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# Nurse Practitioners' Perceptions of their Role and Value in UK General Practice

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## Abstract

This research explores the role and value of nurse practitioners to UK general practice from the perspective of nurses working in these advanced roles. Nursing has had a presence in general practice for decades, but it is only over the last twenty years that it has extended into a traditional medical domain of care and treatment. Research has understandably focused on the ability of nurses to substitute for doctors and there has been relatively little investigation of what *nursing* at an advanced level contributes.

The study is located within a qualitative interpretive paradigm utilising a Social Constructionist (SC) approach which recognises that knowledge is not based solely on objective observations of the world, but is generated between individuals in the course of their everyday life. The theoretical perspective grounded in this epistemological paradigm is symbolic interactionism (SI). This emphasises the construction of the social world and meaning through the use of symbols, particularly language.

Thematic Analysis (TA) is utilised deliberately as a research strategy guiding sampling, data generation, collection and analysis. A purposive sample of ten nurse practitioners was selected. Semi-structured interviews were conducted, digitally recorded, transcribed and the data analysed using Braun and Clarke's model.

Four broad themes were identified from the narratives; the enactment and development of the nurse practitioner role, its value to the organisation and function of general practice, the impact of nurse consultation upon the patient experience and finally, how the role has integrated into the primary health care team.

The findings demonstrate that rather than one generic nurse practitioner role in general practice there are multiple constructs, driven at macro level by political necessity, negotiated at micro level by the needs of individual general practices and framed within a professional vacuum of non-regulation. This has not been fully explained before. The research provides a clear and original understanding of what nurse practitioners can contribute to general practice through the diversification of their roles, not as substitute but as part of a diverse, fluid team working collaboratively to address the needs of the general practice population.

## Acknowledgements

My grateful thanks to:

**If you want to go quickly, go alone**

**If you want to go far, go together**

African proverb

# Contents

## Introduction

This project explores the nurse practitioner (NP) role in UK general practice and intends to develop an understanding of the role from the perspective of individual nurses with particular emphasis on how they articulate value to general practice.

**The research aim is;**

**To explore nurse practitioners' perceptions of their role and value to general practice.**

**The objectives which will facilitate this aim are;**

1. **To articulate the scope and development of their individual roles.**
2. **To explore how NPs perceive they contribute to the organisation and delivery of services in general practice.**
3. **To explore how the NPs perceive their role impacts on patient care in general practice.**
4. **To consider how the NPs perceive their role impacts on other members of the practice team.**
5. **To articulate the meaning the nursing element of the role still has for nurse practitioners in general practice.**

Uniquely in general practice, nurses are managing complete episodes of care from undifferentiated presentations of acute and minor illness to long term conditions such as Diabetes Mellitus and Asthma. This demands a level of clinical skill together with diagnostic reasoning and prescribing which have not previously been seen in nursing. It inevitably changes the nursing role, now straddling a medical and nursing divide and combining a medical toolkit with a nursing orientation.

Research has understandably focused on the ability of nurses to take on some part of the medical role, in effect to 'substitute' for doctors. And whilst it has demonstrated that the service provided by NPs is safe and broadly acceptable to stakeholders within general practice; to doctors, patients and other nurses, there is a paucity of research

into the role itself, what meaning it has from the nurse's perspective and what value *nursing* contributes to the new service.

This project has particular significance at this time. The NHS is changing, and for reasons of economy, workforce and patient-centredness, there is movement of services from secondary to primary care. This brings the delivery of care in general practice sharply into focus and issues around workforce flexibility and funding occupy government and NHS organisations.

Professionally there is renewed interest in advanced level practice. Nursing is changing; new roles are emerging in response to healthcare changes and challenges from new health professionals make it more important than ever that nurses working in advanced roles can articulate what they do which is unique and has value.

The project has particular personal significance too. In common with the participants in my study, I am a nurse practitioner in general practice. In 2001, whilst working as a practice nurse I was presented with an opportunity to apply for and secure a nurse practitioner role across two general practices; a 4th generation Personal Medical Services initiative expressly tasked with improving patient access. The nurse practitioner role was one of the central pillars of the new initiative and has been successful. I studied to Masters' level to underpin the role and became an independent nurse prescriber in 2005; part of the first cohort to be able to prescribe from the entire British National Formulary excluding controlled drugs.

Nationally I have a role as committee member for the Royal College of Nursing Advanced Nurse Practitioner forum, tasked with advising and promoting the advanced role within the college and on the wider professional stage. The forum's involvement in the development of a process of credentialing for advanced practice is very exciting and if it comes to fruition will be a great achievement for all who have worked tirelessly to have the role recognised by peers, employers and the general public. It is a role I enjoy and perceive to be poorly understood and valued, and for this reason as well as for its significance in the current politico-economic and professional climate, I have chosen as my research project, to scrutinise and interpret the added value of this role to general practice.

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## Structure of the Report

Following this general introduction, **chapter one** focuses on the context of the research study, general practice, its development, organisation and function. The advanced nursing role will then be explored, outlining how it has developed professionally and politically and its introduction into general practice. A broad definition of the role and function is included.

**Chapter two** is a review of the literature. It will present a broad view of the research which has already focused on the nurse practitioner role in general practice, its contribution to the service and what value it is perceived to have.

**Chapter three** outlines the research design. The aim of the study is to explore the value of the advanced nursing role in general practice and the meaning that role holds for nurses. For this reason the approach is qualitative. Epistemological and theoretical perspectives will be discussed and the study set within an ethical framework. Methodology and methods will discuss broad strategy and the processes utilised in the delivery of this study. Thematic analysis provides the framework; recruitment, sample selection, interviews and analysis will be detailed here.

**Chapter four** contains my personal reflections upon a journey as an experienced practitioner and novice researcher and the impact of both on the study.

**Chapter five** provides an outline of the participants, their individual and practice characteristics. It also includes a diagram representing the subsequent four chapters and their domains of practice.

**Chapter six** begins the process of presenting the findings of the study with an exploration of the scope and boundaries of the role from the perspective of the individual nurses.

**Chapter seven** explores the general practice appointment, the nurses' perceptions of their influence upon its structure and organisation and a comparison with their GP colleagues.

**Chapter eight** examines the nurse practitioner appointment as the location of the therapeutic interaction and assesses what happens within this which differs from a GP consultation.

**Chapter nine** explores the effect of the introduction and integration of a new nursing role into the existing general practice and wider primary health care team.

**Chapter ten** summarises the key themes of the study, presents the key original findings located within the current political and professional landscape, outlines the strengths and limitations of the process and makes recommendations for the future of the role in general practice.

This chapter will explore the background to the study; to place it within a historical and situational context, to identify the main themes and drivers, political and professional, which have seen the nurse practitioner role develop in UK general practice. And finally to explore the concept of value within healthcare and begin to consider what the value of the advanced nursing role might be and how it could be evaluated.

## 1.1 The Study in Context

Nursing has had a presence in general practice for decades. Employed directly by general practitioners or attached to an extended primary health care team, nurses have played an important role in the delivery of primary care services to the wider community. In the early years practice-based roles were mainly limited to provision of basic nursing services within the surgery (Reedy, Phillips and Nevell 1976). The decades since then have seen the development of extended or advanced nursing roles in all areas of primary, secondary and tertiary care (Atkin and Lunt 1996, Barton 2006), but it is within one specific area of primary and community care that this study is grounded; within general practice.

## 1.2 History and Development of UK General Practice

With the formation of the NHS in 1948, General Practitioners (GPs) assumed responsibility for the provision of primary care and management of access to specialist care for the entire population. Within one month, 90 per cent of the population had registered with a GP. The 1960s saw new contracts which capped practice list size at 2000 patients per doctor and provided resources for GPs to employ support staff such as practice nurses. The creation of the Royal College of General Practitioners in 1972 saw a renewed focus on the *specialism* of general practice and from 1976, mandatory training and qualifications for all doctors wishing to train as GPs (The King's Fund 2011).

From the beginning, GPs insisted on retaining their independent practitioner status, in effect, sub-contracting services to the NHS. This allowed them a degree of clinical

freedom not available to their consultant colleagues. This freedom came under greater scrutiny during the 1980s and 1990s and the first move towards pay for performance was evident in the 1990 contract when GPs were paid for having smoking cessation, weight reduction and health screening clinics in their practices; clinics largely managed by practice nurses (The King's Fund 2011).

Until 1991 GPs played no part in commissioning health services for their patients, rather it was the local health authorities who were responsible for both the planning and contracting of services for the entire population. The NHS and Community Care Act (1990) changed this, creating 'purchasers' and 'providers' in the local health system. It created two models or tiers of commissioning; one based on health authorities, and the other based on general practice. (Department of Health DOH, 1990). From 1991, GP practices which fulfilled specific criteria could apply to be 'fundholding' practices. They held real budgets from which they purchased primarily non urgent care, deciding where they placed contracts for services as diverse as orthopaedics and dermatology. They also had the right to keep any savings they made. This was a radical departure from the original spirit of the NHS and put GPs in competition with other provider services and each other.

The first health initiative of Tony Blair's labour government in 1997 'The New NHS: Modern, Dependable' dismantled much of the internal market characterised by GP fundholding because of concerns that it increased inequality through a two tier system of healthcare. In its place it established Primary Care Groups(PCGs) responsible to District Health Authorities (DHAs), tasked with developing primary and community services, commissioning specialist services and improving the health of local populations (DOH 1997a). In a further reorganisation in 2001, DHAs were replaced by Strategic Health Authorities and PCGs by larger Primary Care Trusts (DOH 2001). Further structural changes in 2006 reduced the number and increased the size and responsibilities of both of these organisations; however this served to weaken their ties to local communities.

Further legislation in the form of the NHS (Primary Care) Act, and its consequent Personal Medical Services (PMS) contract provided extra funding for general practitioners to develop innovative services and facilitated the introduction of new

clinical roles including the nurse practitioner, into practice (DOH 1997b). PMS contracts were funded at a higher rate than the traditional General Medical Services (GMS) contract, with the additional funding intended to pay for these new practice-based services (DOH 1997b).

The defining feature of the Labour government's approach to health policy in the period 1997 to 2009 was a new emphasis on reducing health inequality and improving healthcare quality. Major initiatives of that period focused on reducing waiting times in secondary care and providing timely access to general practice (The Kings Fund 2011, O'Shea 2013). Access targets for general practice were first introduced in the NHS Plan (DOH 2000), and established the principle that from 2004, patients should be seen by a primary care professional within 24 hours and a general practitioner within 48 hours. To meet these targets the government incentivised practices through a series of contractual measures such as extra payments, delivered and monitored, through the Quality and Outcomes framework (QOF).

The 'Darzi report', 'High Quality Care for All" published in 2008 under Gordon Brown's Labour government, shifted the emphasis from rapid delivery of care with centrally imposed access and treatment targets to quality measures which encompassed patient outcomes and experiences and greater local flexibility in service delivery (DOH 2008). For primary care, the report advocated establishing at least one large polyclinic independent of the local general practices in each PCT area. These clinics could provide a list-based GP practice and GP access for patients who wanted a walk-in or pre-bookable appointment, but who were registered with a GP practice elsewhere. This proposal was controversial from the beginning. The BMA opposed it stating that funds allocated to the new polyclinics would be better used funding general practice, and some PCTs expressed concern that they were being forced to allocate resources to develop a centre which they did not need (Monitor 2014).

In 2007, even before the recommendations of the Darzi report, the RCGP in its document 'The Future Direction of General Practice: a roadmap', proposed that practices could work collaboratively in 'federations', ranging from informal loosely affiliated networks to formal legal entities, to improve services to their communities. Whilst the basic unit of care would remain the GP practice, by collaborating in this way

it was suggested that practices could reduce back-house costs and invest in new services (RCGP 2007). The proposal was different from the polyclinics because in most models GPs retained control, simply coming together as,

> ...an association of general practices and community primary care teams that come together to share responsibility for developing high quality, patient focussed services for their local community (RCGP 2008a p3).

In the years since then, the number of primary care federations in England has increased until in 2015 a national survey suggested that 37% of GPs were working within an informal or formal collaborative network (RCGP: Nuffield Trust 2015).

A change of government in 2010 saw another health service reform and another change of direction for general practice. The Health and Social Care Act launched in 2012 by the Conservative-Liberal Democrat coalition introduced substantial changes in the way health services were organised (DOH 2012). For general practice it meant a further reorganisation in the commissioning of services; the abolition of PCTs and the transfer of responsibility for purchasing services to groups of GPs and other professionals in newly designated Clinical Commissioning Groups (DOH 2012). There is more change ahead as CCGs now have the opportunity to take responsibility for co-commissioning of general practice services, including negotiation of local incentive schemes as an alternative to the QOF framework (NHS England and NHS clinical commissioners 2014).

And this remains the current organisational context of most UK general practices. Still independent health organisations, sub-contracted to the NHS, organised and managed by general practitioners working alone or in collaborative networks, delivering services to their local community within a broader context of clinically-led commissioning with GPs taking the lead in purchasing care for their communities.

In economic terms, it has been an equally challenging and uncertain period for the NHS and general practice. Following the financial crisis of 2008-09, Britain was forced to implement harsh austerity measures across all sectors of the economy, including public services. In 2009 the NHS chief executive, Sir David Nicholson, alerted the NHS to the potential shortfall in funding over the next decade; a consequence of the

stagnant economy, increasing demands from an ageing population and increasing costs of medicines and other treatments (Roberts, Marshall and Charlesworth 2012).

In addition to financial pressures impacting on general practice, a policy briefing prepared by the Nuffield Trust before the 2015 general election outlined further organisational problems facing the service. Whilst the authors maintained that there was no crisis in standards of care and that public satisfaction with the service remained generally high, they did identify a looming workforce crisis which could potentially destabilise general practice. They outlined crucial contributory factors; low morale and burnout leading large numbers of existing GPs to consider retirement, insufficient GPs in training to replace them and a general lack of funding for general practice services and infrastructure (Dayan, Arora, Rosen and Curry 2014).

In the new Conservative Government's first Spending Review and Autumn statement in 2015, the Department of Health announced extra funding over a four year period intended to address the economic and workforce issues of general practice and transform it into a seven day service, the aim being that by 2020-21, everyone will be able to access GP services in the evenings and weekends. The review further suggested this was achievable by recruiting an additional 5000 GPs to the workforce together with 5000 new 'healthcare professionals'(Department of Health and HM Treasury 2015). One problem with attempting to increase the GP workforce in such a short timescale is that training one additional GP takes a total of ten years. As the retirement 'bubble' is predicted within the next five years there would appear to be a serious underestimate in the real number of GPs required simply to maintain rather than to expand the service.

In NHS England's (2014) plan, 'Five Year Forward View', they pledged investment in new roles in primary care, ensuring what is described as a *more flexible workforce*. One strand of this strategy is already being developed through investment in fully funded MSc Physician Associate Studies courses. These courses, supported by the NHS and the Royal College of Physicians, are available within higher education institutions including medical schools throughout the regions. The intention is to prepare science graduates for roles in secondary and primary care, as dependent practitioners working under the supervision of consultants or GPs.

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The political direction of general practice may have undergone several transformations during the years since the creation of the NHS in 1948, but it remains as it was first conceived, the first point of entry for the majority of patients accessing health care. Having reviewed the history and development, the function of general practice will be explained.

## 1.3 Function of General Practice

*"90% of all patient journeys begin and end in primary care"*
John Hutton MP, Secretary of State for Health (DOH 2002 p2)

General practice services in the United Kingdom are still delivered through a 'cottage industry' model in which individual practices of varying sizes provide services to a defined and predominantly local community (Addicott and Ham 2014 p7). In many cases the general practitioners still own their practice premises and subcontract their services to the NHS through a regularly renegotiated contract. They usually deliver services in partnership with other GPs and lead a team of clinicians including nurse practitioners and support staff who together form the primary care team (Addicott and Ham 2014).

The bulk of the work of the general practice team is carried out during appointments in the surgery. The general practice appointment provides the environment for the basic currency of health care; a therapeutic meeting and conversation between clinician and patient. Traditionally general practitioner appointments are organised into surgeries conducted in the early morning and late afternoon leaving time for home visits, management and administrative duties. General practitioners usually have ten minutes in which to complete a consultation. The ten minute appointment is a legacy of a previous age of general practice; before an ageing population with complex multiple co-morbidities changed the practice demographic (Freeman, Horder, Howie, Hungin, Hill, Shah and Wilson 2002). A survey of general practitioners in 2012 revealed that over 80% of practices still adhered to the ten minute appointment (Irving and Holden 2012).

How the advanced nursing role emerged in general practice will now be explored. The development of the role will be examined through its specialist and generalist

branches, mapping the important micro and macro initiatives which facilitated its introduction into secondary and primary care.

### 1.4 <u>History of the Advanced Nursing Role</u>

Advanced nursing practice is recognised as a higher level of nursing which encompasses a range of non-traditional, post-elementary nursing roles (DOH 2010). It is broadly divided into two domains; role expansion, in which core elements of nursing are preserved and additional skills and areas of practice are encompassed into a specialist role and role extension; in which skills or areas of practice previously the remit of another professional group are incorporated into an advanced generalist role (Daly and Carnwell 2003).

Both of these share common roots with the development of advanced roles in the United States; the advanced generalist from the need for primary care doctors in rural areas in the 1960s, and the clinical nurse specialist from the work of Francis Reiter, who identified a need to focus on and improve patient care in hospital settings as far back as the 1940's (Leary, Crouch, Lezard, Rawcliffe, Boden and Richardson 2008).

The modern clinical nurse specialist first emerged in the early 1970s following the publication of the Salmon Report which suggested a new hierarchical management structure for nurses in hospital settings, a hierarchy with titles above ward sister (Ministry of Health and Scottish Home and Health Department 1966). Ruth Martin was a pioneering clinical nurse specialist in the 1970s, working in neurosurgery in Manchester. She expanded the work of nursing; assisting, advising and teaching medical staff but always retaining her focus on the patient and delivery of excellent nursing care (Castledine 2002). Where she led others followed but it was not until the 1990s, when the New Deal for junior doctors dramatically reduced the number of hours they were permitted to work in training, that numbers of clinical nurse specialists really began to increase (Loveland 1992, Wilkinson 2008). The need for medical cover meant that a new generation of nurse specialists also absorbed some medically focused work such as assessments, venous cannulation and diagnostic testing (Castledine 2002).

The new hierarchy of clinical specialism was expanded further in 1999 with the publication of 'Making a Difference', the new Labour government's framework for a more flexible career framework linked to proposed changes in NHS pay and conditions. It defined a form of consultancy incorporating four clinical practitioner levels with nurse consultant at the top. It further suggested that nurse, midwife and health visitor consultant posts would have responsibilities in four areas, expert practice; professional leadership and consultancy; education and development; practice and service development linked to research and evaluation (DOH 1999). An additional clinical specialist role appeared in 2001 when the NHS plan (2000) called for a 'matron figure' a senior experienced nurse tasked with ensuring the basics of ward nursing were being performed properly and the patient experience of hospital care was improved (DOH 2000).

Since then the clinical specialist role has developed rapidly and has a presence across secondary care. The focus of the role can be a specific disease area such as diabetes or inflammatory bowel disease; a particular population group such as children; a care arena such as pain management or a treatment category such as chemotherapy (Vidall, Barlow, Crowe, Harrison and Young 2011). In many cases nurses are non-medical prescribers and also incorporate education and management into their roles. They are seen as valuable team members and their work as crucial to the changing configuration of the NHS and to patient outcomes (Vidall et al 2011).

**Politically** the road to advanced generalist nursing role in general practice was rather slower. In the 1970s, whilst practice nurses in the UK were still carrying out tasks delegated by their General Practitioner employers, American nurses working in similar settings had started to extend their role into new areas, performing clinical assessments of patients autonomously, managing common disorders and in some cases working as surrogates for physicians (Reedy 1978).

The nurse practitioner role was formally introduced into UK general practice by Barbara Stilwell in the late 1980's. A pioneering nurse, she believed that nurses working at an advanced level could provide real choice in first contact care in general practice (Stilwell 1988). Working in an advisory role with the Royal College of Nursing in the 1980s and 1990s, she was influential in developing the first accredited nurse

practitioner courses in the United Kingdom, courses which produced the first leaders of the nurse practitioner community.

The Cumberledge Report on community nursing in 1986 strengthened the case for advancing nursing asserting that "the principle should be adopted of introducing the nurse practitioner into primary health care" (p32), further suggesting that key tasks would involve interviewing patients, diagnosing and treating specific diseases and conditions within agreed medical protocols and importantly, allowing direct access by any patient who wished to consult (Department of Health and Social Security DHSS 1986).

After a tentative beginning, numbers of nurses working in advanced roles expanded rapidly during the late 1990s and early part of the 21st century. Significantly, new Personal Medical Services (PMS) contracts introduced as a result of the 1997 NHS Primary Care Act, allowed general practitioners greater flexibility in employing staff to directly address the health needs of their patient populations (DOH 1997b). As a result there emerged new clinical posts straddling the nurse-medical interface which allowed services, previously considered to be core medical, to be undertaken by experienced and appropriately trained nurses (Por 2008). The introduction of access targets (DOH 2000), a medical recruitment and retirement crisis created by the 2004 GP contract, transfer of services from primary to secondary care (DOH 2006), and an ageing population (National Statistics 2010) further increased the need for new practitioners in general practice and opened the way for nurses to expand their roles. 'Liberating the Talents' outlined a framework for nursing in primary care which encouraged nurses to take on new clinical roles in practice and work in innovative ways to meet the needs of the local population (DOH 2002).

Advanced generalist roles were emerging in other allied spheres of practice also. The NHS Improvement Plan (DOH 2004) tasked PCGs with introducing and promoting the role of the Community Matron. The intention was that a skilled nurse would provide the first point of contact for patients with complex long term conditions being cared for in the community. In particular, they were tasked with coordinating care which might help reduce unnecessary hospital admissions.

The final element in the development of the advanced role in a political context was the ability to prescribe medicines. It was the Cumberledge Report (DHSS 1986) that first recommended community nurses should be able to prescribe from a limited formulary. But it was not until a private members bill in 1992, that primary legislation was introduced which lifted restrictions on non-medical prescribing and opened the way for appropriately trained nurses to prescribe (DOH 1992). It soon became clear that for nurses working autonomously in general practice a restricted formulary of medicines was not enough to manage complete episodes of care. A further layer of prescribing qualification was introduced, Independent and Supplementary, and from 2006 all nurses with this qualification, now termed Nurse Independent Prescribers, who were registered with the Nursing and Midwifery Council were able to prescribe from the entire formulary, with the exception of controlled medicines (Royal College of Nursing 2012a).

**Professionally,** the publication of the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) 'The Scope of Professional Practice', first identified and promoted the expansion of the nursing role (UKCC 1992). This was followed in 1994 by the post-registration and practice (PREP) document which established a framework and standards for specialist practice and offered a conceptual descriptor for advanced practice (UKCC 1994). The increasingly dynamic nature of healthcare and nursing roles required a more definitive framework and the UKCC embarked upon a 'listening exercise' involving key stakeholders in advanced practice from across the four countries of the UK. Consensus amongst the participants was that advanced practice should be aligned to a holistic expansive view of nursing. However the final recommendation by Council was that as there were neither agreed definitions of advanced practice nor criteria against which standards could be set, the UKCC should avoid setting explicit standards and instead consider how specialist practice could embrace nurse practitioners working at advanced level (Rolfe 2014). Whilst a further attempt was made to recognise and clarify advanced practice through the work of the 'Higher Level Practice Steering Group' which formally piloted recommendations throughout the UK via assessment of individual practitioners (Castledine 2003), the concept was ultimately abandoned by the new Nursing and Midwifery Council (NMC) as being overly complex (Rolfe 2014).

Eight years later, the NMC made a further attempt at consultation on advanced practice, on this occasion by online survey and questionnaire. Despite a warning that the process was flawed the NMC accepted the findings and determined that the new level of practice should be termed 'advanced nursing practice' and that it should be registered (NMC 2004). Whilst this remained the stated position of nursing's regulatory body, work on the new framework was delayed and finally overtaken in 2009 when a report to the UK Department of Health by the Council for Healthcare Regulatory Excellence (CHRE) suggested that nursing's professional code encompassed advanced practice and further regulation was therefore, unnecessary,

> ...what is often call advanced practice across many of the health professions does not make statutory regulation necessary (p1)

As a consequence, in March 2012, a statement from the NMC postponed any work on the regulatory framework for advanced practice and outlined its intention, in an austere financial environment, to focus instead on fitness to practice (NMC 2012b).

'Modernising Nursing Careers' (2006) published by the Scottish Executive but representing a four countries approach, outlined changes needed in the nursing workforce to reflect and address changes in healthcare. Importantly for advanced practice it advocated the 'standardisation of advanced level skills' (p15). This call for change led to a Department of Health position statement, a generic benchmark which applied to all clinical nurses working at advanced level regardless of setting or patient group. It identified a minimum threshold of twenty eight elements, clustered around four themes or pillars of advanced practice; clinical/direct care practice; leadership and collaborative practice; improving quality and developing practice; developing self and others (DOH 2010).

Publications by the three other countries within the UK have addressed the same issues of advanced practice within their own health and education systems. The first and most comprehensive of these is the 'advanced practice toolkit' developed by NHS Scotland (2008), hosted on their website but intended for use UK wide. It contains a consensus framework for advanced practice which is grounded in the ICN definition and framework for advanced practice and RCN competencies and which also references and is referenced in work undertaken by NHS Wales and The Department of

Health for Northern Ireland (National Leadership and Innovation Agency 2010, DOH 2014).

The Royal College of Nursing has attempted to clarify the position for nurses working in advanced generalist roles through the publication of competences for practice (RCN 2012). This document details areas such as receiving patients with undifferentiated and undiagnosed problems, having the authority to admit and discharge patients from their caseload, refer to other health care providers and provide a leadership or consultancy function as required.

But even with these publications and statements there is still confusion. The decade since 'Modernising Nursing Careers' has seen a number of different advanced or expanded nursing roles emerge. Barton (2006) suggests that the consequence of this is an "unregulated and confusing array of titles" presenting particular challenges and problems in the recognition and development of advanced practice. A survey conducted by the Royal College of Nursing (RCN) and the Department of Health (Ball 2005), identified 5 commonly used role titles: nurse practitioner (NP), clinical nurse specialist (CNS), nurse consultant (NC), specialist nurse (SN) and advanced nurse practitioner (ANP). The review established that, of these, SNs, NCs and CNS are more likely to be employed in secondary care and be involved in some clinical work but with more educational or research focus to their roles. In contrast, NPs and ANPs spend most of their time on direct patient care; interacting directly with patients, assessing health needs, performing physical examinations, making diagnoses, prescribing and initiating treatment plans (Ball 2005).

Internationally, countries are at different stages in implementing advanced roles. Carney (2016) in her review of regulatory dimensions of practice, found a lack of consistency in regulatory systems, education and preparation for advanced practice and identified up to thirteen different titles being used to denote advanced level nursing, including advanced nurse practitioner, advanced practice nurse (APN) and clinical nurse specialist (CNP). Despite some variation across states, the United States has the most developed framework for advanced practice. The National Council of State Boards of Nursing APRN Advisory Committee recognises four categories of advanced practice nurses (called Advanced Practice Registered Nurses); encompassing

generalist roles, midwifery, anaesthetics and clinical specialisms (Duffield, Gardener, Chang and Catling-Paull 2009). Within Europe, Ireland has possibly the most defined and formal recognition of advanced practice. Nurses working in advanced roles as nurses or midwives have been registered with the Nursing and Midwifery Board of Ireland since 2011 (International Council of Nurses 2014).

In the UK however, non-regulation together with a lack of registered professional titles and standardisation of educational pathways has led to role confusion for nurses, other health professionals and the public (Carney 2016). A broad definition will now be presented.

## 1.5 Definition of the Nurse Practitioner Role

Emerging from this global context the NP role is recognised by the International Council of Nurses' Nurse Practitioner/ Advanced Practice Nursing Network (2001) as,

> ...a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level (p1).

This definition is a commonly quoted broad benchmark of advanced generalist practice. It recommends Masters' level entry but leaves credentialing or registration to the individual countries. In terms of characteristics of practice it advocates a broad church which incorporates elements of the four pillars of advanced practice detailed by the four countries of the UK (DOH 2010). ICN recommendations are appended (appendix one).

The RCN recognises the 'expertise' of the NP as his or her ability to operate as a 'generalist', providing complete episodes of care to patients with urgent needs, long-term conditions and in preventive health (RCN 2012b). And these advanced generalist roles are found in the greatest numbers in general practice.

For the purposes of this research, the advanced nursing role will be limited to that generally termed 'nurse practitioner' and more recently 'advanced nurse practitioner'

in the research literature. And for reason of continuity, the term 'nurse practitioner' will be used throughout this report.

### 1.6 <u>Measuring Value in General Practice</u>

Value is a difficult concept to define. In its literal sense it can indicate a fair price or return, a principle or quality deemed desirable or worthwhile, or the worth in usefulness or importance of the holder (Oxford Dictionary 2016). How value is measured depends upon its meaning *in context.* Articulating and measuring value in a specific role or situation is often subjective, its contribution difficult to fully uncover and clarify. Articulating value in the health care system exemplifies this difficulty. It can be measured in positivist terms; in observable outcomes, improved mortality data, crude numbers seen in clinics or practices, clinical frameworks which seek to promote value which has statistical significance. In general practice the Quality and Outcome Framework (QOF) is used as a proxy for value through thresholds passed and points awarded for achievement of specific standards, for example, the number of patients with blood pressure in target range or simple recording of seizure frequency for patients with epilepsy within the previous 12 months.

Cost-effectiveness is a concept commonly used in health care as a means of defining worth or value in economic terms. It compares the costs or health effects of a single intervention or a number of interventions to determine which represents the best value for money (Phillips 2009). For example; prescribing generic medicines which have the same efficacy but are cheaper than branded medicines is considered the most effective use of a prescribing budget. In terms of the nurse practitioner role cost-effectiveness might relate to a different distribution of human resources within the team, one which shifts work from GPs to less expensive clinicians. But whilst economic value is important, it does not necessarily provide clarity with regard to the value and impact of the role. Key components of cost-effectiveness; quality and content of consultations are not examined in these calculations (McLaren 2005). They cannot express the impact of the caring dimension of nursing or aspects of care which are difficult to quantify but make an important contribution to patient care. The aim then is to articulate what this added *something* is that nurses bring to a role traditionally undertaken by general practitioners.

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This chapter has located the nurse practitioner role in general practice within a historical and professional context. General concepts of value in health care have been explored and will be further examined within the next chapter; review of the literature.

The aim of this project is to explore nurse practitioners' perspective of their role and value in UK general practice; to identify and explore what they feel they add to a service traditionally undertaken by GPs.  The literature review is intended to contextualise this aim, to explore the contribution made by this advanced nursing role to the organisation and function of general practice and also to examine what impact it has on stakeholders; the public and other health professionals.

A systematic approach to searching the literature was utilised because it ensured a comprehensive and rigorous methodological approach. Explicit statements about inclusion and exclusion criteria ensured that the articles identified addressed the search question. A critical review of the literature that explicitly considered the methodological approaches adopted in the individual studies and the rigour with which those studies were conducted was utilised in order to offer a balanced judgement of the contribution of outcomes and conclusions to the study question.

## 2.1. The search question

The question to be answered by this review is;

What is the contribution of advanced nursing practice to general practice?

## 2.2. Search Strategy

A search strategy was developed to identify research articles whose focus was specifically on general practice in the United Kingdom. Research into advanced roles in other sectors of the NHS or other international health care systems was not included. Whilst the advanced nursing role is in evidence around the world, health care systems are very different and results might not reflect the context or reality of the NP role in the UK.

Electronic databases utilised: Cumulative Index to Nursing and Allied Health Literature (CINAHL Complete); MEDLINE; The Cochrane Library; British Nursing Index; Database of Abstracts of Reviews of Effects (DARE), Nurse Researcher Online.

Grey literature sources:

- Websites (Department of Health, Royal College of Nursing, National Statistics Online, Nursing and Midwifery Council, Royal College of General Practitioners)
- Incremental searches – reference lists from retrieved research articles.

Initial searches were completed during 2012 and further searches were conducted at regular intervals until the end of 2015 to identify any new research. Databases were searched from January 1999 onwards for relevant studies. This time-frame reflects the greatest expansion in advanced nursing roles in general practice, an expansion framed and supported by three critical policy documents; 'Making a Difference' (DOH 1999) which identified a new career structure for nurses incorporating a 'higher level of practice'; The NHS Plan (2000) which articulated an expanded role for nurses in primary care and 'Liberating the Talents (2002) which further outlined that role in first contact care and in the management of long term conditions. This generated a burst of research activity into these new roles as they emerged in general practice.

## 2.3. <u>Search Terms</u>

Sets used:

1. advanced nurs*; nurse practitioner; general practice

2. advanced nurs*; nurse practitioner; general practice; patient*; patient satisfaction; consumer satisfaction; contribution; value

3. advanced nurs*; nurse practitioner; general practice; attitude*; contribution; value

Both 'nurse practitioner' and 'advanced nurse practitioner' were used for the search because they are the titles commonly used in general practice. Clinical nurse specialist and nurse consultant are titles generally associated with secondary care and were not utilised. Even limiting in this way identified some studies based outside of general practice, for example, in unscheduled care settings.

