aggrieved they were very likely to get a negative response. Whilst this seems obvious, several participants observed that some practice nurses tend to take a 'them and us' view of general practice, seeing the doctors as having all the advantages without recognising the challenges they face in maintaining a viable practice.

PN4- " I was talking to practice nurses and they were all complaining.... about GPs because they don't feel they are being reimbursed for all the extra work that they are doing, often funding their education themselves or through drug reps.... and they seemed to be rebelling a bit."

The ability to understand the GPs' perspective was fundamental to building a strong working relationship.

6.3.5 Education

This theme represented a major proportion of the issues raised in the nurse interviews, but less so with the other participants and included a broad spectrum of perceived educational deficiencies for practice nurses related to achieving training, education or gaining qualifications. Some factors influencing this were the availability of information on courses, the education ethos within the practice, mentorship and in-house training, the need for educational preparation when moving from secondary to primary care, and the effects of training on patient care.

A major thrust of this theme was a perceived lack of responsibility taken by any particular body for developing, funding and providing education to adequately equip this group of nurses. As a result there was a lack of clarity about what training is actually required for the role, and a great deal of uncertainty about how to prepare new staff, along with the fact there is no structured educational progression linked to career development. The ad hoc nature of finding courses to suit the individual role was not viewed as a flexible and acceptable system, but an inadequate one.

PN4- "I think it's appalling... really, we've gone backwards but unfortunately I'm afraid it's because general practice...is run by a whole raft of different GPs and there is no common standard imposed on the practices."

There were many negative comments identifying the particular problems practice nurses face in accessing education to achieve and maintain competence in a rapidly changing clinical field. GPs were generally less aware of this difficulty than practice managers, who often had responsibility for finding courses for a new nurse and found it difficult to know where to look and what level was appropriate. A general lack of availability of courses was compounded by the inconsistencies in content, duration, cost and quality.

Induction was recognised as vitally important, especially for nurses from a secondary care background. There had previously been a local university induction programme with theoretical and practical elements which was highly rated by several participants and the discontinuation of this had created a gap for new nurses. Most practices therefore had to provide in-house induction training and this varied from 'none at all' to 'a huge amount of support'. Many commented that the lapsing of previous mentorship arrangements with other practices meant that there was no safety net for new nurses working in an unsupportive practice.

One of the barriers to accessing education was the level of practice support. There were practices with a very strong education ethos, where opportunities were actively created and supported. However, there was huge variability, with some practices demonstrating a lack of awareness and low involvement with the result that nurses did not know how to apply for funding or study leave. Some of the most supportive individuals made very critical comments about practice nurse education, particularly around the lack of a national framework to provide a benchmark. The language used in some cases was strong, with words such as 'appalling' and 'indefensible' being used to describe the fact that there is no national agreed standard for practice nurse education and no mandatory requirement for training to undertake the role.

Two nurses described the positive impact of working in a GP training practice on their opportunities for nurse education, with both of them being involved in the GP registrar programme and benefiting from the GP trainer in the practice. Several participants linked education to quality of care, with the potential for lower clinical standards as a consequence of poor educational preparation and support.

PN4- “... that concerns me that the younger nurses don't know that you don't just tick the box for that you should be giving the patient whole care and that's where you think.. 'Do they know that?'"

6.3.6 Organisational culture

Data relating to the culture of the practice arose from discussion about access and barriers to support for role development. Participants talked about the ‘feel’ of the practice in terms of ethos, beliefs and the overall culture that dominated the environment.

PM2 – “The whole team is a little business and the culture of that is probably vital.”

This essence of ‘the way things are done’ captured how it felt to be part of that practice and related to organisational structure and leadership style. This encompassed elements of power-sharing in terms of degrees of influence and control relating to decision-making about the way nursing care was organised and delivered. It also concerned the level of formality within the practice and this was to do with openness, permission to challenge and fluidity of boundaries between individuals.

PM4- “‘so is there any tension here? is there an issue here? is there a problem here?’... lets get it out in the open, lets find out what it is that's causing the problem and be open about it.”

In practices with a predominantly task-centred culture the emphasis was on procedures rather than relationships and this created segregation according to responsibilities. In those with a role-centred culture there tended to be segregation according to job title and this created a divide between different grades of staff. The degree to which these effects were experienced depended to a large extent on the leadership style within the practice and whether it focused on creating or preventing segregation.

Practice culture was mentioned by many participants as influencing the way that the nurse's role developed and was supported. Some of this was to do with openness and approachability, with staff being confident they knew 'how things worked' and what level of support to expect. This was particularly positive where there was a 'no-blame' culture, where mistakes were used as a learning opportunity and peer support was strong. A few participants commented that practice nurses are attracted to general practice because of the relatively flat hierarchy and if this is so, it would not be surprising if they are resistant to managers that impose excessively bureaucratic structures. Because of the apparent significance of leadership style and culture, each case was given a descriptor to identify their predominant features, based on Handy's classification of 'style theories' (Handy 1993):

- Autocracy – authoritative, top-down decision-making
- Bureaucracy – highly ordered with hierarchy and delegation to departments
- Democracy – consultation, shared decision-making and power

Practice culture was also referred to by participants as having an impact on relationships and team working. Practices with an authoritative approach were viewed by nurses and managers as restricting nurses' opportunities to influence their own development due to the lack of consultation. Bureaucratic practices, which segregated clinical staff and had 'heads of department' meetings, were associated with more negative comments about culture and team spirit.

PN6 – "I have, very little communication with GPs.... everything, if there's a problem it's always done through my manager.... there's no friendship whatsoever in this practice between the GPs and the staff."

One of the aspects of a perceived positive practice culture was joint reflection at meetings where the question 'is this working?' was encouraged and all nursing staff were included in the discussion and decision-making. Overall, there was an association between the type of practice culture and the level of opportunity for nurses to develop their role and this is discussed in depth later in the analysis of data.

6.3.7 Management and planning

This theme concerned specific organisational systems and administrative processes that were in place to run the practice such as finance, team structure and communication methods, appraisal and study leave. There was wide variation between practices as to how formal these systems were, with some seeming to operate very hierarchical bureaucratic systems and others being quite unstructured.

PM6 – “We are, in this practice, highly protocolised and... use templates and systems....I'm practice manager but have heads of department and so if we have an issue then I expect our heads of departments to be able to liaise together.”

The relevance of practice size to procedural systems was a subjective issue, with those from large practices extolling the virtues of a big practice and those from a small one describing the benefits of those. Large practices had higher levels of organisational structure and bureaucratic process, which tended to create a more formal environment and this was seen by their advocates as improving efficiency and quality. In contrast, those who chose to work in a small practice described close working relationships and awareness of each others roles as providing greater confidence in effective team working.

GPI – “In a small practice...people need to get on and invariably things get a bit personal sometimes, you know 'how's your daughter, how's your son' that sort of thing, get to know each other on a personal level. In a bigger practice I don't think that exists.”

Larger practices were seen as offering a richer skill mix and opportunities for specialist roles as opposed to the necessity for generalist, flexible roles in a smaller practice. Larger practices were also viewed as providing more opportunity for release from the practice for attendance at events, due to greater cover by colleagues.

Financial support for courses was variable across cases and was not the only factor in nurses feeling ‘supported’. One nurse had been sent on many courses and felt the practice had been very generous, yet she felt unsupported because there was no team spirit and inadequate communication and mentorship. Most GPs and practice managers commented on the need to

prioritise funding for training in relation to financial pressures and the needs of the service. Most participants described identifying training needs through an appraisal process, although that did not always translate into actual provision of appropriate education. Several participants expressed concern about how to attract new nurses with a high proportion of current practice nurses reaching retirement age, no framework in place to educate nurses that may come from secondary care and no central process for coordination of recruitment.

6.3.8 Opportunities for innovation

Comments grouped into this theme encompassed descriptions of two types; situations that restricted development and therefore offered the potential for change and also positive opportunities as yet unrealised. Some of the obstacles to development that were identified provided insight into areas that practice nurses saw as limiting their opportunities. Sometimes the limiting factor was their unawareness of existing guidance and frameworks that could help them negotiate change. Sometimes it was about their not knowing how to influence missed opportunities.

PN6 – “If I send the GP a practice note it doesn't always come back to me, they might resolve it, I never actually learn what the outcome is or they do send it back to me but the answer's not very helpful it doesn't really teach, I don't really learn from it and I find it very frustrating there's no discussion.”

Some participants suggested potential innovations to improve the way the practice nurse role involvement is supported, including mechanisms that could be used, methods to enhance negotiation and networking to improve the chances of implementing sustainable change.

PM2- “I think the RCN could be doing an awful lot more for primary care that they're not doing at the moment and also with the advent of the Care Quality Commission, because we're all going to have to be accredited now I would like to see something in that document around nursing.”

National Practice Nurse Lead- “Having a General practice Nurse lead or an independent nurse lead at the Department of Health would be very useful I think, someone who is independent nurse who works for nursing homes, practice nursing and

so on, because a lot of the issues that are raised for nursing are just for nurses that are directly employed directly by the NHS.”

PN5 – “Now if you're going to devolve more and more to the nurses which the GPs are, they have to stop being insular, 'my practice, your practice, his practice, I'm not paying for his practice' they have to come together now and say 'right it's time for us all as the GPs in this PBC to form a package for our nurses so we're all the same.’”

Other comments categorised from participants as ‘drivers for change’ in this theme provided suggestions about ways to influence and improve the development opportunities for practice nurses. These included –

- working with the Care Quality Commission on setting minimum standards for employment that are linked to practice accreditation;
- retaining freedom from NHS trust employment and aligning with medical deaneries for education along the lines of the GP registrar training scheme;
- financial incentives or contractual obligations for GPs linked to practice nurse professional development support;
- a nurse lead at the Department of Health representing non-NHS nurses;
- having Clinical Commissioning Group supported ‘schools of general practice nursing’ where the funding is top-sliced and responsibility for ensuring a local viable workforce is shared and
- creating a shared database with trusts so that training information can be shared.

Whilst these data represent a small proportion of the whole they are valuable as they may provide insight into possible solutions to some of the problems raised. Referring to obstacles to change, many cited the independent contractor status of GPs as producing an individuality that characterises general practice.

GP6 – “You will get a different view from every different practice you talk to.”

This meant that attempting to achieve standardisation for any part of practice nurse employment would be difficult as consensus would be hard to reach. Change would have to

be perceived as acceptable to all or at least not detrimental, to have any chance of being adopted. Negotiation skills were perceived by several participants as key to successful working in general practice, in the context of knowing how important their role is and understanding how to maximise the positive impact they can have within the practice.

6.3.9 Perceived inequalities

The essence of the contributions grouped in this theme was perceived differences between practice nurses and other professionals, placing them at a disadvantage. This concerned aspects of employment conditions, the low professional influence of practice nurses, their lack of a collective voice and therefore ability to address inequalities such as not being entitled to 'Agenda for Change' terms.

PCT Nurse Advisor – "In general practice, because each practice unit is much smaller.... people feel they have no where else to go. They often end up going to the Union.... sometimes I think it's often reassurance for nurses that actually... "no i'm not being daft."

The predominant feature of this theme was a sense of 'being hard done by' and having no power to do anything about it. This theme related to comments made predominantly, but not exclusively, by nurses and the context was the independent contractor status of general practice causing a lack of consistent structures and systems in place that could provide collective responsibility and uniform standards of employment, such as holiday entitlement and paid study leave. Whilst this was the least often mentioned theme, it held some important clues as to the mindset of those practice nurses that felt less well supported, and therefore provided some insight into the challenges in providing education and professional development support for this group.

Also included in this theme were comments relating to feelings of isolation and the professional risks associated with it.

PN5 – "I find it very isolating practice nursing, even though there other nurses in the building you don't really know what's going on out there.... you don't know what you don't know."

6.4 Interpretation and analysis of findings

The process of coding made the data accessible for interpretation but the main challenge was in displaying these data in such a way that could provide a ‘way in’ to interpret them in relation to the characteristics inherent in each case, turning them from the raw state into something from which meaning could be derived. The themed data was therefore ‘cut’ in a variety of different ways, analysed and compared to explore relationships, search for meaning and identify any patterns and linkages between themes and cases. Theme distributions from each nurse, manager and GP were compared in the following ways;

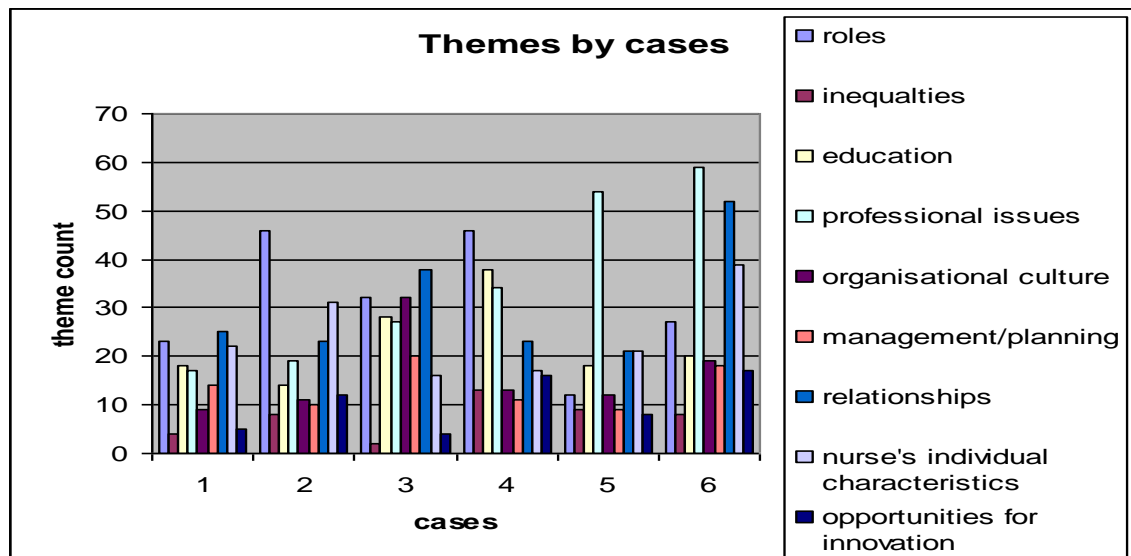
- across cases, i.e. case data aggregated and compared to each other;
- across professional groups, i.e. data from each profession aggregated and compared to each other;
- within their professional group, i.e. same professionals compared to each other;
- within their case, i.e. same-case participants compared to each other; and
- repeated cross-case analysis.

The analysis started by determining patterns of theme distribution across all cases and professions as well as within each profession. These represented high level scans of the distribution of themes that guided the analysis, focusing on the investigation of apparent patterns and associations and ignoring ‘blind alleys’. This high-level scanning was used as a step to guide the analysis so that the focus for in-depth investigation was based on more than a ‘hunch’. This led to an intensive qualitative exploration of each case before finally returning to a cross-case comparison of the main findings. Through this process a methodical and thorough investigation of the data was achieved. The steps are described below.

6.4.1 Cross-case comparison

The first high-level assessment aggregated the data to incorporate all case participants and compared them across cases. Some cases shared a predominant theme, i.e. roles in case 2 and 4, professional issues in 5 and 6, relationships in 3 and 6. However, as this only related to one theme it was not a strong basis upon which to focus deeper investigation. Overall there was no consistency in distribution in pattern of themes raised across the six cases and there were no themes that were consistently predominant across all cases (see Figure 14).

Figure 14 – Comparison of theme distribution across cases



This result is not surprising, as each practice was deliberately selected to provide a different combination of a range of characteristics, with the potential to examine whether any of those proved to be of particular relevance to the subject being explored. It would therefore have been surprising if the cases bore a strong resemblance to each other, although it might have been anticipated that those that shared similar characteristics, such as size or rurality, might have looked more similar. The fact that some cases had a ‘spike’ in common was noted (roles in 2 and 4, professional issues in 5 and 6) but there was not enough information at this stage about what the possible links between these practices might be.

The next stage was an examination across and within each professional group to see if they shared similarities or differences peculiar to their professional group or in common with others.

6.4.2 Cross-profession comparison

The themes were displayed by professional group to illustrate the emphasis placed on particular themes by each (see Table 3), with green shading highlighting similarity in frequency between groups, while red shading denotes a group that differed from the others.

This illustrated that the managers' mentioning of themes was usually closely aligned with one of the other two groups. Nurses were the most common outlier compared to the other groups.

Table 3: Theme count by professional group

	Role	Edu- cation	Relation- ships	Prof Issues	Nurse Charac's	Manage- ment	Org Culture	Inequal- ities	Opp's innov ⁿ
Nurses (6)	57	60	66	94	54	28	27	29	20
GPs (6)	59	36	48	56	36	22	34	6	15
Managers (6)	70	40	68	60	56	33	34	9	27
Commentators (3)	25	18	23	34	46	13	19	12	21

The nurses' mentioning of professional issues, inequalities and education was considerably higher than the practice managers and GPs, which suggests they were more concerned with opportunities to maintain competence and work within their regulatory framework, and had a perceived sense of disadvantage that was not shared by the other two groups.

There were broad similarities between the distribution of responses from each group on 'opportunities for innovation', 'organisational culture' and 'management and planning', and they all gave them a fairly low mention, suggesting that these themes were not deemed to be very significant. Role was the most mentioned theme by practice managers and GPs and although the number of comments by nurses was similar, they emphasised professional issues, relationships and education more. This strengthens the sense that the nurses were more concerned with some of the factors that are associated with their role rather than just its definition. The GPs made considerably less mention of nurse's individual characteristics and relationships than the other two groups, who both placed a similar emphasis on these themes. This aligns with the difference in approach between doctors and nurses, where medicine places more emphasis on problem-solving and nursing requires a more holistic approach. It is unlikely to be a gender trait as four of the six GPs interviewed were female.

In contrast to the other groups, the key commentators' most-mentioned theme was the nurse's individual characteristics. There were only three key commentators so their total count of 46

mentions for this theme was proportionately a lot higher than in the other groups. They were also proportionately higher than the practice nurses in their mentioning opportunities for innovation. It might be expected that as the key commentators were all nurses their responses might have most closely matched the practice nurses. However, their responses were markedly lower than the practice nurses on professional issues, relationships and education, being more aligned with the GPs on these issues. On role and inequalities they had a similar count to the practice nurses. The reason for involving the three key commentators as participants was that they might combine the insights of being a nurse with the benefits of being involved in the development of the professional group in a wider context than the individual general practice setting. Their senior roles and breadth of experience at regional and national levels gave them a different perspective from nurses just working in one practice. Despite some indications of profession-specific differences between nurses and the other two groups in terms of education, professional issues and inequalities, the fact that they mentioned these more often and had a different emphasis was not enough to guide a deeper exploration as to the underlying causes for this. The analysis therefore continued to look for other parallels to provide more evidence about where to focus a deeper investigation.

6.4.3 Intra-profession comparison

When grouped together and examined as nurses, GPs and managers, no pattern to indicate that participants within the same professional group shared common priorities emerged. Instead a considerable variation arose between same professionals in the frequency they raised each of the themes (see Figures 15, 16 and 17). This indicated that looking at aggregated professional groups had limited value and that belonging to a particular professional group was not a major factor in terms of the issues they raised in their interviews. An in-depth exploration of the distinctions between the three professional groups was therefore not worthwhile. However, there was something to be gained by looking at the distribution patterns of individual professionals across all cases. The graphs are produced below to illustrate this.

Figure 15 – Frequency of themes mentioned by practice nurses

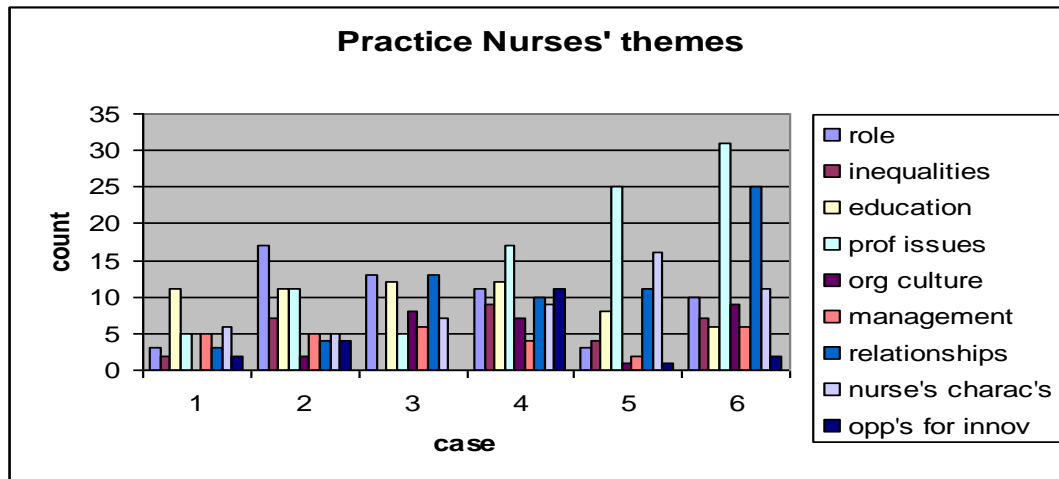


Figure 16 – Frequency of themes mentioned by GPs

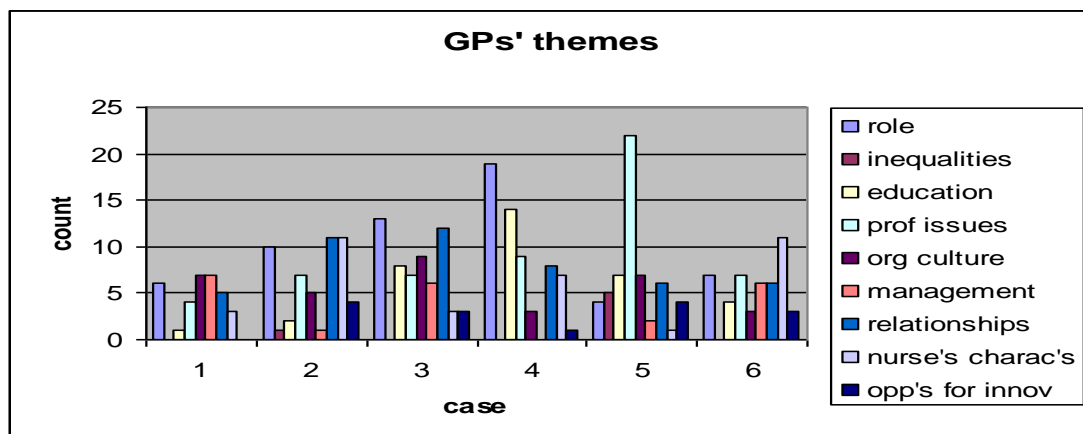
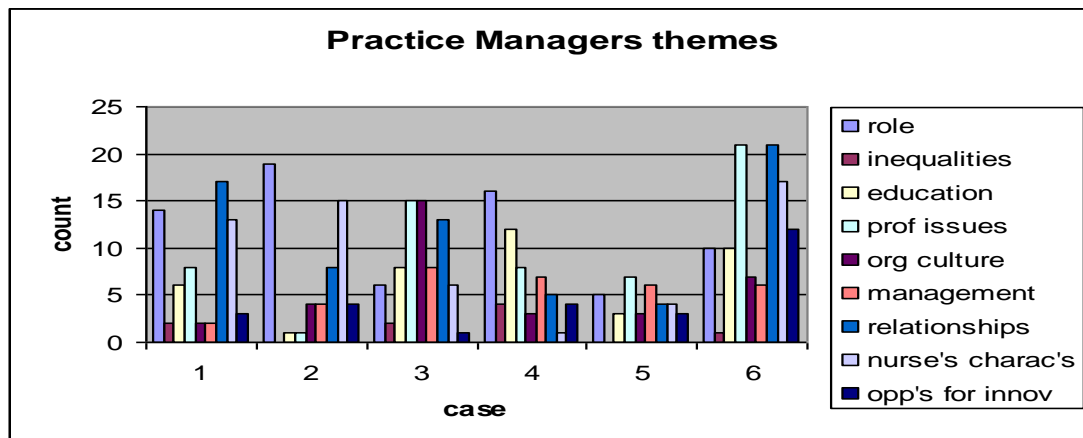


Figure 17 – Frequency of themes mentioned by practice managers



Figures 15 to 17 illustrate a degree of similarity between individual participants within-case, which was not apparent from reading the transcripts. In case 3, the nurse and GP had a similar distribution of themes. In case 5 the nurse and GP pattern looked very similar across role, inequalities, education and professional issues. In case 4 the GP and practice manager had a similar pattern. In case 6 the nurse and practice manager had a similar pattern. However, in cases 1 and 2 each participant had quite a different pattern. This lack of any consistency but presence of some matching within case rather than within professional group suggests that shared views might be more common within practices rather than between professionals. This insight would not have been gained without examining the graphs above and it provided justification for an in-depth in-case analysis, comparing participant responses to see if there were practice level factors that influenced them. This provided a useful steer to the analysis as it provided prior knowledge of potential links between cases, which would not have been otherwise apparent. Each case was therefore analysed in detail, to provide more understanding about the experiences in different types of practice. This involved analysing what each participant said as well as labelling some of the characteristics that were not formally classified as variable features, such as the predominant type of culture (democratic, bureaucratic etc) and the level of support for enhanced practice nurse role development.

6.5 In-case analysis

Case 1

This practice was the second smallest, with a patient population of 5,450 and 3 GPs. It was situated in an affluent suburb of a town, had an excellent QOF performance and an average patient satisfaction score. There were three part-time nurses, comprising two senior generalists and a treatment room nurse plus a HCA.

Table 4 – Case 1 practice profile

	Patient Popul'n	No. GPs	Train GPs?	No. nurses	QOF Score (2009/10)				location
					clinical	org	patient satisfaction	nurse exp	
Case1	5,450	3	No	4 (p/t)	100%	100%	Average	Exp	Urban

There were noticeable differences in the themes raised between the professional groups (see Table 5). Each of them had their own particular focus, quite distinct from the other. The most mentioned theme for the practice nurse was education, the GP had a fairly even distribution of themes mentioned and the practice manager had three predominant themes; roles, relationships and nurse's characteristics.

Table 5 - Themes from Case 1

	PN1	GP1	PM1
Roles	3	6	14
Inequalities	2	0	2
Education	11	1	6
Professional issues	5	4	8
Organisational culture	0	7	2
Management/planning	5	7	2
Relationships	3	5	17
Nurse's characteristics	6	3	13
Opp's for innovation	2	0	3

Each of the participants' interviews will be discussed in turn below, identifying their main foci.

Practice Nurse 1

The practice nurse interviewed had over twenty years experience and had been with the practice most of that time. She had a strong focus around educational access and standards as well as the need to provide mentorship and support. Her description of how the practice nursing role is determined focused mainly on service requirements and the need to be flexible,

PN1: *"because it is so fluid general practice, you have got to really move with the needs"*.

She commented that the practice nursing role was partly determined by the size of the practice, with small practices requiring a more comprehensive generalist role rather than being able to specialise as in a bigger practice.

PN1: "In a bigger practice you can have that luxury of having nurses who are asthma nurses or chronic disease nurses, whereas in a small practice you have got to be multi-functional."

She described the lack of a career framework with an established educational preparation.

PN1: "... it hasn't got that professional development structure like you can get in other parts of nursing, I don't think."

Many of her comments linked the variability of the work and the lack of responsiveness of education programmes in preparing the nurse for that. She described the way that practice nursing work is dictated by NHS policy and the requirements that GPs had contractually and that this resulted in a reactive approach to role development as opposed to proactive. She said this made it difficult to know how to prepare educationally, as new roles might incorporate new skills at very little notice, as was the case when GPs were required to undertake renal function screening in chronic kidney disease. One of the perceived problems about educational support was the fact that no institution was pro-actively responding to the changes in need.

PN1: "I don't think they [universities] even know the need is there... they don't think it is...in their remit and there's no one else who really feels it's in their remit either."

The relationship with GPs featured in her commentary as an influence on accessing the education that is available, in so far as a GP who respected the nurse and appreciated their work was more likely to be receptive to requests for support. However, she did not put much emphasis on the GP-nurse relationship, nor did she dwell much on the practice culture or management style. This could be linked to the fact that she had been in the same practice for many years and therefore had stability and continuity in that relationship and it was therefore not uppermost in her mind. However, this was in contrast to her GP who, unusually when compared to other cases, made more mention of organisational culture, management and

relationships than the nurse did. This difference suggests that either the GP was more conscious of the effects of environment and relationships than the nurse or they were more of a priority for him.

This nurse described the advantages of working in general practice being related to size and formality of structure.

PN1: *“You haven’t got that hierachy that you have to go through that you might have in a larger organisation.”*

and

PN1: *“You have more freedom to adapt good clinical care to the way it works in your practice.”*

However, this was offset in her view by the disadvantages of the huge variability between practices and the consequences this can have on opportunity and quality. This illustrated the dilemma that practice nurses face when choosing an employing practice; they may gain some freedom by choosing an informal practice but lose support that comes with more formal structure.

GP 1

The GP expressed himself in an authoritative manner, saying that staff needed clear guidance about their role.

GP1: *“...they need to be told what to do and when to ask.”*

He exerted a strong degree of control over the way that employees are selected and what they do. He explained that he chooses staff with great care to ensure they fit in and that they are respected members of the team but need very clear boundaries about their role. He described creating a supportive practice culture that engenders a strong team, where nurses who fitted in and worked well within the clearly defined boundaries would be very well supported and protected. His described method of winning cooperation was:

GP1: *“You say 'this is what you need to do' because we discussed it in appraisal and it'll be fine.”*

Loyalty was important to him and he expressed the view that being a smaller practice enhanced relationships; that the team would all know each other better and this would make communication easier. The assumption he made was that in a small practice it is much more evident when someone does not fit it and this was why it is so important to choose his staff carefully. This viewpoint suggests that GP/nurse contact might be higher in a small practice and therefore any relationship problems are magnified and more concentrated than in a large practice where they would be absorbed and diluted by numbers of staff.