Similarly, general practice was used in each set to try and limit studies to focus and exclude any located in secondary care. This did identify some studies based abroad, particularly in the Netherlands but these were excluded manually. Restricting to 'UK'

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general practice did not identify sufficient studies as not all specifically identified 'UK' in their titles.

Contribution was captured using the proxy terms; 'quality', 'contribution', 'worth', 'impact' and 'patient satisfaction'.

Having retrieved the articles in hard copy, the biographies were searched for other articles which might be relevant but had been missed on the electronic search. It was reassuring that this uncovered very few potential new articles. It was reassuring also that the articles I had retrieved were cited several times in other bibliographies.

As a result of these initial searches, 178 potential studies and papers were identified. These were examined and individual items selected for inclusion in the review if they were considered relevant to focus (119 excluded for example 'opinion' articles). Manual review of abstracts and full text excluded a further 40 papers for reasons of inappropriate study settings (not United Kingdom), or not restricted to focus (not related to general practice).

In order to be considered the articles had to be randomised controlled trials, systematic reviews, inductive studies and observational studies.
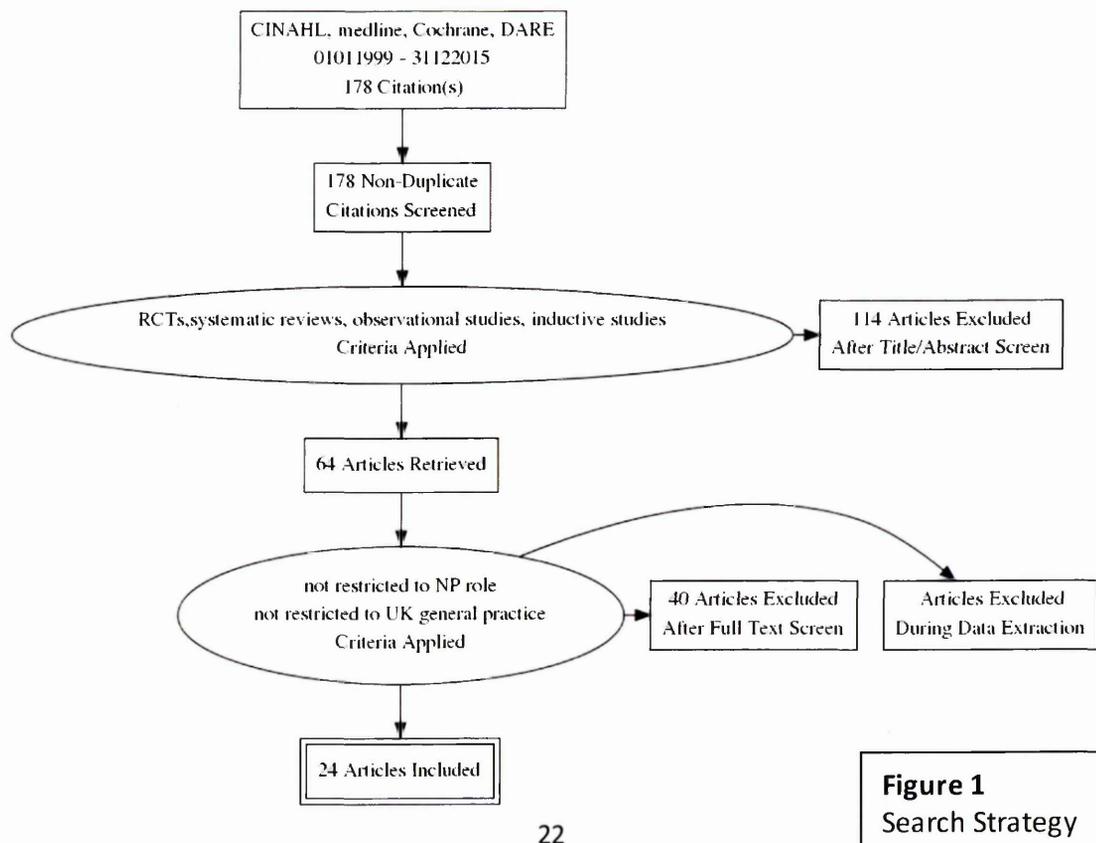


Figure 1
Search Strategy

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**Table 1** Eligibility criteria

| Inclusion Criteria | Exclusion Criteria |
| --- | --- |
| Paper reports on NP or ANP practice | Paper not focused on NP or ANP |
| Context is UK general practice | Context is not UK general practice |
| Published between 1.1999 and 12.2015 | Published before this time framework |
| Published in a peer reviewed journal | Discussion document, editorials. |
| Published in English language | Not published in English language |

The research studies were critically appraised prior to inclusion in the review. A relatively quick measure of quality was made on external factors. Determining the source of the study, for example, the journal of publication, the reputation of the author and the academic institution were useful indicators (Booth 1996). More detailed assessment was made using a critical appraisal tool specific to the research paradigm. Critical appraisal skills programme (CASP) assessment tools relevant to the study design were utilised (CASP 2013). None of the remaining 19 articles were excluded on the basis of poor quality. There were concerns about the Cochrane review's overall findings (Laurent, Hermens, Braspenning, Grol and Sibbald 2005) and about a large review by Bonsall and Cheater (2008). Both are included as they contain some useful evidence within the overall structure, but the issues of quality will be addressed.

As discussed earlier, the early years of the 21st century saw the greatest expansion in numbers of nurse practitioners in general practice and consequentially the greatest number of studies examining that role. The priority for clinical enquiry at that time was to examine the ability of nurses to take on some part of the medical role, in effect to 'substitute' for doctors and deliver care traditionally seen as the remit of the medical profession. Considering the predominantly biomedical culture of general practice it was inevitable that much of this research would be quantitative. The articles retrieved are focused around three areas of enquiry; an examination of the nurse practitioner workload comparative to the general practitioner, exploration of the patient perspective and attitudes of other professionals towards the NP role. These will be examined separately and in detail now.

## 2.4. Value to General Practice

A comprehensive review for the Cochrane Library, Laurent et al (2005) identified sixteen quantitative studies which examined substitution by nurses either in first contact care (twelve studies) or management of chronic conditions (four studies). Of these, thirteen were randomised or quasi-randomised controlled trials and three were controlled before and after studies. Quality was assessed against nine criteria, however, none of the included studies matched more than seven criteria and some matched as few as three or less. Whilst it is not clear what assessment tool was utilised, and Cochrane subsequently moved to a domain-based evaluation in 2007, it would seem unlikely that a score of three demonstrates a study of high quality. However, the review team concluded that *"...appropriately trained nurses can produce as high quality care and achieve as good clinical outcomes for patients as doctors..."* (p2). Only one study was powered to assess equivalence of care and there were significant methodological limitations in all studies. At least one was conducted in North America where first contact care is very different and others were located in non-general practice services. Despite publication in 2005, many of these studies were conducted in the 1970s when the nurse practitioner role was barely established and certainly would be unrecognisable from the expanded role of the last decade.

Included in the Cochrane review was a randomised controlled trial (RCT) which has been frequently referenced individually and has direct relevance to the question and the time frame. Published in 2000, it was a large multicentre study based solely in general practice focusing on the differences in care between general practitioners and nurse practitioners (Kinnersley, Anderson, Parry, Clement, Archard, Turton, Stainthorpe, Fraser, Butler and Rogers). The study was rigorously constructed with sample size powered to demonstrate significance in the primary outcomes (patient satisfaction and resolution of symptoms at two weeks), with effective recruitment and randomisation strategies and statistical analysis included in the report. Having calculated the primary outcomes together with the number of prescriptions issued and investigations ordered, both proxy measures of comparability with medical practitioners, the study concluded that nurse practitioners provided a "high standard of care" and supported their extended role in practice. It identified that consultations

with nurse practitioners were longer than for medical colleagues but did not attempt to explain why and how this impacted on patient satisfaction.

In their systematic review published in 2002, Horrocks, Anderson and Salisbury combined data from Kinnersley et al's (2000) research and other randomised controlled trials and prospective observational studies to determine whether or not nurse practitioners working in primary care could provide *equivalent* care to doctors. Disappointingly, due to the dearth of quality studies in the United Kingdom they included in their review a small number of North American studies and non-first contact general practice services. In their summary of evidence from the qualitative studies they determined that,

> Nurse practitioners seemed to provide a quality of care that is at least as good, and in some ways better, than doctors (p821).

They based this on specific quality measures including communication skills, accurate diagnosis, appropriate investigations performed and relevant advice on self-management or treatment. Clearly here there is some evidence of value-added to the service by a nursing role which is synthesised with core medical skills.

In contrast to the quantitative approach taken in studies so far, a substantive 'integrative' but not systematic review examined the limitations and benefits of nurses taking on aspects of the clinical role of general practitioners, from a qualitative perspective (Rashid 2010). The author's stated intention was to determine whether or not the findings of the Cochrane review (Laurent et al 2005) were still relevant in view of the rapid expansion of nurses' roles in UK general practice. The review utilised only research published after 2004. Eight qualitative studies were identified and assessed using a published but not validated appraisal tool. However, because of the small number of studies identified, not all quality criteria were rigorously applied; the justification being that had they been, the number of studies would have been smaller still and the review would have lacked any credibility. Indeed even the few studies included lacked any homogeneity, with some focusing on non-core general practice services and some on practice nurses who had expanded their role rather than solely on nurse practitioners. Rashid concluded that the evidence base to support the rapid expansion of nurses undertaking aspects of medical work was weak and that there was

also little consideration of cost-effectiveness or use of resources. Conclusions also focused on lack of patient choice and nurses' ability to manage complex problems.

In their review of literature, Bonsall and Cheater (2008) attempted to identify the impact of the advanced nursing role on patients, nurses and colleagues. It is included here not as evidence of the contribution and value of the advanced role, but rather as evidence of the difficulty in using published research to direct or support practice. It did not claim to be a systematic review, rather to provide an overview of recent changes in the delivery of first contact services. It included 88 studies, many from New Zealand, America, Canada and Australia. No inclusion criteria for studies was specified, rather it was determined by the scrutiny of one researcher. No discussion of the methodological quality was attempted and inevitably then, there is insufficient linkage between conclusions and evidence. The studies were a mix of quantitative and qualitative, isolated RCTs alongside observational alongside single case studies. It made broad claims for the role; that it improved access to general practice services for *some* patients, that it provided equivalent care for *some* medical conditions, that it *may* benefit and facilitate workload changes. However, the range and scope of this paper, the number of articles included and the lack of clear information about study quality make it impossible to draw any real conclusion about the contribution and value of the expanded nursing role in general practice. Studies were included from widely different health care systems and again these are not easy to accurately identify within the review. In such a project, good quality research which might inform and illuminate is lost in a melee of mediocre and poor studies. It is therefore impossible to assess whether or not even the overview offered by the authors has any real value to clinical practice.

A large, methodologically sound ethnographic study involving general practitioners, nurse practitioners and practice managers from nine general practices across the North West of England, examined the redistribution of medical work from doctors to other members of the clinical team (Charles-Jones, Latimer and May 2003). Through their discourses, participants identified a process of categorising and allocating patients to different clinicians according to their assessment of the presenting problem. The authors determined that the process had established a *"hierarchy of*

*appropriateness"*, in which individual patients with the most complex problems are allocated to the practitioners with the most expertise and experience, the general practitioners, and those with minor or self-limiting illness to nurses. Clearly there is some value to general practice in making the most appropriate use of limited resources. Yet there is still an effect of this change to be considered; that allocation based on the health professional's judgement of "fit", matching the presenting problem with the resources inevitably detracts from patient choice and reduces an individual, in the authors' words, to little more than a *"biomedical diagnosis"*. In such a process, nurse practitioners are actually preventing patients from seeing doctors when they and their problems are deemed to be 'inappropriate'.

A small amount of research has focused on the value of the advanced nursing role to general practice in economic terms, and more specifically cost-effectiveness. The transfer of some core medical duties to nurses would suggest a cost saving to the National Health Service (NHS), a saving which could potentially fund other services. Yet the case for economic effectiveness is also not proven. A multicentre randomised trial conducted in 2000, examined the cost effectiveness of nurse practitioners and general practitioners as first point of contact in general practice. It concluded that NP appointments were considerably longer than those of GPs (11.57v7.28min; adjusted difference 4.20, 95% confidence interval 2.98 to 5.41), they performed more tests and asked patients to return more often. When patient satisfaction and clinical outcomes were included in the results, there was no evidence for greater cost effectiveness despite significant salary savings for the service (Venning P, Durie, Roland, Roberts, Leese and Venning C. 2000). The authors concluded that savings on salary appear to be offset by longer consultations, higher patient recall and increased use of tests and investigations.

Hollinghurst, Horrocks, Anderson and Salisbury (2006) modelled the cost data from two randomised controlled trials (Venning et al 2000, Kinnersley et al 2000), to compare the cost of services provided by nurse practitioners with that of salaried general practitioners. They determined that employing a nurse practitioner was likely to cost much the same as the salaried GP, but with the considerable variation in skills, qualification and experience, cost was only one part of the skill mix decision. Pay

scales have changed over the last sixteen years and without financial additions such as medical defence fees, the stark pay differential would suggest that nurse practitioners are considerably less expensive than salaried GPs with average hourly rates of £25.37 v £43.06 quoted in a survey conducted in 2014/2015 for a general practice managers group (First Practice Management 2015). However, as with Horrocks et al's (2006) evaluation other factors, such as shorter consultations and more patients seen by salaried doctors in each surgery session should be taken into account.

Nonetheless, practices have continued to employ nurse practitioners to manage increasing demands for access to their services. In a systematic review of innovations in service provision in the UK, Chapman, Zechel, Carter and Abbott (2004) identified telephone triage and nurse led care in general practice as two areas in which access to and capacity of general practice has been changed by the introduction of the nurse practitioner role. They concluded that whilst there was some evidence that telephone triage improved access for some, there was an inevitable trade-off for those patients who preferred a face-to-face consultation with their own GP. Further evidence from the ESTEEM trial, a pragmatic cluster-randomised controlled trial of telephone triage in four centres in the UK demonstrated that nurse triage resulted in an overall increase in total primary care workload compared with usual care, but a decrease in GP face to face contacts, suggesting a redistribution of work from GPs to nurses. However the ESTEEM study report failed to differentiate between nurse practitioners and practice nurses with additional training (Campbell, Fletcher, Britten, Green, Holt, Lattimer, Richards D, Richards S, Salisbury, Calitri, Bowyer, Chaplin, Kandiyali, Murdoch, Roscoe, Varley, Warren and Taylor 2014).

Nurse practitioner triage of requests to general practice for in-hours home visits was examined in a non-randomised comparative study based in a large general practice in London (Edwards, Bobb and Robinson 2009). The nature and outcome of each patient contact was recorded on a data collection form and this, together with the patient's electronic record, was scrutinised by the research team. Outcomes included telephone advice, face to face contact in practice with a GP or NP, home visit by the GP or referral to the GP for further advice. The study concluded that NP assessment of home visit requests was feasible and could free up GP time for surgery work but

resulted in more face to face consultations with patients and more prescriptions issued.

A small qualitative study by Perry, Thurston, Killey and Miller (2005) using a convenience sample of patients and staff in a single UK general practice, attempted to identify whether or not the nurse practitioner role facilitated access to care that met the need of patients. Semi-structured interviews were conducted with eleven members of the clinical and administrative staff and with fourteen patients who had consulted with the nurse practitioner. The study demonstrated that within this individual practice, the nurse practitioner role did widen access and did increase the number of appointments available. However the authors concluded that this could have been achieved by the addition of any practitioner to the team, suggesting that the fact the practitioner was a nurse, was incidental. It was also noted that much of the satisfaction expressed by patients related to the caring dimension of the individual nurse's role; a characteristic which could be person, gender or role-specific.

Whilst research in this section has discussed contribution to general practice and the implications of nurse practitioners substituting for general practitioners, evidence of value has been difficult to uncover. If there is to be evidence of added value from the introduction of the nurse practitioner role in general practice, it is perhaps more likely to emerge from the patient satisfaction agenda. Value to the patient journey will now be reviewed.

## 2.5. <u>Value to Patients</u>

Two randomised controlled trials examining the satisfaction of patients with nurse practitioner consultations in general practice have been conducted. The first which was discussed earlier, studied same day requests for consultations in general practice in which patients were randomly allocated to either nurse or general practitioner appointments. The study concluded that generally patients consulting nurses were significantly more satisfied with their care, although there were some unexplained differences across age ranges (Kinnersley et al 2000). The second study, a multicentre, randomised controlled trial assessed the acceptability of nurse consultations for minor illness in general practices in London. Questionnaires and self-reported health status

measures were used to generate statistical data. The authors found that patients were generally more satisfied with nurse than general practitioner consultations; this was statistically significant in the areas that measured general satisfaction, professional care and perceived time (Shum, Humphreys, Wheeler, Cochrane, Skoda and Clement 2000).

A rather different view emerges in a later qualitative study by Redsell, Stokes, Jackson, Hastings and Baker (2007) which attempted to determine patients' views on the introduction of the advanced nursing role to manage a range of minor illness. Based in two volunteer general practices, researchers interviewed 28 patients attending for urgent, 'same day' appointments prior to their consultation with either the GP or the nurse practitioner, and with 19 of the original 28 participants after their consultation. Before the consultation patients were asked to talk about who they were consulting with on that day and whether or not they would have preferred to consult with someone else. After the consultation they talked about more general issues of who they would prefer to consult with and why. General themes emerging from the study focused more on the role of the GPs, seeing them as the experts and nurses as a resource to facilitate the smooth delivery of care. GPs were regarded as having greater skills, knowledge and authority and remained the preferred health professional for serious problems. Patients in this study did not consider that nurses could substitute for doctors but did value the extra time and information provided by the nurses. A major theme identified by the participants was the value of continuity of care. However they saw this as a continuing relationship with their general practitioner and not with the nurse. Whilst this was a small study, only two general practices and two nurses, it does demonstrate that patients seem to value nurses but prefer to see them enhancing care given in general practice rather than 'substituting' for general practitioners.

This issue of, on one side satisfaction with nurse consultations but on the other preference for GP consultations is further highlighted in a national survey of the treatment of minor illness conducted in Scotland in 2006. This study involved the distribution of postal questionnaires to a national sample followed by telephone conversations with respondent volunteers (Caldow, Bond, Ryan, Campbell, San Miguel,

Kiger and Lee 2007). It was a large study, representing views from general practices throughout Scotland, with a full range of age groups, educational backgrounds and income. The quantitative data from the returned questionnaires was analysed for satisfaction, attitudes and preferences of the respondents. They concluded that patients would always want their choice of health professional to be available as first contact and that most preferred this to be a doctor. The mixed method design allowed researchers to explore the patient perspective in greater detail, and confirmed the findings of other studies that whilst the nurse practitioner role was 'acceptable', the choice agenda was being ignored.

More detail about which presentations patients felt could be managed by nurses is offered in one section of a large qualitative study undertaken in general practices in Torbay. Researchers sought the views of patients regarding the redistribution of medical work from general practitioners to nurses (Branson and Badger 2008). A postal questionnaire achieved a relatively poor response, only 28% (241 of 860) were returned. Further information was gathered through focus groups recruited via posters in general practice waiting rooms. Patients' views were generally positive with 68% of the admittedly low quotient returned questionnaires agreeing that work could be delegated from doctors to nurses. However the tasks they thought could be delegated were current nursing duties and management of self-limiting illness. They were less willing to consider delegation of more complex acute presentations and expressed reluctance in these cases to see professionals other than GPs.

A comparative study of general practitioner and nurse practitioner consultations by Seale, Anderson and Kinnersley in 2005, explored treatment advice given to patients. An observational study, it analysed digital recordings of consultations for time spent with patients and amount and type of information provided. Eighteen matched pairs of consultations from nine general practices were included, consultations where 'same day' appointments had been sought by patients for acute illness. The results demonstrated that nurse practitioner appointments were longer than those for medical colleagues, in part because they provided a disproportionately greater amount of advice and information concerning treatments and potential side-effects. The discussions involved greater repetition of information and attention to emotional and

social factors. Whilst other studies have demonstrated similar outcomes, as an observational rather than a retrospective study which relies on practitioner or patient recall, it does seem to provide contemporaneous evidence and support for the nursing role.

The time factor is explored in greater detail by Williams and Jones (2006), in their qualitative examination of nurse practitioner consultations. They interviewed a 'judgement' sample of ten patients, the number determined by their expressed wish to *"limit the breadth of exploration while maximising the opportunity for in-depth analysis"*. Consultations were with the same nurse practitioner, interviews were transcribed and thematic analysis by both authors suggested that 'time' was a recurring feature of all narratives. Patients appeared to value the time the nurse was able to spend with them, discussing not only their immediate illness but also external factors which might influence this; family, work and relationships. They further appreciated the more detailed information and advice provided.

The third theme which emerged from the literature review was the effect that the nurse practitioner role had on other health professionals within the practice, the wider primary care team and wider still, within the profession of nursing. This will be explored in more detail.

## 2.6. <u>Value to other Health Professionals</u>

GPs have been identified as the main beneficiaries of the advanced nursing role in general practice. It has been conjectured that workload would reduce, that nurses would take on more of the acute presentations leaving GPs to manage the more complex. This should have value, as identified in the *'hierarchy of appropriateness'* by utilising scarce professional resources judiciously. But the few studies which have been conducted into this new medical / nursing interface have demonstrated mostly barriers and antagonism motivated by concerns about professional territory and identities.

In an exploratory study of attitudes towards the NP role in general practice Carr, Bethea and Hancock (2001), interviewed GPs who had not worked with a nurse practitioner before and found concerns about training and role definition. In a further

study utilising the information drawn from these initial interviews, Carr, Armstrong, Hancock and Bethea (2002) developed a postal questionnaire which was sent to all GPs within Lincolnshire and Sheffield. Of the 33% returned, approximately 25% were from GPs who already employed nurse practitioners and perhaps not surprisingly, were overwhelmingly in favour of greater expansion of the role in primary care. However, they perceived treatment room work to be an integral part of the role, perhaps suggesting more an expansion of the roles of their practices nurses than an autonomous practitioner. There was also broad support for the role from the GPs who did not employ nurse practitioners, although very few had any fixed intention of introducing the role into their practices in the near future.

Wilson, Pearson and Hassey (2002) conducted four focus groups involving 25 GPs from training practices in Yorkshire to explore their attitudes towards the developing nurse practitioner role. They identified three main areas of concern; nurse capabilities, threats to GP status including job and financial security and structural and organisational barriers. One of the practices involved in the study admitted to having initial concerns about the nursing role but having employed one nurse practitioner, they found the difficulties were completely outweighed by the positive contribution she had made to the practice.

It appears from the literature that attitudes of nurses towards those working in advanced roles in general practice have not always been supportive either. In a qualitative study of the nursing roles within a primary health care team, interview transcripts revealed considerable antagonism towards nurses extending their roles. This move was seen as a threat to the profession and professional identity, adversely affecting traditional roles within general practice and the wider community team (Williams and Sibbald 1999). The research team concluded that the erosion of professional boundaries could lead to uncertainty and low morale.

Long, McCann, Mcknight and Bradley (2004) conducted focus groups and interviews with members of three multidisciplinary primary care teams including general practitioners, nurse practitioners, practice and district nurses in Northern Ireland. Their aim was to investigate how the introduction of the new nurse practitioner role had affected other team members. They discovered that whilst there was considerable

support from most members of the team, some were confused about the role and others were simply resistant to the introduction of a new 'specialist' role. They concluded that much of the antagonism was caused by a lack of understanding of the new role and suggested that better definition of boundaries would assist in integration.

The issue of identity, of role boundaries within the nursing profession is echoed in the study by Charles-Jones et al (2003). A view emerged of nurses moving away from their traditional role into a hybrid role which aligns them more closely with medicine. This separation of function leads to a hierarchy within general practice nursing teams which has not existed before. It creates a hierarchy as damaging as the *"hierarchy of appropriateness"*; the hierarchy of *value* in which advanced nurses categorise themselves at the top separated from other nurses and from a view of the traditional nursing self by their newly acquired 'medical' skills.

It only remains to ask if value to the wider nursing profession can be identified from the expansion of the nursing role into this new territory. In his ethnographic study of student nurses undertaking a clinical degree programme (BSc Nurse Practitioner) Barton (2006) found that an area to be considered is that of career progression. Nursing has long laboured within a structure which is very limited, both in terms of horizontal role change and vertical hierarchy. The expansion of nursing into this advanced clinical area certainly provides another option for an underdeveloped occupational structure, one which might keep good, experienced clinical nurses at the frontline of health care rather than moving into management or academia to further their careers.

## 2.7. Discussion

It is no surprise then that the flurry of early studies into the advanced nursing role were trials examining effectiveness of the role or comparison with a control; the general practitioner. No surprise either that the Cochrane study (Laurent et al 2005), the single RCT (Kinnersley et al 2000) and the systematic review (Horrocks et al 2002), were published in the medical press with its positivist publication bias. There needed to be a retrospective justification and examination of the role, and the studies needed

to be of experimental design, generating a level of evidence that general practitioners and the wider 'scientific' community trusted.

As a result the available literature contains evidence of the contribution of the nursing role, and its capacity to safely substitute for the medical, concluding that in general, outcomes in terms of health status, resolution of clinical problems, treatment and advice are comparable to those of doctors. There is also some evidence that the role improves access and increases availability of appointments in general practice. Evidence of contribution certainly, but it still seems difficult to move the debate forward to issues of demonstrable value added. In areas which would be expected to show value such as cost effectiveness and savings to the NHS, the evidence is equivocal. The only area which could be argued to show value would be that of skill mix, the "hierarchy of appropriateness" described by Charles-Jones et al (2003). Even this is contentious. In a patient centred service, the notion of allocating 'problems' to clinicians with an appropriate level of expertise, of reducing individuals to the level of biomedical diagnoses, seems contrary to the patient choice agenda.

The research suggests that patients do value nurses. They appear to value the extra time nurses spend with them, the more detailed advice and information given and the greater attention to the emotional and psychological dimensions of their problems. The research demonstrates too that patients value continuity of care. But whether for reasons of trust, experience or habit, they prefer this to be with a general practitioner rather than a nurse. It seems that old perceptions of the doctor as expert are hard to dispel. The concern still remains that whilst nurses can contribute much to the smooth running of care, their ability to detect and manage more serious health problems has not been addressed.

Research into the value of the new nursing role to the general practice and wider primary care team perhaps dates from too early in the expansion of the NP role to be particularly useful. Many of the studies are over ten years old and attitudes may have changed as nurse practitioner roles have become embedded in the primary care system.

The further question of what value there is to the profession in extending the nursing role into areas which have traditionally been the domain and responsibility of the medical profession, remains to be properly addressed and answered. And it is important that the profession does this. It must be able to articulate what is uniquely nursing, to ground and secure the therapeutic value of nursing in the advanced role. The lack of clarity, the lack of endorsement by regulatory bodies, the lack of uniform training and titles all inevitably muddy the professional waters and contribute to the boundary confusion experienced between nurses in advanced roles and their colleagues. Being able to articulate what the nursing contribution is and the value that has would surely be a first step in addressing intra and inter-professional tensions.

## 2.8. Conclusion

The quality of research, both quantitative and qualitative, has made this review difficult to execute and interpret. Both research approaches have relevance; experimental studies were essential in providing objective evidence for effectiveness following the introduction of the new role; qualitative in exploring and interpreting the experiences of all stakeholders. But there are limitations in the studies produced by both; from the single randomised controlled trial, powered to demonstrate equivalence of care, to the qualitative study involving only two general practices and two nurses out of the many throughout the United Kingdom. The problem of studies including only small numbers of nurses permeates both research approaches and lack of detail about the process makes it difficult to know if results are related to the role or to the personal characteristics of the individual practitioners.

Much of the research into the nursing role in general practice was conducted during an early period of rapid expansion in nursing numbers. During that time, health professionals and patients were becoming accustomed to the role but there was still confusion and misunderstanding about what it involved and what it could deliver. There is sufficient evidence now of contribution, safety, acceptability, even glimpses of quality that mean, with the current pressures on budgets and resources within the NHS, the advanced nursing role is likely to remain and develop. But there is little evidence for more than this and none specifically addressing the issue of whether or not the advanced nursing role adds something different, something of intrinsic value

to the service; as alternative rather than substitute. In addition, whilst general practitioners, members of the practice and wider nursing team and patients have been asked what they perceive to be the contribution and value of the advanced nursing role, so far, nurses have not been asked what they feel their unique contribution might be.

## 2.9. <u>Study question and objectives</u>

The research question grounded in the literature review is;

How do nurse practitioners, working in general practice, perceive and articulate the contribution and value of their role?

This primary research question will be explored through the following broad objectives;

1   To articulate the scope and development of their individual roles.

2. To explore how NPs perceive they contribute to the organisation and delivery of services in general practice.

3. To explore how the NPs perceive their role impacts on patient care in general practice.

4. To consider how the NPs perceive their role impacts on other members of the practice team.

5. To articulate the meaning the nursing element of the role still has for nurse practitioners in general practice.


The first four will be discussed in detail in broad themes each within a single chapter whilst the last, how it feels to be a nurse in this role, will be allowed to permeate through the other themes. The findings are presented in chapters five to nine.

The next chapter will focus on the approach taken to the study, how it was framed within an epistemological and theoretical framework and how it was constructed and delivered.

This chapter will detail the epistemological and theoretical underpinning of the study, how data were generated and how thematic analysis was utilised to explore and interpret that data. It will conclude with a discussion of the ethical dimension and rigour of the research process.

## 3.1. Introduction

The decision about which approach to take, qualitative or quantitative, focused on the type of data to be produced.  The intent, born of personal interest and the findings of the literature review, was always to explore how nurses articulated their roles, the meaning it had for them and how they perceived this had value to patients, the wider professional team and the profession. Whilst the review of literature in this field has demonstrated that quantitative research can identify value in raw terms of access to care, cost-effectiveness and patient satisfaction it could not discriminate or appraise the hidden potential of having nurses working in advanced roles in general practice. It could not articulate if or what value this new nursing role adds to general practice. Only a qualitative approach can illuminate these issues.

Qualitative research encapsulates a spectrum of co-terminus and overlapping epistemological approaches, schools and movements all guided by the belief that the purpose of scientific enquiry is not, as the objectivists would have it, just about revealing possible truths (Denzin and Lincoln 1988).  It is about how truths are constructed through interactions between individuals and their subjective world, what they mean to those individuals and how they are experienced (Robson and McCartan 2016a). It is less concerned with investigating situations or events which can be measured or observed objectively, instead focusing on questions which offer the potential for insight and explanation whenever and wherever there is a gap in understanding (Wilson, Williams and Hancock 2000).

The choice of research approach depends upon the purpose of the research endeavour, the researcher's own philosophical assumptions about the nature of reality (ontology) and the best way of enquiring into the nature of that reality (epistemology)

(Kartas-Ozkan and Murphy 2009). As it relates to this project the ontological question is concerned with the nature of advanced nursing practice; what it is. The approach taken is inherently relativist, expressing the view that there is no single way to know advanced practice, rather a number of socially constructed alternative realities (Snape and Spencer 2013). In identifying and describing the research design, reference will be made to Crotty's (1998a) four elements that inform a research study; method, methodology, theoretical perspective and epistemology.

## 3.2. Epistemological Approach

Epistemology is concerned with the nature of knowledge; how the phenomenon under consideration is known and understood. The approach taken is interpretive and inductive. Interpretivism rejects the view that it is possible to conduct value free, objective social research instead asserting instead that the researcher must explore and understand phenomena through the participants and their own perspectives (Snape and Spencer 2013). The approach which has best fit is social constructionism. This considers how nurses working in advanced roles have constructed their new realities, their beliefs and explanations and what effect this has on patients in their care, other individuals within their sphere of practice and indeed, upon the profession of nursing.

Whilst social constructionism (SC) emerged from the interpretivist paradigm, its sociological roots arise from Berger and Luckmann's (1966) "The Social Construction of Reality". They argued that reality is not an objective fact or truth but is produced and communicated; it is socially constructed. They portrayed everyday life as a reality interpreted by individuals and subjectively meaningful to them. They described it as an "intersubjective" world, one shared with others, emphasising the need for individuals to continually interact and communicate with others. Berger and Luckman (1966) recognised the face-to-face situation as the most important experience of everyday life and one from which all other interactions derive. Central to this are 'sign systems' and principal amongst these is language,

> ..everyday life is above all, life with and by means of the language I share
> with my fellow men (p51).

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Social constructionism as it is used now has been influenced by Kenneth Gergen, a social psychologist and highly respected social constructionist since the 1970s. He identified salient themes central to a constructionist perspective (Gergen and Gergen 2003, Gergen 2009). Firstly, Social Constructionism takes a critical stance towards 'conventional' scientific knowledge. Whilst not suggesting that traditional science is unimportant, he emphasised the view that it cannot explain the world in its entirety, nor can it reveal universal truth. He asserted that understanding is not dependent on empirical validity so important in the positivist / modernist stance; rather that it rests on linguistic, historical and cultural opportunities and circumstances. Gergen (2009) further described a crisis of "**value neutrality**", a weakening of belief in the attainable impartial observation so prized in scientific enquiry and which has contributed to its lofty position and authority in Western civilisation. He considered that science can never be objectively accurate, that all investigators have values and opinions and their conclusions are inevitably shaped by them.

Secondly Gergen challenged the idea of the 'individual knower', of a rational, self-directing agent of change. Rather he described a **communal view of knowledge**, one that is shared, understood and proliferated by members of a specific discipline, professional group or culture. Thomas Kuhn's influence is seen here, with the proposition that knowledge in any discipline or professional group depends on a shared commitment to a paradigm (Kuhn 1962). The emphasis shifted from the individual mind as the source of knowledge and understanding to a belief in its grounding in communities and shared relationships (Gergen 2009).

Thirdly, Gergen acknowledged centrality of language as vital to the construction of meaning and knowledge. He drew extensively on the work of Ludwig Wittgenstein, a significant 20th century philosopher who identified **shared language** as pivotal in ensuring shared understanding of objects or events occurring within a specific community. He suggested that "language games" are a linguistic exchange created and rehearsed to ensure our descriptions and explanations are mutually understood. The games are rule-based; they develop reliable and predictable patterns and form vocabularies (Gergen 2009). This broad view of language as being communally created

and culturally specific is congruent with the work of Kuhn; and places shared language at the heart of community life, or indeed at the heart of Kuhn's view of paradigms.

### 3.3. <u>Constructionism or Social Constructionism</u>

Gergen (2009) identifies the critical difference between constructionism or constructivism and *social* constructionism as the location in which meaning develops. Constructionists see meaning as constructed or construed within the minds of individuals. For social constructionists meaning is communally constructed, within and through social interactions, in community relationships.

Social constructionists argue understanding is generated between individuals and groups in the course of everyday life, that knowledge is fabricated, 'constructed' through social interactions of all kinds but particularly through language (Burr 2003). Furthermore, SC suggests that there are "knowledges rather than knowledge", indicating that a phenomena can be described in several ways, giving rise to different and multiple ways of interpreting and understanding it (Willig 2008).

It can be seen then that social constructionism is inherently relativist; it accepts the legitimacy of different views of phenomena and makes no judgement about them (Crotty 1998b). It does not confine reality to one view or one truth, but perceives a multiplicity of realities constructed by different people as they interact with phenomena and with each other. More than this social constructionism claims that ways of understanding are culturally and historically relative; meaning that it is specific to particular cultures and periods in history (Burr 2003). This is seen in the way views, perspectives and beliefs change over time and how certain ideas and practices are acceptable in some cultures but not in others.

This 'way of knowing', the generation of meaning through social interaction is particularly relevant to this study. Advanced nursing practice is perceived as the construct, one that is fabricated through repeated interactions, one that is culturally and historically relative, one that changes over time and context and one from which it is possible to draw a multiplicity of meaning and reality. What exists depends on an individual's interaction, interpretation and understanding. The nature of nursing is not

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seen in an enduring substantial form, but rather it exists within socially constructed schemas which inevitably change across history and context.

### 3.4. Theoretical Perspective

Symbolic interactionism (SI) has already been identified as a major influence on the development of social constructionism as an epistemological paradigm. It is a theoretical perspective originating with the work of the American pragmatist philosopher George Mead (1934) in the early twentieth century and further developed by his student, social psychologist Herbert Blumer in the 1960's. It provides a useful lens with which to view the research study and its outcomes. It is described by Burr (2003) as emphasising the construction of the social world and meaning through the human use of symbols in communication, most importantly language. Blumer (1979) utilised and developed Mead's work, suggesting that SI is based on three premises. Firstly that human beings act towards objects based on the meanings that these objects have for them. Objects can be thought of as *physical* - trees, chairs, houses; as *social* – mother, friend, student or as *abstract* – morals, beliefs and ideas. Secondly, that the meaning of these objects is derived from or arises out of the social interaction the individual has with other people. And finally, meaning is handled in and modified through an interpretive process. SI does not see the meaning as emanating from either the object or the individual but rather as arising from the process of interaction between people. And out of this process of interaction emerges common meaning. As Blumer (1979) states:

> .. objects in the sense of their meaning must be seen as social creations.. as being formed in and arising out of the definition and interpretation as this process takes place in the interaction of people (p11)

This focus on meaning as a social product of interaction is pertinent to this study; it occurs first at the level of interaction between nurse and patient or nurse and fellow clinicians, where meaning is constructed and again at that of interviewer and interviewee, where it is revealed and interpreted. The role of the researcher is to understand and interpret these multiple constructions.

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### 3.5. **Methodology**

Methodology is understood as the theory of how research should proceed to produce valid knowledge about the social world or phenomenon under consideration (Braun and Clarke 2013). Crotty (1998a) describes it as the strategy, plan or design behind the choice of methods; Strauss and Corbin (2008) as a way of thinking about and studying social phenomena, Braun and Clarke (2013) as the framework within which research is conducted; Silverman (2006) as the choice we make about cases to study, methods of data gathering, the planning and executing of a research study. Silverman (2006) further suggests the methodology can be broad, i.e. qualitative or quantitative, or narrow, i.e. grounded theory or conversational analysis. All qualitative methodologies share a common purpose; to understand a phenomenon from the perspective of those experiencing it (Vaismoradi, Turenen and Bondas 2013).

When first reflecting upon my research interests, I considered focusing on how nurse practitioners articulated their role in general practice; what they considered to be the enduring elements of nursing which bridged the gap from basic registration to the extended role. Discourse analysis would have been my preferred approach had this been my final enquiry. Having explored the literature this seemed to unnecessarily narrow the focus and as I broadened this to include exploration of their perceptions of value, I considered other approaches which might be more appropriate. Interpretative phenomenological analysis (IPA) linked theoretically to phenomenology seemed likely to limit the discussion to an individual subjective experiential account rather than the interpretation of the role I was seeking. Grounded theory, with its focus on understanding the phenomenon in its entirety rather than interpretation of the many different facets of the concept, again seemed to constrain my project aims (Braun and Clarke 2006). After some deliberation I determined that the approach which most closely reflected and incorporated my theoretical and epistemological stance was Thematic Analysis (TA). The term 'approach' is used here to differentiate it from the narrower term 'methods'. This indicates that TA is used deliberately and positively as a strategy which incorporates a small sample of research participants selected purposively, a data collection method which facilitates close interaction between researcher and participant, and a comprehensive analysis method which both

manages and makes sense of the data (Snape and Spencer 2013). This is consistent with a broad qualitative interpretative paradigm.

The debate around the use of thematic analysis focuses on whether or not it is simply a set of techniques or tools to analyse qualitative data or something more, an entity in its own right, in the way that discourse analysis is considered a distinct methodology because it adopts an explicit social constructionist approach to qualitative data (Wetherell, Taylor and Yates 2001). In comparison TA has traditionally been viewed as an analytical tool to be used within other methods (Boyatzis 1998, Attride-Stirling 2001). Boyatzis asserted that TA was simply a process for encoding qualitative data and defined three stages of enquiry,

> recognising an important moment (seeing) precedes encoding it (seeing it as something) which in turn precedes interpretation (p1)

Braun and Clarke (2006) were the first researchers to claim TA as a method in its own right, describing it as an "accessible and theoretically flexible approach to analysing qualitative data" (p2). The flexibility they describe enables TA to be utilised within different research paradigms; inductive, theoretical, experiential and constructionist. Of these, constructionist TA, focusing on how meanings and experiences are actively formed through interactions and co-constructions within the social world, is congruent with the epistemological and theoretical perspectives of this study (Braun and Clarke 2013). Similarly TA it is not prescriptive in terms of data generation or collection.

### 3.6. Methods

Research methods are broadly described as the techniques or procedures used to gather and analyse research data. They are understood to include recruitment to the study, the sampling frame, the interview schedule, data generation and data analysis. They will be described here in detail, enabling readers or researchers to follow and audit my research journey.

### 3.6.1. Recruitment to the Study

The research focused on nurse practitioners working in general practice. To recruit nurses from across the United Kingdom an invitation to participate was issued via the Royal College of Nursing Advanced Nurse Practitioner (ANP) forum discussion zone and

a poster display at a national ANP conference. The ANP forum is comprised of members of the RCN working at advanced level, appointed to assist the college in developing strategies for future direction of advanced nursing practice. The forum website hosts an online discussion zone accessible to nurse practitioners across all areas of the NHS. The invitation to participate in the research prompted interest from across the United Kingdom and responses were returned via the zone administrator. The ANP national conference was open to RCN members and non-members similarly working across all sectors, together with nurses who may be considering a career change to advanced practice in all its forms. The poster display at the conference enabled me to speak to individual nurses who expressed an interest in the study and obtain contact details and some information about their current roles and experience. This was useful when deciding who and how many nurses to interview.

Only nurse practitioners working in England were interviewed. This was a pragmatic decision based on having sufficient interest from nurse practitioners within England and the limitations of time and distance to travel in order to conduct face to face interviews (appendix 2).

Sixteen expressions of interest were received from the initial approaches and of these eight were selected to interview. It was anticipated at the beginning that between eight and ten interviews would be optimum to ensure criteria for selection of participants were achieved. These criteria are detailed in section 3.6.2.

Little definitive information is available to guide a decision concerning numbers to interview; rather the literature talks of achieving 'saturation'. This means sampling continues until additional analysis no longer contributes anything new about a concept. In this way resulting theory is considered conceptually dense and grounded in data (Schwandt 2001). Whilst this is a helpful definition from the conceptual viewpoint, it provides little practical guidance prior to data collection. Guest, Bunce and Johnson (2006), in their review of qualitative interviews, suggest that data saturation has mostly occurred by the time twelve interviews have been analysed and after that new themes emerged infrequently. They further suggest that basic themes are present as early as six interviews.

### 3.6.2. <u>Selection of Study Participants</u>

The research participants were selected using purposive sample techniques. Purposive sampling is defined by Crookes and Davies (2004) as,

> ..judgemental sampling that involves the conscious selection by the researcher of certain subjects or elements to include in the study (p 232)

In essence purposive sampling allows the researcher to choose a case or participant based on feature or features identified as being pertinent to the study. It demands careful thought about the study population and consideration of potential similarities and differences which may be important (Joffe 2012, Silverman 2013). ) It should also be acknowledged that the sampling strategy can be limited by other factors, in particular by time and resources (Silverman 2013).

Judgement about these features was grounded both in the personal experience of the researcher and the literature review. I wanted to interview nurses who had a range of experience and qualifications and who worked across a broad spectrum of general practices. The following characteristics were considered when making sampling decisions.

1.  Professional qualifications – nurses with recognised professional NP qualifications and those who had developed roles in-house were included.
2.  Length of experience as a nurse practitioner –from recently qualified to several years in practice
3.  Nurses working as a single nurse practitioner and as part of a team of NPs in practice
4.  Practice profiles – general practices with different list sizes and populations; training and non-training practices, urban, sub-urban, variation in list sizes.

Time and distance to travel to conduct interviews were factors. I interviewed most of the nurse practitioners in their workplace during their lunch breaks or time away from their clinical duties. I interviewed two participants in London rather than in their home towns on the South Coast.

From the expressions of interest it was possible to identify those potential participants who were working in clinical roles in practice and also obtain some preliminary

information relating to my prerequisite sample characteristics. Three of the nurses who expressed an interest were declined as they were still in training, 3 because they were working outside of England and a further 2 because of duplication of participant characteristics.

As the research progressed and themes began to emerge from the data, I identified and approached a nurse practitioner who had both a clinical role in practice and a national strategic role to participate in the study. I felt this would offer the project a different standpoint, a broader overview of professional practice on a national stage. In addition two nurse practitioners who had been in clinical practice and had moved on to other roles were approached and invited to participate in the project. The aim here was to try and explore another perspective; to determine whether or not the views of the nurses currently in practice had resonance with those who had moved on from the role and also to try and identify any gaps in the data. Interviews were conducted with one NP who had moved into a clinical role in urgent and unplanned care and one who had moved into practice management.

### 3.6.3. Data Generation

It was determined that the most appropriate way of accessing rich naturally occurring data around advanced nursing practice was face-to-face interview. Interviews are used extensively in qualitative research. They are described by Kvale and Brinkmann (2009) as an attempt to,

> ..understand the world from the subjects' points of view, to unfold the meaning of their experiences, to uncover their lived world (p1)

Interviews can range in type from structured and formal to unstructured and conversational; the latter offering greater opportunity for exploring meaning and perspective (Fontana and Frey 2008). The interviews in this study were determinedly semi-structured, aiming to facilitate an in-depth or intensive interview. Charmaz (2006) defines their value in research as allowing,

> ..in-depth exploration of a particular topic or experience, and thus, a useful method for interpretive inquiry (p.2).

In this project the aim of the interviews was to ask the participant to reflect upon his or her nursing practice, not simply in a descriptive way but to probe and generate data which conveyed what she felt the role added to the service and what meaning the nursing element still had for them as professional nurses.

Alternative methods of generating data were considered. A postal or online survey was a potential means of achieving a large sample and therefore a wider range of views, but it lacked the facility to gather the depth of data and meaning which interviews offered. (Robson and McCartan 2016b). Similarly focus groups are useful when the researcher wants to gain a range of views about a specific issue. They were discounted mainly because of their inability to generate in-depth data but also because of the logistics of gathering sufficient nurses from a wide geographic area together at a specific time.

### 3.6.4.  The Interview Schedule

The interview schedule was constructed around the aim and objectives of study (see introductory chapter and literature review). Each was translated into two or three questions which aimed to probe experience and prompt reflection and personal perspective. There are therefore thirteen questions, five of which covered basic demographic data, qualifications, general practice profile and specifics of their individual nursing roles. Subsequent sections considered what the advanced role added to general practice, how it affected other members of the team, the wider effect on the profession and how nursing in the advanced role felt to the individual NPs (appendix 3). The questions were mainly broad, open-ended and non-judgemental. Charmaz (2006) suggests that the style of interview should be conversational, that the researcher must engage with the process by asking for clarification, shifting the conversation and "*following hunches*" where necessary.

I piloted a shortened interview schedule with two nurse practitioner colleagues; one of whom worked in my own general practice and one in a neighbouring practice. Interviewing was new and uncomfortable and transcribing was time consuming but the overall process was invaluable in clarifying my thoughts about the final project.

### 3.6.5. Data Collection

The interviews were conducted at the participants' place of work or an agreed site during their free time. The volunteers were offered no inducement to participate, consent forms and information about the project were initially e-mailed to each potential participant and a written copy signed before the interview took place. The interviews lasted between forty and ninety minutes. The interviewees were given pseudonyms for the purpose of the research report.

All interviews were digitally recorded. Whilst using field notes to record the major themes and answers could have been employed it was felt that this would be intrusive, interrupt the flow of the interview and as a single researcher, could potentially miss important information (Willig 2008). Al-Yateen (2012) suggests that the process of recording can in itself affect the interview because the participants may not engage fully or naturally if they are aware of or concerned by having their words, opinions and attitudes recorded, but this was not the case in this study. It seemed as the interview progressed that participants were less aware of the recording equipment and more relaxed. Being interviewed as an experienced professional nurse by another professional nurse may have helped this process.

All transcriptions of the digitally recorded interviews were stored securely with their pseudonym codes on a personal password protected computer.

### 3.6.6. Data Analysis

As already identified the research approach incorporated Thematic Analysis (TA). It appears from the literature that there is no single unique way of conducting TA, rather different authors suggest different methods; Attride-Stirling (2001) utilises thematic networks, web-like illustrations of basic themes, organising themes and global themes which summarise the main concepts of a piece of text. Guest, MacQueen and Namey (2012) describe their *applied* thematic analysis as drawing from a range of theoretical and methodological perspectives with a focus on making analysis "transparent, efficient and ethical" whilst utilising an "expanded toolbox" of different analytical tools.

For the purpose of this study I have adopted Braun and Clarke's (2013) stages of thematic analysis (1) transcription; (2) familiarisation with the data set; (3) generation of initial codes; (4) searching for themes; (5) reviewing themes; (6) defining and naming themes; and (7) writing and finalising analysis. This appears to offer a useful framework for a novice researcher and one which should ensure the process is transparent.

Interviews were recorded and transcribed by the author. Although this was a laborious procedure involving many hours of careful transcription, it was considered an invaluable experience, facilitating complete immersion and familiarisation with the data. Active re-reading is advocated by Braun and Clarke (2006) coupled with note taking as a means of beginning to identify codes and understanding the data.

Codes are the basic element of the analysis process. Two types of codes are identified within thematic analysis; semantic and latent. These identify a 'level' at which coding will take place; semantic codes are descriptive, exploring the explicit or surface meanings of the data and making no effort to explore beyond this. In contrast, analysis at the latent level allows researchers to go beyond the rational and obvious content of the data and construct meaning (Braun and Clarke 2006). Analysis of this kind is congruent with a constructionist approach exploring and theorising about meanings which underpin what is actually articulated in the data. Production of initial codes from the data involved identifying a feature, a word, a concept which was interesting or surprising. It was helpful to consider Auerbach and Silverstein's (2003) criteria for identifying relevant text for coding;

- Does it relate to your research concern?
- Does it help you to understand your participants better? Does it clarify your thinking?
- Does it simply seem important, even if you can't say why?

At the outset of the project I intended to use the qualitative data analysis software, NVivo, to create codes and themes. It appeared from the literature to offer a means of consistent coding, storage and retrieval of data (Bergin 2011). However it quickly became apparent, as Fielding and Lee (2002) suggested could happen, that the

distance between me as researcher and coder and the data increased and I became preoccupied with the process of coding rather than the codes themselves. Nvivo was abandoned early in the analysis and instead I highlighted words and phrases and from duplicate transcriptions began the laborious process of cutting and pasting words into a large journal. This 'in vivo' coding, using words and short phrases directly from the transcripts is considered appropriate for all qualitative methods and particularly useful for novice researchers (Soldana 2009). It maintained my connection with the original data and matched with longer data extracts which explained the code. Literally hundreds of codes were identified and recorded. Braun and Clarke (2013) term this process, *'complete coding'* (p210) the identification of *'anything and everything'* (p206) of interest or relevance within the entire dataset.

When this process was completed, codes began to be collated at the broader level of provisional or *'candidate'* themes. These are intended to capture something that is recurring in the data, a pattern; something that unifies the codes and something meaningful in relation to the research question. Braun and Clarke (2013) define the difference quite simply,

> A good code will capture one idea; a theme has a central organising concept. (p224)

Good themes need to make sense alone and fit together to form a coherent analysis. They need to tell a convincing story of the data and one that reflects the research question. Identifying candidate themes is not a passive process; they do not emerge from the data. Rather it involves active engagement of the researcher with the data, an ability to make choices about interpretation and a willingness to let go of the organising structure of the research question and go where the data leads (Braun and Clarke 2013).

Themes can relate to each other in different ways; laterally or hierarchically. In hierarchical relationships there is an overarching theme which organises and structures the analysis and below this a number of nested themes and subthemes. An example of the coding process is presented in (appendix 4). Mapping themes visually through relational diagrams is advocated as a way of 'seeing' the data but I struggled with this until quite late in the study. My early mind maps were simplistic and the

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result of trying to fit data into a pre-conceived thematic framework; a consequence of being an experienced nurse practitioner and a novice researcher.

Themes were reviewed and revised several times over the course of the study as my supervisory team asked for deeper and richer coding and interpretation of my data. It was an arduous process but each revision brought new meaning and understanding until I felt I had faithfully captured the essence of the realities of advanced practice for my participants.

In the same way that themes were constantly revised throughout the course of the study, the chapters, each a platform for a single theme, were constantly revised and redrafted to ensure theoretical and conceptual cohesion. To ensure they honestly reflected the data analysis and the perspectives of the participants.

An important aspect of the study was to ensure that it was ethically sound and conformed to the highest standards of quality and integrity. To ensure this I have addressed ethical considerations identified within the Economic and Social Research Council (ESRC) framework through Beauchamp and Childress' Four principles (Beauchamp and Childress 2008).

A research proposal was submitted and approved by the Faculty Research Ethics Committee. A copy of this can be found at appendix 5.

### 3.7. Ethical Considerations

Beauchamp and Childress's Four Principles approach is a widely used framework for examining ethical considerations inherent in health care and in research. One of the guiding principles 'respect for autonomy' acknowledges the individual's right to deliberate self-rule; the right to make decisions based on personal deliberation. This requires researchers to obtain the participants agreement to participate before the study begins, and describes an obligation that that consent should be 'informed' (Beauchamp and Childress 2008). A copy of the participant information and consent forms and can be viewed in appendices 6 and 7.

The consent form contained a specific statement detailing the right of any individual to withdraw from the study at any time without giving reason and without prejudice.

One participant did invoke that right and withdrew from the study after data collection.

Confidentiality is the implicit promise that personal information, including all the data produced in the course of the interview will be protected and private (Beauchamp and Childress 2008). Keeping this promise shows respect for the individual's autonomy. In accordance with this principle all interview data was anonymised and each participant given a pseudonym at transcription. Only demographic details including length of time in the NP role, experience and qualifications were included in the analysis.

Beauchamp and Childress' (2008) two parallel principles of non-maleficence and beneficence also guided the research process. Non-maleficence, essentially 'first do no harm', ensures that potential adverse effects for the research participants are considered. It was not anticipated that the research questions would pose any harm but discussing sensitive information about personal, professional practice can be uncomfortable. None of the participants asked for the interview to be halted or showed any distress. There was no potential benefit for the individual participant; there was no inducement, personal or financial, for the nurses to take part in the study. They all expressed the view that they wanted to be part of a process exploring the contribution of their own profession to the service of general practice.

### 3.8. Ensuring and Enhancing Rigour in Qualitative Research

All research raises issues of trustworthiness and rigour. Qualitative research is concerned with meaning in context, it is subjective; it requires an active engagement between researcher and data which rejects neutrality and objectivity. In their landmark text, 'Naturalist Enquiry' in 1985, Lincoln and Guba asserted that criteria generally used to evaluate quantitative research, validity, reliability, and generalisability were not meaningfully applicable to qualitative research, replacing them with new concepts of credibility, dependability and transferability. Others disagree, suggesting that the criteria still have relevance but must be operationalised differently to take into account the different framework, process and outcomes of qualitative research (Mays and Pope 2000).

**Validity** refers to issues of truth, the extent to which an account accurately reflects the social phenomena it is describing (Hammersley 1998). This is translated in qualitative research into *credibility*, defined by Ulin, Robinson and Tolley (2005) as,

> ..confidence in the truth of the findings, including an accurate understanding of the context. (p25)

Corbin and Strauss (2008) suggest this can be assured if the researcher provides clear evidence of the data collection and analytical processes so that readers can follow and assess how findings or conclusions were reached. In addition there should be sufficient detail so that readers can decide for themselves whether findings are credible or not. The aim then is to create transparency in all the research processes, from sampling through to final analysis so that the truthfulness of the process and the findings can be assessed by all who read or review. One way of ensuring this is to use a qualitative research evaluative tool. I considered Tracy's (2010) 'eight big tent criteria for qualitative research and Yardley's (2000) 'open-ended, flexible' principles; both of which offered a worthy overview but did not appraise the process of analysis in any detail. As I had chosen Braun and Clarke's (2006) model of thematic analysis to organise and make sense of the data, it seemed appropriate to use their '15 point checklist of good thematic analysis' (p96) to ensure the process was conducted methodically and accurately. Using quality criteria to evaluate qualitative research is controversial. Bochner (2000 p269) suggests that a focus on criteria has as its subtext a tacit desire to "authorize or legislate pre-existing or static set of standards that will thwart subjectivity and ensure rationality". Whilst this is clearly against the principles of qualitative enquiry Tracy (2010 p839) suggests a more pragmatic view, proposing that evaluative criteria, "..are useful. Rules and guidelines help us learn, practice, and perfect". And that when handled sensitively they do not detract from the rich interpretation and complexity of the research.

Cresswell (2014) suggests eight procedures which help to establish credibility in qualitative research and recommends that researchers engage in at least two. These include thick description, triangulation, peer review and member checking. Of these, 'member checking' is generally considered an important means of improving a study's credibility (Cresswell 2014, Lincoln and Guba 1985). This involves returning data,

analyses, interpretations and conclusions to the participants so they can judge the accuracy of the account developed by a researcher or research team (Creswell 2014). Member checking was not included in the design for my study. It is most useful in phenomenological studies where the aim is to record as closely as possible the experiences of the individual. In social constructionism however, where the researcher is actively involved in interpreting the data, member checking is largely redundant. The analysis is not intended to be a reflection of the participants' experiences as they understand them, rather an interpretation situated within the subjective paradigm. External scrutiny of the project was an important part of that interpretation and included debriefing with my supervisory team and presentations to other students and peers. The fresh perspective these offered, the challenges to coding, interpretation and analysis, were invaluable.

**Reliability** is generally understood to mean the extent to which the research findings could be replicated if another study using the same of similar methods was undertaken (Burr 2003). This has less importance than validity in qualitative research because replication is generally not the aim. Significantly, a social constructionist paradigm, based on the premise that there are multiple realities created by individuals in natural settings and that those settings and contexts change over time rejects any concept of replication. Instead of reliability then, words such as consistency and accuracy have been suggested although the most commonly utilised surrogate is identified by Guest, MacQueen and Namey (2012) as *dependability*. According to Ulin, Robinson and Tolley (2005) dependability refers to,

> whether the research process is consistent and carried out with careful attention to the rules and conventions of qualitative methodology.

Shenton (2004) recommends that the final report should contain sections devoted to a) the research design and its implementation b) the operational details of data gathering c) a reflective appraisal of the project. These elements enable readers to assess the extent to which appropriate research practices have been followed. My report contains each of these elements and would enable the study itself to be repeated.

**Generalisability** refers to whether or not the results generated in one study could be meaningfully applied to different populations (Braun and Clarke 2013). It is the operationalisation of the quantitative standard of external validity. In qualitative research *transferability* describes the extent to which some aspects of a specific study could be transferred to other groups of individuals or contexts. Qualitative researchers seldom concern themselves with this as the main aim of most studies is to provide a rich contextualised understanding of human experiences (Polit and Beck 2010). However, transferability can be enhanced through a collaborative approach. In essence, this means that it is the researcher's role to provide careful description, that detail Lincoln and Guba (1985 p316) describe as 'thick description', which allows the reader to make judgements about extrapolating findings to their settings and communities (Polit and Beck 2010). Within this project, participant characteristics and general practice demographics have been described in detail (chapter five, appendix 8).

Detailing the boundaries of the study is also important in increasing the potential for transferability, for example, the number of participants interviewed and the time period over which the data was collected. But ultimately the results of my study need to be understood within its context; general practice and the characteristics of its participants; nurse practitioners. It is rare for qualitative studies to be repeated in other settings; rather the findings contribute to an overall understanding of the phenomenon under investigation (Shenton 2004). Complimentary studies, whether they support or contradict my findings, would add to the understanding of the multiple realities of the advanced nursing role in general practice.

A further important issue and one that receives much attention in the quantitative/qualitative debate is the potential for the researcher to bias the findings of the study. This relates to the personal and often informal interaction between researcher and participant and is more of a concern in interviews than in, for example, fixed response surveys (Guest et al 2012). The recommendation of many acclaimed researchers and theorists is to be reflexive and admit how their presence may have affected the data collection process (Finlay 2002, Corbin and Strauss 2008).

### 3.9. <u>Reflexivity</u>

Reflexivity is the process of explicitly acknowledging the personal and political values which the researcher brings to the project. Finlay (2002) describes reflexivity as a thoughtful, conscious self-awareness. In research it refers to the continual evaluation of subjective responses. It occurs from recruitment to completion of the research process, it demands that personal impact on the process is made transparent. And more than this it is about using personal attributes and knowledge consciously to facilitate the research process. Sharing personal and professional values with participants, rather than biasing the outcomes increases trust and disclosure and can have positive benefits. Indeed Taylor (2001) suggests that separation of researcher from the research is impossible, that the researcher should remain self-aware and attempt to understand how his or her presence, attitude and identity can influence the situation. The researcher is at the same time participating in and interpreting the data. This is not seen negatively, as a potential bias, but simply as a position to be acknowledged.

There will be further examination of my personal reflexivity in chapter four.

This chapter has located the study within a qualitative interpretive paradigm, framed and understood through social constructionism and symbolic interactionism. The further detail about methodology or strategy underpinned the choice of research methods. Finally the chapter detailed ethical considerations which promote integrity and quality and began the process of understanding how rigour in the research process can be enhanced through concepts of credibility, dependability and transferability. The next chapter will discuss reflexivity in greater detail focusing on my role as researcher within the study.

# Chapter four: Reflexivity

As already described in chapter three, reflexivity is a concept central to qualitative research. Braun and Clarke (2013) determine that it occurs when the researcher acknowledges and reflects upon his or her active role in the research process, on how personal values, interests and standpoints have affected the construction of new knowledge. Whilst the importance of reflexivity is not in doubt, there are concerns from some authors about its feasibility (Corbin and Strauss 2008). Cutliffe (2003) suggests that we cannot completely account for that active role when so much of what transpires occurs at a deeper introspective level of consciousness. Our opinions, beliefs and attitudes are so much a part of who we are that they are not always fully recognised or understood.

Nevertheless reflexivity remains a valuable instrument. Willig (2008) suggests there are two types of reflexivity, personal and epistemological which are central to the research process. The first brings the researcher into the research, making us a visible part of the process and encouraging us to reflect upon the ways in which our own values, experiences, beliefs, wider aims in life and social identities have shaped our work (Braun and Clarke 2013)  It also involves thinking about how the research has changed us as people and researchers.

Epistemological reflexivity requires us to engage in questions about process, such as how has the research question defined and limited what can be 'found'; how has the design of the study and the method of analysis 'constructed' the data and the findings. This encourages us to reflect upon the assumptions we have made in the course of our research, assumptions about the world and about knowledge itself and the implications of such for the research and findings (Willig 2008).

These concepts of personal and epistemological reflexivity will be considered in relation to four aspects of my research journey; my road to advanced practice, a novice researcher and the research process.

### 4.1 <u>My Experience of Advanced Nursing Practice</u>

Coming from a general practice background, encultured into the rhetoric of evidence-based practice, I am grounded professionally in the positivist paradigm. Quantitative research, hard 'evidence', guides my everyday practice; which clinical pathway I follow for the problem I am dealing with, which medication has the greatest evidence of effectiveness, which intervention has the greatest chance of success. And in amongst all of this it is easy to lose sight of other important features of practice; what meaning health and illness have for individuals, what other factors impact on the effectiveness of any management pathway I might choose.

That positivist view has also coloured my view of my profession. I have been preoccupied with concerns about quantitative expressions of worth to general practice; number of patients seen, QOF points achieved and I have ignored other aspects of the role which might have value but cannot be expressed in numeric or economic terms. But in the course of my doctoral journey I have reflected more and more on the basis of the evidence I have utilised and trusted. And the exposure to more qualitative enquiry has been significant in how I practice now and in the research project I chose to pursue.

As a first step in the process of reflexivity, I should as Braun and Clark (2013) suggest, acknowledge who I am and describe the similarities and the differences between me and my research participants. We are all women; there seem relatively few male nurse practitioners in general practice and none answered my call for participants. I have been a qualified nurse for 33 years, having trained under the apprenticeship system before degrees were commonplace. As a practice nurse for thirteen years in a small urban practice straddling a deprived council estate and an area of more affluent private housing I performed task-based activities delegated to me by my general practitioner employer; tasks such as dressings, childhood immunisations and some health education activities such as smoking cessation. I enjoyed the role immensely and would probably have remained there had the opportunity for transition to a nurse practitioner role not been offered. I started work as a nurse practitioner in training in 2001. This is what I bring to the project.

## 4.2  A Novice Researcher

In my nursing field I am considered if not expert then a highly proficient nurse practitioner. I am well qualified; I work autonomously within a multidisciplinary general practice team and I represent my profession at national level as a member of the steering committee of the RCN Advanced Nurse Practitioner forum. I am respected and valued within my team and my professional sphere. But it was not always so. And I remember clearly the anxiety generated by transitioning to that new role fifteen years ago.

The process of becoming a researcher, was not, as Benner (1984) suggested, a passive, direct path from novice to expert. Rather my path was more naïve to novice. I had little understanding when I started of the impact this process would have on me and the enormity of my undertaking. It was, as is so often and so casually stated, 'a steep learning curve'. I maintained a reflective journal throughout the research process, using it to record my first impressions of each interview, of meetings, of items I read and found illuminating. It also recorded moments of panic, of doubt, when I did not feel I was making any sense of the data, when I was being too inflexible in my thinking. I am an experienced nurse practitioner, accustomed to dealing with the uncertainty of nurse consultation, but this was new and uncomfortable. I wrote in my journal,

> "Really struggling.  My interpretation of the data seems not to be detailed enough. "Interrogate the data" is the mantra. And I am trying but I just don't see what they (*my supervisors*) see." (5<sup>th</sup> May 2014).