Working to protocols and within clearly defined boundaries was important in his view. This seemed to extend to taking responsibility when things go wrong, as

GP1: "they can always say 'this is not me, this is the guideline'".

He did not support the idea of the nurse's scope of practice being greatly extended.

GP1: "Where to stop? You know if you don't define the role, where to stop?"

This GP did not make comments that gave particular emphasis to any of the themes. He had a lot to say about practice nurse roles but it was very much from a one-dimensional perspective, with a strong emphasis on nurses recognising boundaries and on GPs communicating them clearly. He referred to education only once briefly and made no mention of issues that could be coded under 'opportunities for innovation'. This seemed at first to be a rather 'thin' transcript as the GP focused on only a few issues. However, on reflection, the fact that he placed such emphasis on limiting scope and was quite closed to exploring the questions asked is data in itself as it provides a real insight into the way the practice operates and his attitude towards nurses developing their role.

Practice Manager 1

The practice manager was relatively new in post, but had a lot of management experience outside the NHS. He expressed a real interest in role development and saw it as a shared responsibility between the practice and the staff to plan and implement that. He expressed concerns around the evolution of some of the nursing roles, with increased GP delegation

leading to more work being passed from nurses to health care assistants (HCAs), which he saw as,

PM1: “a really dangerous precedent.”

He was uncomfortable about blurred roles between nurses and HCAs and felt that patients are often unaware of the different levels of competence associated with each,

PM1: “because they see them [all] as nurses.”

He was very open to nurses having differing levels of aspiration and saw that they should all be supported. He described a systematic approach to identifying the learning needs of the team and fulfilling their educational needs wherever possible and appropriate. Regarding the relationships and balance of power within the practice, he was hesitant to comment but had some observations.

PM1: “... there are certain expectations here on everybody and I think if somebody thinks slightly out of that expectation it could be quite difficult to bring that into the open.”

In these three interviews there was congruity between participants in terms of their message; that the practice is close-knit and stable, that the senior GP takes a paternalistic approach exerting a considerable amount of control and everyone accepts that model. The view expressed was that the ‘status quo’ must be maintained, with no room for people ‘rocking the boat’ in the interests of innovation.

GP1: “....we had a nurse who started something she had done in a previous practice and we said ‘we don’t do this here’.”

Both the GP and practice manager made comments related to ‘GP dominance’ but the practice nurse did not strengthen this with anything from her perspective. This may be because she accepts the model completely and whilst her comments certainly did not suggest a submissive attitude, she may think there is nothing unusual or problematic about the degree of power held by the GP. It would have been interesting to interview more members of the nursing team to

see if this view was shared. The practice culture for case 1 was labelled an autocracy as it was supportive and controlling with high GP power exerted. The power exerted by the practice manager and nurse was relatively low and the support for enhanced practice nurse role development was low.

Case 2

This case was a large town practice with a patient population of 12,786 and 9 GPs. It was a training practice for GP registrars and the nurses were involved in the teaching. The practice QOF scores were not as high as most, but the patient satisfaction was high.

Table 6 – Case 2 practice profile

QOF Score (2009/10)									
	Patient Popul'n	No. of GPs	Train GPs?	No. of nurses	clinical	org	patient satisfaction	nurse exp	location
Case 2	12,786	9	Yes	5	98%	96%	High	NP	Urban

The unique feature of this practice was that the nurse practitioner and practice manager were partners. There was a noticeably different culture here, where power was shared according to skills and role rather than professional group. There was a hierarchy, but it was based on accumulating knowledge and expertise. All participants in this case talked a lot about roles (see Table 7) and it was clear that much thought and discussion took place about the various responsibilities and allocation of work. There was quite a blurring between the roles of the GPs and the nurses, especially the nurse practitioner, with the GP admitting that she had initially felt quite threatened by this. The nurse raised more issues concerning education and professional issues than the other two participants. The GP and practice manager talked a lot more about relationships and nurse's characteristics than the nurse did.

Table 7 - Themes Case 2

	PN2	GP2	PM2
Roles	17	10	19
Inequalities	7	1	0
Education	11	2	1
Professional issues	11	7	1
Organisational culture	2	5	4
Management/planning	5	1	4
Relationships	4	11	8
Nurse's characteristics	5	11	15
Opp's for innovation	4	4	4

Practice Nurse 2

This participant was an experienced nurse practitioner with a lot of involvement in professional development and mentorship, both within her practice and in other practices locally. It was clear from the interview that her awareness extended beyond the experiences within her own practice. When describing how the practice nursing role is determined she talked about delegation and consequences.

PN2: "You can look at delegating tasks and...it's difficult to quantify and when the GP speaks to me and says about his brilliant idea I find it difficult to say why exactly I'm uncomfortable with it and not happy."

PN2: "So that sort of thing concerns me, again GPs not understanding about risk and accountability and the fact that when you look at delegating to health care assistants it says "the registered nurses in charge is responsible", and it doesn't say anything about GPs at all and it's those sort of things really, you have to be very careful."

This nurse was very aware of the risks associated with role development for nurses and health care assistants, yet she had a highly developed role herself and saw general practice as a positive environment to allow nurses to grow. This presents an interesting balance of risks,

where the practice has to give nurses some freedom in order to develop but remain aware of the risks this could potentially bring in terms of scope of practice and competency.

Inevitably, there are difficulties associated with balancing those risks and she described the tension between nurses having increased autonomy and doctors not quite understanding that there is still an issue of appropriate delegation, recognising individuals' remit and scope of practice.

PN2: "One of the experiences that we've got at the moment of a GP being slightly inappropriate with nursing is that he would very much like the health care assistants to titrate up the ACE inhibitors for the newly diagnosed hypertensives. Now I'm very risk adverse and I am "absolutely no, you have to put the brakes on!" And this is the sort of thing he says "well you know a monkey can do it, what's the problem?""

She described the nurse practitioner role as being 'between doctors and nurses' and therefore creating opportunities but also a degree of confusion due to the overlap.

She also talked about some of the difficulties facing nurses new to general practice, particularly those coming from hospital with little post registration experience.

PN2: "Well, I think new practice nurses flounder...especially if they haven't got an established team to go into...the nurses who succeed end up finding a practice that is willing to develop them really."

The nurse practitioner raised the issue of lack of locally available education. She also had very similar views to the Case 1 practice nurse about the importance of having a framework to support practice nursing professional development. There were also tensions she illustrated between matching nurses' ambition and the willingness of a practice to support them. This was evident where nurses have career development plans that do not mirror the practices needs. In this situation, GPs are wary of a nurse expecting a pay increase and a more senior role, when actually there is no need for it and the practice budget is already stretched. She recommended that practice nurses really try to understand how general practice works as a business and how their role contributes.

PN2: "Practice nurses generally need to have a reality, a sort of awareness about how their role fits into the bigger picture within the practice and be realistic about where they could develop and how their aspirations could be met."

She was clear that there is a big variation between practices in terms of opportunities and support offered to nurses and that having a culture where relationships and professional respect is high were key to effective role development.

PN2: "You start to trust each other and are able to have a dialogue about what you are happy to do and what you're not happy to do and often they are the best places to work really."

GP 2

The GP interviewed in this case had been in the practice for twelve years and talked about how the role of the practice nurse had changed over the last decade from a delegated task-oriented role, to one that has become blurred with the GPs. A large proportion of their nurses had trained and become nurse practitioners, which had impacted on the GP role.

GP2: "How you keep the distinction is perhaps difficult and I think, I mean arguably our role as GPs then becomes endangered...I think nurses themselves then need to think whether they really want to be doctors or whether they want to stay being nurses."

Despite feeling initially a bit threatened by the nurse practitioner role, she valued them highly and felt that they should be well remunerated, as their contribution to the practice was considerable. Discussing the reasons for employing such a high proportion of nurse practitioners, her comments illustrated a high degree of negotiation and persuasion by the nurses in justifying their case for development. This demonstration of nurses influencing GPs illustrated just how different the culture in this practice was from Case 1. The interview included an exploration of what it was that made the GPs offer the nurse practitioner partnership.

GP2: "I think it was probably...1) to show how much she's valued, 2) is retaining, because you know ...we don't want to lose her and third is we value her judgement in

decision making so that you want to hear what she's got to say and therefore to have a role in voting is I think important."

When asked what it was about this nurse's particular attitude and approach that made her so effective in the practice, she described her as a very rounded, balanced mentor.

GP2: "I guess she's in a sense very good in a sort of pastoral way, she does give a bit of support to everybody.. its not just the clinical experience and those sort of things and managerial... she doesn't walk over [people], she's not didactic, not domineering in any way but shes knows her mind. When she's there everybody feels...reassured."

This provided an insight into what particular characteristics that practice valued in their nursing staff and how potentially influential someone possessing them could be.

Practice Manager 2

The practice manager in Case 2 was a real 'champion' for the practice, quite an academic person who focused on management theory and business principles. She had great confidence in the ability of the senior nurse practitioner (interview above) to manage the nursing team and support their development. The practice manager role therefore appeared more focused on the running of the business and less about managing people.

The practice ethos was about supporting people and encouraging them to use available opportunities but not in any way pressurising them. There was acceptance that some nurses like to stay at the level they are and that the practice needs people in less advanced roles to be able to function.

PM2: "... we don't want to push people and we need that role so we wouldn't want to be saying 'well now come on, why are you not being ambitious?'. "

She commented that the relationship between the GPs and nurses was important in determining how they were supported and suggested there was a tendency towards a 'knowledge equals power' culture.

PM 2: "... I can see there is more of a closeness between the specialist nurses and the doctors; I would say because the doctors know that specialists have often got more knowledge and involvement in certain conditions than they have."

In this case both the GP and practice manager talked expansively about the nurse practitioner's individual characteristics and about the importance of relationships, but the nurse practitioner herself did not put much emphasis on these. Her colleagues held her in very high regard and saw her as playing a central role in maintaining harmony and performance within the team.

In summary, this practice seemed to illustrate a very dynamic culture that valued its staff, encouraged role development and shared power. Some of this could be attributable to the very strong nurse practitioner, but the other participants also seemed to take a position that was very supportive and respectful towards nurses. The practice culture was labelled a democracy with the nurse practitioner and practice manager exerting quite an equal amount of power compared to the GP. There was very high support for enhanced practice nurse role development.

Case 3

This practice was a large urban group practice with a patient population of 22,049 and 13 GPs. They were a training practice for GPs and also had a surgical centre with treatment locations across the county. Although their QOF scores were high they had a low patient satisfaction (Table 8).

Table 8 – Case 3 practice profile

	Patient Popul'n	No. GPs	Train GPs?	No. nurses	QOF Score (2009/10)				location
					clinical	Org	patient satisfac'n	nurse exp	
Case 3	22,049	13	Yes	30 (p/t)	100%	98%	Low	New	Urban

The distribution of themes was similar between the nurse and the GP (Table 9), but the content and emphasis of their comments were quite different and there was some incongruence in their expressed opinions about the practice environment. ‘Relationships’ was the only theme that had a consistently high mention across all three case participants.

Table 9 - Themes Case 3

	PN3	GP3	PM3
Roles	13	13	6
Inequalities	0	0	2
Education	12	8	8
Professional issues	5	7	15
Organisational culture	8	9	15
Management/planning	6	6	8
Relationships	13	12	13
Nurse’s characteristics	7	3	6
Opp’s for innovation	0	3	1

Practice Nurse 3

This nurse was new to practice nursing and new to this practice, having been employed about a year. She had been employed by one other practice for a very short time and it had been a negative experience, due to what she called a ‘personality clash’, which she said led to her being poorly supported as she did not fit in.

She described the roles in her current practice as being very varied and segregated, with specialist nurses having a great depth of knowledge.

PN3: “I mean when you meet them all they’re very, very academic and very knowledgeable about their specific [role], including all the medications...most of the time they work autonomously.”

When she left hospital and came to work in primary care the practice nursing role came as a surprise to her, with less supervision and guidance in the day-to-day consultations than she expected. She described a ‘hand-maiden’ perception of the work.

PN3: “I thought you would be sort of the doctor's dogsbody so to speak, that your role was as he said, or she said this needs doing, that needs doing then you followed.”

The reality of the varied and independent role was therefore not as she expected and she found the fact that patients will make an appointment for one thing, but then bring up something completely un-related quite a challenge. Knowing who to refer to when things were outside her remit was one of the problems for her. This interview illustrated how a nurse with lots of previous experience who had felt ‘expert’ in one role can suddenly feel disempowered as a practice nurse. There were clearly defined procedures within the hospital environment that had allowed her to operate at an advanced clinical level, working in a nurse-led team with direct referral rights to consultants. She was therefore struggling to get to grips with a general practice environment which is much less structured, although her practice was larger and more bureaucratic than many.

The level of induction support from the practice nursing team in this large practice had been excellent and the support seemed to be maintained as the nurse developed new competencies.

PN3: “They were absolutely fantastic and it was a case of I would say I can take this give it a try, see how far I got and they were there in the room with me and that happened for 8 weeks and it was only then towards the end of the 8 weeks I was actually saying ‘I'm quite happy to give this a whirl knowing you're next door or knowing you're at the end of the phone’.”

PN3: “And then coming back to ‘OK lets revisit this’ and getting my competences signed off so to me this is good, this is wonderful and this is how it should be. Yes because I do get 1:1 learning,”

However, the nurse did not seem to have looked outside of the practice to see what courses might be available and had not investigated what the arrangements were for funding or study

leave. This might be because she perceived that the practice was providing everything she needed.

It was apparent that this nurse had low self-confidence and did not feel she could approach her GP colleagues on equal terms. This was adversely affecting her ability to work effectively and seemed more linked to her personality than her competence. Despite having previously held senior clinical roles, she said she had very little faith in her own ability and that she would hesitate to agree to take something on in case she could not perform it competently. This extended to a reluctance to approach GPs when she needed advice about a patient, although her experience related to a particular GP being very unhelpful.

PN3: "...this GP had left me waiting 45 minutes and had continued seeing all his other patients while I was still waiting. ...I don't like to be a nuisance. I don't like to... in the end I just stood outside the door of where the GPs are upstairs and the first one that opened the door I said can you sign this please? I was kind of hoping it would happen quicker than that."

She described another occasion where she had asked the same GP for a clinical opinion on a patient and his response was professionally inappropriate so she got another GP to help and put it down to experience.

PN3: "So again you just learn. But it's not fair to your patient..."

This seemed incongruous in a practice that had clear team support systems in place and a strong nursing team. When asked whether her inability to assert herself was due to the general practice environment, she felt it was an individual thing, related to a particular GP being very unapproachable. Combined with her acknowledged lack of assertiveness, this provided some insight into the significance of individual characteristics in effective team working.

GP 3

The GP in Case 3 had been a partner in the practice for over 20 years and had done a lot to support the development of an enhanced practice nursing role. He had alienated some GP

partners by the risks he was prepared to take in their eyes by giving nurse practitioners what he described as a very autonomous role and placing a lot of trust in their professional integrity. He described the way his practice determines the role of a new practice nurse as a combination of service needs, nurses' experience and aspiration. He was supportive of nurses identifying areas they would like to get involved in and train for, seeing this as adding value to the service. There was evidence of a strong education culture within the practice and shared learning between doctors and nurses at joint education meetings. He suggested that the size of their practice impacted on the way things were run, saying that the bigger they got the more like a mini secondary care system they became. He described a highly ordered structure, with GP leads for specialist clinical areas managing the associated nursing team. One of the consequences of this was that GPs feel de-skilled by the nurses taking on more responsibility and making the day-to-day decisions. This also had an impact on their ability to attract and train junior doctors.

GP3: "I think especially the younger doctors find it difficult to get enough experience in things if a lot of stuff is siphoned off to one side."

This suggests that they did not use the specialist nurses to train the doctors, which seems contrary to the shared learning ethos he maintained was core. Talking about how to attract new nurses into general practice he said that their main source of new staff was hospital and they usually chose nurses that would adapt well to primary care.

GP3: "We generally take on people that have had a lot of experience in their field so ITU sisters, casualty sisters, people who've been at the top of their game in the hospital."

When asked about the sort of characteristics that make a nurse fit into general practice particularly well, he referred to their ability to work independently and as part of a team.

GP3: "Well, team players - people who are happy to take responsibility and don't necessarily like to be told what to do all the time, people who have an interest in being autonomous as much as anything."

He talked about the strength of the nursing team and how easy it was for new nurses to access

advice and support.

GP3: “The nursing team is a very cohesive team and the doctors are very approachable, so whenever somebody has a problem they can contact virtually anybody, can just knock on the next door, and say 'I need some help with this' or 'what do I do with that'. So far, we've had no worries about people not knowing what to do coz there's plenty of people to ask and we also email and instant messaging as well as face-to-face.”

This comment did not seem to mirror the experience of the practice nurse who had so much difficulty in approaching one of the GPs. This could either indicate she was, as she said, not assertive, or might suggest there are some GPs that are less supportive than others. This seemed to be borne out by his comments on the reaction of some GP colleagues when he started to develop the practice nursing team and extend their role.

GP3: “You know there were one or two doctors who were very resistant and the nurses wouldn't necessarily knock on those doors...”

GP3: “When I set up the nurse practitioner service here about 10 years ago, it was one of the primary things I had arguments about with my partners, they wanted them to work to protocols and I said that's not going to work; people have to take responsibility and use their experience and training and that has proved to be the right way to do it.”

His response to this was to provide evidence to support his assertion by auditing every single patient the nurses saw, evaluating the outcome and reviewing the number of consultations that needed to be referred to a GP for extra advice. This showed that the nurses were effective and the need for GP consultations was reduced, and convinced his colleagues that it was a good model. He was very supportive of the nurse practitioner role and confident that they could be trusted to know their own limits and work safely.

Discussing the contrast between hospital and primary care, and whether the general practice model posed a potential risk with regard to nurses being less uniformly employed and regulated, his view was that the closer team-working in general practice creates a better, safer environment.

GP3: “No, I think it's safer here and better here, people feel valued here and part of a team which cares... people do muck in and genuinely feel they've got a say in what's going on.”

This GP seemed very positive and supportive about the practice nurses' role and remit and was not aware that one of his nurses is apparently struggling to approach one GP in particular and generally seems to feel rather disempowered. However, in a practice this large, it would be difficult for the GP to be confident that all the nurses were feeling well supported, especially if they did not raise it with him. The team structure appeared to provide all nurses access to the support they needed, but clearly on some occasions the system could fail if there was a difficult relationship between a nurse and one of the GPs.

Practice Manager 3

This practice manager had just retired from the practice but had worked there for a very long time. The practice employed both a practice manager and a business manager who oversaw finance and performance, creating a very business-oriented corporate general practice model. The practice manager's comments aligned with the other two participants in this case regarding the organisation of the practice, with very structured specialist teams and systems in place, and regular GP-led team meetings for each specialty.

PM3: “Yes, there's no excuse that they would go to a doctor that wasn't interested in their subject, there was always a named GP”

The role of the practice nurses was determined by the service primarily, based on the needs of the patients and the practice. Resources were allocated within the practice to support training with an annual budget for use at the discretion of the manager. She commented that finding appropriate courses was a problem and the discontinued practice nurse foundation programme had left a gap.

PM3: “The practice nurse training when they had it... was good! It worked well...and people that went on it years ago said it was brilliant, it gave them more confidence and it doesn't seem much there's much training out there now at all for anything.”

She expressed some anxiety about the lack of assurance that practice nurses are performing competently and how this is heightened by the 'lone working' nature of practice nurse consultations. She cited occasions when she had complaints from patients about the care received from a nurse and the difficulty she had in making a judgement about whether it was justified or not and whether the nurse was safe to practise. She had considered asking doctors to sit in on nurse clinics but felt that would create a false situation where the nurse would possibly perform better than when she was alone and perhaps short of time. There also seemed reluctance from the GPs to tackle poor nurse performance.

PM3: "It was obvious that this other nurse wasn't giving the correct treatment. Well, I reported it to a doctor and he said 'She's retiring soon, don't worry.' "

Some of her concern around competence related to the doctors delegating too much and not really understanding where the nurses' limits were with regard to their scope of practice or level of expertise.

PM3: "I think with triage, that's the hardest and I'm not sure that GPs have really taken on the difficulties that the nurses have. That's one area that does concern me."

She felt the relationship between doctors and nurses was fundamental to successful general practice and that the specialty team system created cohesive partnerships. This close working created an ease with each other that meant the nurses were comfortable about bringing up new ideas at meetings and sharing their views and experiences. There was also evidence of GPs showing professional respect for the nurses.

PM 3: "You'd hear the doctors say 'well, I'll put you onto so-and-so because they're the expert' and I think that's good for the doctor and good for the nurse because some doctors historically didn't like to think that anyone else knew more than them."

She felt this created a professional relationship that was productive. She also had observations about the balance of power with the nurses and GPs, where the size and strength of the nursing team came across as being a force to be reckoned with, particularly when the practice tried to introduce new ways of working. Her comments did not illustrate a positive use of power but suggested a 'union' type of approach concerned with reacting rather than

influencing in a participative way.

PM3: “[The team] was really big...but it could cause problems because they were that strong you know that sometimes doctors gave in when perhaps they shouldn’t”

Regarding the issue of GPs being practice nurse employers, and its potential to cause tensions, this large practice seemed to have made a very clear distinction between the clinical responsibilities of the GPs and the managerial responsibilities of the managers, which in effect shielded GPs from this potentially awkward dual role.

PM3: “... it would be no good any of the staff going to any of the partners, and saying 'I'm not happy, this has happened...' they'd be sent straight to a manager.”

When asked about the characteristics that make a nurse adapt well to general practice her response was primarily focussed on adapting to the needs of the practice.

PM3: “I think someone that shows a willingness to learn, asks a lot of questions... and shows a willingness to help out in times of difficulty. If nurses show the enthusiasm the practice will be more receptive to their requests.”

This practice manager’s expressed view was that the practice nurses held quite a lot of power and influence over the GPs, largely due to the size and cohesiveness of their team. Yet, within that team, there was one junior nurse who, whilst very supported, felt unable to approach at least one of the GPs over a routine task. The overall impression was that the reality of the power exerted by the nurses was ‘them and us’ in nature, rather than being willingly shared by the GPs.

The GP and practice manager in Case 3 both commented on the advantages of being a bigger practice, particularly when it comes to offering support to the nurses and releasing them for training. However, this is slightly contrary to the data from the smaller practices such as Case 1, where they seemed to feel that communication and support was stronger as a result of their size. The size and culture of this practice seemed to create divisions that were necessary for efficiency but counter productive in terms of shared vision and influence. This practice was labelled a bureaucracy, with a hierarchical structure and dominant practice management style

through the business manager who was also a partner. Despite comments to the contrary, nurse power was not considered to be high and there was limited support for practice nurse role enhancement as it was not embedded and accepted by partners.

Case 4

This practice was an average sized rural practice with a patient population of 8,358 and 6 GPs. They were a high performing practice on QOF indicators but had low patient satisfaction. They were a GP training practice and all the nurses were involved in training GP registrars. Their nursing team consisted mainly of nurse practitioners and health care assistants.

Table 10 – Case 4 practice profile **QOF Score (2009/10)**

	Patient Popul'n	GPs	Train GPs?	No. nurses	clinical	org	patient satisfac'n	nurse exp	location
Case 4	8,358	6	Yes	5	100%	100%	Low	NP	Rural

The themes identified by this case showed a different distribution from other cases so far (see Table 11).

Table 11 - Themes Case 4

	PN4	GP4	PM4
Roles	11	19	16
Inequalities	9	0	4
Education	12	14	12
Professional issues	17	9	8
Organisational culture	7	3	3
Management/planning	4	0	7
Relationships	10	8	5
Nurse's characteristics	9	7	1
Opp's for innovation	11	1	4

Education featured more uniformly in this case than any other, with each participant putting a lot of emphasis on it. This practice had been very involved in training advanced nurse practitioners, with GPs willing to act as mentors. It therefore had an unusually strong educational ethos. The nurse in this case raised more issues related to organisational culture than the other two participants and this was unusual as it was a priority for nurses in most other cases. This nurse also described more opportunities for innovation than any other nurse. The only participant with a similar emphasis on this was the practice manager in Case 6.

Practice Nurse 4

The nurse interviewed in this case is a very experienced nurse practitioner, with many years experience as a trainer and mentor. She had strong views about the educational support that should be available for new practice nurses and about the need for a continuous process of multi-professional development.

Talking about how the practice nurse role is determined in her practice, she said that initially the practice decides what they are looking for when they employ a new nurse but as the nurse develops she can influence how the GPs support her role evolving. In some practices she felt this could be constrained due to GPs feeling that extra expertise may result in a salary increase request and that some nurses fail to understand that GPs have to manage their business on a limited funding stream, prioritising how it is spent to ensure the business remains viable. However, she said that some nurses she talked to were funding their own education and then not being remunerated for the extra skills they had gained.

She described a real contrast between nursing in hospital and primary care in terms of employment conditions.

PN4: "I think the fact there isn't a formal set practice nurse job description... it's difficult for some nurses to get their head around that when they've been working in secondary care where they've been on a pay band that's very clear and specific with gateways, and ..that just doesn't happen at the moment in primary care."

However, she hinted that there are advantages to working in general practice that are not widely publicised because the lack of structure and formality can work to the nurse's benefit on occasion, and they would not want to lose that.

PN4: "... they don't want to formalise things too much because you have to be careful what you wish for, you're actually earning a reasonable salary, you're very much your own boss, you can tweak your hours probably... so you're always weighing that up against other things."

She made observations about the attitude of some practice nurses who seem to lack a sense of responsibility and understanding about the nature of working in general practice, referring to a recent conference where she noticed a degree of militancy against the 'cushy life' of a GP compared to a practice nurse. She understood that in some practices the role of the nurse can appear to be just about ticking off their QOF points, but generally the opportunities exist for nurses to shape the role.

She also commented on the impact that nurse attitude, training and skills can have on quality, because if a nurse has not kept her skills up-to-date and does not work in a motivated team, then patients are not likely to get gold standard care. She described the scenario where a single-handed GP employs a single inexperienced nurse and shows her how to perform a new task, with no independent training or assessment of whether either he has taught it correctly or she has achieved competence, and this puts patients at risk. She suggested that there should be standards associated with the employment of new nurses to guard against variability producing poor quality.

She had a lot to say about the training that should be provided for new nurses.

PN 4: "Well the core skills should be...shown by somebody that's competent themselves so somebody that's got some recognised qualification and is recognised that they can teach so they're not just 'see one, do one' but they're actually going through the theory, showing them the practical, allowing the nurse to do it... like we used to have with the [foundation programme] trainers, where we have a trainer who then assessed in practice."

She expressed strong views on the lack of both a locally available course and national standard for minimum core training for practice nurses.

PN4: "I think it's really sad it isn't [available] now, I think it's appalling. You wouldn't do that with any other branch of nursing would you? ...really we've gone backwards... there is no common standard imposed on the practice....it's indefensible. And I suspect there's a lot of near misses and a lot of significant events, I don't know."

Her suggestion was for a multi-disciplinary education model coordinated by the medical deaneries, because the GP registrar training is excellent and practices are inspected to ensure that trainers are performing and standards are being upheld. However, she pointed out that there is no funding for practice nurses to be included in the scheme.

She described factors that she thought were linked to a good practice environment.

PN4: "I think having a group working together the best thing you need to do is get them all on one side. And not be 'anti-doctor' because that happens a lot. So that's one thing and then have regular educational meetings where you just discuss what you have done... continually fostering an atmosphere of learning and actually encouraging people to say "actually I made a massive mistake today." So you need a strong team leader or a doctor in the practice who is in charge. "

She also highlighted aspects of general practice that affect the degree of nursing power.

PN4: "So I think it's doctor personality, practice ethos, and practice management are the three things that will influence the power of the practice nurse."

GP 4

The GP in this case described the evolution of their top-heavy nurse practitioner skill mix as a process that happened by accident rather than design.

GP4: "Yes but we didn't need another one at that point but we said "OK, fine. So...the job on offer is actually being a practice nurse but we'll help kind of look at your

personal development” and...since being in post she has done her whole nurse practitioner.”

On discussing the influence that must have been exerted by the nurses to achieve that, she conceded that they had very effective powers of persuasion. She described how the service had developed to incorporate their role, which was very positive but had then left a gap at the more junior end of the nursing team.

She also commented on the lack of clarity between different practice nursing roles for patients, who she said find it difficult to understand who does what. She also expressed concern about the lack of regulation over the level of training and skills required by the nursing bodies and felt that this presented the danger of huge variation in interpretation by employers in what to delegate to the nurse. The extent to which this occurs would in her view be influenced by the degree of isolation of the practice.

She felt there was a lot of scope for development of the role of the nurse in general practice.

GP4: “.... yes they have got a huge amount of freedom actually, huge. And quite a lot of power as well but this is because we've got a lead that is hugely interested, motivated, works very hard and has the interests of the practice at heart...and that's why I think..... we have a balance that shifted towards more power in our nursing team than perhaps it might be elsewhere.”

So whilst the nurse practitioner had identified ‘*doctor personality, practice ethos, and practice management*’ as the factors that influence practice nurse power, her GP colleague seemed to rate the nurse practitioner as the reason why practice nurses held considerable power.

With regard to education, the GP echoed the comments made by the practice nurse about the induction programme that was discontinued.

GP4: “What I do know is that we used to have the trainees coming out and we don't anymore because I understand that that is not funded, so I'm sure that's a lot to do with

it really. I mean it is difficult as an employing practice to provide that level of experience if you take on a new practice [nurse].....not only is that very time consuming but you might not have the knowledge or skills to be able to set that up or....nor have the time or cost to provide it satisfactorily.”