This had resonance with my experiences as a novice nurse practitioner. This journal entry was written within the first months of starting my new role.

> My entries have become infrequent. I think to some degree that reflects my concern with my role. I dare not commit my feelings and reflections to paper. If I do the weight of doubt and anxiety may overwhelm me and I would give up. This role is so huge, there is so much uncertainty, so much I don't know and I fear it will never be better. (14<sup>th</sup> March 2002)

The reflexive process involves a deep introspection, an inward gaze into each interaction.  Journal-keeping has been suggested as an effective way of developing this personal reflexivity, of recording those thoughts, activities and emotions which help to develop self-awareness and promote reflexivity (McGhee, Marland and Atkinson 2007).

The road from naïve to novice researcher is necessarily time limited, work progressed and I began to understand and see what my supervisory team had so little difficulty seeing. Just as my path as a nurse practitioner took me from those early anxious days to a calmer and more confident place.

### 4.3  The Research Process

I decided quite early in the process of thinking about my project that social constructionism was the approach I wanted to take. Of particular importance was the premise that meaning is communally constructed, within and through the commonplace social interactions of everyday life. And further that there are multiple realities, constructed between individuals, realities which are context specific and which change over time. I perceive nursing in advanced roles to be such a construct developed and understood differently between individual nurses and their patients across general practice.

Symbolic interactionism was an important element of the overall approach to the study. It helped to focus on the importance of symbols in nursing and in particular of language in the narratives. The language of nursing has long been a fascination for me. To hear nurses speak of their professional roles and their deeply held beliefs about nursing and its value, is inspiring. In addition there was an interesting incorporation of the symbols of medicine into their advanced roles; the prescription, the stethoscope, the auriscope. And an abandonment of that most visual of all symbols of nursing; the uniform. The impact on patients was interesting and explained their frequent confusion about whether they were consulting with a doctor or a nurse.

### 4.3.1. *Interviews*

Locating personal standpoint in the research process is important when aspects of who you are and what you believe are so relevant to the study. I was a nurse practitioner and researcher interviewing other nurse practitioners. This 'insider' status can affect the process both positively and negatively; what Mercer (2007) describes as wielding a 'double edged sword'. As an insider it is argued that there is a better understanding of the social setting, that familiarity and a shared history can lead to a stronger rapport with the research participants and this in turn can lead to more meaningful insights.

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But the opposing view suggests that researchers may have difficulty dealing with their own preconceptions about the phenomena under investigation and may unduly influence the entire research process.

This was a continual worry for me. From my journal,

> My concern remains that I am giving their thoughts a meaning they did not intend.

I acknowledged my 'insider status' to the nurses I interviewed. Having them know that I was a nurse practitioner familiar with the context and pattern of their working lives, understanding their concerns and fears about clinical practice because I had experienced the same concerns and fears, made the interview more informal, almost conversational at times. It seemed on some occasions more like two professionals reflecting on their common practice. As a result it was difficult not to see the participant stories through the lens of my own experiences. It seemed that being so close to the phenomenon under investigation made it difficult to listen critically to other professional voices without immediately confirming or criticising them with my own. It was necessary sometimes to view the data with intentional detachment.

According to Burr (2003), reflexivity endorses the principle of equal status in interviews, partners in the co-construction of meaning. It did not always feel like that. Certainly in the first interviews when I was nervous and quite formal, it seemed that my participants were sometimes deferring to me, explaining their practice and looking to me for affirmation or approval. I knew some of the questions about their own practice could be quite sensitive but did not expect to perceive my participants as vulnerable within the process, seeking sanction from me.

### 4.3.2. *Data coding and analysis*

My early coding was not comprehensive and I was attempting to fit my coding into a view of the nurse practitioner role which I held to be true. I found it easier to classify data- driven, semantic codes which described what was happening rather than really interrogating the data to develop meaning. After discussion with my supervisory team I was encouraged to review and recode the data with no preconceived ideas of where

it was leading. This was a liberating moment and resulted in much greater depth and numbers of codes generated.

I attempted to use Nvivo in the early stages of coding, a process which did show some early promise, at least as data storage. But I find I am a more textual than visual learner and the screen views were limiting and not conducive to theme organisation. I therefore resorted to cutting and pasting in vivo words or phrases and other data I considered important, into a research journal / codebook.

As part of the process of immersing myself in the data I listened to the recordings over again and I was struck by how many times my response was "I never thought of it in that way". My preconceptions of what value the role might have were challenged at that early point in the process but it was still some time before those views stopped affecting my interpretation, before I allowed myself to be open and receptive to the narratives.

An important element in managing this closeness to the data and the phenomenon was my 'reflective commentary'. Throughout the project I journaled about my impressions of the interviews, my early difficulties with coding and the importance of suggestions by my supervisory team. For example, a dual coding exercise in which I coded a section of the transcription in parallel with one of the more experienced coders within my team was a cathartic moment for me and led to recoding of large sections of my data. Whilst this inevitably lengthened the research process significantly, it was important to code comprehensively, to get the foundation right. I recorded my feelings as the themes emerged and my sadness as the analysis proceeded. And sometimes there would be if not 'lightbulb' moments then at least moments of such clarity that I could understand and interpret what was being said and revealed to me and begin to make some sense of the experiences of these nurses.

A difficult moment in the study was when a participant who had been interviewed told me she wanted to leave the study and that her interview data should be excluded. It was particularly disappointing as I had specifically asked her to participate because she had left advanced nursing and I anticipated she might offer a different perspective. I admit I was initially quite angry and frustrated but had to remind myself that whilst my

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focus was my research, it was simply not a priority for others. Nonetheless, it was difficult to forget what she had said and the impact that had on my data.

The next chapter will introduce the participants to the reader focusing on the selection criteria which were considered important in the sampling framework; qualifications, experience of working in the general practice environment and practice demographics. It will also introduce the overall structure of the themes as they relate to the central concept of the nurse practitioner role.

How the participants were recruited to the study is outlined in chapter three. Characteristics of the participants can be viewed in matrix format in appendix 8.

### 5.1.1. Participant One

**Dawn** had been a registered general nurse for thirty years at the time of the interview. After qualification she was a staff nurse in secondary care then following a career break to have children, she returned to nursing part-time as a practice nurse.  She spent ten years in this role, undertaking various courses; travel health, child immunisations, family planning and cervical cytology to support her work.  For the last ten years Dawn had been a nurse practitioner.  As she trained before first degrees were widely or locally available she continued to study and accrued enough credits to be awarded a degree, a composite of stand-alone modules including autonomous practitioner and nurse prescribing courses.  She did not have a Masters' degree.

Dawn initially worked as the first and only nurse practitioner in her practice, although a second NP had recently been appointed.  Her general practice served 16,000 patients, with a clinical team of six GP partners, two salaried GPs, one NP three practice nurses and one health care assistant (HCA).  The practice covered a predominantly suburban population, with high levels of private housing but also extended to a small village nearby where they had a branch surgery.

Dawn's role within the practice was predominantly to manage minor illness, but she did hold two surgeries per week for patients with long term conditions who needed medication reviews.  In her acute role, she together with her NP colleague, managed telephone triage each day, responding to same day requests for appointments.  Her main workload was with minor self-limiting illness, anything more complex was referred on to the GP. She could not refer to secondary care or request X-rays.

### 5.1.2. Participant Two

**Mandy** had been a registered general nurse for twenty four years at the time of the interview.  After qualification she had worked as a staff nurse in secondary care, a

sister on a minor injuries unit and then for NHS Direct as a team leader. For the last eleven years she had been a nurse practitioner. Mandy did not have a first degree, but had completed a post graduate diploma which included the autonomous practitioner module. She was a nurse prescriber.

Mandy was appointed together with another nurse practitioner as the first advanced nursing roles in their practice. It served a deprived urban population of approximately 4500 patients. There were 2 GP partners, 2 salaried GPs, A GP registrar in his final year, one Foundation Year 2 doctor, medical students, 2 NPs, 2 practice nurses and a part-time HCA. It was a training practice.

Mandy's role in the practice was predominantly acute first contact care; though she did have responsibility for a small housebound caseload and a management role in relation to the wider nursing team. They did not have a telephone triage service within the practice. Mandy was not involved in management of long-term conditions. She could refer to secondary care.

### 5.1.3. Participant Three

**Ellie** had been a registered general nurse for thirty one years at the time of interview. After qualification she worked as a staff nurse in secondary care in paediatrics and neonatal intensive care. She became a practice nurse after a career break to have a family. She had been a nurse practitioner in general practice for nine years. Ellie had a first degree, a composite of stand-alone modules and nurse prescribing. She did not have a Masters' degree.

Ellie was the only NP in her practice. Her general practice had 10,000 registered patients in a mixed urban/suburban area. The clinical team comprised 5 GPs, two female salaried GPs on job share, 2 GP registrars, one Foundation Year 2 doctor and medical students. It was a training practice. Ellie lead a nursing team comprising 4 practice nurses and 3 HCAs. She also had responsibility for some administrative work. She could refer to secondary care.

Ellie's role varied to some extent, dependant on whether or not there were GP registrars and junior doctors in the practice. When they did not have doctors in training her role was predominantly managing minor illness. She was also clinical lead

for respiratory disease and had clinics for patients with COPD and asthma. She had a small housebound caseload of patients with long term conditions who could not attend the practice premises.

### 5.1.4. <u>Participant Four</u>

**Naomi** has been a registered general nurse for twenty three years at the time of interview. After qualification she worked as a staff nurse in intensive care. She worked as a practice nurse for six years and had been a nurse practitioner for three years. She had an RCN accredited Masters' degree as an Advanced Nurse Practitioner.

Naomi was the first and only nurse practitioner in her general practice. It was a small practice, comprising 3300 patients with a staff of one full time GP, a locum GP who helped out at busy times, a part-time practice nurse and part-time HCA.

Naomi's role in the practice was approximately fifty per cent acute first contact care including telephone triage, and fifty per cent management of patients with Diabetes Mellitus.

### 5.1.5. <u>Participant Five</u>

**Sandra** had been a registered general nurse for thirty years at the time of interview. Following qualification she was a staff nurse in secondary care for five years before becoming a practice nurse. She had been a nurse practitioner for eight years. Sandra had a first degree composed of stand-alone modules including Autonomous Practitioner and Independent Nurse Prescriber.

Sandra was the first and only NP in her general practice. It was an urban practice comprised 17,500 patients and included an area of high social deprivation. The practice was divided across two sites. There were 7 GP partners, 2 salaried GPs, 1 nurse practitioner, 5 nurses and 6 HCAs.

Sandra's clinical role in the practice was approximately thirty per cent acute first contact and seventy per cent management of long-term conditions. Within the former she managed mostly minor illness and the latter mostly diabetes. There was an element of administration involved in her role; she managed the monthly prescription claims and was responsible for some QOF work. She was also responsible for the wider

nursing team, training and rotas. She did retain some elements of her previous practice nursing role, and would undertake smears, childhood immunisations and dressings opportunistically as required.

### 5.1.6. Participant Six

**Gaynor** has been a registered general nurse for twenty years. Following qualification she worked as a staff nurse in private homes and residential care before leaving clinical nursing to work in education. She completed a degree in health and social care before returning to practice nursing. She had been an NP for five years. She had completed a Masters' Advanced Nurse Practitioner degree.

Gaynor's practice comprised 7000 patients in a geographically diverse area covering a deprived town centre and more affluent suburban and village areas. The practice had 3 partners, one NP, three practice nurses and 2 HCAs. The practice trained GP registrars and foundation year 2 doctors but there were none in post at the time of the interview.

Gaynor was involved in first contact care and managed any undifferentiated presentations to practice. She did not manage long-term conditions. She was responsible for the nursing team, including their annual appraisals and training. She was also included in the daily on-call rota for the practice but did not do any home visiting.

### 5.1.7. Participant Seven

**Barbara** had been a registered general nurse for twenty seven years at the time of interview. After qualification she worked as a staff nurse in oncology and care of the elderly before taking a short career break. She returned to nursing as a practice nurse. Barbara had been a nurse practitioner for two years. She had a Masters Advanced Nurse Practitioner degree.

Barbara's practice had 3000 registered patients in a mixed inner city area. They were the named practice for the homeless in the area and also served a fairly affluent population. The practice currently had two part-time GP partners, one NP, one practice nurse and a HCA.

Approximately fifty per cent of Barbara's clinical workload was care of the acutely ill. Her remaining surgeries were predominantly long term conditions such as Diabetes and Asthma. She also managed some of the practice nurse workload including smears and wound dressings.

### 5.1.8. Participant Eight

**Claire** had been a registered general nurse for thirty six years at the time of interview. After qualification she had worked as a staff nurse in nursing homes and a community hospital before having a complete career break for eight years. She returned to nursing as a practice nurse. She had been a nurse practitioner for eleven years. She had a Masters' Advanced Nurse Practitioner degree.

Claire's practice has 13,500 registered patients across two sites, a large city centre practice and a smaller suburban branch surgery. There were 7 GP partners, between 4-6 GP registrars in post at any time, 2 NPs, 4 practice nurses and 2 HCAs. It was a training practice.

Claire's clinical role in the practice was completely focused on acute care. She had no involvement in the management of long-term conditions except when the nurses needed assistance with complex polypharmacy. She also managed the nursing team.

### 5.1.9. Participant Nine

**Jane** had been a registered general nurse for thirty five years at the time of interview. After qualification she worked as a ward sister and clinical teacher before a career break. She returned to work as a practice nurse. Jane had been a nurse practitioner for eighteen years; ten of those in general practice. She had completed a BA RCN accredited Nurse Practitioner degree and a post graduate diploma in emergency care.

Jane's practice had 14000 registered patients and served an affluent semi-rural population. There were 6 GP partners, one salaried GP, 2 ANPs, one NP, practice nurses and HCAs (number not specified). It was a teaching practice for medical students only.

Jane's clinical role in the practice involved both management of long-term conditions and acute care. She had particular responsibility for patients with Diabetes.

### 5.1.10. Participant Ten

Mel had been a registered general nurse for forty one years at the time of interview. After qualification she was a staff nurse and subsequently emergency care practitioner in an Accident and Emergency and Minor Injuries Unit. She had been an NP for fifteen years initially in a GP practice but for the last five years in nurse-led unscheduled care. Mel had a Masters' degree.

Mel's GP practice had 14000 registered patients in an urban practice. There were 5 GP partners, 2 NPs and three practice nurses. It was not a teaching practice.

Mel's role in general practice was to manage undifferentiated presentations to the practice, she delivered acute clinics each day. Her role in unscheduled care was the same. She worked with a team of two other ANPs, seven or eight NPs and health care assistants delivering unscheduled and acute care to patients unable to access general practice in or out of normal surgery working hours.

## 5.2. Research Findings

Following analysis of the data, four distinct themes relating to the nurse practitioner role in general practice were identified. These were; **nuts and bolts of the NP role, the general practice appointment, the nurse practitioner consultation** and **negotiating professional relationships.**



- new team structure
- overcoming barriers
- building a new role

negotiatng professional relationships

nuts and bolts of NP role

- working as an NP
- developing as an NP

Value of NP role

the nurse practitioner consultation

the general practitioner appointment

- seeing the bigger picture
- keeping it nursing
- building relationships
- showing their human side

- booking the system
- opting for the NP apointment

**Figure 2**
Themes

These themes will be explored in detail in the following four chapters beginning with a broad examination of the role of the nurse practitioner in general practice.

This chapter explores the why, what and how of advanced nursing practice; individual journeys, the scope and boundaries of roles and how they have been constructed within the context of unique practices and the wider NHS.

This will focus on two overarching themes; **working as a nurse practitioner** and **developing as a nurse practitioner.**
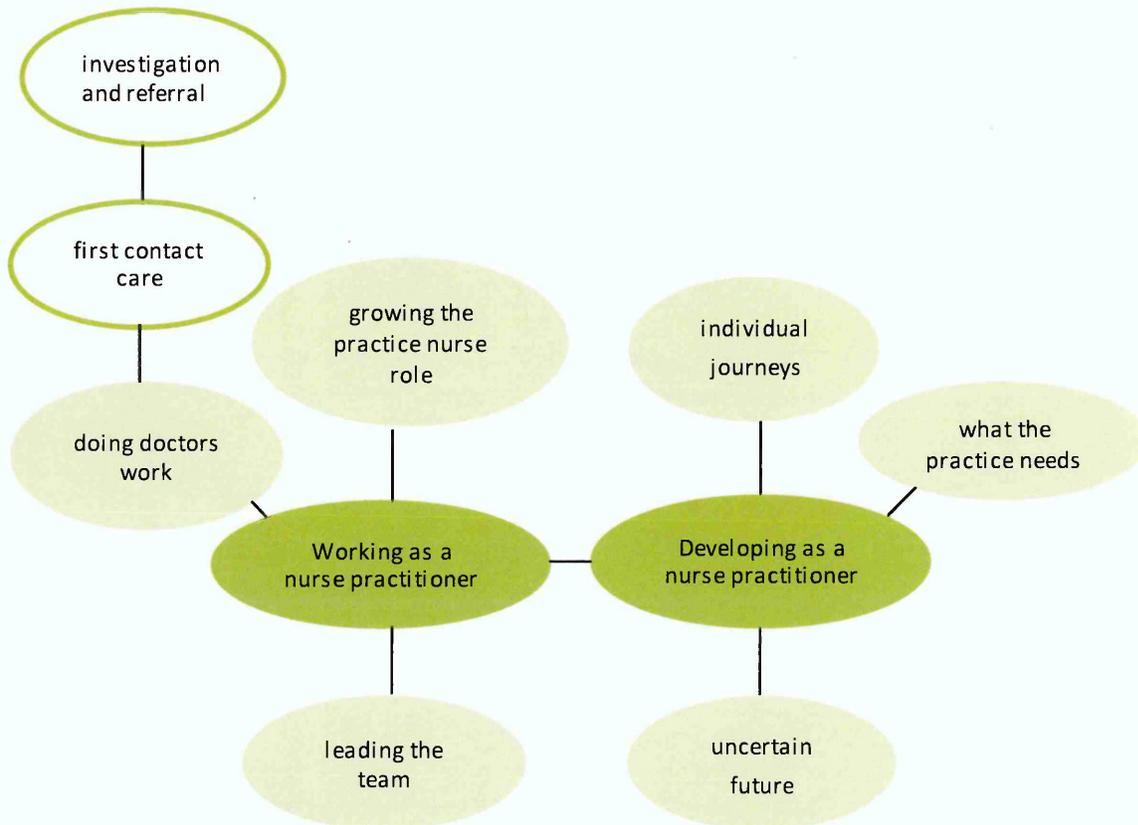


**Figure 3**
The NP Role

There is much discussion of the nurse practitioner role in the literature without there being a clear understanding of who is taking on advanced practice and what the boundaries of that practice actually are (Barton 2006). In general practice there is an

acknowledgement that nurse practitioners work as "generalists" alongside their medical colleagues (RCN 2012). But whilst this defines the context of the role, it does not explain the scope.

## 6.1. <u>Working as a nurse practitioner</u>

This explores the construction and clinical parameters of the role in terms of **doing doctors work, growing the practice nurse role and leading the team.**

### 6.1.1  Doing Doctors' Work

#### 6.1.1.1  *First Contact Care*

For most of the life of the NHS, GPs have provided the first point of contact for the majority of patients with health needs (Laird 2004). The political drivers of the early years of the 21st century changed this and encouraged nurses to take on duties previously seen as the remit of GPs; providing first contact care in walk-in centres, unscheduled care settings and general practice (Department of Heath 2002, Laird 2004).

First contact care is the core business of general practice; defined by the European Society of General Practice/Family Medicine (WONCA Europe 2011) as,

> ..the point of first medical contact within the health care system, providing open and unlimited access to its users, dealing with all health problems regardless of the age, sex, or any other characteristic of the person concerned. (p8)

The introduction of the nurse practitioner role has seen this core work redistributed. First contact care for patients with acute health problems has become an integral part of the role for all the nurse practitioners interviewed. As Barbara remarked,

> What we do as NPs is all stuff traditionally done by doctors.

There was marked variation in the type of acute first contact work being undertaken by individual nurses. Those NPs who had undertaken in-house training through their practices, specifically identified management of minor illness as a key part of their role. Minor illness is any time or self-limiting health problem which generally does not

require further intervention or repeated consultations; examples of these might be otitis media, acute coryza and influenza.

> I think when I first did the minor illness course it took the minor illness away from the GPs, things like chest infections, UTIs, post-coital contraception, it took that away from the GPs. Ellie

> Most days I do minor illness. And to be honest it's stuff that GPs shouldn't be seeing anyway. So it's your coughs, your colds, people have decided in the morning they are desperately ill, you know they're not, but they come in. Sandra

> ..colds, chest infections, muscle pain and strains, rashes, menstrual problems although I usually have to pass those on to the female doctors, ear aches, sore throats. Dawn

Dawn perceived her role as managing the common, self-limiting presentations most of which she admitted "*will get better with time anyway*", but acknowledged her own professional limitations when stating that anything more complex would be referred to her GP colleagues. Ellie recognised that she was managing a component of traditional medical workload which she had taken away from GPs and Sandra, doing the same, suggested that GPs, with their level of clinical skill, should not be seeing patients with minor illness. She recognised also the inevitability of seeing patients whose perception of their symptoms was overstated; that they sometimes thought they were "desperately ill". Interpreting a symptom and placing it in the context of minor or more serious disease is difficult for individuals with no medical knowledge. Yet there persists a professional irritation at this mismatch between what individual patients' think of as a condition or symptom worthy of review by a clinician and what clinicians perceive as an 'inappropriate' use of services (Morris, Cantrill and Weiss 2001).

It is known that consultations for minor illness place a significant burden on the clinical resources of general practice and the use of high cost health care settings places a significant financial burden on the NHS (Fielding, Porteous, Ferguson, Maskrey, Blythe, Paudyal, Barton, Holland, Bond and Watson 2015). There have been attempts to shift this burden of care by encouraging self-care and utilising the skills of community pharmacists. And yet much of the work of first contact care in general practice is still managing minor self-limiting illness, albeit shifted to other clinicians within the team.

Clare was rather disparaging of NPs who managed *only* minor illness.

> Some ANPs only do minor illness. I hate that term. Because we have (GP) registrars they usually manage most of the minor illness to be honest. So on the odd occasion when I see an earache or a UTI, I'm surprised.

Barbara, Gaynor, Mel, Claire and Naomi who had completed specific nurse practitioner training were willing to see any undifferentiated presentation to general practice. This meant that they would consult with patients presenting with any undiagnosed symptom or problem.

> I see any undiagnosed new problem so I see new patients every day; I do the same as the GPs. I do a walk in clinic every morning and they can see me in the same way as the GP. Gaynor

Being on the front line in this way, working alone, making autonomous decisions which if wrong could cause harm to a patient, was difficult. This was outside the scope of their previous nursing roles and they admitted they had found it daunting. But this is what general practitioners were trained to do and what nurse practitioners had to learn if they were to absorb some part of the medical role. Dawn talked of her early experiences.

> It was so different. I had been a practice nurse for ten years; I knew my role, nothing in my surgeries phased me at all. Then after a period of training and supervision I was out there, a nurse practitioner, desperately trying to manage these ill people. In a consulting room, alone with a patient, expecting me to sort their problem out. I wondered how on earth I was ever going to do it.

Participation in first contact care was central to the new role but clearly it was constructed differently across different practices. Some NPs were restricted to managing only patients with minor illness such as coughs, colds, sore throats and skin rashes, whilst others managed patients with any undiagnosed problem such as mental health issues or gynaecological problems. Even amongst those nurses in the latter group, they recognised they still had the safety net of a GP opinion if they were uncertain. But however the role in first contact care has developed or been constructed, it appears that in their individual practices these nurse practitioners had become the first physical connection between patient and general practice services, delivering care, as Gaynor asserted, "..*in the same way as the GP*".

### 6.1.1.2 *Investigations and Referrals*

In addition to delivering direct primary care services to their practice population, GPs are generally viewed as the 'gatekeepers' of the health service, deciding who is referred to secondary care or to other clinical services (Loudon 2008). Some of the nurse practitioners had taken on this work within general practice, making decisions about referral to secondary care consultant services, for invasive procedures such as gastroscopy, and complex investigative procedures such as 24 hour blood pressure monitoring or electrocardiography.

Again there were differences in what each nurse practitioner could do within their clinical role. For Gaynor and Claire there were no barriers to urgent or routine referrals, they were able to make the decision autonomously and refer without reference to their GP employers.

For others the process was either not within their scope of practice or problematic due to the attitude of other clinicians. Jane could recommend referrals but they had to be scrutinised at a weekly meeting with senior GPs before they could be approved and formalised. Neither Sandra nor Dawn were able to refer patients to secondary care.

> I don't refer to the hospital, they have to be seen by the GP, and I can't request x-rays, those have to be seen by a GP too. Dawn

Ellie's experience of making referrals was different and demonstrated a commonly reported frustration amongst nurse practitioners working in general practice.

> It depends on the consultant, some are happy to receive them (referrals). Some will write back to me personally whereas others if you do a referral they just write back to the GP and you don't get any follow up from those.

> And one consultant orthopaedic surgeon sent a letter back to the GP when I had made the referral. It said that he was discharging the patient with advice that if he needed to be referred again he should see a GP first. Mandy

Barbara expressed irritation with a similar situation in her practice.

> When I have made referrals which have been appropriate and signed, consultants then write back to the GP who then hands me the letter. So

> once I wrote back and...opened the letter with "thank you for writing to Dr
> X, in response to the referral I made.."

Whilst expressing frustration the nurse practitioners accepted the situation rather more quiescently than might be expected of individuals with the resourcefulness and mettle to pioneer new roles.

It seems that there is no regulatory or procedural guidance for nurse referrals; rather it is determined on a nurse by nurse basis. Dawn and Sandra, who had progressed from practice nurse to nurse practitioner within their practices, seemed content to leave referrals to the GP. And in their turn it might be theorised that GPs were happy to retain control over who was referred and to which services. Whether that is a financial decision, a means of retaining traditional power or demonstrates a lack of confidence in the nurse practitioners' judgment is uncertain.

For other nurses, for Barbara and Naomi, who had completed specific nurse practitioner training there was exasperation that their referral decisions, based on their assessments of the patient were not accepted by secondary care consultants or community teams. That for some referrals they needed GPs to, as Barbara commented 'rubber stamp' the decision before it could either be made or accepted. Here she explains her difficulties admitting an acutely ill patient to hospital.

> The problem I am having at the moment is that there is a team who does
> home visit (prior to admitting a patient to hospital). And they will not
> accept referrals from nurses. I had a heated conversation with them. I had
> done all the work, the GP hadn't even seen them and still they wanted the
> GP to refer....I have to have a GP to rubber stamp my referral which is
> ridiculous.

Why some secondary care consultants refuse to accept referrals made by nurses whilst others will accept, is unclear. An early study of primary care nurse practitioners and the interface with secondary care suggested that consultants were unaware of the parameters of their role and suspicious of their training and competency. That they were accustomed to working with clinical nurse specialists in various domains and felt more comfortable accepting referrals from them (Price and Williams 2003). Whilst this is quite dated research, the narratives of these nurses suggest that even after a further

decade of collaboration with NPs embedded in primary care, these attitudes have not significantly changed.

### 6.1.2. <u>Growing the Practice Nurse Role</u>

The management of patients with long-term conditions, traditionally the remit of the GPs, has shifted over several decades. The 1990 GP contract first proposed that with appropriate training, practice nurses could be more involved in the monitoring of long-term conditions such as Asthma and Diabetes (Department of Health and Welsh Office 1989, Rashid 2010). A long-term condition is one which cannot be cured but can be treated with medication and/or other therapies.

Whilst all of the nurse practitioners identified first contact care as part of their role, seven of the ten interviewed had time allocated to the management of long term conditions. Claire indicated that she was only involved at the "high end" of managing patients with long term conditions, in effect substituting for the GP when her practice nurse colleagues were unable to manage the condition further. Here Claire is managing medical complexity, making decisions about treatment and particularly about prescribing new medication.

> I do run the DMARDs (disease modifying anti-rheumatic drug) clinic myself, prescribing and managing the bloods myself. And I manage the high end of diabetes, patients who are commencing exenatide (injectable medication) or when the practice nurses are at the end of what they can do.

Barbara reported that half of her appointments were committed to care of patients with long term conditions whilst for Jane it was slightly less.

> So I do two thirds emergency clinics, one third long term conditions. We have two ANPs who practice at this level, my colleague is mostly family planning and minor surgery whereas I do much more chronic disease... I have had to become an expert in diabetes and I suppose asthma. Jane

In contrast, for Sandra and Ellie the majority of their clinical time was allocated to long term conditions; seventy and eighty percent respectively.

> There's only me doing diabetes. I'm the only nurse at the moment who does insulin and exenatide (injectable medication). I do the heart disease, I

don't want to do chest diseases, they keep asking me and I keep saying no. Sandra

I have always been the COPD (chronic obstructive pulmonary disease) lead so I still have that and the doctors refer all the COPD work to me.  Ellie

Both Ellie and Sandra had been practice nurses in their respective practices before becoming nurse practitioners. Indeed eight of the ten nurse practitioners interviewed had been in practice nursing before and most had retained and expanded their roles in the management of long term conditions; Claire in her DMARDs clinic and diabetes; Jane diabetes and asthma; Naomi, diabetes; Barbara, COPD, asthma, diabetes and Ischaemic heart disease. All had undertaken further disease-specific training to support their roles. The difference between how the nurse practitioners and practice nurses delivered care seemed to be about complexity, whether of polypharmacy such as Claire and Sandra mentioned when managing insulin initiation in patients with type 2 Diabetes Mellitus, or diagnosis when Ellie remarked that GPs referred patients to her. In general, practice nurses are not prescribers therefore their role is mainly confined to working to practice-based protocols, monitoring and identifying those patients with more complex needs who require referral to general practitioners (RCGP 2012). Whilst NP involvement in managing long-term conditions could still be interpreted as an expansion of practice nursing, it is the level of autonomy, of still managing within national guidance, such as NICE pathways, but with less prescriptive boundaries and more emphasis on clinical judgement which made it different; which made it congruent with recognised frameworks of advanced practice (RCN 2012b, DOH 2010).

### 6.1.3. Leading the Team

The nurse practitioner role was generally considered to be a senior role and responsibility for other nurses and health care assistants within the practice team was formally delegated to them by the GP.  There is no specific reason why a nurse practitioner should lead a practice nursing team. Certainly none of them had received specific training for the role rather they had assumed responsibility by virtue of higher grading.

How they viewed this 'lead' role varied from nurse to nurse. Gaynor speaking about her appointment as a nurse practitioner had clear ideas about what her role should be within the nursing team.

> When I applied for this it was a first time application as a qualified nurse practitioner it was really that I was coming in purely as that role, not to be a practice nurse, not to be a handmaiden but to be an NP and team leader.

The reality of her role within the team was described later.

> I lead the nursing team so I take responsibility for ensuring they (practice nurses) are here, they are doing the job right, they have adequate training. I do their PDRs (personal development reviews) every year, their rotas and ensure the nursing service runs smoothly. Gaynor

Sandra expressly did not say "lead" but rather that she "managed" the wider nursing team within her practice.

> I manage the nursing team, it's really about looking after the training, we have quite a lot of healthcares (healthcare assistants), six or seven, two on each shift if we can, and they have to be trained in chaperoning, phlebotomy, ecgs, minor surgery, BPs. Sandra

The nurse practitioners generally seemed to view leadership and management as synonymous constructs. Sandra described a task orientated approach which involved her in personally training and supervising other members of the team. Gaynor, describing similar responsibilities, considered herself to be a team leader. Managing a team implies skill-based planning and organisation of service delivery whilst leadership suggests less focus on day-to-day tasks and more on inspiring and motivating staff within the team structure. Rather than synonymous they are actually complementary constructs (Lau, Cross, Moss, Campbell, De Castro and Oxley 2014).

Few of the nurse practitioners played any part in the strategic management of the practice. None were nurse partners. Only Gaynor, Claire and Naomi claimed to have any direct involvement in the strategic management of the team, Naomi spoke about her involvement at practice level.

> I think you're looking at leadership really...I think it's about leading change, looking at service delivery as a whole, looking at not just this is what we do now but how can we improve, what is it we are missing? Look at how the

nursing team works as a whole, how can you improve moral, how can you improve the service.." Naomi

Gaynor described being part of a developmental process within her practice.

We are just coming to the end of a consultative period with the nurses, due to finances, and that showed..we weren't using the nurses in the best way and we weren't really getting value for money. We have nurses who are being paid high grades and not really using their skills to the best effect. It hasn't gone down particularly well but we're working with them.

Gaynor's role here is interesting. She spoke warmly of leading the team. And yet here, in a very public management role she was, in her own words, "the one firing the bullets", in the reorganisation of the nursing services. Rather than being a nurse leader and advocate it appeared she was doing some of the 'dirty work' of the practice, standing as proxy for her GP employers. Again it should be emphasised that none of these nurses were partners or had a financial interest in their practices.

A wider leadership role was described by Claire and Jane. Claire held a strategic role with her local Clinical Commissioning Group, the NHS organisation responsible for primary care commissioning within geographical areas. Jane held a role at national level within general practice organisations and lobbied for recognition and regulation of the advanced nursing role. They felt that their leadership was crucial inside and outside of the practice and that they provided a powerful nursing role, as advocate for teams and the wider profession.

Leadership, I think we have an enormous role to play, being able to look at situations in a broader wider political context as well as the practical. It's all very well being a good clinician but being able to step outside that and...have an eye beyond the consulting room, thinking about policy and practice and how to improve things. So externally you are informing people who are full time policy makers, that what they are talking about does not fit with the reality of day to day practice. And being able to come up with real patient stories that can reinforce what we are trying to do at a national level. Jane

These two roles, accepted and encouraged by their practice teams, take leadership, the modelling of the advanced role and a nursing voice to another level, to a national stage. Few nurses will have this opportunity but being part of this process is important.

The puzzle of the advanced role in general practice is how it has been constructed and developed in the way it has. None of these areas, clinical, leadership, management and

training are mutually exclusive. Individual nurses were performing an eclectic mix of tasks and activities. Scope and boundaries of practice were fluid and roles varied across individual practices.

Some of these nurses, like Mandy, Claire and Gaynor, described their roles in practice as *"working in the true sense",* which they interpreted as substituting for doctors, providing acute first contact services traditionally seen as the territory of medical practitioners (Rashid 2010). Indeed Gaynor described herself as *"an extra GP basically".* Others seemed to be working at an expanded nursing level, building on the role of the practice nurse in preventative health, managing long-term conditions and some minor illness, rather than extending too far into the role of other practitioners. This is an interesting division of medical work when one considers that before nursing established a presence in general practice, general practitioners would deliver all immediate care to patients whether for acute or long term conditions. How this has occurred, what the internal and external drivers were, will be now be explored.

## 6.2. Developing as a nurse practitioner

This will be discussed through three themes; **individual journeys, what the practice needs** and **uncertain future.**

### 6.2.1. *Individual Journeys*

The interviewees had taken different professional paths to their current advanced nursing role. Dawn, Ellie and Sandra had not studied recognised nurse practitioner degree courses but had completed a combination of modular learning and in-house training.

> I had quite a lot of chronic disease experience in various practices (as a practice nurse). Then they sent me on the minor illness course and that was how I got into the nurse practitioner bit. I had a lot of mentorship in practice, went to do my prescribing and top up modules. I had a lot of support from GPs. Ellie

> ...autonomous practitioner module at university, but a lot of the work I'm doing is built up through years of experience, like recognising tonsillitis, coughs and colds. Listening to chests was just done by listening; we have a training stethoscope so we could listen in with the GP and asking what he could hear and what I could. Sandra

..autonomous practitioner module at university and other modules including prescribing to make up a degree. Most of the examination skills I learned at university and have been expanded by the doctors here. Dawn Gaynor had an MSc Advanced Nurse Practitioner qualification and had spent time working with GPs, studying and working as a practice nurse until her training was finished. Mel completed a Royal College of Nursing accredited nurse practitioner first degree, followed by a generic Masters. Naomi and Barbara had completed RCN accredited Masters' level advanced nurse practitioner courses. Those nurses who had undertaken approved and accredited training voiced real irritation at the way the role has been allowed to develop. They felt that the lack of regulation of the role and protection of the title 'nurse practitioner' had contributed to confusion amongst both patients and professionals about what an NP could or could not do. That it had devalued their work and personal commitment in undertaking extended academic and clinical training. Gaynor explained it in this way.

> It makes me quite angry the validation of nurse practitioners, it does make me quite cross because the level I work at and others call themselves nurse practitioners and don't do anywhere near that level of training. And the work we had to do to get through the course was really difficult.

Their preparation for the role also seemed to have been a factor in the way the individual nurses defined and enacted their scope of practice. As already discussed some of the nurses had undertaken first degree or Masters level qualifications in advanced practice, most accredited by the Royal College of Nursing. These nurses perceived their role to be different, to be a nurse practitioner as Mel expressed it, *"working in its true sense"*. This she defined as,

> ...seeing patients with undifferentiated diagnoses, doing assessments, diagnosis, treatment plan and referral where necessary.

The nurses who did not have these qualifications in advanced practice but had worked towards either autonomous practitioner qualifications, first degrees not specifically for nurse practitioners or completed external courses and in-house training, had different parameters of practice. They did consult with patients with minor illness but there tended to be more selection of whom and what could be seen in their clinic sessions. They tended to undertake more clinics for long-term conditions such as Diabetes and Ischaemic Heart Disease, more task-based clinics such as cervical smears or chronic

wound care and more work which was not patient focused; administrative tasks, prescription monitoring, training and monitoring of less qualified staff. They too felt their role had value for the practice and patients.

There remained within the boundaries of practice some latitude for individual nurses to make the role their own. For those nurse practitioners joining practices which had no experience of the advanced role there seemed little understanding of its potential but great personal opportunity to, as Naomi stated,

> .. improve services and bring change and raise standards of care.

These were enthusiastic nurses who wanted to make a difference. They demonstrated vision and commitment in their willingness to extend the role. Barbara approached her GP to suggest a new service in which she would manage patients on warfarin. Others were willing to undertake extra training to provide more comprehensive services to patients; all the nurses interviewed were nurse prescribers, described by Mandy as *"essential to her role",* Ellie and Mandy visited patients at home, Jane had completed extra training to be able to provide new in-house services such as insulin initiation and prescribing of newer injectable diabetes medicines; Naomi had completely revised existing medical services,

> It (the service) was random before. So now patients will have a letter which
> will invite them and trying to arrange it so that reviews are done around
> the patient's birthday, so it's trying to give them some ownership so that
> they think another year older I need to get an MOT.

To what extent nurses were able to do this seemed to be a complex and fluid construct of some of the above factors together with aspects of the individual nurses' personality and skills. Sandra described herself as a *"forceful character",* who *"gets things done".* Claire reported her willingness to debate issues of nursing policy with her GP employers, asserting that if she felt a particular action was inappropriate *"she would not do it".* Many commented that they relished the challenge of the advanced role. Mandy stated that without the opportunity of the advanced role she would not have moved into general practice,

> ..there wouldn't have been something which would have been challenging
> enough for me. Because practice nursing wouldn't be where I would have

chosen to go, and that's not undermining practice nurses I'm just saying that wouldn't have appealed to me. So I think it gave me the opportunity to extend into things I would never have been able to do.

Within these individual narratives there appeared to be two distinct pathways to advanced nursing in general practice. Nurses with accredited first degree level or Masters' identified first contact, undifferentiated presentations to general practice as their main sphere of practice and felt that their academic preparation and training equipped them for this role. The practice nurses who progressed via the second pathway; in-house training with more limited formal academic preparation, managed mostly long term conditions and some minor illness. It seems reasonable to ask, are the second group actually advanced nurse practitioners or advanced practice nurses. Thought they share the same title, they do not work to the same level. Their domains of practice are complimentary with some overlap but they are not the same.

### 6.2.2 *What the Practice Needs*

General practice is unique within the National Health Service because individual practices are owned by the general practitioners and are sub-contracted to the wider service. They represent self-contained units of health service activity. How the service is organised is determined by the general practitioners and delivered in part, by nurses and administrative staff directly employed by them. They further determine the composition of the nursing team and whether services are delivered by medical or nursing staff (Charlton 2010).

Some of the nurse practitioners were frustrated at being asked to perform duties which they perceived to be outside the remit of the advanced role. Sandra was expected to complete monthly prescription claims for the practice and monitor the quality and outcomes framework (QOF) both of which directly contribute to practice income.

> I do a lot of the QOF work. At this time of year I am responsible for it and do the organisation, look at it and try to sort out where we're losing points and bring them in...the epileptics I sent out a lot of text messages yesterday and they should be ringing me back today, it's just the seizure frequency.

Ellie, who within her role still had to perform monthly electronic patient searches because nobody else could or wanted to, described herself as *"an expensive clerk"*.

She further commented that her role changed according to the composition of the medical team. When the practice had no registrars; junior doctors on general practice training schemes, she was expected to do more acute clinical work. When they had a full complement of GP trainees she was expected to take on more chronic disease activity and practice nursing tasks.

> ...time spent on acute illness depends on the registrars...when we only had one registrar it was nearly all NP stuff. Ellie

She admitted to a level of dissatisfaction with this situation.

> I suppose mainly I felt frustrated as for 6 months or more (when registrars were in post), I would be used for a few minor illness appointments and my free appointments would be used to fill in the gaps. The main frustration with this was that I was often given treatment room work and it was things like dressings and ear syringings which could just be slotted in, even phlebotomy and ECGs.

Nurse practitioners were commonly required to perform practice nursing tasks. Indeed some were delivering full smear or wound care clinics alongside their acute and chronic disease workload. They saw this as a poor use of their time and skills.

> I am at the moment doing some practice nurse work, smears, dressings, that sort of thing. I do not do baby vaccines or travel immunisations because I'm out of date. It's annoying really. I don't want to retrain as a practice nurse. Barbara

Evident in both of these statements is not only frustration at being unable to use newly acquired skills but resistance to being forced back into more task-based roles and a real concern about the risks of de-skilling. The practice nurse role is highly specialised, guidance on immunisation schedules change, smear taking procedures change and it is incumbent on nurses working in these roles to keep their skills current and competent. Having to move from one area of specialist practice to another is demotivating and hazardous. But the evidence that it happened captures the great dilemma at the heart of the new advanced role, nurses willing and able to develop advanced skills may still only be able to utilise them at the discretion of their employer.

Amongst the nurse practitioners interviewed, two, Mandy and Mel consulted only with patients with *"undifferentiated diagnoses"*. When asked why she did not have any involvement in the management of long term conditions, Mandy replied that,

..the role that I perform is not necessarily replicated in other GP practices..some of their nurse practitioners tend to be more focused on chronic disease management whereas in my role, because of what our surgery needs, I don't have much to do with that at all.

In Mandy's case, what the practice needed was first contact care; initial management of new presentations to the clinical team. Even though Mandy felt that this was an appropriate use of her skills it still demonstrates that the scope and boundaries of her role were externally constructed. That in effect she was still filling a gap in services. Her practice needed a nurse practitioner to manage first contact care. It would be reasonable to suppose that should other areas of clinical practice be deemed of greater importance, then her skills would have been channelled in their direction.

For some of the nurse practitioners interviewed "what the practice needs" defined their roles. Rather than being valued for the unique nursing contribution they could make to practice and patients, they became a stop-gap service for any other area of practice which was understaffed, taking on tasks at the discretion of their employer, the general practitioner. In most cases they perceived this to be inappropriate and a poor use of their advanced clinical skills.

Inevitably as employees working for and answerable to their general practitioner employers, nurse practitioners are constrained by the direction and goals their GPs wish to pursue. GPs make all the strategic decisions within the practice; they decide the composition and skill mix of the nursing team; they decide who may or may not be part of the management team; they decide when, where and how these nurses may practice and they decide how much latitude nurses are allowed when trying to change or develop services. It seems that despite advancing personal and professional skills, nursing remains locked in a system in which the role of the nurse is directed by those parties who have more influence in decision-making and policy direction (Turner, Keyzer and Rudge 2007). No wonder then that some nurses cling to the consultation as the place where advanced practice can be self-directed.

### 6.2.3. *An Uncertain Future*

The political climate which facilitated the introduction of the nurse practitioner role has been discussed in detail in chapter one. But the changing landscape of the

National Health Service and general practice in particular continues to influence the role on a day by day basis. In this current period of economic austerity general practice budgets are as vulnerable as any other sector of the NHS to enforced reduction and change. This in no small part affects the composition and performance of practice teams.

When discussing potential developments to her role as nurse practitioner, Naomi was advised by her general practitioner employer that it was impossible to plan or make changes as he,

> ..didn't know what model they (GP practices) would be working to in 2-3 years' time.

This demonstrated the uncertainty of general practice funding in the current political climate and the GP's concerns about future reorganisations within the wider health service.

Barbara noted that in her previous practice the general practitioners had allowed nurse practitioners posts to lapse and had taken on junior doctors in their second post registration year to fill the gap.

> ..by the time I had finished two had already gone and they hadn't replaced them. They didn't want NPs anymore and it was all down to money. Because they were a teaching practice they got junior doctors to do what we were doing and got some money for taking them on. And it was such a shame.

The 'junior doctors' in this scenario were qualified clinicians in foundation year two of their post registration training but may equally have been registrars beginning or completing their general practitioner training. They spend between four, six and twelve months working with the practice team. Neither are directly employed or paid by the practice.

Another future threat to the NP role in practice is the arrival of the physician associate (PA). PAs are being suggested as a possible "solution to overburdened general practices", a new health professional capable of carrying out face-to-face urgent and non-urgent consultations and management of long term conditions (Drennan, Halter,

Joly, Gage, Grant, Gabe, Brearley, Carneiro, de Lusignan 2015). Some of the nurses interviewed felt strongly that this role should remain nursing.

> In my opinion this is a nurse practitioner role. You need to know how to nurse patients before you can look after them at any advanced level. Mandy

> We are better attuned and pick up things that perhaps others (PAs) might not. I don't think just being science based means they'll be good at all other aspects of the job. Sandra

> PAs don't have the background. It goes back to nursing. It goes back to those people who make good nurses, who wanted to be nurses. This is not just about science. It's about being good with people, being good nurses. Ellie

Their opinion, that nursing offered something else to the role, that taking science graduates and teaching them clinical and communication skills reduced the role to a new task-based dependency on GPs was not the right direction for the NHS. Only Naomi perceived the role to have some benefits. She felt that there could be a place alongside nurses for physician associates. That they had one real advantage over nurses in advanced roles; that patients would understand what and who they were.

> I don't see it as a problem as long as the role is clearly defined and patients know what to expect from that person...The trouble is when you get a plethora of nursing titles and roles, patients get confused. At least with physician associate it tells you what it is.

Whilst the drivers of the past created the political climate for the increase in nurse practitioner posts in general practice, it seemed that the current austere economic climate was constraining them. Together with the challenges of a new clinical role in general practice, the Physician Associate, this has the potential to make nurse practitioner posts vulnerable.

## 6.3. Discussion

The title general practitioner is understood to define a medically qualified doctor providing a complete spectrum of care to patients within a community setting. The training and academic pathway is fixed, benchmarked and leads to a nationally recognised qualification. The role and duties may have some small differences

dependant on the location and character of their individual practices but when a patient presents to a GP they can be confident of the services he or she can provide.

It might reasonably be assumed then, in parallel with their GP colleagues, that all nurse practitioners working in general practice in the United Kingdom would have broadly the same role and duties. That they would have received broadly the same educational preparation and practical training. That they would have broadly the same skill set and be able to function in the same way whatever the setting or population.

The nursing narratives presented here do not bear out that assumption. The role seems to be a hybrid nurse/doctor construction with a pick and mix approach to acute and long term care and organisational activities which fails to articulate a single, generic nurse practitioner model. And as a consequence nurse practitioners are working in different ways in different practices.

It appears from the narratives that rather than one single generic representation of the advanced role there are multiple constructs dependant on various internal and external factors. For each nurse interviewed it is possible to theorise which of these factors; training, political or practice, has been the major influence in how the clinical role has been constructed. For Gaynor, her Masters' level academic and practice training has defined her scope of practice; Mandy had taken the opportunity offered by political changes to advance her role into general practice; Ellie had boundaries of practice delineated by *what the practice needs* and that changed according to the personnel in post and the availability of junior medical staff. Perhaps it is only in general practice that the role could develop in this way. Nurses here are directly employed and managed by GPs. In secondary care nurses working in advanced specialist roles are more clearly defined and perhaps significantly, both nurses and doctors are employees of the same acute trust. Issues of medical drivers and control of nursing at practice level may not be so obvious here.

It seems to me that the value of the advanced role in general practice as articulated by these nurses appears to be its flexibility. Worker flexibility has been defined as the number of different team tasks that a team member is able to carry out successfully (Molleman 2009). For nurse practitioners in general practice it encapsulates the

flexibility to undertake some of the tasks traditionally performed by medical colleagues; flexibility to undertake general nursing duties when required by the practice or the patient; even the flexibility to combine these with administrative or management tasks.

Interestingly the nurse practitioners reported feeling they had some measure of control and indeed viewed flexibility very positively. Autonomy seems to be a key concept here. Autonomy reflects the freedom an employee has to make decisions about the what, when and how of their role. Low level of autonomy suggests that the individual has no control over their work processes and high level that the individual perceives he or she has considerable freedom to make decisions concerning the arrangement of their work (Molleman 2000). These nurses felt they had a high degree of autonomy; that they had the freedom to decide what they were doing, when and to whom. Yet their narratives do not support this. Rather they demonstrate that they were often used to absorb other clinical tasks as and when the practice deemed necessary. Clerical work, immunisations, routine wound dressings are essential tasks within general practice but when performed by a nurse practitioner they are an expensive use of a highly skilled clinician. This devalues, even exploits the advanced role, using it to fill holes in a leaky service.

Perhaps as a result of this flexibility there is a vulnerability to the advanced role not experienced by other nursing disciplines in primary care. Nurse practitioners are susceptible as never before to the vagaries and changes in political direction. They have filled a gap in services left by a GP recruitment crisis and workforce changes. And as has been discussed, they are vulnerable to the development of new clinical roles such as the physician associate.

At a time when nurses are urged to define their unique contribution to health care, the role of the nurse practitioner seems to distort and confuse the debate. These pioneering nurses have taken on skills not traditionally the remit of their profession. They have developed new knowledge and new ways of working. But it is debateable to what degree nurses have *taken* these duties and roles rather than merely *assuming* those tasks which GPs see as dreary and routine and which they are happy and willing to shed.

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It is difficult to see what could change this situation. Some of the nurses interviewed bemoaned the lack of regulation. They perceived that only protection of the nurse practitioner title and a single unified professional and academic pathway would give them credibility, would define the boundaries of the role and reduce confusion and vulnerability. Yet there is an inherent tension here. Regulation might actually reduce the ability of these innovative nurses to deliver patient focused services. Regulation might thwart their flexibility to be what the practice needs. Regulation might not suit general practice and general practitioners because tighter controls on advanced practice could affect how they deploy their staff to fill gaps within their service. A consequence of regulation in this scenario might be to drive GPs back to investing in salaried medical practitioners where they are available, or to explore the potential of more dependent practitioners such as the physician associate.

Having explored the scope and boundaries of practice for these nurse practitioners, and the internal and external drivers which have helped construct their individual roles in practice, the next chapter will focus on the practice environment and their value to a patient journey.

This chapter will explore the contribution made by the nurse practitioner role to the organisation and function of general practice as articulated by the participants, with a particular focus on the appointment itself as the environment in which a clinical encounter between patient and professional occurs. General practice and the GP appointment system were described in chapter two, therefore, this chapter begins with a brief description of how nurse practitioners construct and deliver care in their surgeries. The findings will then be explored using the patient journey through general practice as lens, focusing on two overarching and interconnected themes; **'booking' the system** and **opting for an NP appointment**.
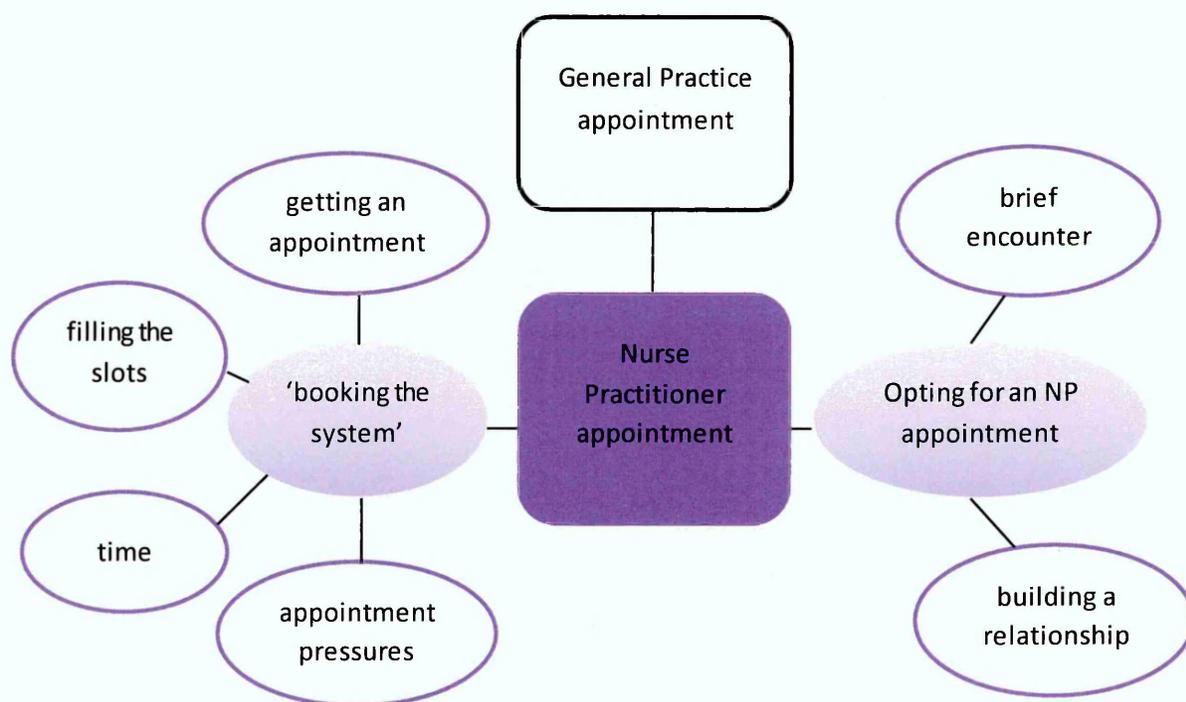


Figure 4
The general practice appointment

## 7.1 The Nurse Practitioner Appointment in General Practice

As has already been discussed in chapter five, these nurse practitioners were providing new appointments in practice for patients with acute health problems and long term conditions. The appointments were organised into clinics or surgeries in the same way as GP appointments but they tended to consult at different times of the day and for longer periods than their GP colleagues. Naomi reported that she had clinics scheduled for late morning, allowing time for telephone triage earlier in the day, and additional clinics for long term conditions in the early afternoon between 2pm and 4pm. Mel had appointments for acute health problems scheduled throughout the day from 8am until 5pm. This pattern was repeated across practices affording them greater flexibility in the provision of appointments. Whilst the organisation of their working schedule might differ from nurse to nurse, the length of the consultation showed remarkable uniformity. All of the nurse practitioners interviewed had or were intended to have fifteen minute appointments.

## 7.2 Booking the system

How the patient negotiates the system to secure an appointment in general practice and the effect of the nurse practitioner role at each stage will be explored through **'booking the system'** and three broad themes; **getting an appointment, filling the slots, time and appointment pressures.**

### 7.2.1. *Getting an Appointment*

The patient journey begins with recognition of need and a decision to seek medical care (Gulliford, Figueroa-Munoz, Morgan, Hughes, Gibson, Beech and Hudson 2002). Patients can generally make appointments with their general practice by telephone, face to face with the reception staff and in some cases via online booking systems. For most of these the general practice receptionist is the person with particular responsibility for allocating patients to either general practitioner or nurse practitioner appointments. Some UK general practices also offer telephone triage; a system in which patients with a health care problem speak to the nurse or in a few cases the GP, their problem is then assessed and managed by advice only, referred to another more

appropriate service or an appointment made for a face to face consultation (Bunn, Byrne and Kendall 2005).

Half of the practices employing these nurse practitioners used telephone triage to manage same day requests for appointments. Of these one was GP-led, three were NP-led and one utilised only practice nurses trained in house to manage telephone requests. None of these practices used computer-supported triage, rather they relied on the clinical decision making skills of the clinicians involved. Some of the nurses were enthusiastic about its use in practice, perceiving it as an effective means of facilitating access for patients who might otherwise struggle to make an appointment and a way of allocating patients to appropriate health care resources.

> I do some triage, you know, does this person need to be seen? So I can sort those out and put them in appropriate appointments. Sandra

It allowed Dawn and Naomi to assess and prioritise on the basis of health need, which patients needed to be seen urgently that day.

> ..my colleague and I manage telephone triage, requests for advice and requests for urgent appointments. I have two surgeries per day seeing patients with minor illness. Dawn

> In the mornings from 8.30 – 10.30 I do telephone triage. And from 10.30 – 12.30 I'm seeing all the patients I've triaged. Naomi

Before Naomi came into post in her practice, patients were often told to call back on a daily basis to access appointments for acute problems. She considered the appointment system to be, *"unhelpful"* for her patients.

> ..they ring up and are told, oh, there are no appointments left. I just can't believe the way it is managed, patients ring up, not feeling well and they say sorry we've run out of appointments and they are told to ring up the next day and go through the whole thing again.

Naomi perceived that receptionists were making decisions based on availability of appointments rather than on health care need. She did not feel this was appropriate or that the receptionist was the person best placed to determine that need. And within the boundaries of her new role she believed she was able to make a difference for patients.

I've told them I will always assess the patient and take it from there. I think this is a way for patients to talk to someone. I've been told I'm so glad you've called me back. I've been trying to get to see someone. So I think that has made a definite positive impact for patients.

Mel's practice utilised telephone triage differently. Rather than a way of prioritising demand and allocating to health care resources as required, it was used quite openly by the GPs as a means of bypassing the general practice appointment system and providing a brief consultation with a GP or NP. Whilst this might seem a practical way of managing workload, the absence of face to face consultation was very unpopular. She stated that for her patients.

...there was overwhelming, overwhelming dislike of it...(and)...on the whole patients felt that genuine access to their GPs was blocked.

Barbara had initiated a triage service in her practice, a service she felt worked well for her patients. However, her GP employer disagreed and it was abandoned.

We tried it and I thought it worked quite well but one of the GPs wasn't very keen and didn't think it saved much time over all. Not sure I agreed...I used to have some of my appointments blocked for these phone calls and I would either bring them in, give them advice or arrange an appointment later in the week and the patients were satisfied with it.

The GP's response was focused squarely on potential time savings and discounted the perception of the nurse that the service was effective and that patients valued it.

Telephone triage has proved a rather contentious innovation in general practice. And the experiences of these nurse practitioners probably reflect that. Triage was introduced in part as a response to a supply and demand crisis and the need to find a way of balancing the increasingly complex needs of patients with the provision of same day access for all (Osborn and Thompson 2014). Triage places a clinician on the front line making decisions based on their assessment of health need, but also facilitates the distribution of work throughout the primary care team, echoes of the 'hierarchy of appropriateness' described by Charles-Jones et al (2003). Patient preferences were not necessarily a priority. Indeed the National GP Patient Survey reporting in July 2015 noted that of the patients who contacted their practice for an appointment, the overwhelming majority wanted to see a GP. Very few wanted to speak to a GP by telephone (6.5%) and fewer still wanted to speak to a nurse by telephone (1.0%) (NHS

England 2015). This would seem to illustrate that triage was not intended to meet patient preference but to manage patient demand.

Patients with reduced mobility or a chronic illness which makes leaving the home difficult or impossible, have significant problems gaining access to an appointment. They rely on home visits to attend to their acute and routine medical needs. This was recognised and addressed by two of the nurses interviewed. They helped to develop innovative services which made them the named and responsible clinician for all housebound patients within their practice. Mandy was one of these nurses.

> I am responsible for a housebound case list so that people who can't access the surgery aren't disadvantaged.

Historically home visits have been the domain of the GP. The idea that nurse practitioners who assess and treat patients within the practice can manage home visit requests is not new and has been extrapolated in some cases from primary care out-of-hours triage and assessment by nurses. However there is little evidence that significant numbers of practices have employed NPs in this way and whilst it may seem a practical way of freeing up GP time there is very little supporting literature around their role in providing home visiting (Edwards et al 2009, Jiwa, Bakewell, Foster and Gerrish 2001).

Accessing care and making an appointment can be a complex process for patients. In their qualitative study of general practice, Gallagher, Drinkwater, Pearson and Guy (2001) suggested that a satisfactory outcome for the patient and the practice depends on the interplay of many factors, including health need, patients' expectations of the system, the attitude and actions of receptionists and availability of appointments. General practice receptionists, in their role as administrative gatekeeper, are critical in this process. Nurse practitioners may increase supply of appointments but their only means of directly managing access and perhaps gaining some control over their own working environment is through telephone triage.

### 7.2.2. *Filling the Slots*

The receptionists are largely responsible for managing the general practice appointment system. As administrative gatekeepers they facilitate entry to the clinical

domain, determining which patients are suitable for which clinician in the team, including nurse triage. GPs generally set practice policy, determining how many appointments are available and with whom. In addition they determine how these are utilised within the appointment system. In Claire's practice the general practitioners determined that nurse practitioner appointments must be filled before theirs could be booked.

> When I first came here the GPs were afraid my surgeries would not be filled, so the rule was that my appointments had to be filled first.

Mel described a different system in her practice. She stated that a number of GP appointments would be embargoed at the end of GP surgeries each morning for use *"on the day"*, should the routine appointments be fully booked. However they were rarely used and instead reception staff were instructed to put any extra patients in with her.

> It's normal practice for my GPs to tell reception staff not to book patients into these slots. Instead they tell them "can't Mel see a few extras?" And I'm already full.

Both of these suggest that GPs are explicitly instructing receptionists to book nurse slots before or instead of their own. This may be a defensive action on their part, the effect of which is to protect their time at the expense of their nursing staff. But it could equally be concern that patients might not accept the NP appointment if given a choice of doctor or nurse. Mel felt this was plausible and perceived a level of coercion apparent in the way reception staff allocated patients to her appointments, reporting that,

> I honestly think they (patients) were a little railroaded, that even when they asked for an appointment with the doctor they were allocated by the receptionist to my surgery on the whole.

Claire also recalled hearing reception staff booking appointments for patients at the desk or on the telephone, assuring them that,

> They (the nurse practitioners) can diagnose and prescribe just the same as the GP.

This last statement and its assumption that nurse practitioners can substitute for GPs, might indeed reflect a level of confidence in the individual nurse practitioners.

However, other nurses experiencing similar, felt that rather than being an endorsement of their skills, it was simply a strategy to encourage patients to take nurse practitioner appointments. Mandy identified this as being problematic at times within her practice.

> Sometimes I look at my surgeries and think how did such and such patient end up with me? I think often it's a case of the receptionist not having a GP appointment available and so they just transfer their logistics problem to me.

As in Mandy's case, when receptionists under pressure simply added more patients to an already full clinic, these receptionists were making decisions which did not necessarily address the needs or preference of the patient but which did address the immediate need to offer an appointment. Their focus was firmly on throughput: the flow of patients through the system of general practice. This serves the function of general practice rather than the patient.

As the person "out front", receptionists bear what Neuwelt, Kearns and Browne (2015) describe as the 'emotional cost' of any mismatch between the *need* patients express and the *care* they receive. But the offer of an appointment, any appointment, at least relieves immediate pressure on the receptionist. This could be seen as a criticism of reception staff but it should be remembered that they are bound by their own lowly place in the hierarchical structure of general practice, and must abide by doctors' implicit and explicit rules.

Another feature of 'filling the slots' is the re-categorisation of the patient, not as an individual with a health need but as a presenting problem or symptom; a cough, a chest pain, a headache, which can be allocated on the basis of perceived severity or importance. Here there is some element of practice policy; for example, the allocation of patients with minor ailments to nurse practitioners. But the person making that decision is not a clinician but the receptionist, the person with the least medical knowledge within the team. This makes them very powerful, particularly when demand for GP appointments is outstripping supply (Offredy 2002).

Walk in clinics address capacity issues within general practice and bypass the normal appointment system. So instead of receptionists filling the slots, patients would

present to the practice at an allotted time and wait to see a nurse practitioner or general practitioner. Rather than reception staff shaping which clinician consulted with which patient, the clinicians themselves were complicit in categorising symptoms and problems and who was the most appropriate person to manage them. Jane, speaking of the walk-in clinics for acute illness held daily in her practice, stated that patients are,

> ... not allowed to pick a GP over a NP, we may see it as preferable in some circumstances but as a rule they are not allowed to pick. We don't have any truck with that and we have huge support from our GPs on that.

Her description of the organisation of the service made it clear that it was not patient focused, that it was organised to facilitate the management of demand for practice services rather than individuals. "*We don't have any truck*" is an interesting idiom to use. The inference was that the nurse practitioners, supported by their GP colleagues, generally would not and did not allow patients to see a clinician of their choice. Indeed that a preference for a particular clinician, GP or NP, was perceived as something obstructive or unreasonable. This has some resonance with the actions of general practice receptionists who, when faced with patient demand were prepared to use any slot, GP or NP to solve the immediate problem of availability of appointments. Yet in that scenario nurses perceived those actions to be unreasonable.

There are parallels between how receptionists fill the slots and the hierarchy of appropriateness outlined by Charles-Jones et al (2003). In their study of the redistribution of medical work in general practice, they explained how some medical work, particularly around minor ailments had been 'downgraded' and allocated to nurses. This not only served to move lower value work to other clinicians but reinforced professional hierarchies based on skills and expertise with the GP the person at the top. It seems now that this has cascaded down to reception staff who are themselves re-categorising patients as a health problem and allocating them to the different strata of the team based on their perception of complexity. In principle this seems like an appropriate use of resources, but it also reduces patients to a sum of their symptoms rather than as individuals with their own agenda or preferences.