The consequences to this lack of adequate training were inappropriate referrals to either a specialist or a GP, which is neither cost effective nor in the best interests of the patient. Another risk she highlighted was that if a nurse is not confident and feels anxious about her skills then she is more likely to miss things and therefore perform poorly.

She was clear that GPs were the right people to employ practice nurses and that this allowed them to respond to service changes directly.

GP4: “... I do think we're the right people to be the employer.... I think it would be difficult to manage our service if there were too many other external influences on what they were providing. And I don't know that the motivation would be the same of the team.”

Regarding relationships with the nursing team, she had little to say when asked directly, although the frequency of mention in general was no less than other GPs.

GP4: “...we actually talk about clinical things we mostly have a relationship over clinical matters.”

Neither did she comment particularly on management issues or opportunities for innovation, but this was also in common with other GPs.

Practice Manager 4

This practice manager was a very active member of the local practice manager group and placed great emphasis on the importance of appropriate training and education for staff. She talked about the development of the practice nurse role in terms of increasing skill mix to deal with the politics of ensuring patients have access to same-day assessment and the way that this has created a differentiation within the team she compared to the ‘old SEN/SRN’ model.

So practice teams have evolved around the clinical skills needed to fulfil the practice commitments and the practice nursing role has had to evolve to match that.

She had strong views about the arrangements that should be in place to ensure that all nursing staff in general practice had the right skills for the job and she highlighted the risks to patient safety if this was not the case.

PM4: "What you don't want is for some awful dire clinical adverse incident to happen on your doorstep, but it can do when people are doing things and they're not fully aware of what they're doing."

Recruiting new nurses was an issue because the number of practice nurses retiring is not matched by available replacements, which she described as a heavy burden on practices that will:

PM4: "...only get worse unless we get some kind of training structure in place."

Recruiting nurses from hospital posed problems she said, because,

PM4: "I'm afraid the infrastructure's rubbish for someone to come in to do practice nursing. It's really just not there. There is no formalised training now. The [HEI] used to do a six month package which I used to use and it was great. I would like to see that back again, that they have to get through that in order to be able to call themselves a practice nurse."

Along with some of the other participants she found that this placed a huge burden on general practice to train their nurses in-house, and that meant having someone in their own organisation that they were sure was competent to train and up-to-date with their knowledge. The current 'pick-and-mix' arrangement for training results in her view in a variety of standards and skills levels that is not necessarily appropriate. She was critical of the national nursing bodies for not taking a more proactive role with practice nurses and felt that the advent of the new accreditation process with the Care Quality Commission offered a real opportunity to put some regulatory standards in place around the employment of nurses.

Talking generally about relationships between nurses and GPs, she was clear that the practice must provide an environment that is facilitative and supportive. She created opportunities for this through governance meetings and physical space that encouraged interaction and felt that the nurses were confident and assertive and quite able to relate to the GPs as equals.

In summary, there were strong similarities in the picture described by each of the participants in this case although they all had a different emphasis. The practice culture was educative and participative with achievement by all being highly rated and was thus labelled as a democracy. Nursing power and influence were highly developed in the practice and there was a high level of support for the enhanced practice nurse role.

Case 5

This was the smallest practice and one that was experiencing a challenging time involving considerable change and adaptation due to a new GP partnership. The practice was set in a rural village and currently had three GPs and three part time nurses. The practice appeared not to have been performing highly, as demonstrated by the low QOF scores and very low patient satisfaction. The combination of all these factors presented a real contrast to some of the other cases, which made it valuable as a data source.

Table 12 – Case 5 practice profile QOF Score 2009

	Patient Popul'n	GPs	Train GPs?	No. nurses	clinical	org	patient satisfac'n	nurse exp	location
Case 5	4,694	3	No	3	96%	90%	Very low	Exp	Rural

The most startling observation from the themes raised in this case was the high frequency of mention for professional issues by both the nurse and GP, which was a combination unmatched in any other case. In contrast, mention of roles was lower than any other case. Relationships and nurse's characteristics were mentioned a lot more by the nurse than other participants.

Table 13 - Themes Case 5

	PN5	GP5	PM5
Roles	3	4	5
Inequalities	4	5	0
Education	8	7	3
Professional issues	25	22	7
Organisational culture	1	7	3
Management/planning	2	2	6
Relationships	11	6	4
Nurse's characteristics	16	1	4
Opp's for innovation	1	4	3

Practice Nurse 5

This nurse was new to general practice, but had many years experience working as a community nurse and therefore in close proximity to GPs. Her description of the practice was disturbing, in so far as she described very low levels of support, but high levels of delegation and expectations of extended scope of practice. This created an environment where nurses were working under extreme pressure to meet patients' needs with little opportunity for training, supervision and reflection. The practice nursing role in this practice was described as being,

PN5: "very much determined by how much you're willing to take of what the GP wants you to take."

PN5: "You get to 5 o'clock at night and you've got four very extreme travel vaccination programmes, and you know you've not got any training in that and there's no-one else in the building, so that's when the pressure comes on you."

She clearly articulated the pressure that practice nurses face by being employed by the GP, who also delegates their workload.

PN5: "When that person says 'I'm paying you your wages, I want you to'....you have to be quite firm about your parameters, coz from the NMC, you're accountable..."

Most of this interview focused on either the risks associated with unsupported nurses working in isolation, the difficulty in managing the GP nurse relationship or the behaviour that a nurse needed to develop to be effective in negotiating her role. This nurse seemed to be coping with the challenges but felt concerned about more junior members of the team and for nurses working in isolation in other practices.

PN5: "And the trouble with practice nursing is you don't know what you don't know. So you think you're doing it according to the right plan and it's only when you go to one of the practice nursing meetings and somebody says 'what did you think of the new protocol?' and you think 'what protocol?'"

Talking about the lack of training available for nurses new to general practice, she identified the consequences of this in terms of them not being aware of the role's scope and the knowledge they should have to fulfil it. She identified the risk that through following a practice protocol, but not adhering to best practice guidance they may be unconsciously incompetent. She thought there should be a compulsory introductory course to provide an initial assessment of what nurses know and what they need to know, with the education available to fill the gap. With regard to the GPs' role in ensuring competence, she was clear that there should be a formal requirement to ensure that GPs fulfil this responsibility.

PN5: "Yes I think it should almost be compulsory that they have to have a contract that GPs can't just take on a nurse, sit her down and say 'do that'...GPs I have spoken to about this come back with 'well they're in the NMC; they're accountable for their actions'."

Her view of GP support for practice nurse professional development was not positive.

PN5: "The Dr's don't want to pay for courses, they don't want to let the nurses off, they want the nurses to come in and do their job."

Discussing how she managed to cope with the demands of practice nursing in an isolated practice, she was clear about defining her own professional boundaries and being positive, but assertive with the GPs when first employed.

PN5: "I just said that 'I can do this, this, this and this. But I can't do that'."

In her experience of working with GPs and other doctors she maintained that so long as the nurse behaves respectfully as a professional equal, she will be treated as such. Her advice to nurses that struggled with finding that balance was to:

PN5: *“Be ‘up front’ about what you are able to do, be willing to train to do things they want you to do and don’t be a doormat.”*

Her approach to winning their respect and support was:

PN5: *“It’s not your job to tell them but to show them how lucky they are to have you.”*

This interview rounded off with her making observations about the wider political scene and making recommendations about how to improve the lot of the practice nurse, through collaborative working between Clinical Commissioning Groups to raise the standards together and reduce the variations in quality of education and practice.

PN5: *“Now if you’re going to devolve more and more to the nurses which the GPs are, they have to stop being insular, ‘my practice, your practice, his practice, I’m not paying for his practice’; they have to come together now and say ‘right, it’s time for us all to form a package for our nurses so we’re all the same.’ “*

GP 5

The GP from this practice was not a partner and was therefore not involved in the transfer of the business but would be employed by the new partnership once in place. Her views were therefore not typical of the employing GPs, but gave some insight into the GP perspective. She was a junior GP with not many years' experience and this, combined with her salaried status, seemed to give her impartiality about the way GPs and nurses work together. Describing the role of the practice nurse within their practice, she expressed concerns about what was expected of them in view of the level of training they had to support it.

GP5: *“I think we’ve got good practice nurses with day to day practice nurse stuff but you can see that mentally they’re are capable of more than that but they’ve just not got the training so far...but there does seem to be high expectations of them and they’re expected to almost perform a nurse practitioner role.”*

Her concerns related to the pressure nurses were working under, the quality of patient experience and medico-legal issues around appropriate delegation and competence. She was very surprised that there is no mandatory practice nursing qualification and was acutely aware that for nurses coming from secondary care the clinical difference in role is a ‘*huge leap*’. She suggested that a practical training involving shadowing and mentoring should be in place.

Her comments on relationships centred on the lack of professional equality in this practice, with a very non-participative style of management from the GPs.

GP5: “I’ve worked with nurses who are at that [senior] level. I’m quite used to working with those that I just feel that I’m on a par with, that they’re just my colleagues. So it’s quite a difference coming here.”

She felt that the lack of an opportunity to sit down together and say “is this working?” was a real weakness, but this was unlikely to happen whilst the practice was in such a state of flux.

Practice Manager 5

This practice manager focused mainly on processes that are in place within the practice or the PCT to provide guidance to staff. In some ways she seemed disconnected from others in the practice in that her descriptions of how things worked seemed ‘arms length’. It appeared sometimes as if she was not answering the core question but giving a quick response. For example, when asked about what training resources were available locally, she talked only about where courses are located and said nothing about the actual courses. When asked about professional development support she focused solely on protocols being approved. There may have been many reasons for this, such as pressure of work, the difficulties the practice is going through, not trusting the interviewer or lack of time. Nonetheless, it was a feature of the interview that was quite different from the other participants, who invariably wanted to talk a lot.

She had little to say about role, referring to the appraisal process as the method by which role is determined and balancing the functions of the current team against the practice needs. She

was very positive about the fact that new staff received an induction and the nurses receive additional in-house training and supervision in the first few weeks. She was less clear about how competence was assessed and training needs acted upon, but thought the lead nurse would have documented it. There was an allocated practice training budget that was available to support funding requests. There was incongruence between her own and the nurse's responses on training availability. The nurse had said that there was poor availability and the doctors did not want to release nurses to attend. Whereas the practice manager said that they were lucky to have the local hospital providing training and that "9 times out of 10 they can go." However, she did comment that information about training was very poor and she was not sure how nurses could find out about what was available.

PM5: "...it's knowing where the courses are, what's available and when. I mean I don't know whether it does go direct to the nurses but I very rarely see anything come through specifically for nurses."

When discussing the minimum qualifications she would expect a practice nurse to have, her response suggested that this issue is not really within her remit.

PM5: "...the GPs - they would know when they're interviewing of what level of standard they would want but personally I haven't been involved in that I'm afraid."

With regard to maintaining competence, she was clear that the nurses have a responsibility to be up to date and felt that it was quite a burden for them, and that it was a shame the practice did not have any guidelines about what the standard should be, so that they could help organise the training. In response to questions about what support is given to practice nurses to develop their role and how they negotiate that with the GPs, her response focused on protocols.

PM5: "Well with regards to the support and everything we've got the protocol directives that are weekly brought to the GP managers' meetings, the lead nurse brings the directive and then it's agreed, so obviously every time it's agreed then the nurses know that they have got the GPs' authorisation."

Superficially her description of the practice culture was positive and supportive, but it was difficult to find evidence of this on further questioning and she could not expand on her responses about it. When asked about how easy it was for the nurses to challenge or negotiate things with the GPs, she said that relationships between the nurses and GPs were generally good, but it was difficult to interpret some of the meaning in her comments.

PN5: "I mean they do have a good relationship but on the other hand it is a case of you've got your GPs and your nurses. I would say 80% of the time it's very good but on occasions then the GPs are sort of the powerful ones."

Her description of how problems are resolved did not demonstrate a high degree of power or influence in managing this.

PM5: "If there are any problems then we try and like air any differences at these meetings and discuss them until we agree because then you've got all the GPs there and its not one nurse versus one GP. You've got the nurse lead that brings the matters there however, if the other nurses want to come along to the meetings providing it's not too sort of sensitive areas then they are invited along. And then there's (name) and myself who occasionally go between. If there are any problems...the patient services manager probably gets more involved than I am so we do try and address things and get things resolved."

This indicated a system that is not clearly defined and therefore 'muddles through' when there are problems. Sometimes staff would go to the patient services manager, sometimes the practice manager. Sometimes only the senior nurse would attend the meeting and sometimes the other nurses would be invited. It would be hard to feel confident that staff knew what to expect when they wanted to raise an issue. The practice manager did not have delegated authority as the power was held firmly by the GPs.

In summary, this practice presented a rather fragmented front, with some incongruity in perceptions between participants during what must be a time of uncertainty and anxiety for staff. The culture in this practice was labelled autocratic, as decisions were top-down and power was held by the GPs. Nursing influence and practice manager power was low and there was low support for developing an enhanced practice nurse role.

Case 6

This case was an average sized practice in a rural setting with strong integration with health and social teams outside the practice. Multidisciplinary team meetings were the cornerstone of the practice culture, where patients were discussed, joint care plans developed and learning shared.

Table 14 – Case 6 practice profile QOF Score (2009/10)

	Patient Popul'n	No. GPs	GP Train?	No. nurses	clinical	org	Patient satisfac'n	nurse exp	location
Case 6	8,700	7	No	9	99%	96%	High	New	Rural

The themes raised by the participants in this case were marked by the fact that the practice manager and practice nurse both had the highest frequency of mention on professional issues and relationships when compared to the rest of their professional peers across the other cases, and the practice manager had the highest mention of opportunities for innovation out of all participants. However, despite these similarities in frequency, the emphasis was very different, demonstrating the value of conducting a qualitative rather than quantitative content analysis.

Table 15 - Themes Case 6

	PN6	GP6	PM6
Roles	10	7	10
Inequalities	7	0	1
Education	6	4	10
Professional issues	31	7	21
Organisational culture	9	3	7
Management/planning	6	6	6
Relationships	25	6	21
Nurse's characteristics	11	11	17
Opp's for innovation	2	3	12

Practice Nurse 6

This nurse was new to practice nursing having come straight from a hospital and she was fairly recently qualified. Her description of how the role of the nurse is determined in the practice focused on the service needs and skill mix of the team. She was surprised however, not to have had a competency assessment to determine her level of experience on commencing the job and found the induction period brief.

PN6: "I sat in with a couple of practice nurses literally for a week maximum and was shown how to do hypertension checks and pill checks and we looked at some templates for wound care dressings, things like that, and straight away I started doing all those things literally the third week, I was on my own."

She described a system that was paper-based in that she had an induction pack with objectives and a reflective framework, whereas what she really wanted was more one-to-one teaching and clinical supervision time with experienced nurses. Clinical supervision was a real issue for her, as she felt it should be built into work time but was told she should organise it in her own time. She felt that her clinical workload meant that she was unable to spend any time with more senior nurses or GPs learning from their experience. However, the practice had been extremely accommodating and generous in supporting training and she had been on several long-term condition courses and was planning to do diabetes training shortly. She felt that there was a gap for nurses new to general practice and that an accredited foundation programme with taught and practice-based elements should be in place.

With regard to the practice culture she described a high level of order and policy, with templates for everything, but she felt that meant the nurses tended to work by rote rather than thinking for themselves. It was clear that she was frustrated by a system that didn't really suit her style of working, as she wanted more interaction and discussion and felt she could not achieve this. Meetings tended to involve senior 'heads of team' and whilst she felt the Nurse Practitioners were approachable, sometimes she wanted to talk directly to a GP but could not.

PN6 – “The GP never speaks to me directly and I've never really discussed any clinical issues with the GP; usually I'd have to discuss it with the NP first.”

Specifically, she experienced problems in approaching GPs for support or advice.

PN6: “No, I don't feel very supported most of the time and I don't feel I can pick up the phone and ask for support really.”

PN6: “Yeah, it's working out what's urgent enough to need to call the GP and if you get it slightly wrong...they're quite unpleasant, they can be quite rude if you interrupt them.”

Her lack of assertiveness seemed to be a barrier in her ability to deal with this.

PN6: “It's just I'm a bit wimpy and I'm not very good at dealing with doctors that challenge me. I'm not very assertive sometimes at giving quick answers back...if they're a bit rude.”

Having the GP as employer clearly influenced her perception of the risks involved in challenging them.

PN6: “Well, you feel you can't really challenge it because they are the employer so you don't want to annoy them too much or they might just I don't know they could give you the heave-ho, but they might make things a bit unpleasant for you.”

Working alone was obviously something new to her and she found the lack of teamwork difficult.

PN6 – “There's no teamwork at all in this surgery, you never work as a team we're very much on our own, so...I feel that's where the problem lies really.”

The overall impression from this interview was that the nurse felt she did not really fit in with the practice system. It seemed that neither the structure nor processes gave her opportunities to grow and develop because there was a mismatch between her working style and the way

the practice operated, and it did not seem likely that the practice would bend to accommodate her.

GP 6

The GP in this practice was responsible for managing the nursing team so he had a particular interest in the topics being discussed. He described the role of the practice nurse as being determined primarily by service needs, the current skill mix within the team and lastly, the aspirations of the nurse. He articulated clearly how the roles had evolved over time from basic treatment room nursing to incorporate nurse practitioner and HCA roles.

He was very aware of professional issues around competency and accountability and was clear that both the nurse and the employer share responsibility for ensuring that the level of competence is appropriate for the work delegated.

GP6: "One of the difficulties I think is that there is no specific training or qualification that you can say that these nurses have to hold."

His description of a six monthly appraisal system was open and consultative, asking staff for suggestions about how the practice could be improved and how they would like to contribute. He also described weekly nurse department meetings and although he did not specify which nurses actually attend; it sounded like these were open meetings as every fourth one was devoted to an educational topic. It was clear they try to help the nurses to keep up to date with clinical practice.

GP6: "Because... if there is a change in policy practice or procedure then we try and have a teaching session on that just so that everyone is aware and child imms is a good example, it's always changing."

He was very clear that their nurses are well trained and supervised, and:

GP6: "certainly don't start any independent practice at all until such time as we are happy that their competencies have been met."

He had a lot to say about how important it was for nurses to understand how general practice works, how they are not part of some big umbrella NHS organisation machinery that is protected; that they have to work hard at maintaining a viable business that makes a profit each year and sometimes financial pressures will determine the decisions they have to make. He stressed that he tries to explain to staff that when this happens that the practice is not rejecting the individual, just that sometimes it is the wrong time for the idea, or they have not thought through how they could present it to the GPs as a win-win. He felt that good communication was essential and that it can be difficult when you work so closely with staff to have to say 'no' on occasions.

GP6: " So the more a nurse is armed in terms of understanding all of that and taking on board and being sensitive to what's happening within the practice, they've far more chance of being successful. The other thing I think is if you sell something on the basis that it will benefit patients,.... if that is the centre of what you're trying to do then its very hard to argue against that. "

Practice Manager 6

This practice manager, who had a clinical background, was a dominant force within the practice and clearly had lots of experience, knowledge and confidence in her role.

She was very clear about the minimum core skills she would expect a practice nurse to possess and said that when recruiting, it would depend on the current team skill mix whether they could risk taking on a nurse that did not have those skills and 'bring her on' within the practice.

She described the practice structure as comprising 'department heads', all of whom she would expect to liaise directly with each other about their teams if there were any issues to resolve. Talking about the lack of a uniform approach across practices to ensuring practice nurses are competent, she spoke of her anxieties about places where this is not well managed.

PM6: "It's a hugely risky place where people are alone and have a lot of responsibility. In primary care you may be the only person in the building at lunchtime when they've all gone off on visits."

Her view was that patients are unaware of the fact that some nurses may not be fully qualified to perform certain tasks, as they will assume that everybody is competent and qualified. The difficulties in tackling the variation between practices were a big challenge, but she suspected that sometimes it needs a critical incident to make them aware of the risks of having nurses that are not adequately trained.

PM6: "I would put it in CQC in the future..... I would want to say it's a minimum standard and you are performance managed against it, but you've got to have it in such a way that they don't kick back...if there's also an incentive for them to do it then they will do it."

Regarding the nurse/GP relationship she had views about gender stereotyping and felt that this was still embedded in nursing and medicine, with traditional general practice not far from a hand-maiden model.

PM - I think it's fascinating. I think its mainly a power struggle. It goes back to really old fashioned traditional roots and I think my observation, not just here but in other practices as well, it is so core and fundamental and it almost goes back centuries to the start of medicine.

Her view was that this professional power was so gender-related that even female GPs tended to take on an 'associate male' persona. She was however, a staunch supporter of the GPs and expressed the view that nurses do not always understand the GP perspective within the practice and that they have needs as well.

PM6: "I don't think doctors are as stubborn or as difficult as nurses quite often think they are. I think they are just as vulnerable. I think they're less willing to be open about their vulnerabilities and I think a good practice nurse can help them to reveal themselves."

She saw part of her role as being an advocate for the GPs and making sure they have some pastoral care to support them in their work. Sometimes this might mean protecting them from the demands of staff, particularly nurses.

PM6: “And they will sometimes then have high expectation of...the level of support they are going to get from the doctors that they can just tap on a doctor's door and he will be able to go through the pharmacology of.... and it's not always that possible especially if he's got a head full of something else.”

Her view about nurses using opportunities was that they were too passive and needed to develop better negotiation skills as well as a more collegiate, coordinated, strength by working together more.

PM 6: “I think practice nurses are inclined to undersell themselves; I think they could be a stronger voice within primary care health overall.”

Overall, this practice seemed to have some discrepancies in internal congruity of perception between the three participants. The GP and practice manager seemed very closely aligned in their views but the practice nurse was quite at odds with them. This could be due to the doctors and manager being unaware of the reality, or it could be that the nurse is not typical and the rest of the nursing team may view things differently. Whichever, is the case, there are obvious difficulties for the nurse as a result. This practice was labelled as a bureaucracy due to the highly structured form with hierarchies and policies. The level of nursing influence was not considered high and the support for developing and enhanced nurse role was potentially there but limited by the culture.

6.5 Extra-case Data

The findings from the six cases provided a comprehensive picture of the views of different professionals within general practice. Three key commentators who had a deep understanding of practice nursing but each from a different perspective were also interviewed, to provide an outside or ‘extra-case’ dataset with which to compare the case findings. This was intended as a measure to test the truth value or credibility of the case findings thereby enhancing rigour (Pope et al 2000). The intention was that by interviewing participants outside of the context but with a deep understanding of it, they could provide verification or challenge some of the assertions made by in-case participants and put it into a wider picture.

PCT Nurse

This nurse sat on the PCT Clinical Executive Committee and had a lead role in advising on primary care nursing matters. She was an experienced practice nurse who had worked independently in practices across the county and therefore had a good understanding of the types of roles and employment conditions in different practices. Her interview was rich in anecdotes illustrating the difference between the ideal world and the real world and identified a lot of challenges that practice nurses face. A major concern of hers was the isolation that many experience, working with no senior support and not being aware of what they don't know, having no reference point about what 'good' looks like and nowhere to turn to for information or advice. The issue of competence and accountability was related to this and she acknowledged the difficulties in tackling this.

PCT Nurse: "It's very difficult I think for a lot of nurses...to actually say I don't feel competent doing this, I don't feel safe and it's seen as a kind of a failing... when actually if you care about the service you deliver and you're professional then I think you need to start being a bit braver about it...but it's easier said than done I think."

She felt that nurses were often their own worst enemies and could be a lot more proactive in shaping the way their role develops by being clear about how their contribution improves the service.

PCT Nurse: "I think the nurses that...have the most self confidence and are much more assertive will actually kind of say 'this is my identified gap, this is what it will do for the practice, this is what we need to deliver it, I'd like to do it'."

She had a view that role development is related to nurse age and personality in terms of assertiveness and passivity, but also that practice nurses sometimes have no alternative employment choices and so have to conform to something that goes against the grain. She suggested that practice nurses should learn to use national standards and guidance more to support their case for development as this often carries more weight.

She was of the same view as practice manager 6 about the need for practice nurses to network and join together to have a more collaborative way of working and a more collective voice.

Local Medical Committee Practice Nurse Advisor

This participant was an experienced nurse practitioner in general practice and had undertaken national projects on behalf of the Department of Health to improve practice nurse access to professional guidance and standards. She was also a professor in primary care nursing and currently running an on-line practice nurse induction programme.

Discussing how practice nurse roles are determined she had concerns that often practice nurses do not consider the needs of their practice, their team and sometimes even their patients when they are planning their own professional development. She added that the structure of general practice where nurses are sometimes not included in team meetings does not help tackle this blinkered attitude.

LMC Nurse Advisor: "And just generally speaking they will often think how hard done by they are if they don't get what they want, rather than put themselves in the GPs' and practice managers' shoes."

She was also of the view that there is a gender power play at work in general practice and that older practice nurses in particular conformed to the stereotype of handmaiden, making it difficult for new nurses to break the mould. She recognised the importance of networking with people that have the authority to make a change whether that is at a local or national level. She also suggested that having a nurse in the Department of Health representing independent and general practice nurses would be a real step forward as they have no national collective voice and are often therefore forgotten in national policy development.

She felt there was also much that needed to be done to address the mindset of some practice nurses who resent having to do things in their own time or at their own expense and do not recognise that if they give a little they will benefit in the long run.

LMC Nurse Advisor: "...trying to change the culture of general practice nursing whereby I will only do things if I'm paid and I won't do things if I'm not paid, because just in my experience if you put the extra mile in the rewards are enormous..."

She saw a need for a lead practice nurse at Clinical Commissioning Group level, to tackle these issues and provide leadership for this group of nurses and develop a local shared education and mentorship system.

University Lecturer

This participant, a senior lecturer at a local university, had been involved in the design and delivery of the practice nurse induction programme that so many participants had spoken about. Her view was that post-registration education should all be at Master's level as nurse registration moves to being a graduate profession. She had many years' experience of teaching practice nurses and nurse practitioners and provided a different perspective on some of the issues around accessing appropriate education.

She described a range of practice nursing roles from a task-orientated nurse through to a 'one-stop practitioner', with a role similar to what would previously have been done by a GP. She also identified different groups of practice nurses with different levels of motivation. There was one group that are 'seeing their time out' and just want a bit of up-dating, and there is a group that really want to develop their role. Some of that is dependent on the practice culture and the opportunities that are presented but her view was that it is largely dependent on the individual. She felt that since the discontinuation of the induction programme there was a gap in education at the foundation level to provide a safe starting point for new nurses. There should be access to a skills-based course:

Lecturer: "...to take people through the first year so that they have the knowledge, and skills and confidence to do whatever it is they need to do."

This seemed at odds with the fact that all post-graduate education is now at Master's level, which would exclude a significant proportion of the current workforce. She was clear that there are risks associated with practice nurses not having the tools to do the job properly and she cited the independence of general practice as the root of the problem. She was aware that national initiatives had been developed and publicised but felt they had not been successful in turning round the situation.

Lecturer: "...but each of these little projects has only got so far and it's never got to the stage of really engaging the whole of general practice and coming up with a plan that everyone signs up to, and that actually happens."

Talking about the characteristics that she sees in students who have obviously had the motivation to apply for higher education courses she said:

Lecturer: "Well generally they I think are usually quite self-aware and insightful both about themselves but also about some of the attitudes and motives of others...tried very hard to negotiate and influence often one particular partner or practice manger or other members of the team."

Some of the students she came across had pushed their practice for support but had found that the more they tried the more resistance they met, so they actually moved on and found another practice to work in.

Having recognised the gap in foundation level education her recommendation was that pre-registration placements in general practice was the way to prepare future generations of practice nursing. However, there is no funding arrangement in place for this, no mentors to provide training and assessment and no accredited education programme to support nurses who decide to work in general practice once qualified.

Her closing comments were around the lack of progress in engagement with GPs, with the recommendation that establishing pre-registration placements for student nurses in general practice would better prepare the next generation.

6.6 Final Cross-Case Analysis

The in-case analysis of each participant had provided information about different professional perspectives and the influences that practice variation can have on role and professional development. The exploration of some of the aspects that had been highlighted in relation to the organisational culture theme provided a deeper understanding of the part this has to play.

This had sharpened the focus of analysis to draw out key characteristics that seemed relevant to addressing the research question. These were:

- Support for practice nurse role evolvment
- Practice culture and leadership style
- Degree of nurse influence
- GP training practice status
- Access to training funding
- Level of practice manager power

The next step was therefore to compare these across the cases to see if any patterns were present. This produced a surprisingly clear result. A rough ‘cloud-map’ was sketched by hand illustrating the key characteristics of each case with the new information gained following the in-case analysis and highlighting in colour those characteristics that were common across the cases. Other case features were noted, including practice size and the role of nurse interviewed. This is illustrated in the diagram reproduced at appendix 14. At this point it became clear that a pattern was emerging and there were associations between certain cases. The visual representation of the colours and matching patterns of their presence in three pairs was striking. The similarities were between cases 1 and 5, cases 2 and 4, and cases 3 and 6. This echoed some of the early indications noted in the initial cross-case comparison of similarities between pairs of cases. A summary of the comparison of theses characteristics across each case is presented in Table 16 below.

Table 16 – Cross-case comparison of key characteristics

Case no.	Size	GP TP?	Training funding	PM power	Role evolvment	Practice culture	Nurse interviewed	Nurse influence
1	small	no	restricted	low	low	autocracy	exp	low
2	large	yes	ring-fenced	strong	high	democracy	NP	high
3	large	yes	available	strong	limited	bureaucracy	new	limited
4	med	yes	ring-fenced	strong	high	democracy	NP	high
5	small	no	restricted	low	low	autocracy	exp	low
6	med	no	ring-fenced	strong	limited	bureaucracy	new	limited

What this visual illustration of the case characteristics demonstrated was an apparent link between small, non-GP training practices that have restricted training funds available and a top-down autocratic style culture that is dominated by GPs rather practice managers. Both the small practices shared these characteristics and in both cases the opportunities for practice nurse role evolution were low. In addition, the influence and power exerted in these two practices by practice managers and nurses was low.