### 7.2.3 *Time*

All of the nurses interviewed reported that they were allocated fifteen minute appointments rather than the ten minutes usually allocated to general practitioners.

> I have fifteen minutes and the doctor has ten... Claire

> I also have longer appointments than the doctor, 15 minutes instead of 10.. Ellie

Although there was no clear basis for this and the origins are probably historic, the nurses were very protective of their fifteen minutes. Their accounts indicate that they valued the longer appointment; suggesting it enabled them to provide an enhanced service to patients, one which they perceived improved the patient experience.

> I have 15 minute appointments which is quite generous so maybe that made them (patients) feel they had more time and weren't rushing. Ellie

> I think patients value the fact that they have a bit longer time, and some patients, not all, are maybe a bit more relaxed. Mandy

All of the nurses commented that the extra time, longer than the GP appointment by five minutes, did seem to create an environment which appeared less hurried and which facilitated a more focused and effective therapeutic intervention.

> In all the surgeries I've worked in, I've had two where I've done permanent jobs but some agency work as well a while ago, we do get longer consultation times than the doctors and that has to make a difference...you can do so much more in that. Barbara

Whilst Barbara did not expand on what the "so much more" might be, other nurses described a number of activities which they were able to perform within the longer consultation and which they perceived were of value to patients.

> I also have longer appointments than the doctor, 15 minutes instead of 10, and it means I can spend a little bit longer with them, explaining things, making sure they know how to take medicines, where to go to get other services or advice, how to fill in forms, lots of things like that. Dawn

> Our consultation times are longer so I think that enables you to give information and clarify if patients have understood. Mandy

These activities; informing, explaining, clarifying are important elements of effective communication in therapeutic relationships, elements which take time to do well

(McGuire and Pitceathley 2002). Other nurse practitioners suggested that the fifteen minute appointment also enabled them to manage multiple problems, something they did not perceive their GP colleagues could do in ten minutes. Sandra suggested that sometimes when patients consult they are reluctant to mention other problems because of the commonly held belief that only one problem can be dealt with in a single appointment. In her practice this rule is explicit and inflexible. Indeed she offered this photograph of a sign on the door of each GP consulting room.



She felt that nurses generally struggled with enforcing this more than doctors.

> ... it's difficult for me to say I'll deal with one problem, which the doctor will do, in our surgeries they put one appointment, one problem, and all the nurses struggle with that. And the doctors say you should have brought them back but there's always the concern they won't come back. So you just get on and do it.

The problem for GPs seems to be that the standard ten minute appointment cannot accommodate the complex co-morbidities they are required to manage; what Shiner, Ford, Steel, Salisbury and Howe (2014) describe as,

> ..a patient centred conversation that deals with multiple medical problems and includes screening, examination, test interpretation, patient education and a review of medications.

It has been suggested that the difficulty of GPs' work may have increased because the more routine is delegated to nursing staff, leaving GPs to manage the more complex patient problems (Charles-Jones et al. 2003). Shiner et al (2014) argue that these patients require longer appointments, perhaps even longer than current NP consultations, but that any change would need to be considered within the context of

more flexible appointments generally. This would be difficult within the constraints of current NHS policy and its emphasis on single-disease management (Wilson 2013).

In a study of how GPs managed their ten minute appointment surgeries, several strategies were utilised including delegation of both clinical and administrative tasks to other occupational groups. Within the consultation GPs also described how they limited the scope and depth of engagement in tasks, how they attempted to use time flexibly according to need, gaining time from some brief appointments and allocating to more complex (Macbride-Stewart 2012). When most of the straightforward consultations, for example the 'sore throat' and 'sticky eyes' are being transferred to nurse practitioners and practice nurses, this altruistic strategy of stealing time from one patient to give to another becomes more difficult and time pressures mount. One appointment, one person, one problem is one way in which GPs try to manage the increasing complexity.

It may seem obvious that having sufficient time for the consultation is an important element of high quality clinical care and a necessary prerequisite for the development of patient-clinician relationship (Braddock and Snyder 2005). But it is not the only element. Williams and Jones (2005) in their qualitative study of patients' perceptions of consulting with a nurse practitioner identified time as being important but suggested that satisfaction with the consultation is a more complex construct associated with other factors such as the clinician's consulting style, communication skills and use of strategies other than prescribing.

Time for nurses is, as Jones (2010) suggested about 'time to care', emphasising that the duration of the appointment has little meaning in isolation. That it reflects only a physical measure, the time allocated to meet health need. That it cannot capture the psychological and social aspects of nursing which impact on relationships and patient experience. This will be discussed more in chapter seven.

### 7.2.4 *Appointment Pressures*

One nurse practitioner interviewed revealed that her GP colleagues were insisting that she reduce her 15 minute appointments to ten, to be "like them". As already described, Gaynor had, "fought to keep my consultation times at fifteen minutes". Her

reason for this was that she tried to manage complex and diverse problems herself without referral to other clinical staff. As previously explained, Sandra felt that the extra time allowed her to manage multiple problems without having to make further appointments, potentially saving time in the longer term.

Sandra also stated that whilst she was intended to have fifteen minutes per appointment when the practice was under pressure, when there were no general practitioner appointments available, this was abandoned in order to meet demand. As a result she would often work extra hours and her clinics for acute illness were often overbooked.

> ...when that happens I can see between 20 and 30 patients between 1.30 and 6pm. For example, last Friday I had extras in and appointments were shortened, and the receptionist said sorry, but nowhere else to put them.

Without any breaks this means Sandra has average consultations of between nine and thirteen minutes. At best, this is less than her usual appointment length and at worst, less than her GP colleagues'. It is unclear whether or not receptionists would ordinarily feel they could add extra patients into general practitioner surgeries in the same way. Naomi did not think so.

> Some patients will have asked for an appointment with the doctor but couldn't get one so they will pop them in with me.  Naomi

There was certainly a belief amongst the nurses that reception staff were more likely to try and squeeze extra patients into their surgeries. Gaynor commented that when this happened to her surgeries, she was forced to actively manage the problem.

> I have to draw a line sometimes before I get burned out and I have to say would you do this to a GP, because otherwise you can't cope with it all.  It's a fine balance because they (receptionists) have a difficult job too.

At a time when the Royal College of General Practitioners (2014) supported by its members have urged a general increase in appointment times to fifteen minutes, an increase designed to enable them to address long-term conditions and multiple co-morbidities more efficiently, this seems puzzling. It might simply be a response to a key concern for general practice in the current climate; how to increase supply of appointments to meet patient demand. But it fails to consider how a nurse practitioner works, the information given, the extra tasks or problems being managed within that

fifteen minute slot, or the value of what happens within a consultation with a nurse which might not happen with a general practitioner. Indeed, considering the 'time' debate, perhaps GPs need to focus on finding ways to increase their own appointments to fifteen minutes.

For many patients accessing general practice, the freedom to choose which clinician they consult with is important (Kearley, Freeman and Heath 2001). Indeed offering patients' this choice is congruent with the ethos underpinning the NHS, an ethos which values patients as individuals with their own history, values and context. There is nowhere in health care where this has traditionally been held in greater esteem than in general practice (RCGP 2008). How these nurse practitioners perceived the introduction of their role and issues around access to general practice affected their freedom to choose and consult with a preferred clinician will now be explored in greater detail.

### 7.3  Opting for a Nurse Practitioner Appointment

> In many practices it requires enterprise, determination and social skill to get to see your chosen doctor (Hill and Freeman 2011 p25)

Having negotiated the systems and policies of general practice to make an appointment, there seemed another obstacle for the patient to overcome. How to secure an appointment with the clinician of their choice. The second theme is **opting for the NP appointment**. This concerns the freedom of a patient to make an appointment with a preferred clinician and to what degree they are actively *choosing* a nurse practitioner. It will be explored through two themes; **brief encounter** and **building a relationship**.

All of the nurse practitioners recognised that in the early days of their role in practice patients were not actively choosing them. That for many their appointment might be the only or the earliest one available.

> I get a lot of them (patients) coming back...they don't want to wait for the doctor.  Sandra

> I think initially, yes, patients were booking with me because they could not see a doctor. Naomi

Nurses recognised that they were not always the first choice but seemed undaunted, confident that over time and familiarity this would change. They also recognised two different types of consultation with patients, both with their own inherent value; one a complete episode of care for symptoms which perhaps patients did not see as being severe, and another, a part of more enduring relationships.

### 7.3.1. *Brief Encounter*

These nurses recognized that patients were more prepared to see them when they considered the health problem to be of less significance or when they were not sure what to do.

> They feel they can come to me with things that are less important.. Ellie

> ..they feel they can waste your time; they can share things with you that they might not want to say to GPs..Jane

> I don't think a week goes by when a patient doesn't say I've come to see you because I didn't want to bother the doctor or I didn't want to take up the doctor's time with this. Gaynor

Nurses did not seem resentful or feel that their role did not have value in these situations. Gaynor felt that perhaps patients did not feel *"judged the same"*, that they were sometimes assessing how serious or trivial the problem was. Consulting with the nurse practitioner appeared to give them permission to express those health concerns they felt would be deemed inconsequential or time-wasting by the GP. This too was considered appropriate by the nurses interviewed. They felt that patients were often correct in their own assessment, that in many cases they did not need the broader skill set of a medical practitioner.

> **Researcher** – other nurses have commented that they get patients who come in and say they've got a problem but they don't want to bother the doctor. Do you ever have that?

> **Sandra** - yes

> **Researcher** – Do you find that disrespectful of your role?

> **Sandra** – No, sometimes they're right. If they've got a sore throat it's not a crisis so they shouldn't be bothering a doctor.

Their view was that within the health care system there was room for a brief encounter, a single contained therapeutic conversation that did not need to be viewed within a wider context of patient choice or longitudinal relationships.

It appeared to the nurses that patients were not always responding impulsively to a new symptom but making quite sophisticated and thoughtful decisions about the urgency and severity of their problem. Dawn illustrated a thoughtful, pragmatic choice made by a patient in her description of a recent consultation. This lady's partner had died and she was distraught. She made a decision to consult with a nurse based on her perception of what she needed from the clinical encounter.

> ..they had not been together very long and people kept telling her that she should be getting over it…But she was really grieving and she came to see me.  She said she had chosen a nurse practitioner, even though she had never met me before, because she didn't want a tablet, she just wanted somebody to talk to and thought a nurse might be more sympathetic than a doctor.

It seems that this patient's perception was that a GP encounter might lead to a prescription for medication and that was definitely not what she wanted to happen. Rather she wanted a clinical encounter which would allow her to talk, to express her sadness and which perhaps she felt would be more therapeutic and less judgemental than a family member or friend. And she had chosen a nurse practitioner for this.

### 7.3.2.  *Building a Relationship*

In addition to these brief encounters, the nurses tended to take a longitudinal view of the issue of developing patient-clinician relationships. They were prepared to admit that in the early days their roles did not provide patients with real choice. Indeed some patients were very anxious about what nurses could do or the care they could give, but over time they as confidence and familiarity increased patients began to actively choose them as their preferred general practice clinician.

> I think initially patients were booking with me because they could not see a doctor. But as time goes on they return because they have confidence in me and making a true genuine choice. Claire

> They choose to see us now.  They didn't to begin with, they were rather apprehensive about what we could do and whether or not we were trained. Dawn

> I often find patients test you out when they meet you for the first time. They'll come in with whatever they have booked for and then they'll ask you something else. It's almost like they're testing you and seeing if they can trust your judgement before they book again. Jane

And they did book again. Which would suggest that they are building trusting relationships with nurse practitioners, reinforced as all therapeutic relationships are, by small successes and positive outcomes.

> ..when they come, you see something, treat it and they get better, they have confidence and come back. Sandra

Barbara referred to her full surgeries as confirmation that patients were actively choosing to see her.

> ..appointments get booked up very quickly and they (patients) have great difficulty getting into see me.

It is impossible to assess whether or not this is a true reflection of choice, or as demonstrated by Claire's narrative earlier, of a system where receptionists under pressure and under instruction, fill NP appointments first. But these narratives do suggest that contrary to some of the research which trumpeted the preference of patients for general practitioners (Rubin, Bale, George, Shackley and Hall 2006), the perspective on choice may have changed. That as years have passed and these advanced roles have become embedded in general practice it is research into patient choice and the nurse practitioner role which lags behind.

## 7.4 Discussion

The supply and organisation of general practice is dominated by professionals and determined by their preferences and boundaries; the hours they prefer to work, the imperative to have salaried employees' surgeries full, the siphoning of patients into nurse-led clinics for long term conditions. It functions as a paternalistic rather than patient focused service, making decisions for patients about who and when they should be seen without fully accommodating their needs and preferences.

The inherent tension throughout the narratives then is how to reconcile better and more rapid access to general practice services with the freedom and ability of patients to choose a clinician with whom they have or wish to develop a personal and

longitudinal relationship. McWhinney (1998) considered this concept of 'continuity of care' to be a defining feature of general practice and described it as an ongoing interpersonal relationship which develops between patient and clinician through repeated therapeutic interactions. This would imply it is a social construct; co-produced by patient and health professional.

Freeman and Hughes (2010) in their investigation of choice and continuity of care in general practice for the King's Fund concluded that in the future, with the declining numbers of medical graduates choosing general practice, it may be necessary to make *"explicit judgements and trade-offs"* between access, choice and continuity of care. It does not further identify particular groups or circumstances in which this might happen but does seem to accurately and prophetically anticipate the current problems in general practice. It could be argued that the emergence of nursing roles in general practice are actually the 'trade-off' the authors predicted. And that the price being paid now and in the future for not addressing the crisis in general practice is a workforce depleted of qualified GPs, being supplemented by nurse practitioners who are inevitably less expensive, faster to train and more malleable as employees than their general practitioner colleagues but who lack the depth of knowledge and skills afforded by medical training.

As has already been discussed nurse practitioners perceived individual patients were making quite erudite decisions about their access to general practice. When the presenting problem was minor and they required timely access some individuals were less concerned with choice of clinician than with the convenience or promptness of their appointment. Indeed this is supported by a series of discrete-choice experiments undertaken in general practice which demonstrated that for some patients, particularly the young or those with minor immediate or low-impact problems the choice or type of clinician was of lesser importance (Rubin et al 2006).

For patients with long-term conditions and for the elderly with multiple co-morbidities who may need to consult in general practice more frequently, research suggests that choice of clinician is important. Rubin et el (2006) demonstrated that these patients preferred to wait for a known and trusted doctor; that for these groups confidence in their clinician, a confidence developed over time, was more important than prompt

access. Campbell, Kontopantelis, Reeves, Valderas, Gaehl, Small and Roland (2010), examined the experiences of patients in general practice during the period 2003-2007, when changes in general practice funding facilitated the introduction of the nurse practitioner role. They demonstrated a modest improvement in access to care for patients with long-term conditions but also identified that all patients found it harder to obtain continuity of care; that important personal relationship with their doctor. The debate for the wider community might now need to focus on whether or not a decline in continuity of care is an acceptable compromise to make for improving access for all groups.

The next chapter will focus on the nurse-patient consultation itself and what happens in this therapeutic encounter which might add value to the patient experience and which might also influence the choice agenda.

Chapter six explored the nurse practitioner consultation in the context of the organisation and function of general practice; what it is, how it is delivered, how it is accessed.  This chapter seeks to explore the consultation itself; the therapeutic meeting between patient and nurse practitioner; what happens within it and how that differs from a consultation with a general practitioner.

This will be explored through four broad themes; **seeing the bigger picture; keeping it nursing; showing their human side** and **building a relationship.**
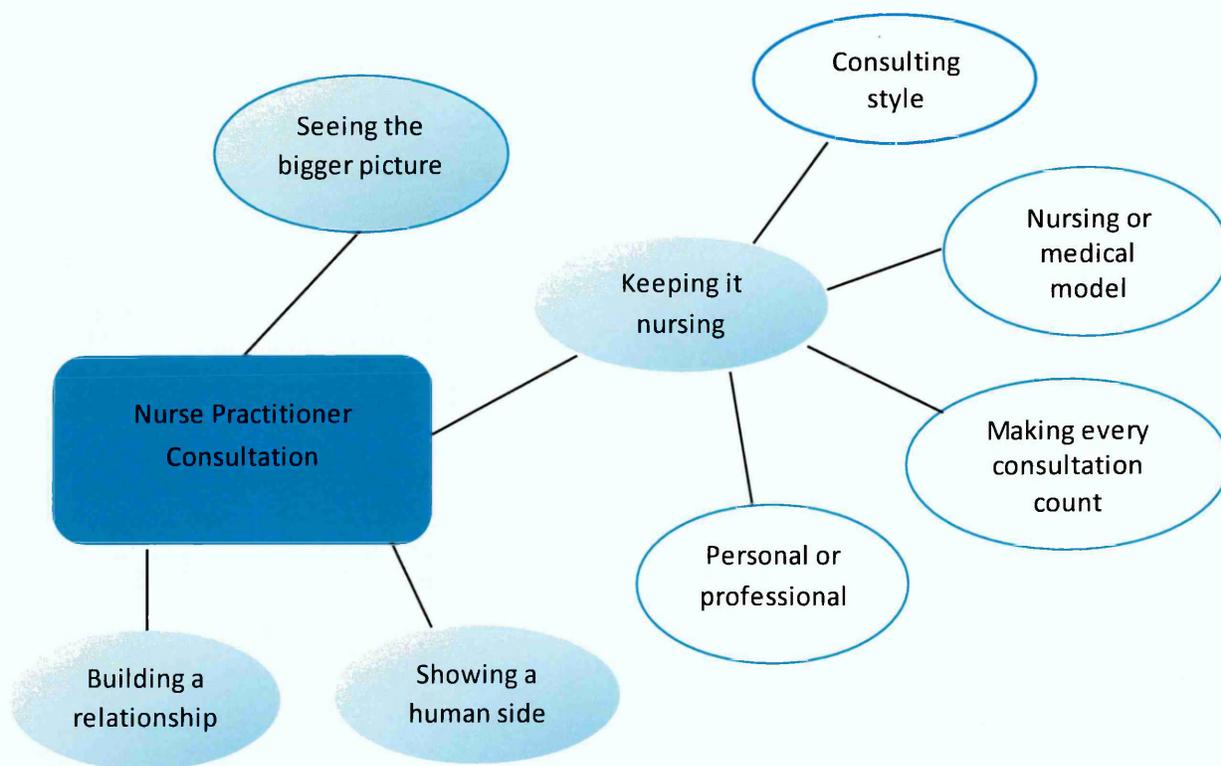


Figure 5
The NP Consultation

## 8.1. <u>Seeing the bigger picture</u>

Many of the nurse practitioners identified a different focus in their consultations compared to their GP colleagues. They understood this to be a different emphasis in the way they approached the problems presented by their patients.

> I have always felt that for doctors the hook is the problem and working through the intricacies of the problem. And I think for nurses the hook is the patient with the problem and the effect that is having on them. Claire

Claire believed that for doctors generally, not exclusively general practitioners, the appeal of the consultation was the problem to be solved. In contrast, she felt that for nurses the appeal was to explore and understand how the individual patient experienced that problem. Others agreed.

> But for nurses it's always been about the person with that problem to be solved. Barbara

> The focus on the patient not just as a collection of symptoms but as a real person is there. Dawn

> I think that's the job, doctors go out to do the job; doctors are trained to deal with the illness, the one thing that's wrong. And nurses aren't. I was trained as an old fashioned nurse, I was trained to look holistically, I was there to deal with the patient. Sandra

Sandra identified this aspect of how doctors and nurses interact with patients as being grounded in their respective professional training. She saw a difference between the training to manage illness and disease she attributed to her medical colleagues and the more holistic approach she considered to be an integral part of basic nurse training.

> Because it's the way we look at things, and it's why I've always argued about the (extra) time we have, because nurses aren't taught like doctors. Doctors are taught to deal with the problem, the patient comes in with an illness or a disease and they deal with that and not the patient. Sandra

All of the nurses interviewed trained in the 1980s and 1990s when the apprenticeship model prevailed and student nurses spent most of their training in clinical practice settings on hospital wards and in the community. Sandra's perception echoed by others, was that this practical grounding yielded a different orientation; a focus

perhaps less on actions and more on interactions. Barbara concurred and gave this example from her practice.

> I have a patient at the moment and for her medical problem, the pathway says we should be doing certain things. But her values determine that she doesn't want to go that way. So we have to retain some flexibility and understanding and view (her) as a person. Barbara

Focusing on her patient as an individual with her own attitudes and values, led Barbara to view treatments or interventions in the context of what the person wanted and not just what the guidance recommended. Dawn and Gaynor felt that patients appreciated this approach.

> I find I'm asking much broader questions about the impact of illness on home and families. And patients feedback to me that often doctors are focused on the computer, don't really look at them, 'do this, come back if it doesn't work'. Whereas I sit back in my chair and listen to them. Gaynor

> I think we see the bigger picture and that's why people like us. We don't treat them like a back pain or a cold or a headache. One of the first questions I ask is what effect is this having on your life. Dawn

These practitioners recognised nursing as having good peripheral vision, a wider appreciation of the patient as an individual rather than a preoccupation with a presenting symptom or problem. They felt nursing sees and appreciates what is happening at the edges. This is highlighted by Sandra and Ellie in their extracts from practice.

> You often get them come in for their diabetic review, and as you are talking to them you're looking at them and might say "what's that crusty thing on your ear?" "It's fine, it'll crust, fall off and it'll come back", But you say "I think we'll get that dealt with". You're not concentrating on the problem and ignoring anything else. Sandra

> I think as nurses we are more holistic. GPs are getting better. I like to think if they come in with a chest infection I am not just focusing on that but thinking about other things as well. Ellie

The observations about a focus on the patient emerged across all interviews. They all perceived a basic difference at the core of the consultation; the person rather than the problem, the attention to the wider effect of illness and its meaning to the individual. They explained this as a difference in the training and attitude of nurses and doctors.

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These nurses had been qualified for between 20 and 41 years at the time of interview. All had qualified before nurse training shifted from hospital to university-based courses. Their experiences of preregistration clinical nursing were grounded in nursing models they encountered during their early training. Models such as the nursing process which emerged in the 1970s as part work-method part philosophy promoting patient-centred care; the Roper-Logan-Tierney Model of Nursing in the 1980s, which offered a framework for holistically assessing a patient based on 12 activities of living and Orem's self-care model spanning the 1960s to 1990s, which identified self-care deficit and the nursing intervention required to compensate and support the individual. (Smith 1991, Orem 1985, Roper, Logan and Tierney 2000). All had in common a nursing perspective, nursing diagnosis, a focus on the individual at the centre and an attempt to empower rather than control.

Medical training during the same period was biomedically focused. Courses were divided into pre-clinical years with an emphasis on biochemistry, anatomy and physiology followed by clinical training spent mostly on hospital placement as part of a consultant firm (Lowry 1992). Evidence-based medicine became increasingly significant during the 1990s with a new focus on incorporating critical appraisal skills into training so that doctors were able to integrate research evidence into clinical practice. More recently there has been a further shift in medical training as medical schools have been encouraged to include specific training in patient communication and interpersonal aspects of medical interventions, together with more community placements (DOH 2003, Madill and Sullivan 2010).

Considering these differences, a biomedical rather than holistic grounding it is understandable that nurses of their age, background and skills understand the focus of their practice to differ from that of their GP colleagues. However as new medical graduates emerge into general practice, graduates immersed in new training methods which fuse the biomedical with the patient perspective, this seeming disparity may also change.

## 8.2. Keeping it Nursing

The nurses interviewed identified a number of elements within the consultation which they felt were intrinsically nursing. These will be examined under the sub-themes; **consulting style; nursing or medical model; making every consultation count** and **personal or professional attributes.**

### 8.2.1. *Consulting style*

These nurses felt strongly that how they consulted with patients was different to their general practitioner colleagues. They felt this had significance in the context of a therapeutic relationship. Again they identified the different orientation; medical consulting driven by managing the problem,

> ..it is a different type of consulting as opposed to medical consulting which is more disease cure driven I think. Naomi

And nurse consulting driven by a nursing orientation which enhanced the experience for the patient.

> So I think it is my consultation style really coming from a nursing perspective and I genuinely do care Claire

They commented that other health professionals recognised and remarked upon the difference between medical and nursing consultations. As a senior clinician in her practice, Claire was involved in training registrars on the general practice vocational training scheme. She reflected upon their reaction to her style of consulting,

> ..we have lots of registrars, I have had them sitting in with me and done tutorials and debriefs with them. They have commented positively on my consulting style.

Gaynor was also involved in training medical students, foundation year two doctors and health and social care students on a nursing pathway. The students commented on what they observed in her consultations.

> I usually say to them just observe and see the different style....they do comment on the different way we consult, say people seem to open up a lot more to nurses.

Claire and Gaynor had completed Masters level degrees in the advanced nurse practitioner role, had been qualified for 11 and 5 years respectively and worked in

large training practices. As a result they had the experience and opportunity to become involved in training other professionals, including qualified doctors. Their reflections upon nurse consulting were positive and complementary, although it should be acknowledged that their remarks are channelled through the nurse practitioners.

Naomi, also trained to Masters' level, had been a qualified nurse practitioner for less time, three years, and worked in a much smaller practice of only 3300 patients. Her opportunities for joint consulting within the practice were limited so from time to time she returned to a previous larger practice to work with a GP there.

> And he always likes it and says he gets a nursing perspective and we do a joint consultation. The GP has said that there is a different dimension; it is a different type of consulting model as opposed to medical consulting.

What that difference in consulting style; what nursing or medical consulting looks like will be discussed further in the next section.

### 8.2.2. *Nursing or medical model*

The nurses explored how they framed and delivered care within the general practice consultation and how they perceived that differed from their medical colleagues.

> I don't feel I fit into a medical model, I think the way I keep it nursing is that I still look at my patients holistically. I think that many doctors also do but they are more structured, blinkered almost, to making the diagnosis and treating rather than looking at the whole. Gaynor

They identified the medical or biomedical model as being the domain of medical practitioners. It is defined by Wade (2009) as a conceptual model which assumes that all illness comes from within the body and is caused by a dysfunction of a part of the body. It ignores psychological and social factors and focuses only on physical features in an attempt to understand an individual's symptoms and illness. The holistic model commonly alluded to by the nurse practitioners acknowledges the importance of factors other than physical signs; the social context of illness, health beliefs and attitudes, the environment. They felt that this model framed and directed their practice and that it had benefit for patients.

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Many patients have said they've found it really helpful seeing me. And I think it's that nursing holistic approach. So you're not just looking at a medical model, it's looking at the ANP kind of health promotion model which we use which is very much looking underneath at what's driving this patient. Naomi

At my previous surgery where they had an ANP, the patients just loved her. They thought she was better than any of the doctors. And it was because of this kind of holistic approach Naomi

Barbara was more pragmatic and recognised that the biomedical model had value within the consultation but that it was tempered and modified by a nursing orientation.

It's inevitable that we have absorbed some of the biomedical model if I have a patient to assess, come up with a diagnosis and prescribe or refer on. And the medical model isn't all bad. It is a major part of the structure that we use…I suppose it's different quantities like a recipe. So yes I may use part of the medical model but that has a purpose in helping me understand what I'm seeing in front of me. And my nurse education has developed my enquiring mind and helps me to interpret what I'm seeing and the information I'm gathering. So it's like a detective story I've got to unravel. Barbara

This perception of the consultation model as a recipe with different quantities or elements which could be adapted according to the needs of the patient is a useful and practical analogy which had traction with other nurses.

I'm not a doctor. I think the whole approach is different. I use the medical model, the history taking, the examination, the diagnosis but we bring a human side to practice. Mel

I do think nurse practitioners consult differently. But they still can use a very medical model when needed. So I think we can dip and out of both. Mandy

This ability to "dip in and out of both", medical model and nursing, seems to be at the heart of how these nurses perceive the advanced role. They see they have the ability to 'treat' patients in a medical way anchored in and grounded by their nursing skills and training. They do not perceive the 'caring' element of nursing to be submerged in the biomedical, nor do they see the curative as being their only function. It seems to be a true synthesis of both.

### 8.2.3. *Making every consultation count*

It appeared that some aspects of the medical model had necessarily become part of the nurse practitioner's skill set. But they felt its synthesis with the best of their nursing skills enhanced the service to the patient. That it translated to a more educative, empowering alternative to a general practitioner consultation, more in keeping with their nursing roots. Naomi offered her view.

> I think the main value is that not only do we treat the patient and the condition but we are giving health promotion advice about how to prevent this problem re-occurring, what led to it occurring in the first place and any behaviours that perhaps the patient could modify in order to prevent it re-occurring. And I think that can really make a big difference for patients if they feel more in control because they've been empowered by being given more information.

Jane also identified this focus on the health promoting aspect of the nurse practitioner role as being pivotal to her work.

> I fiercely am health promotion and health education orientated and I think that is where I have a very different role to the GP. I'm not saying they don't educate the patient, but the way I interpret my encounter with the patient is what's wrong with them, what's going on and helping them get better. I have some nice diagrams and for example, this is why your sinuses are blocked, this is why it hurts and I suggest you try x, y and z.

The nurses suggested that this 'health promotion' grounding, something they felt was inherently nursing, gave them a foundation for talking to patients in a way that was different and more productive than GPs, that it enabled patients to understand and manage problems with greater confidence.

> And the patient goes out better able to deal with the problem. Because we educate. Like antibiotics. I will always explain why I'm not giving antibiotics. I don't just say you're not having them. So they come in asking for antibiotics for this chest infection, and I say well let's just have a look at you. So I listen and explain that the chest is really clear, it's here (pointing to the throat) so you don't need them. Sandra

Nurses like Sandra and Jane felt that they were better equipped, because of their nursing background to connect on a more personal level with patients; that they asked more, explained more and were better at translating complex concepts and decisions into language that patients could understand.

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> I'm having really great success with the diabetics, going through what they actually eat because the healthy eating message is not enough; they need it translating into their understanding. And often I will get comments that nobody has ever explained that to me before. Jane

Naomi compared how she managed her patients with diabetes, with her GP colleague.

> We've been able to improve Hba1c simply because we've been able to get to the bottom of what the issue is for them. So I think from the diabetic point of view, patients feel I am willing to listen rather than being someone who only wants to direct care. I think for some who are goal orientated that works well but for other patients it doesn't work at all.

These nurses felt that having, as Jane described it "a useful encounter", making the consultation count was much more productive in terms of managing individual problems than the more directed, paternalistic manner they perceived GPs would adopt. Research comparing GP and nurse consultations would appear to support their view. Seale et al (2006) demonstrated that nurse practitioners used the consultation to explore more treatment options, gave more information and were more concerned with the acceptability of treatments to individual patients. In comparison, GPs spent more time gathering information directly related to the diagnosis and treatment of the presenting complaint. In quantitative terms, the health outcomes for GP and NP consultations were very similar but what has not been explored is the longer term effects of giving more advice and any impact that may have on re-consulting rates.

### 8.2.4. *Personal or professional attributes*

Many spoke of the 'nursing perspective' they brought to the consultation. This was nebulous and difficult to define. It seemed from their narratives that they were, at times, using very personal attributes and values to illustrate a generic nursing role. Some of these; empathy, humanity, compassion, honesty, caring cannot be claimed by any one professional group but appear to be distinctly person-specific. How far these are characteristics typical of nurses choosing to make the transition to the advanced role is difficult to assess. Certainly there was consensus across all nursing narratives that these characteristics were important factors in their interactions and relationships with patients.

> Patients, many of them with multiple problems, say that I listen. I don't just give them a prescription. *I care* and I genuinely seek to pursue things through until we find some resolution for them. Claire

> I think with nurses it's attitude, patience, looking outside the box... It's looking at what else is going on with that patient. And it's getting to know your patients. Ellie

> I think my main focus is, and this may sound a little woolly and wet, I think that patients will forget what you said, may forget what you did, but they will *never forget how you made them feel*. That's what they take away from the consultation. They're really not interested in your skills, they don't notice that, they expect that, but they will come away from thinking, she was lovely, she really listened to me. Naomi

Naomi perceived that her patients expected a nurse practitioner to have a certain skill set, expected her to be able to manage their health problems. But what kept it nursing was how they engaged emotionally with that patient and how that impacted upon the clinical encounter.

Naomi identified listening, "she really listened to me", as being an important feature of her consultations. Listening, paying attention to the patient story was considered by other nurses to be a real strength of their nursing role. This willingness to listen to patients and their problems is illustrated in chapter seven in Dawn's description of a consultation with a recently bereaved woman. This lady had chosen a nurse, knowing she would be distressed; perhaps feeling more comfortable crying in the presence of a nurse than a doctor; perhaps also seeing the role, rather than the person, as compassionate and caring.

This impression that nurses are understanding and empathetic had resonance with others. Indeed they felt it was important they demonstrated this to patients.

> Often at the end of the consultation I say I am sorry you feel so poorly...it's taking how ill they feel seriously. And seeing them as a person with an illness not just the illness. Naomi

At times it seemed that sympathy was employed quite intentionally to comfort and reassure the patient, almost as a proxy for a prescription when one was not indicated within the context of the consultation.