By contrast, the practices that were involved in GP training, had a protected 'ring-fenced' training budget and a culture of power sharing, had high practice nurse role evolution and high influence exerted by the nurses and managers. Ring-fencing of the training budget had a positive association with role evolution, as did being a GP training practice. However, neither of these factors was independently linked to role evolution, as demonstrated in the one practice with a ring-fenced budget and limited role evolution and the one that was a training practice, but also had limited role evolution. Being a medium or large practice did not seem as relevant as other factors.

The two cases that featured a strong practice management model and a bureaucratic type of practice culture exhibited limited role evolution and limited nurse power. This was irrespective of the practice size, GP training involvement and ring-fencing of budget.

The experience of the nurse interviewed was also linked to the findings on role evolution and nurse influence, with the nurse practitioners having an association with the most favourable conditions. It could be argued that the nurse practitioners were instrumental in creating these conditions, but there is no evidence to support this, other than the fact that they were highly regarded by their colleagues and did exert influence. They may simply have chosen supportive practices to work in. It is hard to determine whether the culture enhanced their development or whether their influence created the culture. Similarly, it could be argued that the two new nurses interviewed described their influence as limited because they lacked experience. However, the assessment made of the level of opportunities and influence was based on all three interviews in each case, not just the nurses' statements, which strengthens their overall credibility. In order to test whether the experience of the nurse interviewed is

linked to the findings on role evolution and influence, it would be necessary to interview a range of nurses within each practice.

6.7 Documentary review

In order to provide a further source of information to facilitate the analysis, a review of available documents in the public domain that provide information about practice nursing roles and professional development was undertaken. This provided information about the position adopted by various organisations with a responsibility to provide clear guidance to primary care about standards concerning employment and training of staff, and accountability for quality of patient care delivered. It also provided a picture of where practice nursing fits into the national workforce and how some of the consequences of the national workforce trends might impact on practice nursing. This provided a different perspective with which to compare the primary data collected through interviews.

The WiPP General Practice Nursing Initiative set out to develop some core principles to support the recruitment and retention of general practice nurses following the introduction of the 2004 GMS contract. This resulted in the development of a ‘toolkit’ of resources designed to clarify the range of roles, skills and competencies in general practice as well as ‘good practice’ guidance in relation to employment and professional development (WiPP 2008c). These were designed for nurses and employers with the aim of providing a credible peer-reviewed benchmark against which individuals could compare local practice, with the aim of reducing anomalies across England. In addition, a career framework was developed, identifying the typical skills and training associated with different practice nursing roles (WiPP 2007b). These tools appear to be highly relevant for practice nurses seeking focused practical guidance relating to role development.

The contribution made by professional bodies to practice nurse standards and guidance is variable. Apart from an RCN publication on practice nurse employment, (RCN 2007) most guidance is generic and does not specifically address the general practice nursing situation (NMC 2008, NHS Employers 2010). The RCN provides on-line access to a practice nurse forum but little in the way of frameworks and guidance with the emphasis much more on

professional networking. A search of the RCN website entitled 'Nurses employed by GPs' produced several statements most of which concerned indemnity, pensions and remuneration. This is not surprising as the function of the RCN is primarily to represent nurses as a union. Two information sheets were particularly related to new practice nurses and the role and responsibilities of the work. They provided clear instructions that the nurse should:

“...make it clear to your GP employer that you will need training and supervision before you can manage certain nursing services.....you must be firm with your employer about the arrangements of the training.” (RCN 2011a)

and

“...ensure that your employer takes the responsibility of preparing you for the job.” (RCN 2011b)

This advice appears to assume that new practice nurses will understand what the role involves before doing it, know what training they need in order to be competent and will have the confidence to articulate all of this to their new employer. Evidence from this study suggests that this is often not the case. The RCN advice also included the recommendation that nurses new to general practice, particularly those working in isolation, should seek clinical supervision and support from an experienced practice nurse (RCN 2011b).

A search on the NMC website for standards in general practice produced only one document, the 'Standards for specialist education and practice for general practice nurses' which defines the educational framework for this specialist qualification (NMC 2001). The other guidance that may have some value for nurses in general practice working in isolation is the position statement on clinical supervision (NMC 2006). This may help them to negotiate support from experienced practice nurses from another practice to reflect on their role and professional development needs. The main purpose of the NMC is the registration of nurses and protecting the public from registrants that do not adhere to the Code of Conduct. It is therefore not within their remit to respond to the professional needs of a particular group of nurses unless there were concerns raised in the public arena about conditions that were having an adverse effect on patient safety.

The RCGP nursing foundation, a sub-committee forum for nurses, managers and physician assistants which focuses on quality and education, recently adopted a set of practice nurse employment standards based on the WiPP work (Crossman 2008, WiPP 2008b, RCGP 2011). Negotiations are underway to include these as part of the independent regulator Care Quality Commission (CQC) accreditation of general practice framework. All practices will have to register with the CQC by April 2013 and the essential standards include a section entitled 'suitability of staffing'. This offers a potentially powerful and persuasive mechanism for establishing some standards, as it incorporates professional credibility and reward. This could provide practice nurses with a real opportunity to negotiate a win-win agreement with their GP employers.

A search on the local PCT website provided several pages of information about general practice but none that mentioned practice nurses. Primary care performance is monitored by a team within the PCT and includes benchmarking data on a range of indicators including QOF, prescribing, complaints and patient access. Only the QOF organisational indicator makes reference to employment of staff but the requirements are limited to basic employment contract conditions. The PCT employs a 'practice nurse lead' but the funding only allows for one day a week, which limits the scope of their role. The PCT does not take responsibility for providing a resource that formally supports practice nurse employment and professional development.

The regional multi-professional deanery linked to the practices in the case study has a commitment to supporting education through the County Workforce Group. The deanery employs a group of Practice Education Facilitators who work in partnership with local healthcare employers and Higher Educational Institutions (HEIs) to assist in developing high quality learning environments, as well as giving direct support and guidance to individuals who in turn support learners. However, this is targeted at undergraduate students and does not currently include general practice, as there is no agreement for pre-registration placements within practices. The deanery developed a preceptorship handbook to assist newly qualified nurses make the transition into working in general practice. The handbook sets out a

framework of knowledge required to work in general practice and offers an assessment template to identify learning needs (East of England Deanery 2011).

It is relatively easy to source guidance on practice competency levels required for specific clinical topics as these are often articulated in frameworks and guidance issued by professional and statutory organisations. These include the National Institute for Health and Clinical Excellence quality standards (NICE 2011), Health Protection Agency (2005), National Cancer Screening service (2011), Education for Health (2008) as well as individual high profile providers of education.

Participants in both the survey and the case study asserted that until there is a national framework with standards for practice nurse employment, the wide variations in employment conditions and opportunities for development will persist. In the case study there was a low level of awareness among participants of the existence of national frameworks and standards to support practice nursing. The documents above were reviewed in relation to the main issues that arose from the research around problems that some nurses experience in accessing information and support to develop their role. They provide information for those uncertain about role definition and associated competency, routes to future development and opportunities available to facilitate the process.

6.8 Conclusions

The case study data identified features in general practice associated with providing optimal conditions for role evolution and professional development support. Practices with a strong lead nurse practitioner, who had a good relationship with the GPs, displayed a high degree of mutual cooperation, respect and power-sharing, resulting in good professional development support and scope for enhancing the practice nurse role. Where this was combined with on-site GP registrar training and a ring-fenced training budget, this represented an ideal practice in terms of offering opportunities for practice nurses. Size of practice did not seem as important as culture; one large practice was less supportive than the other and it had a bureaucratic structure, as did the other practice where support was low. Rural or urban location and QOF score did not seem to be relevant indicators of a practice that was supportive of role development.

The main findings of the case study data analysis are summarised below:

1. Practice nursing roles are variable, with no set 'description' and they need to be flexible and adaptable to meet constant changes in demand, due to primary care policy and general practice priorities.
2. There is an increasingly blurred distinction between the roles of GPs, Nurse Practitioners, practice nurses and healthcare assistants.
3. The lack of formal educational preparation and standardisation of minimum qualifications creates a risk that nurses will not be adequately trained for their work.
4. A democratic practice culture is associated with the strongest support for role evolvment and the highest degree of nurse power and influence.
5. Small practices that are non-GP training sites may have less scope to provide financial and clinical role development support.
6. GP power seems to be exerted more in small practices.
7. Nurses successful in securing professional development support seem to share certain behaviours, including being positive, assertive and recognising the challenges facing GPs in maintaining a successful practice.
8. A segmentation of roles with associated traits can be found in practice nursing.

This chapter has presented a large quantity of interview data and summarised the main findings. The strongest associations to come from the data analysis were that practice culture was linked to the degree of practice nurse role evolvment and influence exerted, with a power-sharing culture being the most favourable, and a 'top-down' being the least so. This seemed more important than other factors, although when combined they also play a part in producing an environment conducive to opportunity. In addition, practice nurse personal characteristics and relationships with GPs had a big impact on the way their role developed and was supported. This raises questions about whether their level of empowerment can be positively influenced in order to enhance their opportunities.

Chapter 7: Discussion

7.1 Introduction

The purpose of this research was to understand more about the factors affecting practice nurse role evolution. This chapter examines the information gained, drawing on the main findings of the case study summarised at the end of Chapter 6 and discussing them in relation to the survey findings and the literature. The focus of the discussion is on the central issues that emerged as having an impact on role evolution; role ambiguity, education, practice culture, nurse attitude and professional power. Concepts of empowerment are explored in relation to practice nurses' ability to influence their own and others' fate, shaping their own contribution to the practice and sharing decisions that affect them. Critical to this is confirmation of the synergistic relationship between structural and psychological elements of empowerment (Knol and Linge 2009), represented in the case study findings by practice culture and practice nurses' behavioural characteristics.

7.2 Practice nursing role

Although they are a small proportion of the total NHS nursing workforce at approximately 20,000 (Drennan and Davis 2008), practice nurses are often the first point of contact for patients accessing healthcare (Poulton 1997) and as such, play a key role in the public perception of the NHS. With political changes continuing to shift care delivery out of hospital and closer to home (DH 2008d), the focus will increasingly be on ensuring effective primary care and practice nurses will be central to achieving this. As such, it is important that their role is well defined and any development is supported by education and training to ensure patient safety. In order to understand the factors influencing role development it was helpful first to explore fully what the role encompasses.

7.2.1 Role range

The survey findings provided information about this role by capturing the range of tasks that practice nurses carry out and the clinical care they provide. The results identified a broad spectrum of practice nursing roles ranging from general nursing tasks such as dressings and injections, to the management of long term conditions and prescribing, and this is consistent with several surveys that identify a similarly broad profile (Ross et al 1994, Atkin and Lunt

1995, Mackereth 1995, Poulton 1997, O'Donnell et al 2010). There was a consensus among the case study participants that general practice depends on practice nurses to perform a major part of the clinical work, which is often associated with achieving practice targets and therefore generating income. Descriptions of the role confirmed there was a high degree of role variability and boundaries between roles were unclear, creating ambiguity. Two main issues emerged from this:

1. Some nurses found the degree of role ambiguity difficult, especially those who had recently moved from the acute sector, whilst other nurses were attracted by it.
2. All nursing roles had a valuable contribution to make but nurse practitioners in practices with a strong educational ethos were able to exert most nursing power, so their contribution was the most influential.

1. Role ambiguity

The issue of clearly defining their role and the associated expectations of their employers concerning its scope was important for the practice nurse participants. The case study found that roles were generally determined by the practice requirements at the time of recruitment, but also that the future development of the role can be negotiated. This was perceived as an advantage by case study participants when compared to working in acute trusts, where hierarchies and structures are more formal, resulting in less devolved decision-making at a clinical practitioner level (Willcocks 1998, Hoque et al 2004). General practice affords those nurses with vision and ambition the opportunity to develop innovative roles to accommodate the practice's needs and their own interests, and an increasing number are now partners in general practice (Benison 2005c, Cook 2005). However, Carr et al (2005) describe most roles as being determined by the need to meet General Medical Services (GMS) targets and they ascribe the development of new roles such as triage and minor illness to the implementation of NHS policy. The case study found that the lack of a standard set of roles and titles in general practice created feelings of insecurity and isolation for nurses moving from acute settings where structure features much more prominently, because they are unsure of what is expected of them and where to find advice. This is supported in the literature (Lovett-Clements 2010). It is therefore difficult for new nurses joining practice nursing from the acute sector to become influential and feel they can exercise choice about their own role involvement.

The two 'new' nurses in the case study found the degree of role ambiguity difficult as it created uncertainty about the boundaries for their clinical practice. They both described feeling isolated and uncertain about the extent of their role and how it related to other practice nurse colleagues, to the point that they were considering leaving general practice. This has also been reported elsewhere, with poor role definition creating a loss of professional identity, which affects morale and patient care (Williams and Sibbald 1999). O'Donnell et al (2010) report a strong association between practice nurses feeling isolated and an intention to leave general practice. Similarly, Stark et al (2001) found factors negatively affecting recruitment and retention included being 'thrown in at the deep end', isolation, GP domination, job insecurity and powerlessness. This might have implications for staff recruitment and turnover, particularly as a significant proportion of the practice nurse workforce approaches retirement age in the next few years (Drennan and Davis 2008). Consequently, a greater understanding of the factors associated with retaining staff in general practice will be important in mitigating this.

O'Donnell et al (2010) found that nurses who reported feeling isolated were more likely to work in a small practice, not to use their full range of skills and to have unproductive appraisals. They speculate that this may be due to being engaged in a wide range of activities with little depth, being uncertain about their role, or covering many areas they feel unprepared for. This resonates remarkably with the case study results, where uncertainty about their role featured strongly in the interviews with the two new nurses for whom this was disempowering as they felt they had little or no opportunity to resolve it. Discussing role definition, Williams and Sibbald (1999) identify the confusion around the difference between a practice nurse and a nurse practitioner as having a negative impact on clarity of responsibilities. This is echoed by Paniagua (2003) who describes a merging of roles and boundaries between nurses, nurse practitioners and GPs, as the practice nursing role expands and becomes more complex and less defined. Although the nurse practitioner role is now more common, there are still conflicting interpretations of the role and how it differs from other nursing roles in general practice (Paniagua 2010). Williams and Sibbald (1999) discuss the loss of professional identity associated with 'ambiguous spaces' created by reform or changing role boundaries

and skill-mix. They outline how, in situations where the depth of a role is extended (enhancement), a task is passed up or down a uni-disciplinary ladder from one care worker to another (delegation), passed across a professional divide (substitution), or where new roles are created (innovation), there is a risk of role ambiguity. This movement around roles can create 'winners' and 'losers' where some staff are likely to feel that they have lost part of their role at the expense of others gaining new responsibilities. This was evident in this case study where managers described some nurses wanting to hold onto their work and GPs talked about losing a large part of their role to practice nurses. Role ambiguity and poor communication can therefore create tensions between professionals and this occurs in settings other than general practice. Advanced practice role development in acute trusts has also been reported as being hampered by role ambiguity, with negative effects on professional relationships and clinical practice (Lloyd Jones 2005). Therefore, positive human resources' management and strong leadership are required to ensure that roles are clearly communicated and staff are consulted and supported in order to avoid the negative unforeseen consequences of unplanned role 'drift'. The case study confirmed that strong nurse leadership and good communication of roles and responsibilities were central to making practice nurses feel supported in their work. Such facilitative supportive human resource management can be expected to enhance performance (Marchington and Zagelmeyer 2005, Hyde et al 2006, DH 2007) and lead to a positive effect on patient outcomes (Sheikh et al 2007).

The effects of role ambiguity were apparent in the case study and extended beyond the two new nurses, to include the nurse in case 5 where there was very little direction and support, but a high expectation that the nurse would undertake whatever treatment the presenting patient required. This placed the practice nurse in the invidious position of wanting to help the patient, fulfil her employer's expectations and balance these with the medico-legal risks of practising on the verge of the limits of her competence. When nurses are uncertain about their role, Williams and Sibbald (1999) found they tend to be unwilling to make substantial changes that extend it, due to being afraid of challenge over whether they are adhering to the NMC Code of Conduct and they may therefore defer to a doctor with less experience than them, which is not necessarily the best outcome for the patient (Williams and Sibbald 1999). Sibbald et al (2004) assert that this has the effect of undermining their professional identity

and their level of autonomy, thereby reducing their ability to make a clear confident nursing contribution.

Uncertainty can inspire or threaten innovation (Williams and Sibbald 1999) and some nurses in this case study described the role ambiguity as attractive because it created an interesting variety and a fluidity that allowed them to adapt and change according to their own professional development aspirations, and the needs of the service. They used this opportunity to demonstrate to their employers how an extension or development in their role could help the practice by improving the care given to patients and supporting the work that the GPs did. This worked particularly well where the nurses also demonstrated a good understanding of the practice priorities and challenges, and came up with solutions rather than demands, using considerable negotiation and persuasion skills. This has the potential to provide aspiring practice nurses with a model to test and develop for themselves, encouraging them to find positive ways to influence their own role and to help the practice achieve optimum performance. The results of this study suggest that the nurses who would fare best in general practice might be those who can cope best with ambiguity, having the personal skills to adapt and to solve problems. This is supported by comments from doctors and managers about the personal characteristics of nurses who succeed in this environment, which will be discussed in detail later.

2. The Nurse Practitioner role

This study describes an environment in general practice that requires nurses to be able to respond to change and learn new roles. Nurse practitioners seem best placed to thrive in this environment as they have a more highly developed and potentially adaptable skill-set. However, the scope of the nurse practitioner role is not universally agreed (Paniagua 2010) and therefore employers' and colleagues' expectations of their skills may vary. This has the potential to cloud further the issue of ambiguity described above. The nurse practitioner role in general practice has been extensively researched and has been found to be comparable in terms of cost-effectiveness, patient satisfaction and clinical outcomes to that of the GP in managing self-limiting illness (Venning et al 2000, Kinnersley et al 2000, Illiffe 2000, Sibbald et al 2004). There is also evidence that experienced practice nurses can provide a clinically

safe alternative to a GP (Shum et al 2000, Chapple et al 1999). The fact that these outcomes hold for both nurse practitioners and practice nurses suggests firstly that it is the experience and skills of the nurse that are important, and secondly, that there may be inconsistent use of the title in general practice. This was supported by the survey findings, where more nurses were using the nurse practitioner title than had completed the training. This reiterates the blurring of nursing roles and titles in general practice (Walsh and Huntington 2000) and the continued inconsistent interpretations of the nurse practitioner role (Paniagua 2010).

In this study nursing power, defined by shaping the nursing contribution and sharing decision-making, was highest in the cases with a strong educational ethos and highly trained nurse practitioners. Both of the nurse practitioners were the managerial lead for their nursing team, both were involved in training and supporting junior doctors and both had been trainers for the practice nurse induction and nurse practitioner programmes at the local Higher Education Institution (HEI). Within this work, education played a big part in career progression, supporting the theory of knowledge and power being closely bound (Foucault 1980). Whilst the nurse practitioner role in this study was achieved primarily through attaining a higher level of clinical expertise, it also appeared to confer a higher degree of nursing power in decision-making, suggesting that there are more benefits than just enhanced clinical responsibility to achieving this status. The colleagues of the nurses practitioners in this case study expressed a high degree of respect for them and their seniority was evident in the way they described a responsibility for ensuring that the nursing contribution achieved the best outcomes for patients and the practice. The nurse practitioners were perceived by their nursing colleagues as being 'different' from other practice nurses and they behaved differently too, in that they confidently articulated their influence in shaping the service. On first sight, this may be connected to the origins of the role having an association with medical work (Paniagua 2010) and being heavily influenced by the Calman Report (DH 1993), which recommended junior doctors' routine tasks should be undertaken by appropriately qualified nurses. Paniagua (2010) describes this doctor-nurse substitution as being poorly defined and variously perceived, with some nurses becoming more medical in the process (Maslin-Prothero and Masterson 2002). However, based on the nurses taking part in the case study, it is likely that confidence might increase with accumulated knowledge and that the combination of

knowledge with confidence may engender greater respect from doctors who value knowledge highly. There is evidence that 'advanced practice' nurses educated to Masters level report higher levels of confidence and enhanced relationships with physicians (Jones et al 2005).

However, GPs are not universally comfortable with the nurse practitioner role. Wilson et al (2002) report concerns amongst some GPs regarding nursing capabilities and scope of responsibilities, and this was echoed by the GPs in cases 2 and 3 of the case study. In case 2 the GP had initial reservations about the role and its relationship to her own. The GP in case 3 was an advocate for the role but faced a lot of opposition and hostility from colleagues when he tried to introduce it in the practice. Sibbald (2008) discusses the inappropriate ratio of nurses to GPs in care provision in general practice, with under-utilisation of nurses who could perform up to 70% of the work, leaving GPs to deal with the complex medical problems beyond the competence of nurses. Awareness of this debate may contribute to some GPs' discomfort and this seemed to be the case for the GP in case 2, who felt that her role had been eroded through the nurse practitioner's ability to deal with a large proportion of the clinical work. Despite evidence of some resistance to the role, nurse practitioners in general practice provide an illustration of a professional elite group acquiring power in decision-making based on increased knowledge and experience (Parsons 1995), suggesting that the theories of professional power which were prominent in the 1980s and 1990s (Jolley 1989) still have some relevance today. How they use the power they hold will depend partly on the relationships and culture within the practice and this will be explored later.

To summarise, both the literature and the findings of this study indicate continued variation and ambiguity in practice nurse role definition and this presents advantages and disadvantages to the profession. For those wishing to enhance their role by extending their knowledge and skills to nurse practitioner level, general practice provides good opportunities. However, those moving from an acute setting should be aware that the lack of a uniform role and structured career path poses a risk in terms of professional isolation when new in post. This is less likely in practices with a strong educational ethos and a dynamic nurse practitioner leading a supportive team. Sharing this information widely could help nurses to be discerning when they apply for posts, potentially reducing the risk of entering employment situations where

they may feel isolated and demoralised. This in turn will be important in ensuring recruitment and retention of high quality staff.

7.2.2 Role segmentation

The participants of this study confirmed not only that categories equivalent to the Dent and Burtney segments (1997) still exist in general practice but they also asserted that all the categories were equally important in terms of providing a practice nursing service. They concluded that this requires all nurses to be supported with education appropriate to them, ensuring that the professional competence of those with lower career aspirations is maintained. However, there was one further development beyond Dent and Burtney's categorisation, regarding the four different interpretations participants made of the categories as described in Chapter 6. These interpretations raised further questions for consideration around the underlying reasons for individual nurses to be perceived as belonging to a category, some of which might be out of their control and may well affect the way they perform. This adds further understanding to what may otherwise be over-simplified in practice, based on flawed assumptions by colleagues or employers. Some employers may expect a young nurse with low domestic responsibilities to be ambitious, whereas she may in fact not be the ambitious 'type'. Conversely, a nurse who combines managing a family with high career aspirations might be very frustrated by the limitations that her life-stage places on her career development and this may affect the way she behaves at work. Understanding these conditions and planning on the basis of them may improve working relationships and performance.

Congruence between personality characteristics and career pathway decisions is likely to have a positive effect on job satisfaction and success in roles. This may allow for nurses and their employers to understand better why some practice nurses appear reluctant to develop their role whilst others use every opportunity to do so. Some might have no career ambition and be uninterested in being able to influence the way their role evolves. Others may be highly motivated individuals driven to achieve higher credentials and to determine their own career path. An increased understanding of this could help both in the recruitment of nurses for specific roles and in creating professional development plans, with realistic expectations for

the nurse and the employer.

The illustrations above suggest that the categories applied in segmentation theory currently allow a variety of interpretations and this affects their reliability and application in practice. This possibly relates to the confusion surrounding practice nurse titles and a clear sense of professional identity (Williams and Sibbald 1999, Kelly 2004). Whilst it cannot be ruled out that changing Dent and Burtney's original terminology in this study might have had an effect on the interpretation of the categories, it seems clear that there are a combination of nuances such as variability in consistency between job title and role, combined with personality and life stage, that also affect the accuracy of segmentation.

In academic terms the reliability of segmentation theory can be challenged in two ways. Firstly by asserting that the definitions of the individual categories must be very clear, unambiguous and up-to-date, and secondly by questioning the rigidity of aligning each nurse to one category, as this case study suggests that nurses may move from one category to another at different life stages, or sit in more than one at a time according to the scope of their role. However, segmentation theory does provide some insights into the association between personal characteristics and role.

7.3 Factors influencing role evolvement

This section explores the key factors that emerged from the study as influencing the degree of role evolvement and discusses relationships between them. These were:

- Education
- Practice culture
- Practice size
- Mentorship
- Practice nurse personal characteristics
- GP/nurse relationships
- Empowerment

7.3.1 Education

It has been established that practice nurse education remains uncoordinated and variable (Stillwell 1991, Prime 2003, Cross 2006, Lovett-Clements 2010). Tinson (2011) describes the

GP employer's expectation that practice nurses will be competent at the outset with associated accountability implications. Stark et al (2001) describe nurses undertaking tasks for which they are not competent and being afraid to voice their educational needs in case they are sacked or downgraded. This study described low availability of professional education, particularly for those nurses new in post with no previous experience in general practice. Some of the problems associated with this related to being geographically remote from an HEI, or the HEI not catering for practice nurse educational requirements. Many of the participants linked poor educational preparation to the risk of adverse effects on the quality of patient care and raised concerns about isolated junior practice nurses with no access to mentorship or professional development support.

There were two main issues highlighted with regard to education:

1. Practice nurses felt disconnected from HEIs and unable to do anything about it.
2. The educational preparation for nurses moving from the acute sector into general practice was perceived to be inadequate.

One case study participant described the lack of connectivity between practice nurses and HEIs in terms of failing to develop jointly a comprehensive education strategy that responds to support changing clinical roles. Practice nurses have little influence with HEIs because they represent a small proportion of nurses and have no collective voice or pressure group through which to exert any power (Paniagua 2003, Tinson 2011). This not only deprives them of the opportunity to design and organise their own educational programmes, it also makes them an easy group for policy makers to ignore and this is compounded by the fact that designing programmes for them is unlikely to produce significant financial or political rewards.

On the subject of education preparation for nurses moving into primary care, there was little enthusiasm from the HEI lecturer around developing an introductory level practice nursing programme. The university was focussed on providing post-graduate education at Master's level, which would make it accessible to only those qualified nurses who have completed a degree, as opposed to those with a diploma level qualification. Whilst this policy direction is consistent with nurse education generally, in so far as all pre-registration programmes are

gradually shifting to degree level, it nonetheless discriminates against a group of nurses that are already educationally disadvantaged (Field 2011, Lovett-Clements 2010). It particularly excludes those 'rank and file' nurses that have no academic ambition but could provide an important element of treatment room care. This raises an issue for the study participants who said that it was important for practice nurses at all levels, including the 'rank and file' group, to have access to the education necessary to achieve and maintain competence. The group who are unaffected by this policy are nurse practitioners, whose post-graduate programme is at Master's level and as such, aligns with the HEI's priority developments. Nurse practitioners in practice nursing slot easily into a wider multi-specialty educational programme for advanced practice and are therefore likely to be seen as legitimate customers by HEIs. Hence, although they are a minority within practice nursing, they have more power to influence the development of educational programmes they require.

Many of the case study participants bemoaned the loss of the diploma level practice nurse induction programme that used to be run locally by the HEIs. This course provided a mix of academic and practical elements, with several nurse trainers providing teaching and assessment for students in accredited training practices. Similar courses are available in other parts of the country, but not universally (Tinson, 2011, Lovett-Clements 2010). Participants rated the local induction programme highly as a foundation for new nurses, saying that it provided a uniform standard of clinical competence and regular access to mentorship and supervision from the trainer. However, the course was a resource intensive investment for a small number of students and as a result it was discontinued. According to participants, the consequence of this is that nurses in this area now have ad hoc preparation to general practice, depending on the arrangements in the employing practice. This retrograde step perpetuates the variable levels of skills and knowledge amongst junior practice nurses and increases the risk of poor preparation for the role, affecting the quality of patient care. Inconsistency and variation in formal education to support practice beyond registration has been raised as a concern by the NMC (2011), particularly in light of evidence that practice nurses are widening the scope of their role to include care previously provided by GPs (Goldsmith 2011).

The importance of connectivity between employers and commissioning of staff education is now being recognised by NHS workforce planning, particularly in relation to supporting the shift of nurses from secondary to primary care, firstly to replace the large numbers of practice nurses likely to retire in the near future and secondly to implement the national political agenda in primary care (Drennan and Davis 2008, Howard 2011). These nurses are likely to be drawn from the acute sector, with the difficulties outlined earlier relating to educational preparation and supervision to support this transfer. National workforce planning currently includes a reduction in commissioned places for pre-registration nurse education as part of the £20billion savings required by the NHS between 2010 and 2015. The Royal College of Nursing anticipates staff shortages as a result (Buchan and Seccombe 2011), which are likely to have an impact on recruiting nurses to primary care, making it all the more important to have effective induction and mentorship in place to retain high quality nurses in general practice. This was echoed in the case study findings, with several participants expressing concern about the effects of losing a substantial proportion of the experienced practice nurse workforce, combined with difficulties in recruiting new nurses with the requisite skills.

A further twist is likely to complicate the dearth of educational opportunities described in the case study. The Department of Health guidance on workforce planning requires all employers to be responsible for identifying staff training and development needs and ensuring that their workforce is competent (DH 2010). The responsibility clearly sits with all providers of NHS-funded care, which will include GPs. One of the central principles of this policy is the belief that healthcare providers understand the training needs of the workforce best and should therefore have the freedom to develop staff to transform services and maintain high standards of healthcare delivery. There is no mention of how this relates to staff employed by GPs. This should be a cause for concern as there is no current workforce development planning mechanism that includes input from general practice and the NHS funding for education does not include general practice staff. It will therefore be incumbent upon practices to decide collectively how to approach this (Lovett-Clements 2010, Field 2011) and this study illustrates the variability in support for education and training across practices. However, there is no escaping the fact that nurses have a duty to ensure they are competent to perform the work that they do (NMC 2008, Goldsmith 2011) and a responsibility to advise their employers as to their educational needs (RCN 2011a and b). This study illustrates how the practice nurses' approach to this will be influenced by their level of

empowerment and ability to articulate and negotiate the professional development they need to practise safely.

The consequences of devolving all responsibility for staff education to the employing practice could prove damaging for this professional group, especially to those nurses that are passive about their own development. The expectation that GPs will plan, support and fund all staff training perpetuates the risk based on past experience, that some practice nurses will not receive the training they need to perform their role competently (Peachey 1992, Prime 2003, Field 2011). The results from the case study show that this is already a problem for some practice nurses. Relying on the practice to support training may also limit career development opportunities that require education funding unless they are deemed essential by the practice. The case study illustrated variability in financial support for training between practices, ranging from 'restricted' to 'ring-fenced' (Table 16, page 218). This seems at odds with DH optimism and confidence that the policy will give healthcare providers the 'opportunity' to invest in training and innovation to improve the quality of services they provide. The guidance does acknowledge some risks to small professional groups and requires them to work together to develop strong and effective local arrangements. A regulatory mechanism to ensure this happens is not mentioned. The likelihood that this arrangement will provide improved opportunities for practice nurses seems remote, although this study identified the type of practice where this is most likely to occur. It remains to be seen how groups of GP employers will tackle the issue and commission appropriate education. The lecturer interviewed in the case study suggested that Clinical Commissioning Groups (CCGs) should develop a practice nurse development strategy that supports the implementation of their commissioning intentions and puts a governance framework in place to ensure that practices do provide adequate training and support. However, with the many competing priorities currently facing CCGs in their quest for authorisation as statutory bodies, it is likely that nurse education will not be high on their agenda.

7.3.2 Practice culture

Practice culture, classified primarily by leadership style, had a big impact on the way that nurses negotiated their role. Although leadership style was not initially a focus for inquiry it became apparent from the case study results that it was relevant. Practice managers' leadership style was variable across the cases and interacted with issues such as GP

domination and practice size, all of which affected professional development support for nurses. It is well documented that organisational culture has a significant effect on staff willingness to take on new challenges (Schein 1990, Jones et al 2005) and this was illustrated in the case study. Three types of culture, all resonating with Handy's (1993) leadership and management 'styles', were identified:

- Autocratic – a top-down dominant use of power
- Bureaucratic – a hierarchy of delegated power
- Democratic - shared power and decision-making

In this study practices with an autocratic culture were small with restricted training funds and no involvement in GP training. The practice managers and nurses had little power and influence as the GPs dominated decision-making. In both these cases, there was a low level of support for role evolvment and little individual control by nurses over the shape of their contribution. In these autocratic environments subordinates are given little autonomy or freedom to innovate and do not participate in problem-solving (Handy 1993, Daly et al 2004). In cases 1 and 5 the advantages and disadvantages associated with this style were evident. It was very clear to staff who was in charge and there was no ambiguity about who would make a decision. However, there was little opportunity for personal growth and innovative development, with the GPs articulating an interest in maintaining the status quo at the expense of practice nurse role evolvment. Whilst both of these practices were small, it is not possible to assert a relationship between practice size and culture, due to there being only two examples. However, as the limitations imposed on role evolvment by an autocratic culture were clear, practice nurses might wish to be able to identify practices with this sort of work environment before joining them. Any associated features typically found in an autocratic-style practice would therefore be helpful to nurses trying to determine whether the culture was conducive to role evolvment.

In the two practices with a bureaucratic culture the practice managers exerted a lot of power and managed the practice as a structured hierarchy, with clear lines of accountability and decision-making devolved to key individuals. The focus of power in these practices was the organisational management system with formal policies and procedures dominating and any evolvment of the nurses' roles being overwhelmingly determined by the practice.

Furthermore, as neither of the nurses interviewed was a team leader with involvement in meetings and decision-making they felt disconnected from the business, with no opportunity to participate other than through their line manager. This made them feel alienated and powerless. The advantages to this style, where leaders tell staff what to do and adhere to strict procedures, are that there is a reliable approach to work which results in technically consistent performance (Daly et al 2004). However, staff are likely to feel insecure if left to their own devices as they are not used to thinking creatively and they are unlikely to question process or discuss their views on it. This can lead to poor communication and team cohesion (King and Anderson 1995). This was evident in case 6 as the nurse said there was no team spirit in the practice and nobody took any interest in each other as people. This was less so in case 3 as there was a very large supportive nursing team within the practice.

It was noticeable that in both the bureaucratic cases a mismatch between participant perceptions emerged. While the practice nurses painted a negative picture about lacking support, the GPs' and managers' opinions differed. In case 6 the GP and manager said they created an open, consultative and supportive environment. Despite these assertions, according to the nurse there was a top-down management style within which her voice was not heard. In case 3 the nurse said she found it difficult and stressful trying to get clinical support from the GPs and described waiting outside their consulting room until they emerged from seeing patients. However, the GP and manager both stressed the easy access to GPs for clinical support afforded to nurses. These data suggest that a formal employment culture that does not facilitate communication and team cohesiveness may leave nurses feeling aggrieved about the support they receive.

In the two practices with a democratic culture nursing power was highest, with shared decision-making and nurses exerting a lot of influence in shaping their own contribution. These practices had a supportive educational ethos and strong nurse leadership by a nurse practitioner, both of whom were the nurse interviewed in the case. Communication and teamwork were dominant features of these practices. The practice managers had good insight into the role of the nurse, valued her contribution highly and encouraged team working and strong cohesion between the nurses and GPs. These features are well established in the

participative style of leadership and create a cohesive committed team with opportunities for creativity (Broome 1998, Daly et al 2004, Jones et al 2005). In addition, these practices provided examples of role modelling by the nurse practitioners, in that they demonstrated high levels of commitment to their work and were very engaged in continuous professional development. Role modelling is recognised as a motivating force for staff which is likely to enhance their performance (Keller and Price 2010).

Further illustration of the apparent impact of culture on practice nurses is gained by comparing cases 4 and 6. At first glance both practices appear very similar. Both shared similar features in terms of size, location and nursing skill mix. Both had strong practice managers, several nurse practitioners and the treatment room nurses were supported by HCAs. However, the ethos in the two was very different. Two particular differences seemed to stand out. In case 4 the nurse practitioner was a strong leader and was deemed by the GP to be the reason that nurse power was high in the practice. In addition, the practice culture in case 4 was consultative and the practice manager was against segregating any of the staff, feeling that inclusion for all was very important, and teamwork was central to the practice ethos. For the nurse in case 6 it was the absence of these very things; empowerment, communication and teamwork that she felt created the problem in her practice. This suggests that these are vital elements for practice nurse role involvement to flourish and a practice culture that actively promotes these is therefore likely to provide a positive work environment for nurses. This creates some potential guiding principles for practices that find it difficult to recruit or retain nursing staff.

To summarise, management and leadership style in the practice had an impact on the role involvement of nurses with a democratic, participative culture presenting the most favourable conditions. The literature search did not reveal any previous studies examining the relationship specifically between general practice culture and practice nurse role involvement, so it is not possible to compare the findings with other similar settings. However, the wider literature describes a well-established link between organisational culture and staff readiness to evolve and adapt to change (Manley 1997, Jones et al 2005, Schein 1990, Keller and Price 2010). The case study illustrated a distinctive pattern across the cases associating role

evolvment with practice culture and it is recommended that further research should test this out in a larger sample.

7.3.3 Practice size

Practice size did not appear to be a factor influencing role development per se, but there were particular features associated with the two small practices in the case study. These were:

- an autocratic culture;
- lower levels of professional development support and
- limited scope for role development.

In both practices the autocratic culture had a marked effect on the way that that nursing roles and training needs were determined. Neither of these practices was a GP training practice, possibly because they had too small a patient population to provide adequate scope for clinical experience. The reduced nurse training opportunities might partly be explained by their smaller overall budgets with limited financial flexibility making the amount available for training less secure.

Another feature of small practices that might reduce training opportunities is the inability of a small nursing team to flex the shifts to allow cover to release staff for training and this would also restrict the capacity to provide supervision and mentorship for junior staff. This trend in small practices was supported by the survey results, finding that large practices were associated with better employment conditions and this included study leave and the provision of in-house induction programmes. The literature identifies a correlation between good employment standards and high employee performance (Hyde et al 2006, DH 2007) with a related positive effect on patient outcomes (Sheikh et al 2007). This would appear to be more challenging to achieve in small practices. There is the potential for small practices to collaborate with other larger practices, particularly in the current climate of Clinical Commissioning Groups emerging, to share some aspects of practice nurse induction and mentorship thereby enhancing the support available to their nurses. The importance of support and collaboration was made clear when O'Donnell et al (2010) discovered that nurses working

in small practices were more likely to feel isolated and this strengthens the argument for peer support and mentorship.

In summary, two features were associated with practice size:

1. Small practices were more likely to be associated with an autocratic culture and have practical difficulties in supporting and releasing nurses;
2. Large practices were more likely to provide in-house role development support.

7.3.4 Mentorship

Participants in both the survey and case study voiced concerns about the difficulties new nurses face in understanding the scope of the work they were expected to do without having support from a mentor to help them acclimatise to general practice. This created a lack of confidence and the case study demonstrated that even where the nurses had previously held senior roles, they felt uncertain as a new practice nurse. Spreitzer (1996) describes ‘self-determination’ or control over one’s own job as being one of the elements required for empowerment. The lack of control experienced by new practice nurses in the study made them feel disempowered and dissatisfied in their work.

The benefits of mentorship and clinical supervision go beyond empowering nurses. They are well documented as supporting nurses to provide high quality clinical care (NMC 2006, 2006b, DH 1999b) although there has been confusion about the various models of mentorship and their application (Andrews and Wallis 2001). Ali and Panther (2008) describe the mentorship role as supporting and guiding, encompassing teaching as well as role modelling, whilst others define it purely in terms of teaching and assessing students (RCN 2007). Elements of both mentorship and clinical supervision can be interpreted as supporting professional development for nurses and Lovett-Clements (2010) asserts that the need to invest in mentorship for practice nurses cannot be over-emphasised. However, the survey part of this study found only 27% of respondents receiving either mentorship or clinical supervision and there were concerns expressed by many participants about the potential effects on the quality of patient care. Benison (2005b) discusses the professional isolation that some practice nurses experience without the support of colleagues and the difficulties they face in

making clinical decisions. This concurs with Stark et al (2001) and O'Donnell (2010) who report job dissatisfaction and low levels of empowerment associated with isolation. Dickon Weir Hughes, Chief Executive and Registrar of the NMC (NMC 2011) also cautions that the professional isolation of practice nurses could jeopardise safe effective practice.

The practice nurses in Cases 5 and 6 both complained about inadequate mentorship and supervision for junior nurses, linking it to having concerns about competence with some nurses being unaware of their own limitations. If practice nurses are recruited from the acute sector with little preparation for their new role and are then expected to work in single-handed clinics with no mentorship, 'unconscious incompetence' can arise. This term is used by the NMC (2012) to describe the defence of a nurse who, due to lack of experience or training, is unaware she may have placed patients at risk. New practice nurses may not realise they lack competence because they have no reference point with which to compare their own performance. The survey found that only 20% of respondents had an assessment of competence in a newly delegated task and this finding was echoed by several participants in the case study, who were surprised their competence had not been assessed before being asked to take on a new role. Particularly in small practices this is likely to be due in part to there being no-one in the practice to supervise and assess them. Some form of mentorship or supervision was available in the practices that had a strong nurse practitioner lead or a large supportive nursing team as in case 3. A professional support system such as this should be promoted as a way to mitigate the risks of professional isolation both in terms of job dissatisfaction and safe practice. As one of the nurse practitioners pointed out, trainee GPs have a rigorous training programme and a period of supervised practice, although they are fully qualified doctors, and there is no reason why nurses should not have access to the same model.

7.3.5 Practice nurse personal characteristics

Collaboration between nurses and GPs was found to be important throughout the research, particularly in relation to enhancing levels of nurse empowerment thereby giving them more influence over the way their role was determined and evolved. Discussing the importance of

the relationship between GPs and nurses, Smith and Salvage (2000) assert the need to replace the conventional outdated paternalistic model of father (doctor), mother (nurse) and child (patient) with a collaborative three-way partnership. They describe the complicated nature of this professional relationship being rooted in a historical difference in status.

*“Nurses’ readiness to be slighted and doctors’ reluctance to be challenged
create an undercurrent of tension”.* (Smith and Salvage 2000:1019)

This reluctance to be challenged was seen in the autocratic practices in the case study, with the GP demonstrating medical dominance, requiring the nursing staff to conform to his definition of their role. Smith and Salvage (ibid.) discuss a difficult transition with nurses becoming more assertive and educated and doctors puzzled and unaccustomed to being challenged, having to accept subservience by nurses as being no longer appropriate. Davies (2000) sees the weight of tradition as very difficult to shake off, due to the continued rule-following of nurses and independent practise of doctors. Moving from this position requires nurses to disregard the assumed subordinate status of nursing and challenge the assumption that the way to achieve power is to internalise medical values instead of defining their own (Maslin-Prothero and Masterson 2002).

There is a consensus that collaboration benefits patient care (Goodwin et al 2011) and in general practice this requires nurses and GPs to have a strong working relationship. Some of the participants in the case study attributed successful relationships to personal qualities in the nurse. This was particularly the case with the nurse practitioners, both of whom demonstrated a high level of empowerment and a positive impact on the GPs. This supported the survey findings where a good relationship with GPs was considered fundamental and where assertive nurses demonstrating an empowered attitude were found to experience higher levels of support.

In a study exploring critical judgements that fellow professionals make about each other and the effects this has on care, Walshe et al (2008) describe nurses carefully maintaining their relationship with GPs to enhance collaboration whilst the GPs assume a leadership role and seem less concerned about the success of the relationship. This was illustrated by nurses in this

case study who described a variety of approaches ranging from deference to assertiveness in order to maintain a good working relationship with GPs and to ensure that the best outcomes for patients were achieved. Walshe et al (2008) found that nurses used ‘game-playing’ strategies to subvert medical authority without challenging the GP directly, in order to achieve a good outcome for patients, and there was collusion between staff doing this, which highlights the complexity of the relationship between nurses and doctors. This example of coercive power was originally illustrated by Stein (1967) who coined the phrase ‘doctor-nurse game’ to describe the practice of nurses making recommendations to doctors in such a way that the idea appears to have been initiated by the doctor.

The early results highlighted from the survey in this study regarding the importance of the GP and nurse relationship were strengthened by the findings from the case study. It emerged from the interviews that personal characteristics in the nurse that were particularly valued and respected by practices could potentially affect the level of support and cooperation offered to her. This finding is supported by a meta-analysis of specialist and advanced roles in the acute setting, which identified nurses’ personal characteristics as significantly hindering or facilitating their role development (Lloyd Jones 2005). In the case study some personality traits were repeatedly highlighted by participants as positive attributes and both of the nurse practitioners seemed to possess them. These were described in the data analysis chapter and are now considered in more depth. Attributes in a nurse that were identified by GPs and managers as being particularly valuable were:

1. Corporate – having the interests of the business at heart.
2. Seeing the ‘big picture’ - understanding where the nursing role fits in.
3. Patient focused – promoting high quality clinical care.
4. Adaptable – willing to take on new challenges.
5. Independent – comfortable with autonomy.
6. Team player – collaborative, willing to share and support others.
7. Assertive – able to communicate with confidence as an equal; clear boundaries.
8. Good negotiator – understanding how to achieve a win-win result.
9. Insightful - good awareness of own and others’ predicaments.

Participants saw the combination of these qualities as the embodiment of the ideal practice nurse. They appear to fall into three categories relating to business focus, collaboration and personal insight. The first three points in the list above related to having an externalised focus that looks outward and considers the context and purpose of the work rather than just the consequences for 'self'. This outlook was considered to be a rare strength by managers and GPs, giving nurses a deeper commitment and willingness to contribute to the overall work as a whole, linking individual actions to patient and practice outcomes. Demonstrating this attitude seemed to win particular favour as it showed empathy for the GPs and managers in the challenges they faced in running the business.

Points 4 to 6 described a personal approach that would maximise the practical impact of the strategic business awareness described above, through providing a flexible, adaptable and collaborative contribution to the practice. Commitment to team work was seen as a positive attribute enhancing the resilience of the practice regarding continuity of service during disruption such as staff sickness. Collaborative working was also considered to improve the overall work performance of staff through providing a supportive environment and raising morale.

The final three points concerned the nurse's interpersonal skills. The ability to communicate confidently and understand other colleagues' perspectives was valued highly. The GP in Case 2 described this as 'nurturing', with the nurse showing a high degree of concern for others welfare and taking time to provide support.

Where nurses demonstrated this combination of attributes, such as in the case of the nurse practitioners, they were highly regarded and that engendered strong relationships, trust and respect and shared decision-making. Without exception, participants that commented on this emphasised the difference it made to the practice having a nurse that was a confident, pro-active team member, who understood the business and supported the GPs.

The attributes outlined above are congruent with the qualities associated with transformational leadership and creating a culture that empowers staff (Bass 2006, Manley 2000). There is an

important parallel here between the fact that GPs gave assertive, collaborative nurses more power and the fact that nurses value a practice where decision-making is shared and they feel part of a strong team. Thus, a symbiotic state seems possible; if nurses demonstrate assertive, collaborative behaviour then GPs may be more likely to be receptive and reward them by sharing power. Similarly, GPs could initiate the effect; if they are willing to share power, nurses are more likely to be assertive and collaborative. So there appears to be a mutually beneficial relationship between these actions. Either action may create the outcome and if both are in place, success will be more likely as they will reinforce each other. This is supported by the literature on transformational leadership, within which an open and supportive culture with shared decision-making is self-perpetuating and empowering for staff (Manley 1997, 2000, Keller and Price 2010). Conversely, an autocratic GP unwilling to share power is unlikely to attract and retain empowered nurses as they will seek a practice that offers the conditions to enable them to grow. This resonates with the theoretical concepts of empowerment described in Chapter 2. The structural elements of empowerment described by Kanter (1977) are fulfilled when employers (GPs in this case) share information, resources and offer opportunities and support. The psychological elements (Spreitzer 1996) are fulfilled through the individual (nurse) demonstrating her positive self-identity, beliefs and motivation. The conditions necessary for creating strong successful practice nurse and GP relationships are clearly inter-dependent and related to empowerment.

7.3.6 Empowerment

Both the survey and the case study results highlight the use of power and sharing of decision-making as associated with the evolution of the practice nursing role. The survey also identified that ‘positive’ nurses were much more likely to be involved in decision-making in the practice than ‘negative’ nurses. As described above, several theories have articulated conditions that are conducive to enhancing empowerment and there is an alignment between these conditions and the nine practice nurse personal characteristics viewed positively by GPs and managers. This suggests that on some level the GPs and managers are aware of the benefits of empowerment but they do not necessarily see that they have any role in creating the conditions for it to flourish, seeing it more as a matter of luck whether nurses possess certain personal characteristics.

This can be explored in more depth in relation to Spreitzer's (1996) four cognitive processes related to developing empowerment shaped by the interaction between personality and environment:

1. Congruence between beliefs, values and the purpose of the job – 'meaning'.
2. Ability to do the job well – 'self-efficacy'.
3. Control over one's own job – 'self-determination'.
4. Impact of contribution to the organisation.

When these processes are all fulfilled, there is likely to be a high sense of empowerment. They are therefore explored below in relation to the nine positive attributes identified in the case study as enhancing GP and nurse relationships (see page 248).

1. Congruence between beliefs, values and the purpose of the job – 'meaning'

Where beliefs and values are aligned with the core role of a job, this is seen to create a sense of worthwhile achievement and personal fulfilment. Nurses are likely to have a set of beliefs and values that are based on altruistic principles (Rovezzi-Carroll and Leavitt 1984). If GPs share these values and create a work environment that promotes them, then nurses are likely to feel fulfilled and empowered. This links to the patient-centred focus of healthcare identified in the case study as a positive characteristic in nurses (attribute 3), which if shared by both GPs and nurses will act as a strong unifying force, giving them a common purpose on which to build. The GPs beliefs and values will also determine the culture of the practice and as discussed earlier, this has a strong association with the level of nursing power held.

2. Ability to do the job well – 'self-efficacy'

A sense of self-efficacy is closely linked to autonomy as it allows the individual to feel personally responsible for the outcome. This independence was identified by GPs and managers as a positive attribute in nurses (attribute 5). Related to this is the nurse's level of competence and skill which was particularly highly developed in the nurse practitioners in the case study. The issues regarding education and mentorship are therefore particularly relevant to nurses' ability to achieve self-efficacy and empowerment (Manjovlich 2007). Developing

competence also requires self-awareness and insight (attribute 9) to be able to understand where there is a skills gap and how it affects the work of others. It also requires an adaptability to learn and change in order to apply new knowledge to practical situations and improve performance and thus outcomes for patients (attribute 4). The fact that achieving self-efficacy also improves the experience for patients reinforces the achievement of congruence between job purpose and values, further enhancing the empowering effect.

3. Control over one's own job – 'self-determination'

This concept resonates strikingly with issues surrounding the level of influence practice nurses have in determining their role, suggesting that failure to shape this will result in low levels of empowerment. The case study results illustrate the many inter-related factors affecting the level of practice nurse control over this, showing that practice culture, education and personal characteristics combine to increase or decrease it. In the case study GPs and managers identified assertiveness and negotiation skills as positive characteristics (attributes 7 and 8) and these are necessary to achieve self-determination. This echoes the positive self-identity, belief and motivation identified as components of psychological empowerment (Spreitzer 1996). Therefore, where non-assertive nurses are employed in a practice with a culture that diminishes their sphere of influence compounded by insufficient education, they are unlikely to have a sense of self-efficacy and will likely feel disempowered.

4. Impact of contribution to the organisation

Having an understanding of how the individual contributes to the success of the organisation as a whole creates a feeling of worth and connectivity between the purpose of the job and the overall business (Keller and Price 2010). In the case study GPs and managers valued those nurses that saw the 'big picture' with a sense of how they fit into the business and how they could support it through collaborative teamwork (attributes 1, 2 and 6). Fulfilling this requires the nurse to have both a sense of 'self' and a belonging to the organisation. However, corporate and collegiate behaviour is not strong in nursing, with fragmented groups competing for dominance and failing to unite in order to pursue common goals (Maslin-Prothero and Masterson 2002). This tendency presents an obstacle to nurses achieving empowerment and should be challenged by those that understand and can articulate the benefits of strong

collaboration to ensure the success of the organisation (Goodwin et al 2011). Bradbury-Jones et al (2008) contend that power can be transferred from different people according to conditions, such as knowledge held. This supports the principle that practice nurses can increase the power they hold by understanding the GPs' perspective, recognising the needs of the business and using evidence to articulate a sound case for their role development that results in a win-win for the practice and the nurse.

Having a sense of meaning, self-efficacy, self-determination and impact can therefore be seen directly to relate to empowerment in practice nursing. The association between these 4 elements of empowerment and the nurse attributes valued by general practice is illustrated in Table 17 below.

Table 17: Nurses' attributes associated with achieving empowerment

	Meaning	Self-efficacy	Self-determination	Impact
Corporate				√
Strategic focus				√
Patient-centred	√			
Adaptable		√		
Independent		√		
Collaborative				√
Assertive			√	
Good negotiator			√	
Insightful		√		

The discussion above has shown that a combination of personal and organisational factors contributes to practice nurses achieving empowerment. A general practice that encourages employees to question, challenge and implement innovative ideas, whilst recognising and accepting that some will be unsuccessful, will create an environment that provides a 'safe' place for nurses to develop their role. This practice culture will therefore both attract innovative nurses and encourage those within the team to flourish and recognise their own potential to change and develop.

7.4 Conclusion

In summary, the factors influencing role evolution can be grouped as relating to education, practice culture, nurse characteristics and empowerment. There are strong links between these factors and changes in one of them appear to have an effect on the others. Practice culture has been demonstrated to affect support and funding for education, which in turn influences the nurse's ability to develop her role and become more empowered. This is consistent with the literature on 'structural' empowerment (Kanter 1977). Personal characteristics in the nurse have been shown to influence the way that the practice responds to her and the levels of power they share with her, with the most positive example being a practice partnership in case 2. These personal characteristics align with the elements of 'psychological' empowerment (Spreitzer 1996). There was a pattern of association across the cases demonstrating that those with a power-sharing democratic culture also have a strong educational ethos and highly influential nurse practitioners possessing all nine positive personal characteristics leading the nursing team. This supports the assertion that there is synergy when both structural and psychological elements of empowerment are present (Knol and Linge 2009). The remaining question is whether nurses that demonstrate high levels of empowerment can exert a positive influence on the practice culture, and help to create the best possible conditions for the practice nurse role to evolve. The relationships demonstrated through the study suggest this to be the case. The fact that nurses with the highest levels of empowerment were also highly regarded and influential within their practices indicates that practice nurses would benefit from education programmes which include the principles and practice of empowerment.

The next chapter provides a critical reflection on the research process.

Chapter 8: Critical reflection on the research process

8.1 Introduction

This chapter reviews the process of conducting this piece of research, identifying strengths as well as areas where further planning or more experience could have enhanced the study, thereby providing learning for future work. The topic of the research was an easy choice for me as it had been a central interest and was a continuation of my previous research. Refining the research question was however a challenge, due to the complex and multi-faceted nature of the issues under exploration. Nevertheless, the essence of the problem to be addressed was, I believe, captured through the design incorporating perspectives on general practice that do not appear to have been researched in combination elsewhere, thereby shedding new light on the subject.

The overall research question ‘What factors influence practice nurse role evolution?’ has been fully explored through the two parts of the research. The survey questionnaire design, the selection of case study participants and the questions that framed the interviews were designed to allow for inclusion of all considerations that might have had a bearing on the research question. The objectives identified as the means to addressing the question were:

1. Investigate how practice nurses, GPs and managers view the practice-nursing role.
2. Explore the availability of appropriate professional development support for the various practice-nursing roles.
3. Investigate the factors perceived by practice nurses, GPs and managers as influencing practice nurse access to professional development resources.
4. Explore any relationships between ‘types’ of nurse such as those identified by Dent and Burtney (1997) and access to professional development resources.

These objectives have been achieved. In Chapter 5 two diagrams illustrated a number of inter-connected systems and processes that are linked to the topic of this research. The ‘interacting perspectives’ diagram in Figure 10 (page 117) illustrated the interacting perspectives of a wide variety of people and organisations, all of whom have a direct or

indirect influence on the way practice nurses' roles are determined and developed. It was important for the study design to capture all of the perspectives identified. The 'conceptual framework' (Figure 11, page 126) illustrated the inter-relationship between organisational features and individuals' characteristics and linked them to structural and psychological elements of empowerment. The theoretical frameworks relating to professional power and empowerment therefore formed the foundation for the research. The research study has comprehensively explored all of the identified inter-related factors in order to gain a deep understanding of the relationships between them in influencing practice nurse role involvement and professional development support. A transparent and detailed description of the design, data collection and analysis has been provided and the conclusions are supported by the data. The particular aspects of the study that demonstrate rigour and ethical research practice are discussed below.

8.2 Strengths and weaknesses of the study design and fieldwork

Conducting the survey as a means to scope the issues and provide a focus for the case study served two important purposes. Firstly, it ensured that the research addressed issues that were relevant to a wide cross-section of the practice nursing population in the UK, thereby enhancing topic-salience. Secondly, it provided a degree of data triangulation from two different empirical sources addressing the same topic, which strengthened the dependability of the findings. The interviews confirmed many of the issues that had been highlighted by the survey, providing more contextual information about factors that were associated with them. Case study research commonly uses a mix of methods with multiple data sources to ensure a maximum depth of information is gathered and the study design provided a model that enabled this. The survey provided a picture of the main issues considered by practice nurses to be important in relation to role definition and involvement but the data could only be superficial and represented only their perspective. The case study, on the other hand, provided a much deeper and more comprehensive picture as it explored the perspectives of people who work with and employ practice nurses and may see things quite differently from them. From a GP's perspective, trying to run a business that is contracted to the NHS, with all the financial pressures and political targets, and being a supportive employer at the same time, is a challenge. Understanding the stresses that GPs and practice managers have to work

under created a fuller picture within which to set some of the practice nurses' comments. Furthermore, the particular features of individual practices such as business partnership problems provided more insight into how some of the associated tensions will inevitably affect practices' responsiveness to practice nurse role evolution. This was well captured through the process.