And I'll do a thorough examination; I will give them so much sympathy. Say this cough is so tough, there's nothing to bring up so it just hurts. And I give them so much sympathy, I'm not giving them what they wanted, what they thought they needed (antibiotics) but I am giving them something else. Barbara

This concept of *"giving them something else"* has resonance with a study of GP prescribing behaviour for presentations of upper respiratory tract infections in children (Rollnick, Seale, Rees, Butler, Kinnersley and Anderson 2001). The authors identified the premise of a *"consolation prize"* offered as a means of reassuring patients when antibiotics were not indicated or offered. This might be a prescription for paracetamol or the promise of prompt access in a few days if there was no improvement. For Barbara and Naomi the consolation prize consisted of sympathy, a demonstration that they had listened understood and cared.

### 8.3. Showing their human side

Some of the nurses were willing to offer more of themselves in consultations, willing to disclose some of their personal side which they felt helped to connect with their patients and which might foster trust.

> And I think we give a bit more of ourselves perhaps, in consultation, sort of show the human side a bit more which can make you vulnerable I think. It's where the nursing part of me is still there, I show myself to be human. I don't have a problem saying to a patient 'have you thought about a mirena (intrauterine coil), I've got one'. I don't think a doctor would disclose something about themselves, but I think that's probably the more nursing, **comfort, nurturing** side. Gaynor

Few of the nurses would go as far as disclosing personal truths, but they felt they demonstrated concern for their patients in other ways. They identified compassion and caring.

> I don't think it makes any difference whether you're a consultant doctor, nurse or student; it's that the patient feels cared for, that's what matters to them. It's all to do with **the attitude of care**; I think nursing without compassion is empty. Naomi

> I think the thing I learned most from my nurse training was to try and put myself in the patient's shoes and think about how that felt. I think that's the bottom line, **these people need to feel cared for**. Claire

Barbara struggled to articulate exactly what she felt the difference between the NP and GP consultation might be. She perceived 'caring' to be a wholly personal characteristic and unfair to claim it exclusively for nursing.

> I specifically don't want to say 'caring' because I don't think that's what it is, but whether it is the humanistic approach, allowing the personal story to come through a bit more, to listen to that and take it on board. I think there is a difference and I wonder if it comes from the way we're taught, the nursing model which still gives a slightly different model, which allows these things to come through. The reason I didn't want to say caring is because to me that is a very personal quality. I know some wonderful doctors and I don't want to imply they don't care. Barbara

Whilst Barbara struggled with the concept of 'caring' as being a uniquely nursing attribute and attitude it was evident from the extracts and the wider narratives that 'caring' or making people feel 'cared for' was articulated frequently by these nurse practitioners. And whilst Barbara may not wish to claim 'caring' for the nursing profession, it certainly seemed that caring shaped and guided the clinical practice of these nurse practitioners.

According to Dr Jean Watson and other caring theorists, 'caring' is the core and heart of nursing (Vandenhouten and Petersen 2012). Watson's theory of human caring is comprised of three conceptual elements, the carative factors revised to the caritas processes which illuminate the essential elements of caring including the practice of loving kindness and the creation of a healing environment, the transpersonal caring relationship and the caring moments or events (Watson 2008). She asserted that in an authentic caring relationship the caregiver (the nurse) and the care recipient (the patient) reach out to each other and connect through the process of healing and caring. This concept of relationship, the one caring and the other cared for is evident in Naomi's statement about how she constructed the consultation, making people "feel cared for". Ensuring they were listened to and taken seriously was an important part of her consultations.

Watson argued that the professional caring relationship between the individual and the nurse had profound therapeutic effects. That it had the power to increase the individual's capacity for 'self-healing' by focusing on their 'inherent wholeness' rather than the label of their disease (Watson 2008). Naomi and Jane, in their work with

patients with diabetes reported great improvement in 'HbA1cs', (a blood test used to assess control of diabetes) by focusing on the patient, on their issues, beliefs and attitudes, rather than by being simply disease focused. They listened to their patients' stories, they negotiated and explained. They helped their patients to better management of their diabetes through a demonstration of a very modern perspective of 'empowered care', helping their patients to health through an authentic caring relationship (Basford and Levin 2003). They demonstrated that sustained intimacy which can only occur through an ongoing longitudinal relationship facilitates confidence, trust, and enables patients to confide in and reveal problems to a nurse which they may not to a GP.

One reason for the development of the theory was that Watson wanted to balance medicine's curative function and aims with nursing's 'carative' attributes. But nurses working in advanced roles have to embrace both. Nursing in the advanced role goes beyond empathy or understanding, and incorporates a commitment to help (Slevin 2003). Not help as in a traditional task driven nursing paradigm; but nursing with a dual caring and treatment focus which offers help which has traditionally only been available from medical practitioners. The risk of these roles and one of the criticisms made of them is that they forfeit the caring nursing focus for the medical focus. Yet what these nurses do is incorporate new knowledge of pathology, new highly technical skills and technological competence into their caring roles.

## 8.4. <u>Building relationships</u>

How nurse practitioners viewed their relationships with patients has been reviewed in chapter six. They saw value in relationships developing over time, constructed by repeated interactions, finding new ways of knowing and relating to each other.

Ellie, an ex-practice nurse with a major role in the management of chronic obstructive airways disease (COPD), identified that knowledge over time as important in how she consulted.

> And for my COPD patients, I know what their chest sounds like and know if it is normal for them.

Dawn recognised that same deeper level of knowing, that intimacy and personal relationship as being of great value when she was consulting with patients.

> I have a guy, if he's walked to the surgery he's got a chest infection, if he's come on his bike, then he's well.

Jane also felt that the investment in a more personal longitudinal relationship could have positive effects in how advice was received and acted upon.

> This role is as much about a relationship, about motivation and behavioural change. If they (patients) trust you and value your judgement they are much more likely to act upon what you tell them.

It also appeared from the narratives that the relationship was important to the nurses as well as to individual patients. Naomi's narrative talked about patients thinking she "was lovely"; Gaynor spoke about her personal feedback from patients as being "amazing", clearly enjoying the job satisfaction her new role gave her.

> I absolutely love the job. I do. It's stressful but you cope with that stress because of the job satisfaction it brings.

Other nurses talked of being valued by their patients and of the importance of retaining clinical relationships with patients.

> The best bit about being a nurse practitioner is that no matter how experienced I get I will never lose my patients. I'll see different patients perhaps, but I'll never lose my clinical contact with them.

## 8.5. Discussion

What these nurse practitioners appear to be shaping in their explanation of how the advanced role adds value to the consultation in general practice is a model of nursing grounded in the humanistic approach. Developed by Paterson and Zderad in the 1970's, humanistic nursing theory identifies the purpose of the nursing role as to assist another individual who needs and has called for help (Paterson and Zderad 1976). Termed call and response, the call for help with a health related problem comes from a person or community, is recognised by a nurse or group of nurses whose response is intended to help the caller with the health need. What happens in this dialogue, the 'and' in the call and response, the 'between' is nursing (Kleiman 2010).

The humanistic perspective calls for an existential involvement; an active presence and engagement of all of one's being. Kleiman (2010 p.342) suggests that,

> In the process of interacting with patients, nurses interweave professional identity, education, intuition and experience with all other life experiences, creating their own tapestry, which unfolds during their responses"

The nurse practitioner brings all that she is; the sum of her experiences, ethics and values together with her new professional perspective, the new pick and mix of nursing and medical skills and competencies, to her response. Importantly for the advanced role the response to the call for help does not mean only providing the help that was expected. And sometimes this means refusing to give the help that was anticipated and wanted, but offering something else in its place. As Sandra and Barbara explained in their narratives, they were not prepared to give medicines, antibiotics, when it was inappropriate to do so, even though the patients sometimes expected that. But they were willing to take symptoms seriously, examine thoroughly, explain their decisions and express their empathy with patients who felt unwell.

Humanism guides these nurses away from the illness focus of the medical model towards the patient focus of nursing. The nurses expressed their perception of nursing's stance; of a focus on a patient with an illness rather than the sum of their symptoms. Dawn spoke of seeing "the bigger picture" in the consultation, of exploring the effect illness is having on the individual's life, Sandra spoke about remaining alert to verbal and visual cues, being observant and monitoring the whole patient, Naomi of her health promotion role in discussing the wider implications of disease, how it occurred and how to prevent it. They felt they empowered individuals to view and manage their health and illness differently.

Inherent in their narratives is a belief in nursing as a place, a 'between' where caring and nurturing can flourish (Paterson and Zderad 1976). The words and phrases they used; Gaynor's comments about practising holistically, of comfort and nurturing; Naomi's about listening and compassion; Claire's of caring; all speak of the elements of nursing and human caring which they bring to the consultation and which they feel are integral to the nursing in the advanced role. They echo the essences Paterson and

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Zderad described as being essential to the nursing role, essences which included empathy, caring, touching, understanding and trust.

Where the dialogue takes place, the interaction between nurse-helper and patient-caller is the consultation. Nurse practitioners seem generally able to manage these consultations in a cooperative manner. They demonstrate a willingness to share control and power and understand that patients bring their own perspectives to the consultation and are competent to make their own decisions. Humanistic nursing theory terms this process transactional which suggests exchange, transfer of information or care from one to another. Yet it appears to be a more dynamic process than that, negotiated and constructed *between* the two individuals, that place where nursing occurs, and is reaffirmed through repeated interaction and shared meaning.

At times, nurse practitioners seem willing to give more of themselves in the consultation than they perceive their GP colleagues will do. In particular Gaynor asserted that she would share personal information if she considered it might be beneficial to the patient. Others would not cross a perceived threshold of professionalism to this degree, but would give generously of their time and empathy; creating a therapeutic consultation in which caring and compassion could flourish. This seems to have resonance with writings on the "therapeutic use of self". Based on psychotherapeutic models and the early work of Peplau, it relates to a "particular set of qualities consciously or deliberately employed when engaging individuals in a therapeutic encounter" (McKenzie 2002 p22). For some those qualities might include compassion and caring, for others, like Gaynor, honesty and a degree of self - disclosure intended to reduce distance between her and the patient and promote confidence and trust.

For these nurses it appeared vitally important that they were still nurses. That what they brought to the role was grounded in who they were and how they were trained. They all spoke of still feeling like a nurse, of taking their training and the values of nursing into the new role with them, but of forging new ways of synthesising them with additional traditional medical skills for the benefit of patients.

The previous chapters have focused on the role, the effect on the organisation of general practice through the patient journey and finally through the nurse consultation as the place where the relationship between nurse and patient is constructed. The final findings chapter will focus on the role of the nurse practitioner within the wider team both in practice and the wider primary health care team.

This chapter will examine how the nurse practitioner role integrates into the existing general practice and wider primary health care team. As discussed in chapter two, in the United Kingdom, 'primary' or first point of contact healthcare for a defined population is generally provided by a primary health care team (PHCT); a multidisciplinary group of health and social care professionals working collaboratively to deliver care as close as possible to where people live and work (De Maeseneer, Willems, De Sutter, Van den Geutche and Billings 2007).

Whilst this may indeed represent the ideal vehicle for healthcare delivery, the reality of primary care is messier.  The PHCT is made up of teams within teams; a general practice hub consisting of general practitioners, clinical and administrative staff all sharing employment ties with the GP. And a broader, loosely affiliated team composed of district nurses, health visitors and social care workers from different management structures, employed by acute and social care trusts. The teams share a common patient group based on a practice or geographic population.

This chapter will explore the effect the introduction of a nurse practitioner had on existing team structure; how new relationships developed and how these impacted on the construction of the nursing role.  This will focus on three overarching themes, the integrated team represented by **a new team structure;** the obstacles to integration of their role represented by **overcoming barriers** and finally, how they overcame these problems to **build a new role** (figure 6 p 130).

### 9.1.  A New Team Structure

The perception of the nurse practitioners was that the introduction of their role actually strengthened team structure.  How this occurred is creatively described by Barbara.

> The way I see it, I call it my philosophy of stickle bricks; I think that we do strengthen the team. Because our roles overlap, and instead of having utterly separate roles where we stand side by side, because we overlap, as colleagues we've got a better understanding of each other's roles.  Barbara

The role could be perceived to be a new 'brick' in the existing structure of the general practice workforce. Before this was introduced the structure, based on the core general practice nursing team and a wider nursing and ancillary workforce seemed complete. There were no perceived gaps. The structure appeared strong, stable almost impenetrable. And then a new role emerged, a new 'brick' which had to be squeezed in and articulate with many others. Whilst Barbara and others perceived this added strength to the team, it could also be seen as destabilising; an unnecessary fracturing of the very form and function of the structure.

Barbara's 'stickle bricks' are small plastic toys which interlock allowing them to be joined together in different ways. This has resonance with what was happening to the team structure; nurse practitioners were fixing and interlocking roles with different clinicians in different ways. The occupational fix or overlap gave them unique insight into other clinical roles. And the nurse practitioners felt that insight had benefit to the wider team. This will be explored further in terms of overlap with medical and nursing roles.
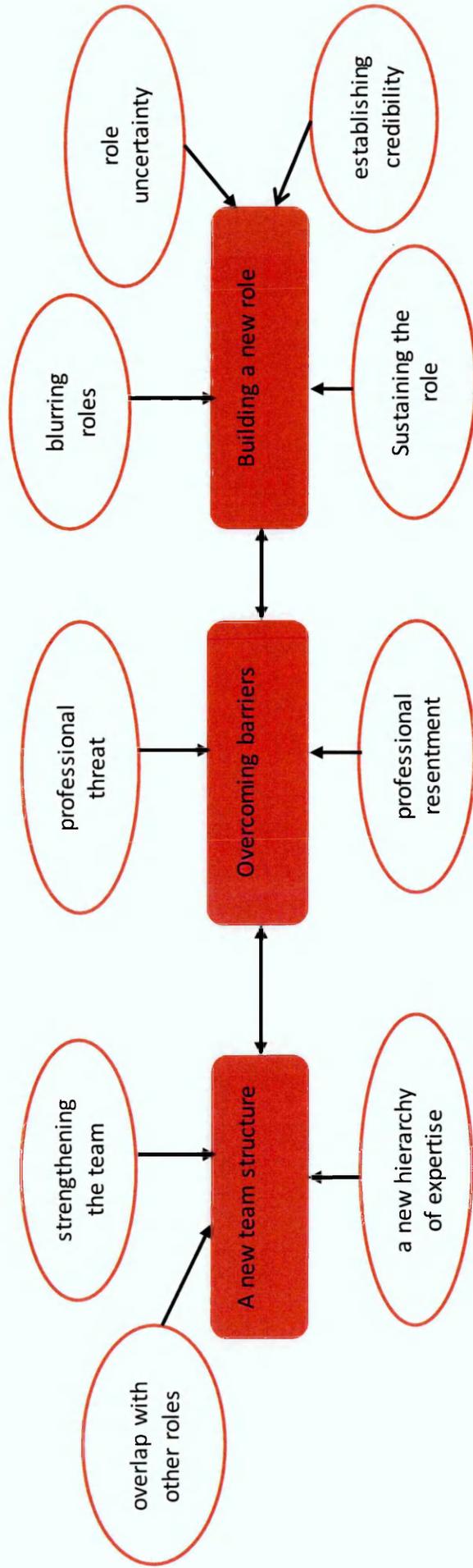
Figure 6
Negotiating professional relationships

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### 9.1.1. *Overlap with Medical Roles*

These nurse practitioners viewed their new role in the team as aligning more closely with their medical colleagues than nursing. Gaynor when asked where she saw her role, closer to nursing or closer to medicine, replied,

> It straddles the two, but I think my role now is closer to medicine.

Whilst they all perceived their roles in acute first contact care, management of undifferentiated presentations or long-term conditions were areas of occupational overlap they were still conscious of a boundary, a limit to the level of complexity they felt able to deal with before referring on to their GP colleagues.

> If I have someone coming in for example with breathlessness and I'm trying to sort out what it is, heart or lung, I might do an ecg, and I would try and work out if they're in heart failure, or have they got an exacerbation of COPD. At least I can manage them basically, and if I am at all concerned I will do the basics on them and then I need to get the GP through. Naomi

> For example, a diabetic patient, her renal function had gone off, feeling a bit tired, starting to feel unwell, very overweight…so I said, let's just check a few background bloods, nothing to see apart from ESR and CRP (inflammatory markers in the blood) were elevated. So I took that to the GP and said where do I go with this? There were no bladder or bowel symptoms, no chest pain, no breathlessness and I said where do I go next? So we have done ultrasound, CT scan. Jane

Even Barbara who perceived the overlapping element of the role to be its strength also recognised there were boundaries to her role and limits to her abilities and competency.

> I can't do everything a doctor does so there is a boundary.

GPs have traditionally been seen as the main beneficiaries of the new role in terms of redistribution of work (Hicks and Hennessey 1999, Reveley 1998). Nurse practitioners have taken on some of their duties and responsibilities at the margins of medical work; creating a connection and occupational overlap not seen between the professions before. Barbara perceived the greater understanding of roles this connection afforded as the cement holding the structure together, making it stronger. She identified this as more than just a checklist of knowing the duties of the doctor; rather that undertaking

similar consultations provided insight into the complexities and pressure of the therapeutic encounter. This resulted in greater respect, cohesion and a shared meaning of general practice which had not existed before.

> My feeling is that there is much less us and them, the doctors do things, the nurses do things and it does draw the team together. There is evidence of this for me for example when we have a practice meeting or discuss cases or they ask me to follow up something. Barbara

Barbara felt strongly that taking on similar or the same duties gave nurses insight, a shared intelligence of the pressure of making decisions every surgery. That doing the job gave an appreciation which could not be acquired in any other way.

> It gives us insight into the pressures of their role, making critical decisions day after day because we are doing that now. Barbara

### 9.1.2. *Overlap with Nursing Roles*

Eight of the nurses had been practice nurses before moving into the advanced role, therefore their understanding of the general practice nursing role could be assumed. In addition they would also be aware of the boundaries and practice territory of the wider nursing team. Yet how they experienced role overlap with other team nurses held little of the optimism articulated in their narratives about overlap with medical roles.

In practices where the NPs had worked as practice nurses before, they were often required to pick up some of the clinical tasks which presented to practice.

> Sometimes smears will get booked into clinic alongside someone with a minor illness. That doesn't worry me. Sandra

> I do flu day (vaccines) like everyone else, why wouldn't I? And if there is nobody else and somebody goes off sick, why shouldn't I do phlebotomy or the dressings? I should be flexible enough to do that. Jane

> Sometimes I am called upon to help out with the practice nurse role, taking smears, giving injections but this does not happen often now. Dawn

The connection and overlap was different from nurse to nurse. Sandra, Jane and Dawn, all ex-practice nurses, were generally content to deal with tasks when required. Some relished the opportunity to be 'hands on'; to be nurses.

> I need to stay hands on. I need to do some nursing. Jane

> I think my greatest strength is hands on patient care and I wanted to maintain that. Claire

Barbara perceived this to be a 'strength'; that having common duties and responsibilities created a connection between the nursing disciplines. But still she was at times frustrated when asked to undertake practice nurse duties, and felt it was inappropriate.

> I am at the moment still doing some of the practice nurse work, smears, dressings that sort of thing. I do not do baby vaccines or travel vaccinations because I'm out of date and I don't want to retrain as a practice nurse. But I'm still doing some of that but it's ok. Barbara

Other nurses were also unhappy at being asked to take on practice nursing duties and felt that it devalued their role in the practice.

> We are trying to make sure the tasks go the nurses. For example, ear syringing, that really annoys me, they shouldn't be booked with me. I don't want to be dealing with that. I need time to deal with other more appropriate things that come in. Claire

The view from these nurses is inconsistent. Those who had practice nurse backgrounds seemed to accept, sometimes grudgingly, that practice nursing tasks could still come their way because of their nursing backgrounds. Jane viewed this as flexibility, Claire as inappropriate use of time and new skills. They reconciled this in different ways, justifying it by statements about maintaining their nursing identity and their contact with patients. Perhaps some of this could be interpreted as individual discomfort at moving into a different sphere of practice; as nurses nostalgic for their previous 'hands on' nursing experience, reluctant to entirely let go. But sentimentality for previous nursing roles had the capacity to hold them back, tying them to a strong social identify and nursing domain.

As identified in chapter six two of the nurses, Ellie and Mandy, visited patients at home who were, because of physical or mental health problems, unable to attend the surgery. Home visiting has traditionally been the role of the district nurse whilst provision of nursing services and monitoring of long term conditions in the practice has belonged to the practice nurse. Public health has traditionally been seen as the role of

the Health Visitor and again nurses are straying into this territory providing advice to mothers and children, on smoking cessation and obesity (Machin, Machin and Pearson 2011). Nurse practitioners in general practice have disturbed the equilibrium of these secure, negotiated boundaries. Substituting for GPs in practice results in NPs delegating tasks to practice nurses. And for the wider team, district nurses and health visitors have at times to defer to them for advice on management of care for patients in the community.

The new overlapping and interconnecting roles which the nurse practitioners perceived to have such value did change the structure of the team. The introduction of a new nursing role, striving to establish a place and fit between other team players was challenging. What effect that had on the existing structure and hierarchical team connections will be discussed further.

### 9.1.3. *A New Hierarchy of Expertise*

Jane and Claire, working in large training practices described a structure, a model of general practice which worked well for them.

> The model we work to, and the sort of general practice I envisage working, with senior GPs working at higher levels, then salaried GPs, ANPs, practice nurses and HCAs. Claire

> We have 6 partners, 2 ANPs, we do have an NP....practice nurses some new and some more experienced. We have the classic "I only do asthma" and for her that is fine, she is comfortable in that role and very good at it and doesn't ever want to change. Another practice nurse who again does not want to get any extra responsibility, she's very happy doing a well-defined practice nurse role. Then we have 2 HCAs, so we have a very good team. A true skill mixed team, a sort of model I see emerging in general practice, with senior GPs almost as consultant generalists, then less experienced GPs and a broad nursing team. The reason it works here is that we have a collaborative response which is team based. Jane

In this team structure, experienced GPs were utilised as an expert resource. Whilst the RCGP prefers the title, 'medical generalist' Jane characterised them as 'consultant generalists', mirroring the hierarchical structure of their consultant colleagues (RCGP 2012b). These GPs had the expertise to manage the greater complexity of general practice whilst also managing and advising an extended team of clinicians and

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attached staff. As has been described in previous chapters, this team construction facilitates a redistribution of the more traditional work of general practice to salaried GPs and nurse practitioners.

Mel working in general practice was aware of this shift in workload. She saw her clinics fully booked, her computer screen full and felt that this allowed GPs to see more complex cases.

> The doctors were interesting, they did see their clinical caseload but they did not see their screen full from dawn 'til end of play like ours were. And for good reason, there are the patients who need more GP attention and you'll be fully aware of all the other calls on GP time which I don't deny are demanding.

Jane saw how it was translated into practice for all practice team members.

> We are doing more of the hospital work across the board. I think everyone is being pushed up a notch. So the HCAs are doing what the (practice) nurses were doing 5 years ago. Jane

Jane was describing the shift in some routine work from secondary to primary care and how general practice had changed to accommodate it (Department of Health 2006, Singh 2006). Skill mix is the vehicle which permits this redistribution of workload across a team, defining as it does tasks and activities and who might be the most appropriate person to manage them. Skill mix has facilitated a new hierarchy through vertical delegation of medical work from GP to NP, particularly around first contact care, and horizontal substitution, role overlap, between nurses, doctors and other clinicians (Richards, Carley, Jenkins-Clarke and Richards 2000).

> I guess where we fit is really around skill mix, people seeing the most appropriate clinician. And skill mix has had a bad press because it's been seen as keeping costs down. But I see it as a good thing, meeting the patient's needs by the most appropriate clinician. Naomi

The nurse practitioner role as articulated here by Jane and Naomi did not challenge the medical hierarchy, indeed it appears to consolidate it. GPs remained at the apex of the team structure not only because of their organisational authority as employer, but also because skill mix redistributed work of lesser value from them to nurses. This served to consolidate the position of the experienced GP as the person with the professional knowledge to manage complexity (Currie, Finn and Martin 2008).

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The nurse practitioner role did challenge existing nursing roles within the team. As discussed in chapter four, many of the nurse practitioners interviewed were leading teams of practice nurses, delegating clinical tasks to them and making management decisions for district nurses and health visitors in the wider team. These are normally tasks undertaken by GPs. It seems the 'sticklebrick' effect, rather than creating overlapping nursing roles, created a new hierarchy *within* the nursing workforce. As will be seen later this had the potential for friction and resentment.

## 9.2. Overcoming Barriers

Many of the nurses interviewed experienced problems developing new relationships with the wider team structure. This will be explored in terms of relationships with other nursing disciplines, interpreted as **professional resentment** and with medical colleagues, interpreted as **professional threat.**

### 9.2.1. *Professional Resentment*

Nurses whose roles developed 'in-house' and who had been practices nurses before changing roles experienced some initial distrust and resentment from their previous nursing colleagues. Dawn described difficulties she experienced working alongside a practice nurse with whom she had been colleagues for some considerable time.

> **Dawn:** The nurse I worked with when I was a practice nurse was rather difficult for a while.
> **Researcher:** In what way difficult?
> **Dawn:** She seemed distrustful of why I wanted to do it, as if practice nursing wasn't good enough in some way.

Gaynor had worked as a practice nurse whilst studying for her advanced nurse practitioner qualification. This meant that gradually she took on more of the general consulting role of the GP and shed the task-based role of the practice nurse. A consequence of substituting for the general practitioner was that sometimes she might need to delegate work to the practice nurses; for example therapeutic injections and dressings, and this caused some tension.

> It was hard work within the nursing team because there was a nurse who was senior to me, been there a long time, and so suddenly I was taking a step above her and it took a lot of working out. It affected relationships for

a while. That was quite tough. I think there is often a little bit of envy amongst nurses. Gaynor

In contrast Naomi's first nurse practitioner position was in a practice which had not had nurses working in the advanced role before. She encountered no problems with the practice nurse there.

The practice nurse here has been fine, she's great. I think she enjoys having an additional resource she can go to.

Naomi suggested that it might be more difficult to upgrade from within an existing nursing team due to personal and professional jealousies. That moving into a practice as a new nurse practitioner might be easier and cause less friction. Mel experienced, what she described as 'coolness' from a nurse within her practice.

I never discerned overt resentment but there was coolness from one experienced nurse who was firmly of the mind-set that "I'm a nurse, nursing is a very defined thing separate from medicine and you're trespassing, you're crossing, you're blurring boundaries". It wasn't for her. And if the conversation went there, always of the opinion that nurses should be nurses and not nurse practitioners.

Some felt this reaction, the 'coolness' or antagonism came from nurses who did not want to advance their role but were critical and distrustful of those who did. Mel identified this in her relationship with another practice nurse in her practice.

When I joined the practice they were already supporting one practice nurse who specialised in diabetes through her masters so that she could broaden her role. But interestingly, she passed the degree but she never made the transition, she never crossed over to the ANP role. She felt safer in her practice nurse role.

Ellie felt that this was also evident in her practice from a nurse who had 'tested the water' by completing her nurse prescribing but had chosen not to use those additional skills and opted instead for a safer role.

We have two nurse prescribers. One has done the minor illness but she really doesn't want to step up to the nurse practitioner role.

'Step up' echoes Gaynor's description of her early relationship with a nurse with whom she had experienced antagonism. She talked about taking a 'step above' as she moved to the nurse practitioner role. Both reinforce the concept of the 'hierarchy of expertise' within nursing in general practice.

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Mandy, who had joined her practice as their first nurse practitioner, had experienced hostility from nurses within the extended nursing team.

> I think there was some resentment to start with, but that mainly came from other senior level nurses outside general practice so I'm thinking within the district nursing team, health visiting team, they were a bit sceptical.

Mandy perceived that the hostility was due to uncertainty about where the role would 'fit' in the existing nursing or primary care framework, perhaps even how that role would relate to theirs in terms of the nursing hierarchy. This suggests some territorial concerns about responsibility and accountability, concerns expanded upon by Dawn.

> As for the district nurses, they do seem rather resentful. And yet when it suits them, for example, when they want to report something about one of the patients or when they want an insulin dose adjusting, they ask me to make the decision and fax letters to cover themselves. That really annoys me. Dawn

This may be a simple defensive measure on the part of the district nurse, ensuring that they are not held accountable for decisions made by another clinician. Dawn's interpretation however, is that whilst hostile to the nurse practitioner role in general, they were content to allow her to make and be accountable for decisions they were not prepared to make themselves. It is unclear whether or not the same district nurses would demand a written instruction from the GP.

These narratives have resonance with previous studies of inter-professional relationships in general practice. These also recounted reported disquiet about the advanced role and its closer association with medicine and highlighted resentment amongst some nurses who perceived nurse practitioners to be elitists who no longer valued nursing (Williams and Sibbald 1999, Charles-Jones et al 2003, Long et al 2004).

### 9.2.2. *Professional threat*

As with the extended nursing team, so there were undercurrents of inter-professional disquiet amongst some general practitioners. Of all the professions, GPs are probably the group most affected by the evolving role. Whilst they continue to employ NPs in increasing numbers, some remain concerned about how it affects their status with

patients. The reaction of GPs in Jane's practice demonstrated that the new role remains a perceived threat to traditional medical power.

> One of the GPs mentioned the other day, how can we get patients to recognise you as NPs, and I say I can't do anymore, it's on my badge, it's on my door and I introduce myself as an NP. Jane

It appeared that whilst her GPs welcomed the role into the practice because of what it could offer, they wanted to be sure that patients appreciated these clinicians were nurses and not doctors.

> I think the GPs struggle with the thought that patient's think my colleague and I are doctors, they find this a bit of an affront. Jane

They were concerned about what patients thought. Concerned that they might perceive other less qualified staff could satisfactorily perform some of their usual duties. And this might devalue their traditional dominant position in general practice. This has resonance with other qualitative studies which reported similar concerns from GPs (Wilson et al 2002).

Resentment and threat, different reactions from the team members but both concerned with roles and disturbance of their own professional equilibrium. Individual professional groups share a common identity (Friedson 1984). But according to Bucher and Strauss, writing in 1961, within each profession there will be divisions defined by specialisation and by intellectual orientation. Nursing is a broad church. Within it there are a variety of nursing disciplines; orthopaedic, general, intensive care and yet more nurses will have diversified to become involved in teaching and management. But the community identify and understanding remains nursing. Part of the resentment felt by nurses, particularly in the practice nursing team, may be due to what Ashforth (2001), described as the effect of 'role exit' on those left behind. That forsaking a nursing role and aligning more closely with medicine may be seen as disloyal, as diminishing the integrity and value of their profession. Naomi suggested that resentment might be greater when nurses had transitioned from practice nurse to nurse practitioner within the same practice. Role exit in this situation is real and personal with the potential to disrupt previous professional relationships.

For the general practitioners role threat may be related more to concerns about retention and control of professional territory and authority. Friedson (1984), in his sociological exploration and explanation of professional power identified control as proceeding from medicine's "jurisdictional monopoly over a defined area of knowledge and a given set of tasks" (p 4). Nurse practitioners challenge this. They invest in the rituals and symbols of medicine through their training in clinical examination, diagnosis and prescribing. They extend their knowledge base into curative processes as well as caring. But a threat? NPs contesting control over some part of the formal knowledge base and skills that general practitioners have owned for decades may be an attractive notion. But in reality it may be little more than opportunism, doctors ceding control over these areas to subordinates, relinquishing activities and tasks they see as of less importance. And nurses being prepared to take up that work.

### 9.3. <u>Building a New Role</u>

Nurse practitioners, trying to fit into an existing structure, trying to develop new networks and relationships within the team are also striving to develop a new and unique role within general practice and primary care. This will be explored in terms of the following themes; **blurring roles, role uncertainty, changing minds, establishing credibility and sustaining the role.**

### 9.3.1. *Blurring Roles*

Team role boundaries are undoubtedly affected by the addition of the nurse practitioner role to the primary health care teams. The stickle-brick effect of attaching to different clinical disciplines in different ways; of occupation overlap; of insinuating themselves into the gaps in the team structure was the result of a shift in workload and responsibilities within the team. This did not affect only health professionals. Patients too were disorientated by the change and uncertain of where role boundaries lay.

Talking about how patients reacted to them in the new role, the nurses reported that on numerous occasions patients thought they were doctors.

Those who come regularly still call me doctor and they laugh and say I know you're not a doctor. But they say you work like a doctor, why aren't you a doctor? Claire

A lot of patients, even though I've been here years, and it clearly says nurse practitioner and clearly doesn't say doctor above your door, still automatically assume you are a doctor. Mandy

I wear a badge, I introduce myself as a nurse practitioner. And they (patients) still often say thank you doctor. Naomi

These nurses had jettisoned the symbols of their previous nursing roles. None of them wore uniform and whilst some still performed nursing tasks learned in basic training, they were all primarily fulfilling a medical function. And by necessity they had assumed the symbols of the medical profession. The tools of the doctor's trade, stethoscope, ophthalmoscope, the prescription pad; were now their tools. Patients, accustomed to consulting with general practitioners; assumed, because the rhythm and routine appeared the same, because the nurses were utilising new clinical skills, diagnosing and prescribing, that they were in fact medical practitioners.