8.2.1 The survey

The survey design adhered to principles that aim to maximise reliability and validity and to minimise error. The risk of survey error relates chiefly to the sample, data collection process and response rate. Every effort was made to reach the total practice nursing population in the sampling through widely advertising the survey by postal flyers, the WiPP website, a journal editorial and conference presentations. Geographical coverage across the UK was broad, reducing the chance of bias due to local variation. Data collection was systematically managed through a computer software programme. The response rate was maximised by ensuring topic salience, pre-testing the questionnaire with a small sample and sending a reminder before the deadline for data collection. There remains a possibility that a significant group of non-responders may have had either additional or opposing views that were not included in this survey. The chances of non-response bias appear low, as there was good inclusion of known variables relating to the total population and the results were consistent with many other similar studies but it remains a potential risk to the validity of the data. It is, however, likely that the nurses who responded were connected to professional networks and had an interest in the topic, producing the risk of a biased sample as the views of marginalized nurses may not have been captured. This risk is reduced by the fact that the non-respondents were, through their demonstrated isolation and lack of connectivity more likely, not less likely to reflect the survey findings relating to access to professional development support.

8.2.2 The case study

The case study design was determined by the exploratory nature of the research objectives, with the intention of examining a wide range of interactions between individuals, structures and processes. Case characteristics were carefully drawn up to ensure that there was variability between the cases. This multiple-case design created the opportunity to examine

potential effects of case characteristics, singly and in various combinations, to provide greater depth of analysis. The sample selected provided a combination of each characteristic, with two nurses from each experience level, a variety of practice sizes and an equal proportion of rural and urban, as well as GP training and non-GP training practices. This allowed for each characteristic to be explored in relation to a variety of others, providing the opportunity for links and associations to be demonstrated. There is a risk that by volunteering and being aware that their colleagues were also participating, the triad in each case might create response bias by being more positive and supportive than truly reflected reality. This was not borne out by the findings, as there were some participants who were quite critical of each other, knowing that their contribution was confidential. Whilst volunteering confirms an interest in the topic, this was not an issue for sample bias as the cases were deliberately selected on the criteria being explored, which were not dependent on engagement or interest in the subject.

Data collection was challenging in the case study fieldwork, as the participants were all very busy working in general practice and the interview was something they had to dedicate up to an hour to. This was quite a high expectation to have as a researcher and potentially jeopardised the complete data-set being collected. Conducting twenty-one interviews and transcribing them all as a part-time student, whilst holding a full-time post was also a challenge and this posed another risk to achieving sample coverage. However, the twenty-one interviews were all completed and the transcripts provided a rich data-set, capturing a range of characteristics and perspectives for analysis.

I was very conscious of the need to be consistent in my interview approach and initially concerned about not deviating from the question schedule. An extract from my reflective journal describes an evolutionary style to the interviews.

“My interview technique improved as I progressed; the first couple were quite stilted and I felt too bound by the questions. Later, I became more confident to let the conversation flow in the direction the participant took it and just bring it back to any areas I felt were missed.” (10th October 2010)

The data collected were recorded and coded using 'nVivo' which created a high degree of order and consistency. There were challenges relating to the way in which the recorded data were presented:

“One of the real disadvantages I found was that you couldn't have a summary of each participant's themes. You could read the whole transcript and see what coding had been applied, or you could look at the individual codes and see who had contributed to them but not all of one person's themes all at once.”

(22nd August 2011)

As a result of this, I complemented the 'nVivo' software with the use of Excel to be able to visualise the frequency of incidence of themes. This gave me more feel for the scale of the issues and the relative emphasis in being mentioned, and allowed me to chart and tabulate them to illustrate this.

8.3 Critique of mixed methods

Although the ontological paradigm for this research study was qualitative, it incorporated mixed methods, combining the use of quantitative approaches to create order and indicate the scale of issues, with intensive qualitative exploration to elucidate meaning. This combination of quantitative and qualitative approaches produced some of the most valuable insights in the case study, but this practice is not without controversy (Foss and Ellefson 2002). There is a view that these research approaches cannot be successfully combined as the two perspectives are irreconcilable (Hammersley 1996). Quantitative research investigates from a positivist or deductive perspective, hypothesis testing and looks for causal relationships with explanations uncontaminated by extraneous variables. Qualitative research by contrast, explores meaning and social behaviours and cannot be separated from context or subjective interpretation. Combining these methodologies would therefore necessitate deviation from a pure ontological paradigm, thereby arguably affecting rigour. However, this position assumes that using numerical or descriptive tools define an entire construct per se. The distinction between methods and methodologies is therefore crucial. Using numerical measurement to describe and clarify the emphasis or priorities within a qualitative study cannot only be justifiable it can indeed enhance the quality of the research (Moffatt et al 2006). Methods are not

universally linked to one paradigm (Foss and Ellefson 2002) and it is now widely accepted that combining methods can capitalise on the strengths of different methods whilst compensating for the weaknesses (Coyle and Williams 2000). Case study is one methodology that lends itself to incorporating various methods. Luck et al (2006) assert that case study can span all methodologies effectively, triangulating sources and methods to provide detailed data to enrich the depth of investigation without detracting from the overall ontological perspective. In this study, the collection and presentation of data in a quantitative format helped to signpost where to focus the qualitative analysis, which in turn afforded a high degree of depth and detail from which to make comparisons and draw conclusions. This was documented comprehensively to provide an accurate audit trail and 'thick description' (Geertz 1993, Lincoln and Guba 1985). There were different benefits to mixed methods in the two parts of the study.

In the survey, the quantitative analysis of the questions illustrated clearly where there were concerns (e.g. low levels of induction training and supervision), which helped to clarify the magnitude of the issues and the emphasis for further exploration in the interviews. The qualitative analysis of the survey text responses flagged up the sort of views and concerns behind some of the responses. These were an important guide to shaping the questions for deeper exploration by providing a sense of what mattered to the nurses and what caused their satisfaction or dissatisfaction. In this way the focus of the case study was sharpened, providing greater confidence about what to explore in order to locate and 'mine' the seam of rich data.

Presenting some of the case study results quantitatively in graphs and charts produced a clear visual indication of the presence or absence of patterns. This was a practical way to bring order to the data and find a way in to the qualitative analysis. A lot of time could have been wasted carrying out detailed comparisons within and between professional groups across the six cases, if it had not been for the fact that a graph had illustrated that most similarities between participants were to be found within-case. Subsequent qualitative in-case analysis then led on to a further cross-case analysis once it revealed patterns previously unidentified that related to particular case characteristics, such as culture. The analysis process was

detailed, rigorous and transparent. Missing out any of the steps could have resulted in failing to identify some of the inter-relationships. This demonstrates the value in case study research of combining qualitative and quantitative methods (Corner 1991, Coyle and Williams 2000, Ritchie and Lewis 2003, Luck et al 2006) and does not detract from the overall ontological approach of the study, which was qualitative in nature, as determined by the research question.

8.4 Assessing rigour in qualitative research

Qualitative research is now accepted as being of equal value to quantitative, so long as it is conducted according to systematic and rigorous principles. Barbour (1999) warns against a check-list approach to using ‘technical fixes’ which does not confer rigour in itself unless embedded in an understanding of qualitative design and analysis. According to Lincoln and Guba (1985), providing a comprehensive audit trail through transparency and thick description gives others the best opportunity to judge the rigour of the research. This was particularly important with regard to the case study, as there was a large volume of data and the inter-relationships were many and complex. A combination of measures was employed in the case study to enhance rigour in the interpretation and presentation of results, using the criteria defined by Lincoln and Guba (1985) and presented in Chapter 5:

- credibility or (truth value);
- transferability or (applicability);
- dependability or (consistency);
- confirmability or (neutrality).

Credibility – The truth-value of the data was ensured through participant checking for transcript accuracy. The interpretation of findings was literal and derived from quoting directly from the data, thereby remaining faithful to the original source. Conclusions drawn through this interpretation were triangulated by comparing them with findings elsewhere in the literature. New information emerging from the data, such as an apparent association between role evolvment and culture, was tested out by comparing it in different contexts; i.e. across different cases or respondents, looking for patterns to confirm the possibility of a relationship. This also applied to deviant cases (Ritchie and Lewis 2003), where a difference

between cases, such as incongruence between nurse and GP perceptions, was examined to determine whether there were features that explained the difference and shed new light on the findings or whether it confirmed there was no relationship.

Transferability - A feature of this research study that enhances transferability was the clear and in-depth description of the sample and the case characteristics, making it possible to select a similar sample to conduct further research. Another relevant feature was the multiple-case design. This contextual variation allowed the exploration of different combinations of case characteristics and increased the likelihood that the findings were not just limited to one context and could therefore have relevance in the wider setting. Stake's assertion (2006) that the optimum number of cases for achieving sufficient depth of focus to demonstrate inter-connectivity is between four and fifteen is borne out by this research. If there had been fewer than six cases, it would not have been possible to demonstrate the existence of three types of practice culture in more than one context and the conclusions would therefore have been more tentative. Clearly the number of cases necessary to demonstrate associations is linked to the number of characteristics under exploration but Stake (2006) contends that beyond a certain point the data become too complex and unwieldy for the researcher to interpret effectively. The approach used in this case study provided a good degree of assurance that the meaning derived from the study has some relevance in the wider setting (Lincoln and Guba 1985).

Dependability – The extent to which a study such as this could be replicated is limited due to variables such as time, geography and individual participant characteristics. As with all qualitative research, the context and interaction between researcher and participants would have a significant impact on reproducibility. However, the detailed and transparent description of sample selection and case characteristics in this research would allow for a similar case study to be repeated, to test out whether comparable results would be found. The transparency also facilitates a comparison with similar studies to make a judgement on the quality of the research with regard to sample bias, response rate, systematic analysis and interpretation (Ritchie and Lewis 2003). The measures used to increase dependability have been described in detail throughout the process, providing an audit trail for others to make such a judgement.

Confirmability – Triangulation with other data sources, reflexivity and peer debriefing were used to assess whether inferences were based on the data or my own assumptions. This was achieved through comparing the findings of the survey and case study to other studies in the literature, through self-critical questioning about the origins of statements and claims, and through academic supervision challenging any assertions made. Pattern-matching (Yin 2008) against other case studies was not possible because the literature review had not yielded other studies with a similar focus and findings. However, there were sources that confirmed the associations made, such as links between organisational culture, education, personality, empowerment and effective practice (Kanter 1977, Spreitzer 1996, Manjovlich 2007). The cross-case pattern matching within this case study showed that cases sharing certain characteristics produced similar outcomes, in terms of strong support for practice nurse role evolvment. As such, inferences were related directly to the pattern that emerged from the findings and not from any pre-conceived notions.

As previously discussed, although it is widely accepted that case study findings cannot be generalised to the wider population, they can contribute to the creation of new knowledge and theories (Yin 2008, Pope et al 2000). By their very nature and design, case study samples are small in order to allow for depth of investigation and this means they are context specific. However, using a multiple case study design, as in this project, with different combinations of variables across the cases and employing cross-case analysis to test whether apparent links and associations may be due to context-specific characteristics, strengthens the transferability of the findings (Yin 2008). ‘Falsification theory’ can also be used in the process of testing the general applicability of multiple case study findings (Flyvberg 2004), whereby if one piece of data does not fit the theory, then the theory is rejected. There is evidence from this study that specific characteristics in combination create an environment conducive to role evolvment. This assertion was drawn from a comparison across the six cases, which illustrated a pattern between cases with common features and no occurrence of ‘falsification’ to contradict the findings. This proposition could be tested in a different population sample using an explanatory or critical case study design.

8.5 Ethics

Researchers have a duty to conduct their work according to ethical principles and these apply not just to respondents, but also to sponsors and fellow researchers (Singer 2008). Nurses as professionals are also bound by their own professional code (NMC 2008). The survey was deemed by the Local Research Ethics Committee not to require an application, as it was considered to be an audit of opinion with no interventions on participants. On the other hand, ethical permission was required for the case study, as the interviews could theoretically produce an effect in participants. In both the survey and case study, National Research Ethics Service (NRES) guidelines were followed to ensure participants gave informed consent and had confidentiality assured. These are illustrated in relation to the stages of the research.

8.5.1 Preparation

Careful preparation was necessary to ensure that ethical research practice was upheld. This included processes preceding any contact with participants, to ensure that the sample was selected and accessed without compromising ethical principles.

1. Negotiating access

Access to the sample in qualitative research is critical to proceeding and any suspicion about the purpose of the research from ‘gate-keepers’ may turn into non-cooperation, resulting in obstacles to getting the research off the ground (Watts 2006). For the survey, access was not an issue as the respondents self-selected from the total UK practice nursing population. For the case study, the PCT was satisfied that the research posed no threat to the interests of patients or practices. They approved and circulated the Participant Information Pack to every practice in the PCT area and interested volunteers were invited to participate by returning a reply slip.

2. Gaining ethical approval

As described previously ethical approval was not required for the survey but an application was submitted to the NRES for the case study and was granted on 29th January 2010 (Ref: 09/H0310/99).

3. Gaining entry to the field

Practice nurse case study participants were required to discuss the research with their GP and Practice Manager and produce a signed form with each participant's contact details. This was partly as a courtesy to the practice to ensure they were aware and partly because it was necessary to have confirmation that all three people would participate, to ensure the sample was complete. No influence was exerted in this process, participants were simply invited to discuss the information circulated and come to a joint decision with their employer.

Institutional authorisation such as this (Watts 2006:388) may have reduced the nurses' inhibitions and minimised the likelihood of problems relating to participation arising between them and their employer at a later date.

One of the most widely used ethical frameworks in healthcare is 'The Four Principles' described by Beauchamp and Childress (2001):

1. Respect for autonomy: respecting the decision-making capacities of autonomous persons, enabling individuals to make reasoned informed choices.
2. Beneficence: this considers the balancing of benefits against the risks and costs.
3. Non-maleficence: avoiding harm.
4. Justice: distributing benefits risks and costs fairly.

8.5.2 Autonomy and informed choice

Subjects participating in research must consent to do so and their consent must be 'informed' (Singer 2008). This means they must have adequate information about the risks and benefits of participating, this information must be understood by them, there must be no coercion exerted upon them, and their decision to participate must be documented (ibid.). There was a small risk of some nurses feeling under pressure to participate in the case study due to my senior position in the local area and my having taught and published on the subject under exploration. For this reason I was careful not to 'select' practices but to invite volunteers. I also widened the geographical scope to include the whole county, where I am less well-known, rather than just my locality.

Survey participants were required to read an information page and click a consent button before entrance to the survey was electronically enabled. Case study Participant Information

Sheets (appendix 7) were produced for nurses, GPs and practice managers. These were sent out to participants to give them time to consider whether or not to take part and were re-issued on the day of the interview, prior to signing a consent form (appendix 9).

8.5.3 Beneficence

Confidentiality is of paramount importance in protecting participants from any adverse effects of being identified as having taken part in research. Anonymity was guaranteed in the survey, as respondents were unidentifiable. Confidentiality for case study participants was handled by assigning a number to each. This could not guarantee anonymity, as it might be possible to identify practices by their described characteristics and individuals by their role. This was clearly explained to participants before they consented.

There was a potential risk in leading practice nurses to question issues about their work that would otherwise not have occurred to them. This could have had consequences for them in terms of job satisfaction or relationships at work. In the case study this was minimised by explaining fully the type of issues to be explored, and seeking consent only from those nurses who were fully prepared to accept that raising these issues may have a consequence for which they were willing to take responsibility.

The nurses could also be subsequently affected by their manager or employer being involved in discussing their role and development, as their employer's awareness of the relevant issues may have been raised. This could potentially have negative consequences if a nurse's role involvement aspirations were at odds with the practice's plan for nurse development. The risk of this was partially mitigated by discussing the professional responsibilities of nurses related to competence, accountability and PREP (the NMC requirements for continuous professional development) before interviews with the managers and GPs. This clarified the central role that competence and continuing professional development play in complying with professional regulation. There was still a small risk of divergent views being highlighted by the research, but arguably these would have to be dealt with in any case before any role involvement could be achieved.

Nurse participants were likely to benefit by achieving increased self-awareness, having considered and articulated their own role evolution aspirations and challenges. GPs, nurses and managers may also have benefited from a greater insight into factors relating to role evolution and a raised awareness of how this impacts on the work of the practice.

8.5.4 Avoiding harm

If any participant had revealed evidence of risks to patient safety due to negligence on the part of a nurse or doctor, the researcher would have been morally bound to address the issue by raising a concern with the appropriate practitioner and potentially their line manager. The National Patient Safety Agency procedure for dealing with a 'significant event' (NPSA 2006) would have been recommended to the practice, along with advice about the NMC procedures regarding concerns about competence to practise.

8.5.5 Justice

One of the 'key contributors' had a job title that some individuals in the field would recognise which meant that the person was not being given the same protection as other participants. This was dealt with by contacting the person and asking if they would like to change the description of their role in the write-up. They were happy to go with the possibility of being recognised and felt that their comments were in tune with statements already attributed to them in the public domain.

In summary, the ethical issues raised by conducting this study were minimal and were guarded against by putting measures in place that were in accord with best practice principles and NRES requirements.

8.6 'Insider' perspective

The concept of 'insider research' in qualitative studies and the risks it poses in terms of bias were considered carefully in this study due to my background as a nurse in general practice. Insider research relates to the proximity of the researcher to the group or subject under investigation (Hodkinson 2005). This can relate to an affinity with the group, (such as gender, race or occupation) or a close association at a higher level with the topic (such as

oppression). The researcher's personal experiences and insights in research are regarded as having both positive and negative effects (Johnson 2009) that cannot be eliminated and must therefore be acknowledged. Perry and Thurston (2004:135) argue that complete detachment from the subject of study is "*neither achievable nor desirable*". They, along with others contend that an 'insider' or 'emic' perspective enhances the ability to intuit, comprehend and analyse data (Davies 2005, Johnson 2009). However, there are dangers associated with insiders 'doing rapport' in order to generate data and the moral issue this creates around the balance of power between researcher and participant is considerable (Holland 2007). Measures therefore had to be employed to counteract the risk that an 'emic' viewpoint would inevitably, to a greater or lesser degree, affect my interviewing approach and colour my interpretation of data.

One of the difficulties I had to overcome early on in the research process was my desire to improve opportunities for practice nurses. This threatened to give me a blinkered view in designing questions and collecting data, as my position assumed that there was a problem rather than being free of preconceptions. This is one of the dangers of knowing the topic under exploration very well and for me it created a challenge in standing back and questioning the basis for the statements I made. Asking the question 'where did this statement come from?' was helpful in testing for bias. Another opportunity to critique my interpretation arose through a consultation exercise on the survey results with a mixed professional audience, which included the RCN, RCGP and Department of Health. Through this process many of the conclusions were discussed and challenged and this provided a valuable critique of the soundness of interpretation.

Data collection during the survey made me confront some of my potential for bias. I found that as the questionnaires came in I was 'looking' for those with issues for exploration and this made me almost disappointed with the respondents that expressed satisfaction with their situation. This reinforced the danger that I might be selective about how I interpreted the magnitude and relevance of the issues that might only be represented by a minority of the data. However, this was mitigated by the fact that I could not influence the data as they were being collected because the questionnaires were completed remotely and anonymously. As

issues emerged they were recorded faithfully and reported transparently. This provided a clear audit trail of the justification for the case study focus, drawn directly from the survey findings and the literature.

Another area that initially caused me some concern was the quality of the text responses in the survey. There was a clear delineation between nurses who were content and sometimes grateful for the support they had to develop their role and those that were unhappy and resentful. The emotive language used by some worried me as I thought it might be disproportionate to the realities of their situation. I captured this in my reflective journal:

“This has made me panic a bit because how can you trust anything they say when it is clouded by their personality and feelings? But I suppose these are all factors that influence how they access professional support and should therefore not be considered as harmful to the data. They actually are data.” (29th July 2007)

Reflecting on the concern I had led me to the conclusion that the strong feelings and personal attitude some nurses displayed might play a part in their role development. This turned out to provide an important focus for exploration in the case study, leading to findings that personality and attitude do influence the way that a practice responds to a nurse’s role development needs.

A comment from my reflective journal in January 2008 during the critical audience consultation on the survey findings highlighted a potential risk of bias. This illustrated the tension I was experiencing in maintaining an impartial perspective whilst producing a report for a project group tasked with a goal to support the implementation of the new GMS contract:

“I find it hard not to get swept up in the energy produced by my findings and subsequent debate in the political and professional arenas. It’s hard to stay detached and objective.” (7th January 2008)

However, this was thoroughly tested through the wide consultation, academic supervision and the university ‘transfer panel’ to approve continuation of the study.

Despite the challenges of my insider position there were benefits when it came to interviewing case study participants as it may have enhanced my credibility and rapport (Hockey 1993). Collegiate identification with the researcher can create greater confidence in participants, which may increase levels of candour, and complexity in their response (Hockey 1993, Johnson 2009). Discussing the ‘ethics of empathy’ Holland (2007) articulates the fine line between building rapport and exploitation, where the researcher ‘fakes friendship’ in order to encourage the participant to reveal fuller information. Thus the researcher has a moral duty to ensure that participants are not coerced or unwittingly led into revealing information they would otherwise not have done, through engaging with participants in a way that might encourage them to cross the boundary between professional relationship and ‘friend’.

The advantages of rapport must also be balanced with the risk of bias due to engaging in conversation with participants or asking leading or loaded questions, which would lay the researcher open to criticism of contaminating the data. This was addressed by using a semi-structured schedule of questions and by consciously avoiding revealing my own views. Mercer (2007) discusses how use of the technique of pause during interviews resulted in participants completing their own sentences with the very phrases she had been resisting supplying for them. My own interview technique became more relaxed throughout the case study, making me more comfortable to smile and nod encouragingly rather than use prompts. Mercer (2007) also recommends limiting the amount of information shared with participants prior to the interview, as this may result in a conversation about the topic which contaminates the interview data. I adhered to this advice by having a standard introduction to the interview and moving straight into the questions after consent had been obtained, so that all participants had the same information at the starting point and free conversation was restricted to after the interview, when the audio-recorder had been switched off. The accuracy of the capturing of data and authenticity of transcripts was assured by returning all transcripts to participants for corroboration. Some participants used the opportunity to make minor amendments to the text but there were no challenges to the accuracy of the account which had been recorded verbatim. Three out of the eighteen did not respond to the request for corroboration.

Interpretation of the data gathered is also a process vulnerable to insider bias. Researchers need to be aware of the partiality of their insider knowledge and the potential for taken-for-granted assumptions. They need to be wary of making interpretations based on their views, assuming that they are more widespread or representative than is the case (Hockey 1993). The process of reflexivity, triangulation and critical academic supervision safeguarded against this. In addition to the supervisors, two research peers were also asked to comment on the labelling of categories. Getting as near as possible to neutrality was the goal (Lincoln and Guba 1985). Whilst it was difficult to suspend my beliefs about nurses working in general practice, I did continually use the reflexive practice of questioning the basis of my judgements to test whether my interpretation was based entirely on what was presented by participants rather than my own experiences. The success of this process was continually tested and challenged through peer de-briefing with my supervisors.

8.7 Learning points

Having reflected on the process of conducting the research, there were several lessons learnt, which should be an outcome of any academic study. ‘Reflection-on-action’ has well documented benefits in terms of learning (Schon 1991). This was illustrated by my ability to receive criticism, reflect on it and use it in a constructive way. In the early stages of the research I relied more heavily on guidance and sometimes found it difficult to own my work and take control of the direction. However, as the research progressed I found I became more confident about accepting or rejecting criticism, recognising the value of critical peer review from experienced colleagues, but also having a conviction about how I should proceed.

8.7.1 Technology

Information technology was one of the major challenges for a variety of reasons. Firstly, with the survey, a company contracted to the NHS provided the software programme and prepared the raw data. Requests for the production of data in different reporting formats to allow for analysis occasionally resulted in misunderstandings. This had no consequence in terms of accuracy but created delays whilst a further request was made and detail was clarified. Secondly, with the case study, I was using ‘nVivo’ for the first time having attended a training course on it five months previously and there was no further coaching or support available

from the department once I started entering data. Once again, this did not create any risks to the quality or security of data but it made the task slower and more difficult. It also meant I did not use the software to maximum effect as I found alternative ways to complete some tasks in 'Excel'. There is a need to improve my IT skills and ensure that with future research I negotiate access to technical support for the duration of the project.

8.7.2 Arrange external evaluation

It is essential to invite abundant objective critical evaluation to provide an 'etic' perspective to counteract any 'insider' tendencies and also to critique associations and links made from the results. It is easier to arrange this at the beginning of the research than to find appropriate volunteers at critical points in the process. I could have planned this better, by identifying the points in the process where an external review would have been beneficial and arranging this at the beginning. This would have increased the amount of evaluation and allowed me to incorporate and learn from it during the research.

8.7.3 Test assumptions

Re-naming Dent and Burtney's categories may have created ambiguity as their meaning was variously interpreted. The revised terms cannot therefore be used accurately to test whether the segmentation categories exist in general practice. I made the assumption that some of the terms might have a negative connotation and I wanted to make them more palatable to avoid a reaction that might inhibit a true response. However, this assumption had not been tested out anywhere and when it came to asking participants whether they recognised the categories, I was not wholly confident about the labels and this may have had a more negative effect than leaving them as originally termed. It is also possible that as the categories were created in 1997, they may have been interpreted differently today even if they had not been altered.

8.7.4 Assess research skills

Careful consideration should be given to any potential skills gaps at the beginning of the period of study, to achieve the best preparation. Learning new research skills, such as how to use 'nVivo' at the same time as conducting the research is not ideal. However, it is also

difficult to retain proficiency in a skill that is newly taught if there is a long gap before using it in 'real' research. Good planning is therefore beneficial.

8.8 Conclusion

This chapter has provided a critical reflection on the process of conducting this research study. The conclusion drawn is that robust systems were used, good practice principles applied and documentation of the research process has been comprehensive, allowing readers to make a judgement about the rigour and potential transferability of the findings. The final chapter draws together the conclusions from the research and makes recommendations for implementation on the basis of the findings.

Chapter 9: Conclusion and Recommendations

9.1 Introduction

This final chapter draws the study to a close; revisiting the aim, assessing whether it was achieved and making final conclusions and recommendations. The main results are summarised with suggestions about how they relate to the practical realities of working in general practice, in the hope that they will be of value to practitioners and educationalists in the field. A framework capturing the essence of the research findings was developed as a practical tool for nurses and their employers.

9.1.1 Reaffirming the study rationale

The aim of this study was to explore role evolution and professional development in practice nursing in the UK. The stimulus for conducting the work was the apparent lack of responsiveness that practice nurses seemed to display at a time of great opportunity to develop their role. The recent favourable political climate with regard to encouraging the expansion of the role of nurses and the primacy of general practice as a locus of policy implementation created ideal conditions to strengthen and develop the practice nursing role (DH 2006b, 2008b, 2008c, 2010b). However, evidence of obstacles to practice nurse role development, including poor access to training remain (Tinson 2011, Field 2011), along with a lack of clarity about the extent of the remit (Paniagua 2003, Sibbald et al 2004). The consequences of practice nurses undertaking tasks for which they are inadequately trained have implications for patient safety, thus raising medico-legal liability issues both for the nurse and their employer (Goldsmith 2011). Resources exist to support role development, although they are not always easily accessible or locally available (Longbottom et al 2006, Lovett-Clements 2010). Despite the favourable political climate, the literature has continued to describe practice nurses as a disempowered, isolated group with many constraints reducing their ability to respond to opportunities (Bell 2007, O'Donnell et al 2010). The rationale for conducting the study was therefore to provide a greater understanding about the constraining factors and the influences they had on practice nurses wishing to develop their role.

9.1.2 Review of study achievements

The aim and objectives of the study were achieved and the focus on exploring factors affecting role involvement was maintained throughout. The literature review provided justification for the focus of the research being professional power and empowerment. No theoretical propositions were suggested at the outset as the research methodology was exploratory in design. The survey described a broad spectrum of elements that made up the practice nursing role, identifying tasks performed and the availability of training to equip nurses to carry them out competently. It also highlighted concerns that practice nurses had about the levels of educational preparation and professional support they received for their work. The survey results also gave an early indication of two factors that seemed relevant to role development; shared decision-making and nurses' attitudes. This guided the design of the case study, which gathered information from additional perspectives, providing a deeper understanding of the underlying reasons for some of the perceptions held by the nurses. The conceptual framework (page 126) for the case study illustrated how the structural (contextual) and psychological (individual) elements of empowerment align with the realities of practice nurse role development. Analysis of the case study data highlighted relationships between these two aspects of empowerment, particularly in relation to practice culture and practice nurse characteristics, whereby certain combinations created an environment conducive to role development. This confirmed the inter-connectivity of structural and psychological empowerment (Laschinger et al 1997, Spreitzer 1996) and provided some principles that could be beneficial in supporting role involvement in practice nursing.

9.2 Summary of findings

The research concluded that practice nursing roles evolve in a variety of ways according to many interrelated factors associated with the practice environment and nurses' level of aspiration and empowerment. Three main assertions regarding the practice nurse's role arose from this study:

1. Role ambiguity is common in general practice and has a disempowering effect on practice nurses, particularly those that are new to this branch of nursing.
2. Nurse practitioner roles exert most nursing power in general practice.

3. Segmentation theory (Dent and Burtney 1997) can help to explain why some nurses are more motivated to develop their role than others.

The variations in practice nurse role definition present advantages and disadvantages to the profession. For those wishing to enhance their role by extending their knowledge and skills to nurse practitioner level, general practice provides good opportunities. However, those moving from an acute setting should be aware that the lack of a uniform role and structured career path poses a risk in terms of professional isolation when new in post. A combination of factors contributes to the way the practice nurse role evolves. These are:

- Education, mentorship and supervision
- Empowerment
- Practice culture
- Practice nurse personal characteristics

Education, mentorship and supervision

Nurses have a duty to ensure they are competent to undertake their work and a responsibility to articulate their education needs to their employers (NMC 2008, RCN 2011b). This research found that the practices that offered the best resources and support for the evolution of the practice nurse role were those with a strong educational ethos, providing employment conditions that include nurse competency assessment and foundation training, a protected training budget, mentorship and supervision. Inconsistency and variation in formal education to support practice nurses has been raised as a concern by the NMC (Goldsmith 2011) but there is no plan articulated as yet to address this. The RCGP has established a general practice foundation which is a forum aiming to ensure that the views of nurses, managers and physician assistants are heard and valued in all aspects of the college's work (RCGP 2012). This forum could influence educational development in general practice and nurses should be encouraged to seek their support. It is apparent that in their guidance the national nursing bodies take a position of recommending rather than regulating any standards of practice nurse education. This makes it all the more important for practice nurses to take responsibility and lead on local education planning and this research suggests that nurse

practitioners in a team leader role may be more likely than most practice nurses to accept this challenge.

Empowerment

Empowerment holds the key to maximising the conditions favourable to role evolution. This is not however a 'single' factor; it represents the combined effects of practice culture (structural empowerment) and practice nurse personal characteristics (psychological empowerment). When both of these elements are combined they appear to reinforce and enhance the positive effect, giving practice nurses the best opportunity to shape their own and others' roles.

Practice culture

The case study illustrated a distinctive pattern across the cases associating role evolution with practice culture. A power-sharing culture that promotes nurse involvement in decision-making and strong nurse leadership was associated positively with practice nurse role evolution. This information should be shared with practices so that they can make a judgement about how they might be able to increase their ability to attract and retain high quality nursing staff, particularly at a time that a large proportion of the workforce nears retirement age. It should also enable practice nurses to assess which sort of practice might offer them the greatest opportunities for role evolution.

Practice nurse personal characteristics

Practice nurses who demonstrate a commitment to the work of the practice as a whole, who link their individual actions to patient and practice outcomes and have an approach that is flexible, supportive and collaborative are likely to receive the best support from GPs and practice managers to develop their role. They are also the nurses who experience the highest levels of empowerment and in the case study these were both nurse practitioners. Increasing awareness amongst practice nurses or those considering practice nursing as a career, that there are nurse behaviours associated with receiving enhanced support for professional development provides them with considerable power to influence their employers. Providing

nurses with evidence that they hold the key to making this happen and giving them responsibility for achieving it has the potential to bring about radical, sustainable change.

In conclusion, there are two major factors that appear to have a positive effect on practice nurse role evolution:

1. A practice culture that promotes empowerment, communication and teamwork.
2. A practice nurse with a collaborative and proactive attitude.

These were captured in the ‘empowering employment principles’ below (Table 18) which could be used to help nurses and their employers create the environment most likely to result in role development, thereby supporting nurses to maintain competence and provide safe high quality care.

Table 18 - The ‘Empowering employment principles’

The ‘Empowering Employment Principles’	
Six elements of practice culture that support practice nurse role development	
Power-sharing, democratic leadership style	Mentorship and clinical supervision
Strong educational practice ethos	Financial support for education
Regular team meetings include nurses	Strong communication
Six practice nurse attributes that influence general practice support for role development	
Committed to the success of the practice	Seeks and uses opportunities for innovation
Links own contribution to patient outcomes	Influences positively and negotiates wisely
Actively creates and nurtures the team	Flexible and adaptable

These elements appear to be inter-related; when one party demonstrates certain characteristics, the other responds in a positive way to develop another set of characteristics that further enhance the first. This is consistent with Knol and Van Linges’ (2009) findings that the structural (culture) and psychological (attitude) elements of empowerment are synergistic when both present.

The question that remained unanswered in this study was whether high achieving nurses choose a practice they think will support their career development or whether the practice environment stimulates the nurse to develop. In other words, do influential nurses choose a certain type of practice or does a certain type of practice create influential nurses? Whichever is the case based on the evidence of the study, an association between practice culture and nurse empowerment exists. Nurses who develop a high level of empowerment are likely to reap the most benefits from working in general practice, through understanding how to positively influence the work environment so as to achieve shared decision-making about their own role evolution.

9.2.1 Benefits for practice

Achieving empowerment encompasses a combination of complex processes related to situational and personal characteristics. It is not a 'skill' that can simply be taught. However, promoting an understanding of modifiable environmental and attitudinal factors related to achieving empowerment may be helpful to those who feel powerless and may encourage them to see opportunities that they can create for themselves. Whilst nurses may not be able to influence the culture within their practice directly, the ability to modify their own attitudes and behaviour and to consciously work on developing self-empowerment rests entirely with them. This depends on the nurses being willing to take responsibility for the process and this will be influenced by their segmentation 'type' (Dent and Burtney 1997). Those that are actually more comfortable not developing their role and fall into the 'rank and file' category are less likely to use opportunities to increase their empowerment and to negotiate change. On the other hand, those nurses that are keen to develop but find difficulties and obstacles along the way could learn how to influence and address some of these through their own actions. This is helpful in understanding how the study results can be applied to practice, firstly for GPs as employers and secondly for nurses. General practice can attract dynamic pro-active nurses by creating an environment that provides the elements of structural empowerment; opportunity, resources, information and support. Practice nurses can improve their own opportunities through learning to recognise and use the conditions likely to enhance their empowerment. As a result, their ability to influence and shape their own role

evolvment will increase, either through selecting an employer that provides a particular environment or through demonstrating behaviours that are likely to achieve a positive response to their needs.

9.2.2 Embedding the learning from this study

The elements that combine to support role evolvment portray a collective responsibility for achieving safe, effective, general practice and an educationally supported career pathway for practice nurses. This responsibility extends beyond the employment situation to include education providers, NHS workforce planners, quality regulators and professional bodies. Each of these has a role to play in terms of moral and legal obligations to ensure that the NHS Constitution (NHS 2009) is upheld so that patients receive high quality care at the point of contact with the NHS by competent, properly trained staff. This research highlights some of the difficulties in providing safeguards relating to these obligations in general practice, thereby presenting a potential risk to quality and safety. Indemnity insurance against patient complaints resulting from Serious Untoward Incidents will not protect practitioners who delegate inappropriately to nurses who are not competent to carry out the task (NMC 2008, RCN 2012). Patient safety reporting will become a requirement of all general practices as part of their CQC registration (CQC 2012). Any potential risks to quality and safety are compounded by the fact that a large proportion of the practice nurse workforce is reaching retirement age (Drennan and Davis 2008) and recruitment of nurses new to general practice is associated with particular concerns regarding training, mentorship and professional isolation (Stark et al 2001). These risks make it all the more important for each organisation to play its part in addressing their obligations to safeguarding patients rather than leaving all the responsibility with individual employing practices (NPSA 2009). A set of recommendations is therefore offered to assist with this process.

9.3 Recommendations

The following policy and practice recommendations aim to facilitate practice nurse role evolution through increasing structural and psychological empowerment.

1. Role definition

Practices should be encouraged to plan and communicate clearly the various practice nursing roles within the team, to improve nurses' understanding of the scope of the role in which they are employed and how it relates to other nurses and GPs within the practice.

2. Education programmes for practice nurses

Education should be widely available and appropriately tailored to facilitate the transition from secondary to primary care. As well as providing clinical training such programmes should include aspects of general practice business administration, collaboration, teamwork, negotiation and empowerment. Consideration should be given to developing joint courses with the Medical Deaneries responsible for training GPs, as there are many similarities between the two roles and learning together will enhance awareness and collaboration between the two professional groups.

3. Mentorship and supervision

All practice nurses, especially those new to general practice nursing should have access to mentorship from a senior experienced and suitably qualified practice nurse along with the opportunity for ongoing clinical supervision. This will help to mitigate the risks associated with professional isolation.

4. Quality regulation

General practices should be required to meet minimum professional education and supervision needs of practice nurses by adhering to standards such as those identified by the RCGP (2011), both individually as practices and collectively as CCGs. The requirements for CQC registration in April 2013 could be a valuable opportunity to

embed this in practice and work should continue between the CQC and professional organisations representing practice nurses and GPs (CQC 2012).

5. Workforce planning and education

The newly created Local Education and Training Boards (LETBs) will have responsibility for coordinating the commissioning of education programmes for all staff working in the NHS. Individual employers (general practices included) will be required to identify the education needs of their staff. The LETBs should ensure general practice engagement and representation in their commissioning planning. There should be a reporting mechanism between LETBs and the National Commissioning Board, who will hold the general practice contracts, to highlight any areas of concern regarding practice nurse training.

6. Education funding

Funding for general practice staff education has been incorporated into the practice 'global sum' since the last GMS contract revision in 2004. The creation of locality CCG-supported schemes where funding is 'top-sliced' from a group of CCGs and responsibility for identifying workforce needs is shared could provide a system for cost-effective education provision. In addition, a database of continuous professional development that is shared with local NHS trusts could reduce costs and enhance collaboration.

7. Recruitment and retention of practice nurses

The 'empowering employment principles' are offered as a practical tool for nurses and employers, to aid recruitment and retention of practice nurses into an environment that supports the development of their role. Further research should confirm or refute the basis for the 'empowering employment principles' by testing the proposition that specific general practice characteristics in combination create an environment conducive to role evolvment, in a bigger sample with an explanatory or critical case study design.

8. Empowerment and nurse behaviours

Dissemination of the results from this study regarding the benefits associated with positive, assertive, collaborative behaviours in terms of winning support for role development may help practice nurses to maximise the opportunities available to them and take a lead in shaping their role. The inter-relationship and apparent enhancing effects of practice culture and nurse attributes on each other should also be further tested.

These recommendations are intended to offer suggestions to address some of the factors identified as obstacles to achieving role development for practice nurses.

Two recommendations for further research are suggested. A longitudinal ethnographic observational study could be conducted to explore in more detail how the complex relationships around practice culture, nurse and doctor behaviour and empowerment influence the role evolution of the practice nurse. Alternatively, a more pragmatic approach would be to introduce the 'Empowering Employment Principles' as an intervention in a practice where there are perceived problems relating to recruitment and effective role development of practice nurses and to monitor any changes.

9.4 Concluding comments

This study was conducted over a six year period during which several major political changes occurred in the NHS, directly affecting general practice and putting it centre-stage in commissioning healthcare (DH 2005, 2008, 2010). This has increased responsibilities for GPs by requiring them to engage with their local Clinical Commissioning Group, which is likely to have an impact on their clinical capacity thus affecting the continually evolving role of the practice nurse. It will therefore be important to ensure that roles and responsibilities are clear and that sound employment and training standards are in place so that high quality care can be maintained. Nurses have a duty to ensure they are competent to perform the work that they do (NMC 2008, Goldsmith 2011) and a responsibility to advise their employers as to their educational needs (RCN 2011b). Employers have a responsibility to ensure their staff are adequately trained and supervised (DH 2010b) and this study highlighted particular

problems this may pose for small, geographically remote practices with little flexibility in resources and team cover. However, these issues need to be addressed in the interests of patient safety and size of practice will be no excuse for not doing so. Currently there is no regulatory mechanism to ensure this happens and it remains to be seen how groups of GPs might tackle the issue and commission appropriate education. Practice nurses can take a lead by lobbying their professional bodies as well as local commissioners and this study suggests that nurse practitioners leading a team may be more likely than most practice nurses to accept this challenge. The emergence of Clinical Commissioning Groups creates an increasing emphasis on general practice as the focus for determining local health needs. Never has there been a more opportune time for practice nurses to flourish and they should be provided with support to do so in order to achieve and maintain high quality care for all. The 'Empowering Employment Principles' provide an evidence-based tool to facilitate this.

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Appendix 1

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

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

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Appendix 3

Survey Participant Information Sheet, May 2007

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

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

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



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Programme

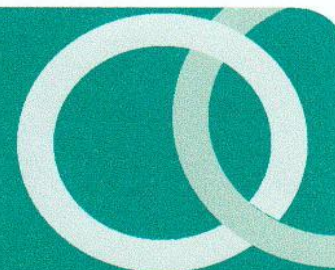
www.wipp.nhs.uk



SNAPshot

(Supporting Nurses and Practice)

Survey



Section 1 About you and your practice

1. What is your job title?

- ☐ Practice nurse ☐ Treatment room nurse
☐ Nurse practitioner ☐ Specialist nurse
☐ Other, please state _____

2. How many hours do you work?

- ☐ Less than 10 ☐ Between 10 and 20
☐ Between 21 and 30 ☐ More than 30

3. How many GPs are there in your practice?

- ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6-10
☐ More than 10

4. How many nurses work at your practice?

- ☐ Just you ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6-10
☐ More than 10

5. How old are you?

- ☐ Under 30 ☐ Between 31 and 40
☐ Between 41 and 50
☐ Between 51 and 60
☐ Over 60

6. How long have you worked in general practice?

- ☐ Less than a year
☐ Between 1 and 3 years
☐ Between 3 and 5 years
☐ Between 5 and 10 years
☐ More than 10 years

7. Does your role involve (you may tick more than one option)

- ☐ 'Treatment room' work
☐ Chronic disease management
☐ Triage
☐ Minor illness management
☐ Minor injury management
☐ Women's' health
☐ Immunisation
☐ Health Promotion
☐ Nurse prescribing
☐ Managing other staff
☐ Other, please state _____

Section 2 Employment conditions

1. In the practice where you work do you have: (tick any that apply)

- ☐ A contract of employment
- ☐ A comprehensive job description
- ☐ Annual appraisal
- ☐ Protected time for study
- ☐ Help in compiling a professional development plan (PDP)
- ☐ Support to achieve the goals in your PDP
- ☐ Mandatory annual training in anaphylaxis and Basic Life Support
- ☐ Regular team meetings with the GPs
- ☐ Pay scales linked to Agenda for Change
- ☐ A clear line of managerial responsibility
- ☐ Protected time for administrative work

Section 3 Training and Education

1. What professional qualifications do you hold?

- ☐ RGN/RN ☐ EN ☐ DN ☐ HV
- ☐ Nurse Practitioner
- ☐ Specialist Community Practitioner
- ☐ Dip N ☐ BSc
- ☐ Other, please state _____

2. What post-registration courses have you completed? (tick any that apply)

- ☐ Cervical cytology screening certificate
 - ☐ Family planning certificate
 - ☐ Asthma diploma
 - ☐ Diabetes diploma/equivalent
 - ☐ Tissue viability/wound care
 - ☐ Travel health diploma/equivalent
 - ☐ Coronary vascular disease and hypertension
 - ☐ Nurse Prescribing
 - ☐ Ear care
 - ☐ Childhood immunisation
 - ☐ Other, please state _____
- _____
- _____

3. When you were first employed at this practice, did you : (tick for yes)

- ☐ Complete a formal in-house induction programme
- ☐ Have access to an identified mentor to support you in the role
- ☐ Complete a foundation practice nurse course within a year
- ☐ Have an assessment of your competence in the tasks you were allocated

4. If you manage other staff, what managerial training have you had?

- ☐ None
 - ☐ Appraising staff
 - ☐ Mentorship (assessing student nurses)
 - ☐ IT skills
 - ☐ Audit
 - ☐ Clinical Governance
 - ☐ Other, please state _____
- _____
- _____

Section 3 Training and Education (continued)

5. What courses does your local university provide for practice nurses?

- ☐ Practice nurse induction/foundation programme
- ☐ Clinically focused study days
- ☐ Accredited modules on clinical topics
- ☐ Specialist community practitioner
- ☐ Nurse practitioner
- ☐ Nurse prescribing
- ☐ Don't know
- ☐ None

6. Who else provides training for you?

- ☐ PCT
- ☐ Pharmaceutical companies
- ☐ Private training companies
- ☐ GPs
- ☐ Local practice nurse group/forum
- ☐ Other, please state _____

7. Is there any training you still require to carry out your current role?

- ☐ Yes ☐ No

8. If yes, please specify

9. Are there any obstacles to you accessing training?

- ☐ Yes ☐ No

10. If yes, are these:

- ☐ Funding
- ☐ Availability of courses
- ☐ Location of courses
- ☐ Being released to attend
- ☐ Getting cover for your clinics
- ☐ Other, please state _____

11. Are you clear about whom to approach for funding for training?

- ☐ Yes ☐ No

Section 4 Professional Support

1. Do you have access to: (tick any that apply)

- ☐ A PCT facilitator/manager who supports practice nurses
- ☐ Mentorship (support from a more experienced practice nurse)
- ☐ Formal, regular clinical supervision
- ☐ A local practice nurse forum/group

2. Do you belong to a union or professional organisation?

- ☐ Yes ☐ No

3. Have you ever been asked to undertake a task you did not feel competent to perform?

- ☐ Never ☐ Rarely ☐ A few times
☐ On many occasions

Section 4 Professional Support (continued)

**4. If this has happened to you, did you:
(tick any that apply)**

- ☐ Refuse to do the task
- ☐ Ask to be supervised
- ☐ Request further training
- ☐ Seek advice from a mentor/PCT
- ☐ Other, please explain _____

**5. What, if any, were the consequences of
your actions?**

**6. How is your role development
determined?**

- ☐ According to the needs of the practice
- ☐ Around your professional development needs
- ☐ A combination of both
- ☐ Neither
- ☐ Don't know

**7. How do you usually resolve problems to
do with your work?**

- ☐ Ask your nurse manager or practice manager to deal with it
- ☐ Speak to the senior partner
- ☐ Arrange a team meeting to discuss the issue
- ☐ Avoidance
- ☐ Not sure who to approach
- ☐ Other, please state _____

8. Are problems ever left unresolved?

- ☐ Often
- ☐ Sometimes
- ☐ Never

**9. How involved in decision-making about
matters affecting nursing are the nurses
in your practice?**

- ☐ Very
- ☐ Quite a lot
- ☐ Fairly
- ☐ Not much
- ☐ Not at all

Please make any other comments related to support and preparation for the work that you do:

Thank you for completing this survey
Please return to: WiPP, Regal Place,
Maxwell Road, London SW6 2HD

Appendix 4b

SNAPSHOT Survey Results

1) Section 1: About you and your practice

1. What is your job title?

Answer	Responses	Percent
Practice nurse	842	72.5%
Nurse practitioner	176	15.2%
Specialist nurse	58	5.0%
Treatment room nurse	8	0.7%
Other	77	6.0%

2. How many hours do you work?

Answer	Responses	Percent
More than 30	525	45.2%
Between 21 and 30	416	35.8%
Between 10 and 20	194	16.7%
Less than 10	26	2.2%

3. How many GPs are there in your practice?

Answer	Responses	Percent
6-10	388	33.4%
4	176	15.2%
5	173	14.9%
2	142	12.2%
3	122	10.5%
1	86	7.4%
More than 10	74	6.4%

4. How many nurses work at your practice?

Answer	Responses	Percent
2	296	25.5%
3	247	21.3%
4	175	15.1%
6-10	168	14.5%
Just You	137	11.8%
5	119	10.2%
More than 10	19	1.6%

5. How old are you?

Answer	Responses	Percent
Between 41 and 50	564	48.6%
Between 51 and 60	342	29.5%
Between 31 and 40	191	16.5%
Over 60	38	3.3%
Under 30	26	2.2%

6. How long have you worked in general practice?

Answer	Responses	Percent
More than 10 years	615	53.0%
Between 5 and 10 years	252	21.7%
Between 3 and 5 years	144	12.4%
Between 1 and 3 years	103	8.9%
Less than a year	47	4.0%

7. Does your role involve: (you may tick more than one option)

Answer	Responses	Percent
Health Promotion	1091	94.0%
Chronic disease management	1084	93.4%
Immunisation	1021	87.9%
Women's' health	1021	87.9%
'Treatment room' work	882	76.0%
Minor injury management	711	61.2%
Minor illness management	681	58.7%
Managing other staff	607	52.3%
Triage	515	44.4%
Nurse prescribing	359	30.9%
Other	1	0.1%

Total number answering = 1,161

Total number answering question = 1,068

2) Section 2: Employment conditions

1. In the practice where you work, do you have: (tick any that apply)

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

Total no of responses to this question = 1,136

3) Section 3: Training and Education

1. What professional qualifications do you hold?

Answer	Responses	Percent
RGN/RN	1034	96.8%
BSc	288	27.0%
Dip N	169	15.8%
Specialist Community Practitioner	165	15.4%
Nurse Practitioner	135	12.6%
EN	73	6.8%
DN	49	4.6%
HV	24	2.2%
Other	1	0.1%

2. What post-registration courses have you completed? (tick any that apply)

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

Total number answers = 1,067

3. When you were first employed at this practice, did you: (tick for yes)

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

Total no of respondents = 1,070

4. If you manage other staff, what managerial training have you had?

Answer	Responses	Percent
Mentorship (assessing student nurses)	322	47.8%
Appraising staff	236	35.1%
IT skills	211	31.4%
None	203	30.2%
Audit	203	30.2%
Clinical Governance	187	27.8%
Other	1	0.1%

5. What courses does your local university provide for practice nurses?

Answer	Responses	Percent
Nurse prescribing	705	66.0%
Accredited modules on clinical topics	667	62.5%
Nurse practitioner	469	43.9%
Clinically focused study days	469	43.9%
Practice nurse foundation programme	414	38.8%
Specialist Community Practitioner	376	35.2%
Don't know	195	18.3%
None	26	2.4%

Total answers = 1,070

6. Who else provides training for you

Answer	Responses	Percent
Pharmaceutical companies	877	82.1%
PCT	867	81.2%
Local practice nurse group/forum	634	59.4%
GPs	354	33.1%
Private training companies	299	28.0%
Other	1	0.1%

7. Is there any training you still require to carry out your current role?

Answer	Responses	Percent
Yes	700	65.5%
No	368	34.5%

8. If yes, please specify (text answers)

9. Are there any obstacles to you accessing training?

Answer	Responses	Percent
Yes	700	65.5%
No	368	34.5%

10. If yes, are these:

Answer	Responses	Percent
Funding	492	68.2%
Availability of courses	384	53.3%
Getting cover for your clinics	362	50.2%
Being released to attend	340	47.2%
Location of courses	292	40.5%
Other	1	0.1%

11. Are you clear about whom to approach for funding for training?

Answer	Responses	Percent
Yes	843	78.9%
No	225	21.1%

4) Section 4: Professional Support

1. Do you have access to: (tick any that apply)

Answer	Responses	Percent
A local practice nurse forum/group	730	71.1%
A PCT facilitator/manager who supports practice nurses	480	46.7%
Formal, regular clinical supervision	283	27.6%
Mentorship (support from a more experienced practice nurse)	279	27.2%
None of the above / Not applicable	113	11.0%

2. Do you belong to a union or professional organisation?

Answer	Responses	Percent
Yes	1001	97.5%
No	26	2.5%

3. Have you ever been asked to undertake a task you did not feel competent to perform?

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

4. If this has happened to you, did you: (tick any that apply)

Answer	Responses	Percent
Refuse to do the task	548	53.4%
Request further training	545	53.1%
Ask to be supervised	352	34.3%
Seek advice from a mentor/PCT	114	11.1%
Other	1	0.1%

5. What, if any, were the consequences of your actions? (Text answers)

6. How is your role development determined?

Answer	Responses	Percent
A combination of both	733	71.4%
According to the needs of the practice	243	23.7%
Around your professional development needs	26	2.5%
Neither	15	1.5%
Don't know	10	1.0%

7. How do you ****usually**** resolve problems to do with your work?

Answer	Responses	Percent
Ask your nurse manager or practice manager to deal with it	373	36.3%
Arrange a team meeting to discuss the issue	276	26.9%
Speak to the senior partner	224	21.8%
Not Applicable (I do not have any problems)	29	2.8%
Avoidance	21	2.0%
Not sure who to approach	17	1.7%
Other	87	8.0%


8. Are problems ever left unresolved?

Answer	Responses	Percent
Sometimes	600	58.4%
Never	300	29.2%
Often	127	12.4%

9. How involved in decision-making about matters affecting nursing are the nurses in your practice?

Answer	Responses	Percent
Very	372	36.2%
Quite a lot	278	27.1%
Fairly	205	20.0%
Not much	140	13.6%
Not at all	32	3.1%

Appendix 5 - Survey promotional postcard, April 2007



Working in Partnership
Programme



SNAPshot

(Supporting Nurses and Practice)

Survey

How well prepared and supported are practice nurses for the roles they undertake?

- NEVER MIND THE RHETORIC, WHAT ABOUT THE REALITY?
- TELL THE TRUTH ABOUT WORKING IN GENERAL PRACTICE!
- HOW WELL SUPPORTED ARE YOU?


This Department of Health funded survey is gathering evidence about the support practice nurses receive.

Don't miss this opportunity to have your say.

The on-line survey is simple, takes only 10 minutes to complete and can be found at:

www.wipp.nhs.uk/snapshot

Visit the website now to ensure your views are included.



ROYAL MAIL

HQ 6092
POSTAGE PAID GB

Address line 1

Address line 2

Address line 3

Address line 4

Address line 5

Address line 6

Address line 7

'Critical to ensuring that general practice responds effectively to future primary care needs is a strong, highly-skilled, knowledgeable and well resourced practice nursing workforce. To help make this a reality the Working in Partnership Programme has developed SNAPshot, a survey of current general practice nursing. As a nurse in general practice, please complete this important survey as soon as possible to help us plan and develop a flourishing and vibrant nursing workforce for the future.'

Lynn Young, Primary Health Care Adviser, RCN



Royal College
of Nursing

If undelivered, please return to: WiPP, Regal Place, Maxwell Road, London SW6 2HD

Appendix 6

Letter to prospective participants, version 1, October 2009

Faculty of Health



University of East Anglia

School of Nursing and Midwifery

Edith Cavell Building
University of East Anglia
Norwich
Norfolk NR4 7TJ

Telephone
01603 597000

Dear Colleague,

Study Title: An exploration of practice nursing role development

You have been identified as working in a practice that meets the selection criteria for the above research project which aims to explore how practice nurses agree their role and what factors affect their access to the education and professional development support that they need to do their work. This should provide valuable information to education providers, commissioners and managers, as well as nurses and GPs.

You have been sent the enclosed information pack by the PCT to protect your personal details from being divulged to me without your consent. In the pack you will find a Participant Information Sheet which gives information about the study and how it will be carried out. There is also a 'confirmation of interest' reply slip and a stamped addressed envelope.

The study requires 3 participants from each surgery; a practice nurse, a GP and a practice manager. You have been identified as the practice nurse within your practice that meets the selection criteria. Please take time to read through the information sheet, discuss it with your colleagues and come to a joint decision about whether or not you would like to be involved in the study.

If you decide to take part in the study, please return the reply slip, signed by all 3 potential participants within 2 weeks of receiving this invitation. I will then contact you by telephone to arrange a convenient time to visit the practice to conduct the interviews.

Thank you very much for your time.

Yours sincerely,

Sue Crossman
Researcher

Participant Information Sheet; Version 1, October 2009

Study Title: An exploration of practice nursing role development

You are invited to take part in this research study. Before you decide, I would like you to understand why the research is being done and what it would involve. This sheet is in two parts; part 1 gives general information about the research study and part 2 gives more detailed information about how it will be conducted.

Part 1

Background

This research study will try to find out more about what influences the way in which practice nursing roles develop and what factors affect access to appropriate resources to support them. The reason for conducting the research is that previous studies suggest that there is variability in access to adequate resources to enable nurses to achieve and maintain competence to perform their role. The aim is to improve understanding of the factors and processes involved, so that the role and educational needs of practice nurses may be clearly defined and comprehensively supported, with the potential to enhance competence levels and support high quality care.

The study

This research uses a case study approach whereby eight nurses across one PCT area will be interviewed about their role within the practice and their access to professional development support such as education, local networks and clinical supervision. In addition, their practice manager and GP will also be interviewed to provide their perspective on the subject. Data will also be collected from representatives of key organisations such as the PCT, local education provider, Royal College of Nursing and Royal College of General Practitioners. In addition, a document search will be conducted to provide evidence of frameworks and policies on the subject.

The participants

A sample of eight nurses will be drawn from the practice nurse population in the NHS Norfolk area. The nurses will be selected from practices with varying profiles regarding size and staffing ratios, to provide information about nurses from a range of employment conditions. You have been randomly selected from a list drawn up by the researcher. It is up to you whether you decide to take part in the study and you are free to withdraw at any time.

What will the participants be asked to do?

You will be invited to participate in the study by consenting to one interview. This can be held either at your place of work or in the University of East Anglia. The interview will be semi-structured which means you will be asked some standard questions, but will have the opportunity to provide extra information that you feel is relevant. The interview will last approximately one hour and will be audio-recorded to allow for accurate transcription. You will be invited to comment on the transcribed text regarding its accuracy. There will be no remuneration for taking part in the study.

Possible consequences of participation

This research does not involve any intervention or change to your professional work. It will involve you thinking and talking about your role, your professional development needs and how adequately they are met. It is possible this may have consequences if this causes you to question the support you currently receive. It is also possible that your manager and GP will become more conscious of your role and need for developmental support. These potential consequences may be positive or negative in nature depending on the working relationships within your practice. The researcher will be available to talk over any concerns you may have about this and consider possible courses of action open to you, before you consent to take part.

Possible benefits

The purpose of the research is to improve knowledge about how to help practice nurses achieve and maintain competence. As a result, the findings of the study will be of interest to nurses, GP, educationalists, and policy-makers, with the potential to enhance competence and support high standards of care in general practice.

Part 2**Confidentiality of data**

The researcher will adhere to ethical and legal frameworks guiding research practice. Each participant will be assigned a number so that the data recorded will be anonymous. Only the researcher will know who has participated and will keep all information confidential. All data will be held by the researcher and no-one else will have access to it. The results of the study may be published in a professional journal but there will be no way of identifying participants.

Who has reviewed the study?

This study has been reviewed by an academic panel in University of East Anglia and the local Research Ethics Committee.

Withdrawing from the study

You may decide at any time that you no longer wish to continue with the study. If you decide to withdraw, your data will be destroyed.

The researcher

Sue Crossman is a PhD student at the University of East Anglia and a former practice nurse. Sue has undertaken several research projects in general practice and has a good understanding of the nature of practice nursing. This project is an independent study, with no sponsorship and no involvement from any other organisation.

Complaints

If you have any complaints about the way you have been treated during the study, please discuss this with the researcher in the first instance. If you remain unhappy and wish to complain formally, you can do this by writing to:

Professor Richard Gray,
Professor of nursing research,
UEA School of nursing and midwifery,
Edith Cavell Building,
Norwich
NR4 7TJ

Email: richard.gray@uea.ac.uk

Indemnity insurance

This study is covered by the University of East Anglia insurance to provide indemnity should participants experience any harm through negligence on the part of the researcher with regard to the design and management of the study, and by NHS Norfolk with regard to the conduct of the study.

Researcher contact

If you have any concerns about participating in this study, wish to discuss it or to withdraw from it, please contact Sue Crossman.

Telephone: 07799 054112

Email: suecrossman@netcom.co.uk

Confirmation of Interest reply slip

Study Title: An exploration of practice nursing role development

Yes, I confirm that I would like to take part in this study.

-----	-----	-----
Name (practice nurse)	Signature	Date

-----	-----	-----
Name (GP)	Signature	Date

-----	-----	-----
Name (practice manager)	Signature	Date

The best time to ring the surgery to arrange the interviews is -----

Surgery details

Practice name:

Address:

Telephone number:

Please return this reply slip in the enclosed SAE to:
Sue Crossman, Washpit Farmhouse, Rougham King's Lynn, Norfolk PE32 2SQ

I shall telephone you within a week of receiving your response. Thank you.



University of East Anglia

School of Nursing and Midwifery

Consent Form

Study Title: An exploration of practice nursing role development

Please initial box

I have read and understood the information sheet about this study dated.....
I have had the opportunity to consider the information, ask questions and been given
satisfactory answers.

☐

I understand that my participation is voluntary and that I am free to withdraw at any time
without my legal rights being affected.

☐

I consent to taking part in an interview, and for the information obtained to be published
as part of the study, subsequent to my checking the accuracy of the content.

☐

I consent to my interview being audio-recorded and transcribed

☐

I understand that the results of the study will be published. Any quotations
from my interview that may be used will be anonymous.

☐

I would like to receive a summary of the final results when the study is
complete.

☐

Name of participant

Date

Signature

Name of researcher

Date

Signature

Case study interview schedule Version 1, October 23rd 2009

Study Title: An exploration of practice nursing role development

Introductory statement

The purpose of this research is to find out about your role as a practice nurse and the sort of support you receive for professional development. There are no right or wrong answers. I will be asking you some questions, but they are only intended to guide the conversation and make sure we don't miss anything important out. I am interested in anything you feel is relevant to the way your role is negotiated and developed. The interview is being audio-recorded. If you want to stop the interview at any time, please just let me know. We have about one hour for this interview, if we need it.

Topic areas to be covered

1. How is the practice nurse's role determined? Who is involved in the process and how are decisions made?
2. How do you think other professionals view the practice nurses role? What might influence their view?
3. What resources should be available to support a nurse new to general practice?
4. What do you think should be in place to ensure competence as the practice nurse role develops?
5. What influences their access to these resources?
6. If there are barriers to these resources, what might the consequences be?
7. How would you describe the relationship between GPs and practice nurses?
8. What are some of the advantages and disadvantages for nurses being employed by GPs?
9. How would you suggest tackling some of the disadvantages?
10. How would you describe the nurse's/your attitude in terms of assertiveness?
11. Whose responsibility do you think it is to ensure practice nurses maintain competence?
12. How, if at all, does practice nurse attitude affect their access to professional development resources?

13. Which of the groups below best describe you/your practice nurse's predominant characteristics?
- a) Academic, keen on educational progression, research and acquiring seniority through qualifications.
 - b) Managerial, interested in improving performance, efficiency and supervising others.
 - c) Clinical specialist, focused on developing advanced clinical expertise in one specialist area.
 - d) Generalist, enjoying the variety and breadth of general practice nurse work.
 - e) Another – please describe.
14. How might these characteristics affect their role evolution and access to professional development support?
15. How might this information be used to provide appropriate resources and improve access for different types of nurse?
16. How do you think the local and national provision of resources such as educational courses, standards of employment and career frameworks been influenced and driven?
17. Why has the development of national policies and frameworks had such an apparently low impact on real life conditions for practice nurses? (Corbett, Gray, Bell)

Appendix 11

Letter accompanying interview transcript: version 1 October 23rd 2009

Faculty of Health



School of Nursing and Midwifery

Edith Cavell Building
University of East Anglia
Norwich
Norfolk NR4 7TJ

Telephone
01603 597000

Fax
01603 597019

Dear

Study Title: An exploration of practice nursing role development

Thank you very much for allowing me to interview you on _____. I have now transcribed your interview which I enclose with this letter. I am sending it to you so you can read it at your leisure.

If you still agree with what you have said you do not need to do anything else. However, if you have changed your mind it is perfectly acceptable to make changes in the text until it says exactly what you want to say. If you want to make any changes you will need to do so within two weeks and return the adjusted transcript to me as an email attachment.

If you indicated on your consent form that you would like a summary of the final report, this will be sent to you once it is completed. This will take several months.

Thank you for your participation in this study,

Yours sincerely,

Sue Crossman

Appendix 12

Case studies coding audit trail

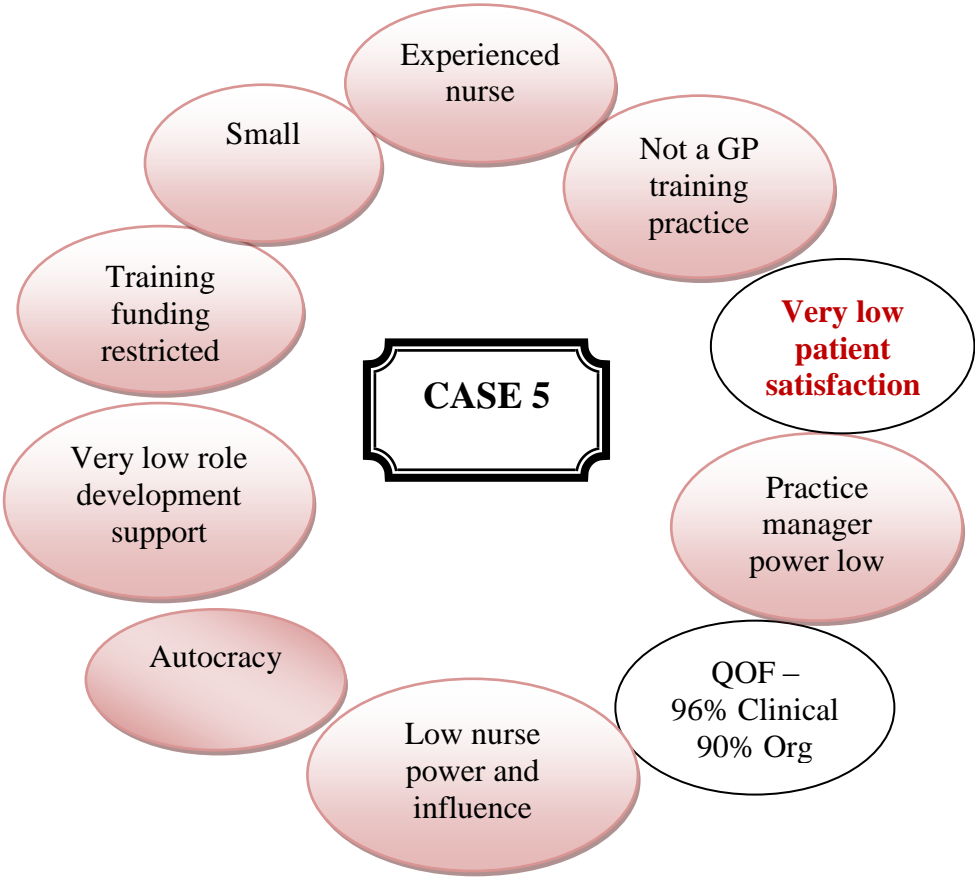
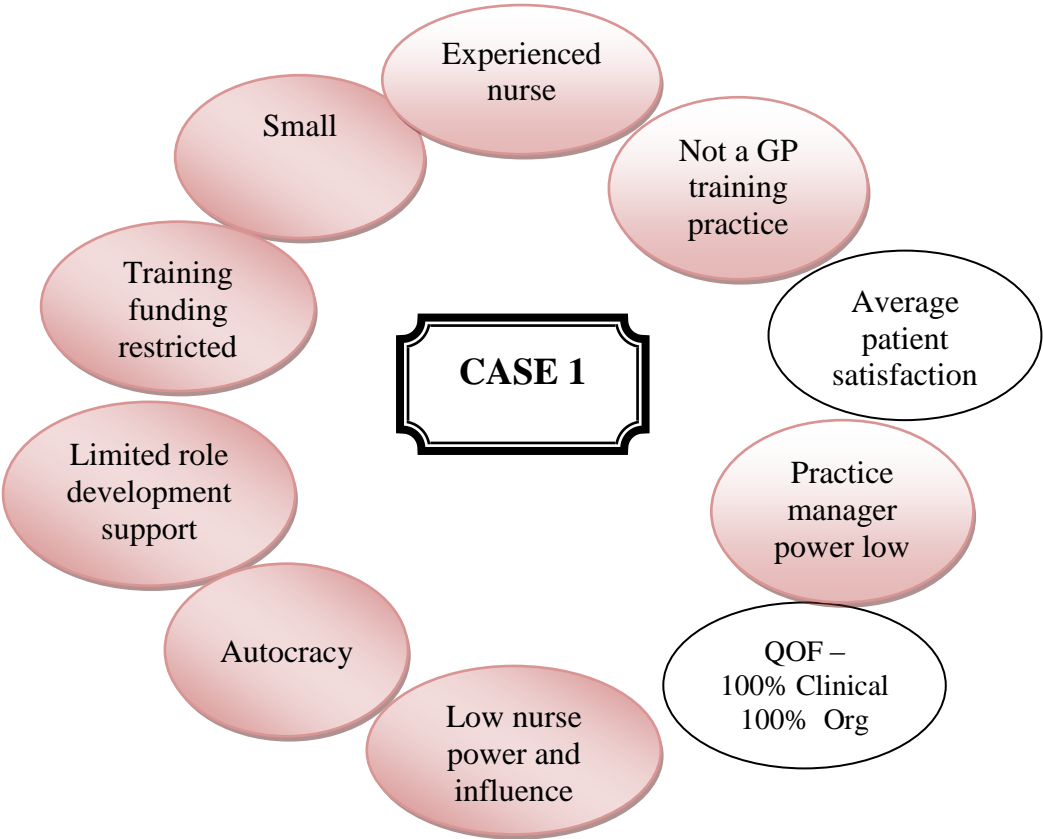
Process:

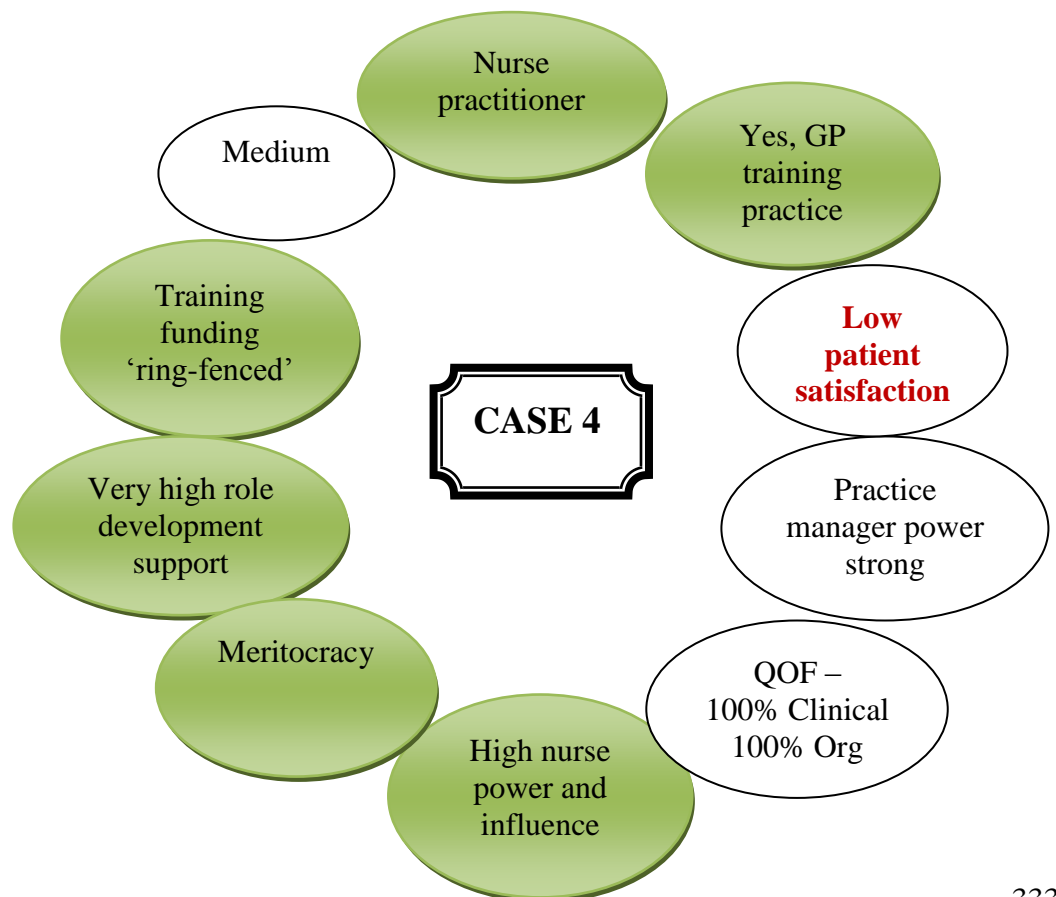
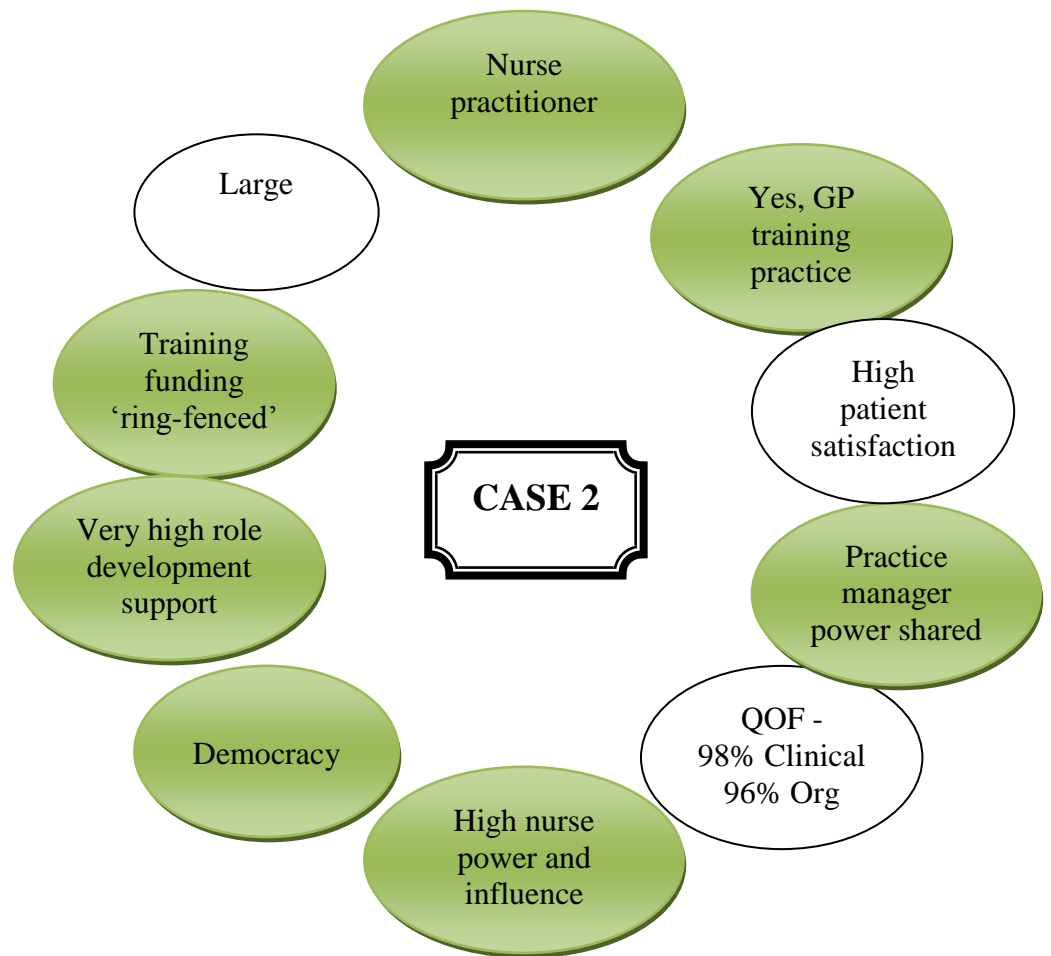
1. Transcribe interview and read through for accuracy.
2. Send copy to participant and receive feedback/corroboation
3. Read through line by line and code data in nVivo with a short-hand descriptor
4. Do this once for each case, building up the list of codes with each new case
5. Print coding summary report for each participant as a record of first coding
6. Enter on Excel spreadsheet all participants and all codes
7. Re-read each transcript and revise coding in light of total list, which includes codes created subsequent to first read through
8. Keep a list for each participant of new codes created
9. Check all newly created codes have not been double-entered for any participant
10. Check original codes plus newly created codes add up to new total for each participant
11. Print revised coding summary for each participant and update Excel spreadsheet
12. Check totals on spreadsheet agree with those on coding summary
13. Change to bold each participant total following second coding.
14. Check consistency of interpretation in content of texts assigned with each code.
15. Group codes into higher categories by colour-highlighting those that belong together.
16. Analyse similarities and differences in coding between individuals within cases
17. Analyse practice characteristics in relation to case findings
18. Record prevalence of codes between cases and between different professional groups
19. Search for any features that are common between cases and professional groups that might have a bearing on the codes
20. Search for any features that are very different between cases and professional groups that might have a bearing on the codes

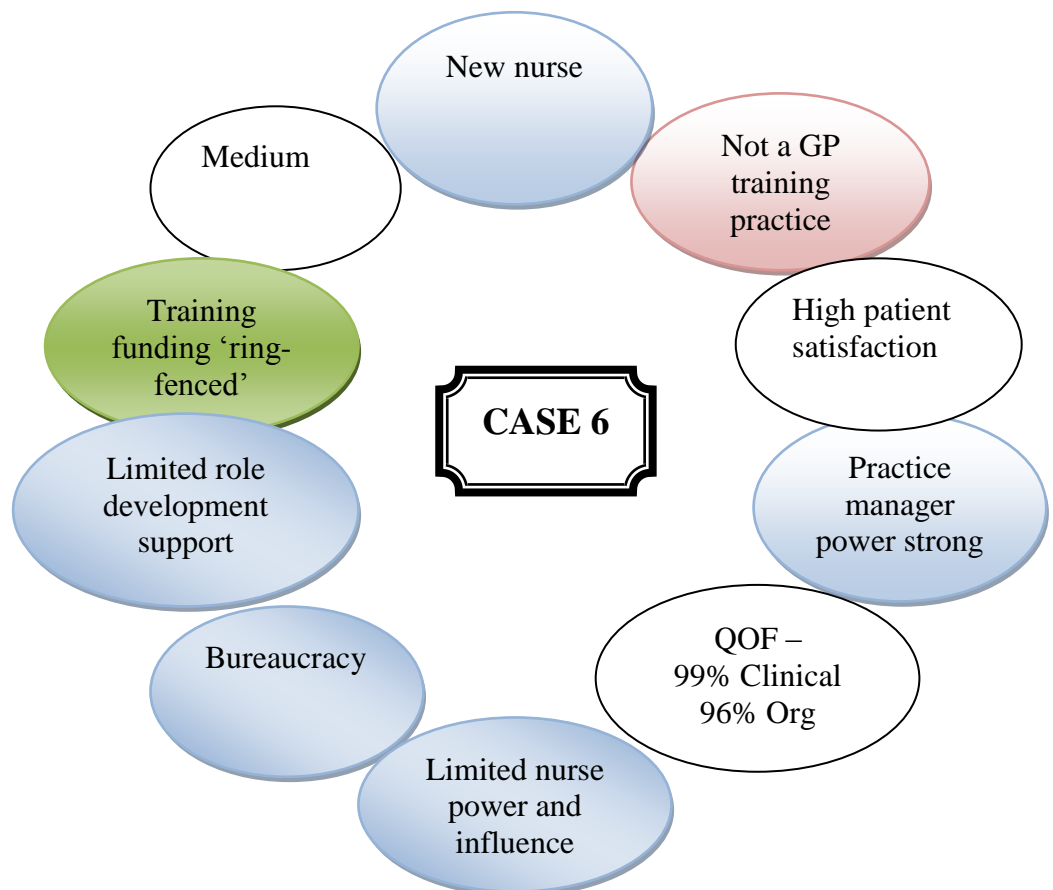
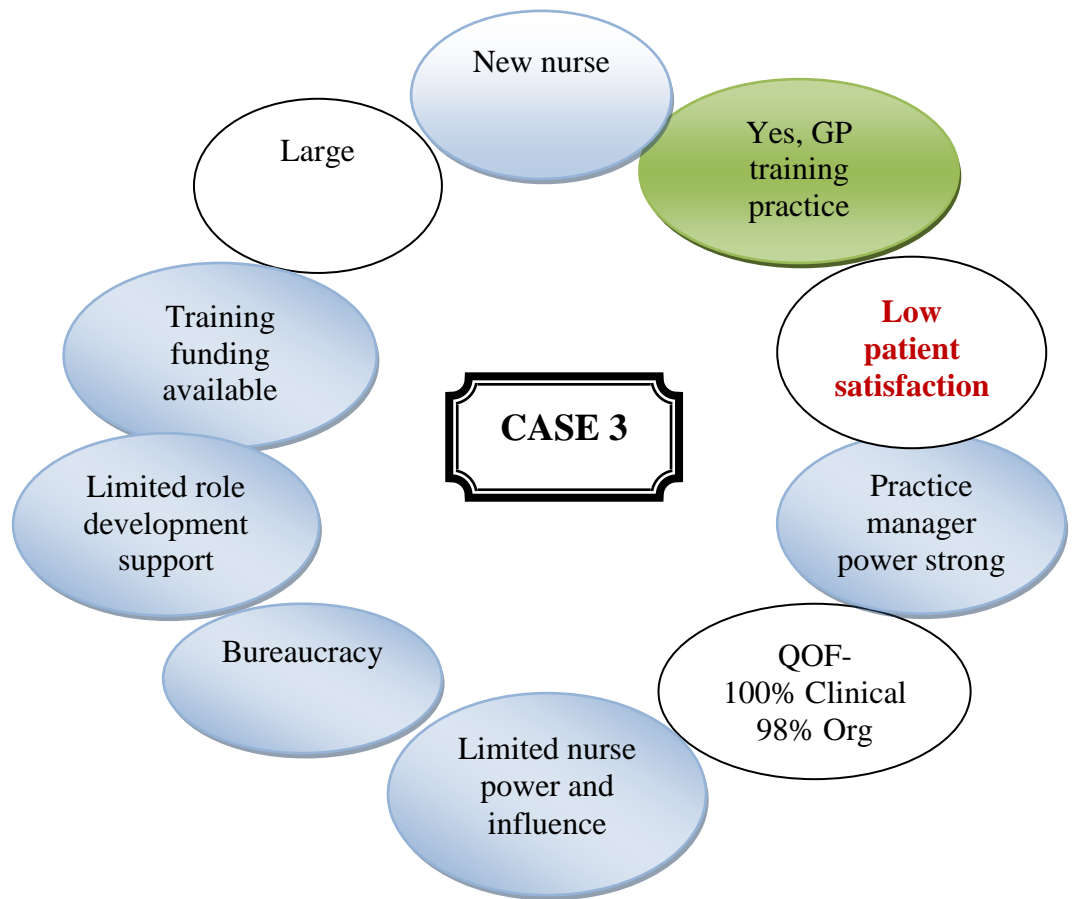
Appendix 13
Codes and higher category 'themes'

ROLES Autonomy Benefits of segmentation Clearly defined roles Diverse roles Generalist role GPs not understanding role GP delegation GP-nurse role blurring Limitations of role Matching skills to role Pioneering role Poorly defined roles Rank and file Role evolution segmentation of roles Specialist roles Team skill mix 16	RELATIONSHIPS Communication Employer/employee tension Empowerment Gender GP approachability GP dependability on nurses GP/Nurse relationships GP dominance Improved collaboration Incongruence in shared understanding Mutual respect Power Team spirit Trust 14	EDUCATION Coordination of education provision Deanery MDT education Education provision inappropriate Effect of being a GP Training Practice Effect of training on clinical care Factors in accessing education Flexible learning methods Foundation programme GP versus PN mentor Induction support In-house education Lack of available education Primary care preparation Qualifications bring opportunities Standardised education 15
PROFESSIONAL ISSUES Accountability Assessing competence Clinical supervision Competency concerns Guidelines and protocols Mandatory standards Mentoring Protocol limitations Responsibility for competence Scope of practice Patient benefits to enhanced role Patient safety risks 12	NURSE'S INDIVIDUAL CHARACTERISTICS Career stage Motivation Adaptability Aspiration Confidence Corporacy Engagement with national guidance Negativity Personality Assertiveness Pastoral nurturing by nurses Poor IT skills Resistance to change Role modelling Unwillingness to travel 15	MANAGEMENT AND PLANNING Appraisal Attracting new nurses Circulation of training info Financial constraints Financial support good Inadequate communication networks Income generation Nursing hierarchy Probation Protected training budget Quality Service needs Size of practice 13
ORGANISATIONAL CULTURE Contrast between hospital and primary care GP Nurse meetings GP paternalism Low training ethos in practice Managerial style Missed learning opportunities Nurse manager Vs PM Peer support Practice culture Strong practice education ethos 10	INEQUALITIES Limited options No carer framework No collective voice Not fairly rewarded Nurse isolation Poor professional support Professional inequality Unsupported junior nurse 8	OPPORTUNITIES FOR INNOVATION Advantages of general practice Drivers for change Low awareness of national frameworks Negotiation Networks Nurse leadership Obstacles to standardisation PN role vital 8

Appendix 14 ‘Bubble diagram’ illustrating cross-case comparison of features







Appendix 15 Cross-tabulations for Chi Square Tests

1. Frequency table for cross-tabulation; Number of GPs and annual appraisal

No. of GPs	Annual appraisal: yes	Annual Appraisal: No	Total
1	63	22	85
2	108	26	134
3	104	15	119
4	135	33	168
5	152	19	171
6-10	347	36	383
>10	65	6	71
Total	974	157	1131

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	27.770 ^a	6	.000
Likelihood Ratio	26.285	6	.000
Linear-by-Linear Association	21.128	1	.000
N of Valid Cases	1131		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 9.86.

2. Frequency table for cross-tabulation; number of GPs and clear line management

No. of GPs	Clear line mgt: Yes	Clear line mgt: No	Total
1	29	56	85
2	70	64	134
3	63	56	119
4	81	87	168
5	80	91	171
6-10	227	156	383
>10	46	25	71
Total	596	535	1131

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	26.339 ^a	6	.000
Likelihood Ratio	26.582	6	.000
Linear-by-Linear Association	14.818	1	.000
N of Valid Cases	1131		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 33.59.

3. Frequency table for cross-tabulation; number of GPs and in-house induction

No. of GPs	Formal In-house induction: Yes	No	
1	17	61	78
2	37	88	125
3	22	94	116
4	53	106	159
5	47	113	160
6-10	162	201	363
>10	34	33	67
Total	372	696	1068

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	45.291 ^a	6	.000
Likelihood Ratio	46.309	6	.000
Linear-by-Linear Association	32.505	1	.000
N of Valid Cases	1068		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 23.34.

4. Frequency table for cross-tabulation; number of nurses and in-house induction

No. of nurses	In-house induction: yes	No	Total
1	27	98	125
2	80	182	262
3	70	166	236
4	58	102	160
5	51	62	113
6-10	74	81	155
>10	12	158	170
Total	372	849	1221

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	84.516 ^a	6	.000
Likelihood Ratio	94.983	6	.000
Linear-by-Linear Association	.213	1	.645
N of Valid Cases	1221		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 34.43.

5. Frequency table for cross-tabulation; number of nurses attending formal foundation course in 1st year

No. of nurses	Formal course in 1 st year: yes	No	Total
1	17	108	125
2	37	225	262
3	34	202	236
4	22	138	160
5	11	102	113
6-10	23	132	155
>10	1	169	170
Total	145	1076	1221

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	26.092 ^a	6	.000
Likelihood Ratio	39.887	6	.000
Linear-by-Linear Association	11.582	1	.001
N of Valid Cases	1221		

a. 0 cells (0.0%) have expected count less than 5. The minimum expected count is 13.42.

6. Frequency table for cross-tabulation; length of service and nurse involvement in decision-making

Length service	Not at all	Not much	Fairly	Quite a lot	Very	Total
<1 year	1	9	12	6	11	39
1-3 years	4	20	23	22	17	86
3-5 years	9	28	29	30	25	121
5-10 years	7	30	43	52	86	218
>10 years	11	53	98	168	233	563
Total	32	140	205	278	372	1027

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	65.923 ^a	16	.000
Likelihood Ratio	64.688	16	.000
Linear-by-Linear Association	47.990	1	.000
N of Valid Cases	1027		

a. 3 cells (12.0%) have expected count less than 5. The minimum expected count is 1.22.