### 9.3.2. *Role Uncertainty*

Together with the confusion expressed by patients, the nurses themselves sometimes struggled to cope with the uncertainty of a new professional role and identity.

Initially when we first started, because we were the first ones in this area, we didn't know how the role was going to develop and I think the idea that the original PMS (personal medical services) practice had for nurse practitioners was not really what the role developed into. Mandy

The implication here is that Mandy did not know what her role would be when she was first appointed; that it became a different construct over time driven by the needs of her practice. There was uncertainty too about the nurses' own abilities to manage the demands of the new clinical role. This was evident in their narratives about their early clinical practice.

...certainly in the early days I would be scared to send them (patients) home, I rang them at home later that day and the next day to see if they were ok. Gaynor

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When I first started I used to follow them up. I would worry if I had got it wrong, had they been admitted to hospital. Sandra

So when I first started the job I found it really stressful.. I was extremely anxious about seeing children because I wasn't paediatric trained and it meant I would spend masses of time coming home, reading, researching. Naomi

These demonstrate perhaps the greatest challenge of the advanced generalist role; making autonomous clinical diagnoses and management decisions about patients presenting with undifferentiated symptoms, common or chronic conditions. When the responsibility for those decisions became personal and practice was truly autonomous, it was daunting. Indeed Sandra admitted to feeling "...scared all the time". Making clinical decisions at this level is really about managing uncertainty and fear; uncertainty in a new professional arena; fear of missing a serious illness, fear of making an incorrect diagnosis or giving inappropriate treatment. And tolerating that uncertainty and conquering that fear is an unavoidable part of advanced clinical practice; particularly practice which takes nurses out of their usual professional domain of practice and into another (Thompson and Dowding 2001). Indeed Mel commented on how she accommodated this, how it became part of everyday practice.

There is a mantra in general practice, 'the tolerance of uncertainty' and this is about how much uncertainty you can cope with. You are used to it, you are front line, you make those decisions every day.

Mirroring that personal uncertainty, tolerating and managing it, these nurses also needed time to establish their professional credibility within the wider team. And this occurred on two levels, micro- at the front line, changing minds about what they as individuals could do, and macro- , establishing credibility of the new role within the wider team and profession.


### 9.3.3. *Changing Minds*

Gaynor, in her description of working relationships with the wider nursing team, felt that she had worked hard at developing trusting rather than authoritative relationships.

There wasn't a real integrated working team with district nurses when I came here and I've worked on that. They knock on my door and ask about

patients and they see I'm able to prescribe for them. If they're worried about patients they'll often come to me rather than the GP. Gaynor

Jane perceived that her willingness, "just to be a nurse", gave her professional credibility with her practice nurse colleagues.

> ...not that I mind doing a 4 layer bandage, I'm willing to do it, but it's not a good use of my time. I do think because I am willing to do it, I am respected more within my (practice nurse) team. Jane

For some nurses like Sandra this acceptance seemed to be personally driven. When asked how she had managed the change in her role from practice nurse to nurse practitioner and its effect on other nursing staff she simply replied.

> I've been in the practice longer than any other nurse here. So they adjust to me rather than the other way round.

Amongst GP colleagues, the nurse practitioners interviewed generally felt that this battle for recognition and acceptance had been won. They felt valued by their GP employers for the work they did in general practice. For some, especially those taking up posts as the first nurse practitioner in individual practices, it had taken time to build trust and confidence in their abilities.

> I feel totally valued. It has grown in the time I have been here, now they treat me as one of them. Gaynor

> Well the GPs, the senior GPs in particular, they value me, they come to me, particularly around diabetes, they come to me and ask what should we do? It took a long time. Sandra

Interestingly Jane perceived her value to the practice in terms of a medical dichotomy, as having moved out of a purely nursing hierarchy with a role and skills equal to that of her GP colleagues.

> I would be valued at least as much as a salaried GP in my practice.

For others it was not clear whether or not GPs were convinced of the new advanced role so much as appreciative of having a skilled, flexible worker capable of substituting for doctors and for nursing colleagues, as and when needed.

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### 9.3.4. *Establishing Credibility*

These nurses felt it particularly important that the nurse practitioner role was recognised and accepted by nursing colleagues. Dawn expressed frustration at the perception that rather being nurses trying to create a new nursing role, NPs were simply trying to be doctors.

> There are so many tensions between the different nursing groups, NPs and community nurses that I do sometimes wonder if it's worth it. We are all nurses after all but some seem to think we have outreached ourselves, that we are trying to be doctors and generally we are not. We still want to be nurses; we just wanted to try something different, to challenge ourselves. Dawn

Whilst acknowledging they had taken on some of the duties and responsibilities of their GP colleagues they did not feel they were leaving nursing behind, indeed Barbara spoke of taking nursing with her into the new role.

> I don't think we're moving away from nursing, because of what we bring with us. We are still the people who chose nursing as a profession so we still bring who we are and we bring all that we have developed through our nurse training into this role.

Barbara asserted that establishing credibility as a nurse practitioner, as with any change, takes time, familiarity and confidence.

> I think (NP role) has great value, even with some resistance which is inevitable when you bring in a new role. When I was a hospital nurse I remember when nurses first started to put cannulas in and give IV drugs, the shock horror that caused but now it is fully accepted. It's just when something is new.

Barbara recognised that in her practice, her modelling of the new role was having a positive impact on other members of the nursing team.

> Nurses generally have been really interested in what I do and asking questions. And some expressions that it might be something they might like to do.

Gaynor perceived role modelling to be important in changing mind-set so that other nurses in general practice would see the NP role as something they might want to do.

> I think within general practice there is a clear pathway which there never used to be. I think for junior nurses it's very good. I have a practice nurse at present who has definite career aspirations to do my role as time goes on.

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And there is now a clear pathway there for her and we are paving the way,
She thinks that's fantastic. The student nurses... are absolutely amazed
when they see what we can do.

### 9.3.5. *Sustainability of the Role*

Having worked so hard to develop a new role within the structure of general practice,
potential future developments within the NHS pose new challenges. The physician's
associate is proposed as a new potential gap-filler within primary and secondary care.
Culled from a biomedical or science background it is proposed that these graduates
will have two years training and then be placed in primary or secondary care as
dependent practitioners under the supervision of doctors (Parle and Ennis 2015). The
nurses interviewed were all aware but as yet only mildly concerned about their
possible deployment.

> I don't think just being science based means they'll be good at all the other
> aspects of the job. The relationship between you and the patient, we are
> better attuned and pick up things that perhaps others might not. Our big
> role is education, some of these illnesses just need education. Sandra

> My personal opinion is that this is a nursing role, you need to know how to
> nurse patients before you can look after them at any advanced level. The
> level of care and understanding (between nurses and science graduates) is
> just not comparable is it? I would compare it to PCSO (police community
> support officer) and the police. I'm not saying they are not good at what
> they do but I do see it as a dilution of the profession and that to me lowers
> standards. Mandy

There is an interesting duplicity in Mandy's statement. A resonance perhaps with the
role of the nurse practitioner in Mandy's comparison of PCSOs and police officers. NPs
have been accused of being poor replacements for GPs, that their training does not
have sufficient depth and that their knowledge is inadequate for the complexity of
illness they may encounter (Wilson et al 2002, Carr et 2001).

### 9.4. Discussion

The demands on and composition of the primary health care team have changed
dramatically over the last two decades. Shortages of GPs and increased demand for
services have provided the impetus for a more team-based approach to primary care
and diversity in team members (Freund, Everett, Griffiths, Hudon, Naccarella and

Laurant 2015). New roles have been introduced; community matrons, health care assistants, community pharmacists, and old roles have been expanded; GPs with special interests and nurse practitioners (Williams and Sibbald 1999, Charlton 2010). More changes are planned as community services align geographically with social services and there is even open discussion that these teams of the future may not need to be led by a general practitioner (Watton 2013). The RCGP (2013), in their vision for the role of the GP in 2022, understandably challenge that but confirm that practice teams of the future will need to change, that they;

> ..will also require the skills and expertise of nurses, physician assistants and other professionals who have undergone specific vocational training in community-based settings and are trained for their generalist role, which will complement that of the expert generalist physician (P19)

The reality of teams has changed as the reality of the healthcare landscape has changed. Bleakley (2013) in his description of contemporary healthcare draws comparisons with Baumann's (2007) theory of 'liquid life', the concept of a society in which the conditions for its members are changing faster than can be consolidated into habits and routines. Similarly the demands for healthcare have escalated and continual policy change by consecutive governments has made any attempt or hope for stable teams unrealistic. Team members must endure constant reconstruction of identities and tolerate uncertainty about their own roles. Bleakley (2013) further describes contemporary teamwork as inhabiting,

> ..a place between established routines and improvisation under conditions of increasing uncertainty or ambiguity where demands for new knowledge and skills may not be given enough time to bed in.

This new fluid reality mirrors the fluidity of the advanced nurse practitioner role itself. Its construction and imposition on team structures has disturbed the equilibrium of the team and other team members. Traditional role boundaries have become porous as tasks and responsibilities leak from one professional grouping to another. Rather than Barbara's 'sticklebrick' effect strengthening the team, this blurring of roles has caused resentment and perceived threat to professional sovereignty amongst co-workers. It seems that the importance of those role boundaries was overlooked in the pursuit of a new and more flexible

workforce. Policymakers have not understood or paid too little regard to how professional role identity, its uniqueness and integrity is sustained by boundaries and how they shape a social understanding of what individual professions and disciplines can do or offer (Ashforth 2001).

Different types of inter-professional relationships are seen in primary care teams. The relationships are task-dependent and can be collegial, demonstrating *equal* power trust and respect, collaborative, *mutual* power, trust and respect or authoritative, exhibiting unequal power, directive and paternalistic characteristics depending on the situation and the professionals involved (Schmalenberg, Kramer, King, Krugman, Lund, Poduska and Rapp 2005). GPs still dominate the clinical hierarchy retaining power within their own team hub with the general practice nurses relatively powerless as a consequence of their employee role. The wider team are co-dependent and despite different management and employment structures they are intended to work together for the benefit of patients. All of these different relationships need to be blended to deliver effective care to the local community. A willingness of team members to work collaboratively is identified as central to an effective team (Xyrichris and Lowton 2008). How effective the team is then is in no small part determined by how clinicians with both diverse and overlapping skills relate to each other and perform together within the team.

In their exploration of professional role identity amongst another professional group within the wider PHCT, health visitors, Machin et al (2011) found that a stable role identity rather than hindering interprofessional collaborative practice, helped to facilitate good relationships and working practices. That role boundaries were important, and being able to articulate the unique contribution they made to teamworking was a prerequisite for success. The nurse practitioners in this study articulated their collective struggle to work collaboratively within the team, a process perhaps affected by their inability to successfully articulate their unique professional identity and attributes.

The early relationships experienced by these nurses did not hold much promise of effective team working. Added to the resentment of nursing colleagues at the closer alignment of their roles with medicine, was the assumption that they would lead

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nursing teams simply because of the higher status accorded to NPs within the general practice hierarchy. The effect of this was, as Nancarrow and Borthwick (2005) suggested might occur, the creation of a new internal nursing hierarchy. General practice nurses, traditionally subordinated to their medical employers were creating their own subordinate workers within the nursing team. Nurse practitioners delegated tasks to practice nurses, planned care and made clinical decisions for patients in the community and made referrals to nursing teams. All were relatively new activities for nurses, more commonly performed by general practitioners and more easily accepted perhaps when they were.

Despite the threat to status expressed in this chapter, there appeared less conflict between the NP and the GP roles. It seems likely that despite adopting some traditional medical tasks and duties, the NP role did not disturb the professional hierarchy within the team. And in particular did not disturb the GPs' powerful positon at the top of that hierarchy. Micro-level relationships here are characterised less by collaboration and negotiation and more by traditional power relationships, the authoritative exploitation of less powerful by more powerful professional groups. (Currie et al 2008).

The macro-level relationship between medicine and nursing demonstrates similar inequality. Leonard Stein (1967) described it in terms of a 'doctor/nurse' game which made explicit the power relationship between the two professional groups and the social game played to maintain that balance. It was a simple and universally understood hierarchy. Doctors retained the high ground; they had the hard knowledge to make ill patients better. Nurses, usually women, contributed to the care of patients under the direction of the doctors (Radcliffe 2000), reflecting Watson's 'curative / carative' divide (Vandenhouten and Peterson 2012). Clearly much has changed over the decades since Stein's original theory. Indeed when he revisited his work he found that there had been progress; nurses had shed some of their handmaiden role, were contributing more to treatment decisions and were enthusiastically redefining their role in health care (Stein, Watss and Howell 1990).

In the decades since, nurses have continued to strive to remove themselves from this inequitable relationship. The drive to make nursing a graduate profession, the

creation of a unique body of professional knowledge, carving out new roles which are distinct and complementary are all means of achieving this aim. And yet the new nurse practitioner role in general practice appears to patients, nurses and GPs to reflect medicine more closely than nursing. It has crossed traditional nursing and medical boundaries and been influenced by both spheres of practice. And as has been seen in this chapter, there are conflicting views about the value of this; some consider it beneficial and some that it causes confusion and strain.

In advancing into new spheres of practice, it seems that nursing has chosen to perpetuate the doctor/nurse game by emulating the medical profession and squandering an opportunity to expand its traditional caring role (Holyoake 2011). In secondary care this has involved taking on duties such as clerking patients and venepuncture, traditionally the role of junior doctors. And in primary care it has involved developing clinical skills, managing patient presentations and prescribing; traditionally seen as the role of general practitioners. The relationship at micro level might feel professionally complementary, respectful and appreciative but how can it be when even the idea that nurses come to feel valued by GP colleagues, reinforces the hierarchical relationship. Value and professional esteem is theirs to offer and give, and the nurses' responsibility to earn. There is no notion of this being a reciprocal relationship.

Fuelled by workforce shortages, in a political climate that encourages and supports workforce flexibility, new roles will continue to develop. Consideration of the impact on individual professional relationships at practice level and the broader doctor-nurse game at the macro political level seems to have been ignored or sacrificed for the short term gain of a new professional direction. Whilst nurses feel successful and valued, it would appear that the medical profession and policy makers are the real winners in the game.

The next chapter will summarise the themes and present the key findings of the project grounded in the political and professional context of advanced level nursing.

This chapter will reprise the four major themes derived from the data (diagram 2) followed by a discussion of the key findings emerging from them. My final reflections will explore the findings and their impact upon my perception of my profession. An examination of the strengths and limitations of the study and final recommendations for the future enactment and research into the advanced role concludes this project.

The research aim is;

To explore nurse practitioners' perceptions of their role and value to general practice.

The objectives which will facilitate this aim are;

1. To articulate the scope and development of their individual roles.
2. To explore how NPs perceive they contribute to the organisation and delivery of services in general practice.
3. To explore how the NPs perceive their role impacts on patient care in general practice.
4. To consider how the NPs perceive their role impacts on other members of the practice team.
5. To articulate the meaning the nursing element of the role still has for nurse practitioners in general practice.

## 10.1 Summary of Study Findings

The study findings are detailed in Chapters six to nine. They illuminate the effect and value of the nurse practitioner role through four domains; role, practice, patient and team. The main themes will be summarised again here.

### 10.1.1 *Scope of the Nurse Practitioner Role*

Chapter 6 explored the why, what and how of the advanced nursing role in general practice; who was advancing their practice and through which route, how that role was constructed between nurses and their employing GPs and what mix of tasks and

activities ensued. This was mapped through two broad organising themes; **working as a nurse practitioner** and **developing as a nurse practitioner**.

Nurses were providing care in a number of key areas. Acute first contact care for minor illness and undifferentiated presentations; management of long term conditions such as Diabetes Mellitus and Asthma, managing or leading the practice nursing team, administrative and practice nursing duties were all identified by nurses and incorporated to varying degrees into their everyday practice.

How the roles had developed in this way was a fluid construct of what the nurses were trained or prepared to do and the needs of the practice or their employing GPs. There appeared from the narratives to be two distinct pathways to advanced practice but multiple clinical realities. Some of the nurses had undertaken specific training to BSc or Masters' level whilst others had been practice nurses and advanced their nursing role within the same practice.

The value of this to their practices was flexibility. The flexibility to manage patient demands for acute services, the flexibility to step back into a practice nursing role according to service demands and the flexibility to combine these with a range of management, training and administrative roles when needed. Whilst this was viewed positively by some nurses it does not reflect nursing creating a new role, determining what they uniquely can do, rather it is about being useful and filling gaps when and where the service demands.

### 10.1.2. *The General Practice Appointment*
The context of the study is general practice and the focus of chapter 7 was the contribution made to its organisation and services by nurse practitioners. This was explored through two organising themes; **'booking' the system** and **opting for the NP appointment**.

**'Booking the system'** focused on the ways in which nurse practitioners had increased the capacity of general practice by providing new appointments for acute and long-term conditions and the problems and benefits associated with this. It became clear that the supply and organisation of this service was driven by the needs of the practice and the preferences of the dominant health professionals within the service; the GP

employers. The tension within the service was how to reconcile better and more rapid access to care with choice, the freedom and ability of the patient to choose their clinician and build an ongoing therapeutic relationship.

It appeared that the introduction of the nurse practitioner to general practice, whilst necessary in terms of providing services to manage increasing demand had created a barrier between patients and their preferred clinician, the GP. **Opting for a nurse practitioner appointment** detailed how these experienced NPs observed patients making quite erudite decisions, determining that when the problem was minor, prompt access to an alternative clinician was acceptable. And that in some cases patients were deciding that they wanted their care to be provided by nurse practitioners rather than doctors.

### 10.1.3. *The Nurse Practitioner Consultation*

Chapter 8 explored the consultation as the place where the therapeutic interaction takes place between nurse and patient. Organising themes of **seeing the bigger picture; keeping it nursing; showing their human side** and **building a relationship** were developed to capture what these nurse practitioners perceived to be their unique contribution to a patient journey, what they provided which was different and had worth; the essence of their 'added value'. Through their words, their stories and their enthusiasm, they articulated the contrast between their consultations and those of their GP colleagues.

In particular, they identified a different emphasis in the way they consulted; a focus on the patient rather than the symptom, a holistic, nursing orientation which they felt had value and which patients responded to. They perceived this to be an ability to synthesise elements of the biomedical model with their nursing skills and background to establish a real connection and rapport with patients. They felt they asked more and explained more than their medical colleagues and as a result patients were better informed and more able to manage health problems.

They described professional and sometimes personal attributes which they felt enhanced the patient consultation and journey; empathy, humanity, compassion and a greater willingness to give something of themselves; to disclose, to appear human and

even vulnerable within the interaction. They felt this would not happen within a GP consultation. What these nurses demonstrated in their approach to the new role was a model of nursing in which they brought all that they were, personal and professional, to respond to patient need. This guided them away from the biomedical model towards a place where the consultation was managed cooperatively, by listening, negotiating and interacting with patients, their families and carers.

### 10.1.4. *Negotiating professional relationships*

Chapter 9 explored the integration of the new nursing role into existing general practice and wider primary health care teams through three broad themes; **the new team structure; overcoming barriers** and **building a new role.**

The perception of these nurses was that the introduction of their role actually strengthened team structure. That their new skills in managing part of a traditional medical workload gave them a unique insight into both nursing and medical worlds. However the new alignment of their nursing role with medicine created antagonism amongst both of these groups. Concerns were expressed by nursing colleagues that they had abandoned their professional roots and heritage, and by doctors, that they were trespassing on medical territory and challenging their status and relationship with patients.

How to negotiate these troubled waters caused concern for most of the nurses but their focus remained to be recognised, not as an instrument of the medical profession, but as a new nursing professional capable of combining some parts of the medical model with the skills and orientation of nursing.

### 10.2 Discussion of key findings

What became clear from these themes was how lack of clarity, consistency and identity impacted upon the enactment of the role in general practice. This raised unexpected questions; about the role itself, how it was articulated across different practices and what value or limitation it might have in healthcare. It also raised questions about advanced practice, what future that might have and what it should look like.

The discussion then will begin with how the nurse practitioners in my study enacted their individual roles in practice and how those roles correlate with the concept of 'advanced nursing practice'. It seemed from the data that rather than articulating a single generic role, these nurse practitioners practised in quite different ways. Ten interviews revealed ten different roles. Each marking a place on a continuum from practice nurse to autonomous advanced practitioner. How each developed was a fluid construct negotiated at micro level between nurse and employer, driven by training and the needs of the practice; a construct susceptible to change according to economic climate and workforce issues. This then is proposed as the key original finding within the project. Literature identifies the nurse practitioner role as a single, distinct level of advanced practice. But this research recognises multiple clinical realities each fulfilling need within their practice, each individually constructed, each recommended and championed by the nurse practitioners as having value for their patients.

### 10.2.1. *How do we recognise advanced practice?*

'Advanced level practice' has been applied inconsistently to a number of different nursing roles resulting in confusion amongst health professionals and the public. The position statement published by the Department of Health in 2010, described a generic benchmark of advanced practice comprising 28 elements clustered around the four domains or pillars; clinical/direct care; leadership and collaborative practice; improving quality and developing practice; developing self and others. The RCN provided a more specific description of nurses working at advanced level in primary care, stating that expertise is grounded in an ability to work as a generalist providing complete episodes of care to patients of any age and with a variety of presenting problems and health needs including acute first contact care, long term conditions, health promotion and public health (RCN 2012b).

The most critical part of this statement in terms of a generalist role is "*providing complete episodes of care*" reflecting a high degree of autonomy, complex clinical decision-making skills, prescribing and scope to refer to other services, together with the confidence and willingness to manage the uncertainty which inevitably accompanies practice at this level.

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Of the ten nurses interviewed only one, Gaynor, fashioned a role that could be considered as working at an advanced level as articulated by this definition. Gaynor had completed a recognised Masters' degree as an advanced nurse practitioner, she worked autonomously within the clinical arena, she consulted only with undifferentiated presentations, managed her own follow-up appointments, prescribed, shared in the daily on-call emergency rota, trained medical students, supervised the work of the junior doctors in the practice and was involved at strategic level planning the shape and delivery of services.

For the other nurse practitioners interviewed there were multiple constructs of the role, multiple and changing realities of nursing in general practice. Across the dataset three distinct roles were identifiable; a highly autonomous role utilising advanced generalist skills as demonstrated by Gaynor and to some extent Claire, who in addition to managing undifferentiated presentations to general practice had a role in managing complexity in long term conditions; this role or level I have termed Advanced Nurse Practitioner. A much more limited role was enacted by Sandra, Ellie and Dawn, managing mostly long term conditions, minor illness and some practice nursing duties; a level I have termed 'Practice Nurse Plus' and a third group, more difficult to define, who managed first contact care and some long term conditions who I have termed Nurse Practitioner. This distinction is demonstrated in figure 7 as role differentiation contained within the broader level of advanced practice. It would have been easy to represent this as a hierarchical model mirroring the current structure of general practice with biomedical knowledge and skills at the top and more traditional nursing task and protocol based activity at the bottom. Rather I prefer to portray this as a flat model reflecting Barbara's perception of 'sticklebricks'; overlapping, collaborative and complementary roles providing a diverse skill set which can be accessed by the practice population.
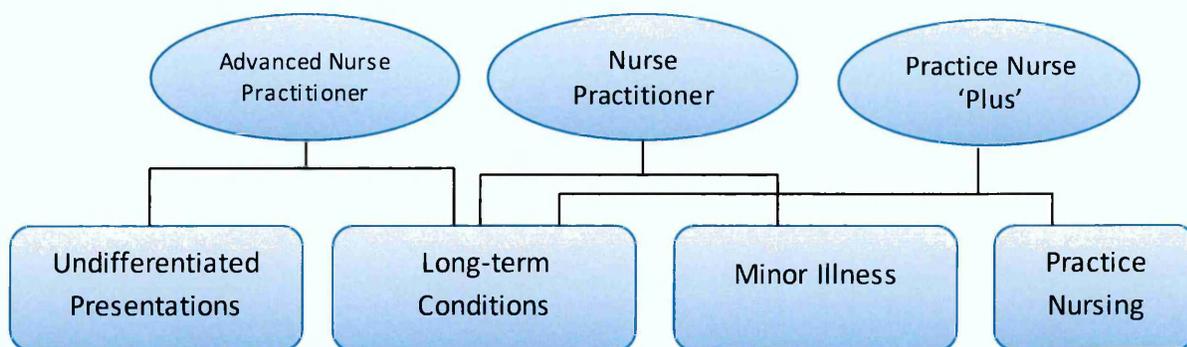
Figure 7
Model of NP Role differentiation

Nurse practitioners working in more autonomous roles recognised these differences in practice and attempted to create distance between themselves and those nurses they perceived to be practising without their level of training, by adopting the title **'Advanced Nurse Practitioner'**. They felt that the training they had undertaken, the clinical skills they had accumulated and the decision-making they exhibited in managing patients presenting with undifferentiated symptoms, established a different level of advanced practice. But using Gaynor's practice as a benchmark, modelling a broad well-developed role encompassing autonomous clinical practice, leadership and influence at a strategic level, it seemed that other nurses did not attain or were not consistently working at this level.

Within the second group, termed **Nurse Practitioner** highlighted in figure 7, it seemed that nurses were working almost at a transitional level; whether through their own intent or the requirements of their employer is different in each case and sometimes difficult to uncover. Barbara probably had the most disordered role within this group. She was managing long term conditions and first contact care for acute minor illness autonomously but still performing some practice nursing duties because the practice needed this. In common with Barbara, nurses in this group were undertaking some management of long term conditions but there was no indication that what they were doing was inherently different to what practice nurses with additional training in long-

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term conditions were doing; conditions such as Ischaemic Heart Disease, Diabetes and Asthma. The majority of nurses within this group had trained specifically as nurse practitioners whether at first or Masters' level except for Mandy, who had ceased her post graduate training at diploma level. Certainly Barbara and Naomi were trained to do more, but because of the way the role was negotiated at micro-level they were not working to level or to title but to a role defined for them. Without the full engagement of skills their roles do not appear to fulfil the broader criteria and standards of a truly autonomous role.

The final group is termed **'Practice Nurse Plus'** (figure 7). The nurses here were still engaged in administrative duties and some practice nursing tasks within their practice, performed either opportunistically within minor illness clinics or in planned sessions. The 'plus' within the heading relates to their engagement in long term conditions and management of minor illness. Either of these areas could be termed a 'specialism' in its own right and this seems to site the nurses' roles within a more specialist domain within general practice. For some this ad hoc way of practising was troubling; Ellie was unhappy at being confined to practice nurse duties when GP registrars were managing minor illness, and Sandra was unhappy when she was allocated tasks such as ear syringing, when she felt her new skills would be better applied to management of minor illness. But the reality of their roles was that they could be deployed wherever there was a gap in service provision.

These nurses did not have recognised first degree or Masters' level qualifications in advancing nursing practice or the advanced nurse practitioner role. Their roles had developed because the GP employers recognised a demand for management of acute first contact care for minor illness and they were already in practice and willing to undertake further training. They were not managing undifferentiated presentations and their boundaries for practice were stringent. For example, Sandra stated that she would not manage or prescribe for patients with mental health problems and would not consult with children. These were referred to a GP. Dawn managed triage and was therefore able to control the problems appointed to her own clinics, more complex problems again would be referred to the GP.

Their practice would seem to align more closely with an existing primary and community care professional role. 'Specialist Practitioner – general practice' is already available and constitutes an NMC recognised and registerable qualification (NMC 2016). However, as an extended role this is also considered to require Masters' level preparation which none of these nurses have.

Whilst it suits an ordered mind to have such role delineation, I have to accept that the reality is fluid. Even within such broad boundaries, the nurses moved between different areas, sometimes reluctantly, sometimes enthusiastically, but always driven by what the practice needed. In particular, the 'nurse practitioner' grouping was populated by nurses with Masters' level education and preparation who were not utilising their skills to their full potential. For example, Jane who asserted that she worked as an advanced nurse practitioner referred to a colleague working at advanced level as a 'nurse practitioner'. She identified the difference as the ability to manage undifferentiated presentations; in her practice the nurse practitioner was able to choose which patients she reviewed from the walk-in clinics, whereas Jane could not. This caused her great frustration. And yet, within other areas of her role Jane was not managing long term conditions autonomously and was often called upon to perform practice nurse tasks. She did not object to this deployment, enjoying the hands on contact with patients, but it was a distraction from her autonomous advanced role and demonstrated again the dilemma of working at this level in general practice.

The notion of autonomy is important here. Each nurse considered she was working in an autonomous role without really considering what meaning that had in professional practice. Our understanding of autonomy originates with the 18th century philosopher Immanuel Kant and his writings on morality and moral authority. Our understanding of personal autonomy, the right of the individual to be self-directed and make personal decisions is the basis for current biomedical ethics. It derives from Kant's assertion that autonomy is the "property the will has of being a law to itself" (Kant 1996).When applied to professional practice, a broad definition of autonomy might be a personal control over clinical practice and the exercise of judgement (MacDonald 2002). Friedson (2001) asserted that knowledge acquired though 'scholarly education' forms the basis of professional autonomy and discretion in actions. In this definition there is

an explicit link between autonomy as the freedom to choose between alternate actions and a willingness to take responsibility for those actions. Dworkin (1988) and McParland, Scott, Arudt, Dassen, Gasull, Lemonidou, Valmaki, Leino-Kilpi (2000) assert that attaining professional autonomy is therefore dependent on knowledge and the ability to make choices but also on freedom from coercion and external control.

This seems to be at the heart of professional autonomy for these nurse practitioners. There existed a spectrum of independent practice in their narratives and roles; at one end, nurses such as Gaynor and Claire willing to manage whatever presentations were made to practice, to accept that inherent clinical risk and uncertainty and at the other, nurses such as Ellie and Dawn working as less dependent but not entirely autonomous clinicians, their practice limited by their own training and the directives of their GP employers.

Rowe (2010), suggests that 'to dare' to undertake new clinical responsibilities marks the beginning or real autonomy. As Skar (2010) discovered in his research into its meaning in nursing practice, it develops as nurses experience "new and challenging situations where there are no standards or routines to follow" (p6). When nurses 'dare' they move to another place where they begin to exercise autonomy which incorporates real and substantial control over their own practice (Rowe 2010). Even when the individual is prepared to accept autonomy within her sphere of practice, the ability to do so can still be obstructed or hindered by other factors including public perceptions, organisational and contractual factors and the lack of support and respect of other health professionals (MacDonald 2002). These factors were evident in the clinical practice of many of these nurses; in the way Ellie could be redeployed when junior doctors were available to manage minor illness, in the resentment of nursing colleagues experienced by Dawn and in the distrust of patients expressed by Jane.

How this professional role has been able to develop in the way it has, as individual fluid constructs dependent on training, practice and political context is complex. In the United Kingdom advanced nursing practice has developed opportunistically, driven by a number of factors. A policy decision to shift the management of long term conditions to primary care together with an increasingly aged population with complex co-morbidities has increased demand for general practice services (Maier 2015).

Shortages of GPs in the workforce has provided impetus for adopting a team-based, skill-mix approach to general practice (Freund et al 2015). Nonetheless, a major professional contributory factor in this indiscriminate role development has been a lack of regulatory or formal governance arrangements, guiding and framing the role.

### 10.2.2. *Regulation of the advanced role in clinical practice*

Governance and regulation are important concepts here. Governance is described by Maier (2015), as the structures and processes, through which policies are enacted to achieve goals, including legislation, regulation and oversight. Regulation refers to legally binding policy instruments defined by central government which set rules and standards and thereby limit access to a profession or practice (Maier 2015). In their individual reviews of nursing regulatory and governance frameworks, Carney (2016) and Maier (2015) discovered marked variation in how these have developed internationally. Maier (2015) identified three approaches; national level regulation and registration for advanced practice such as exists in the Netherlands, Ireland, New Zealand and Australia; decentralised regulation and registration in Canada and the United States and unregulated, setting-dependent and voluntary governance arrangement in the four countries of the United Kingdom and in Finland (Maier 2015).

National regulation occurs by statute or government decree and involves national-level registration, protection of professional titles and definition of scope of practice (Maier 2015). These are legally binding instruments which limit entry to a profession and set minimum standards for practice. This national recognition of role and level of practice legitimises the profession, provides clarity for the public and other professionals and sets clear standards for the protection of public safety (Heale and Buckley 2015).

Decentralised regulation such as occurs in the USA and Canada is the result of federal government transferring responsibility to individual states or provinces. The development of the LACE (licensing, accreditation, certification and education) consensus model in the USA is an attempt to standardise a framework for advanced practice and reduce the inconsistency in state practices which prevents nurses' from working across different states. This form of regulation is characterised by marked variation in practice within countries (Carney 2016).

In the United Kingdom the profession of nursing is regulated at first registration by its regulatory body, the Nursing and Midwifery Council but there is no regulatory framework to govern, limit or frame advanced level practice. There is no protection of titles and no consensus on educational pathways to the advanced role. Prescribing qualifications are registered with the NMC but governance arrangements are left to individual settings and employers (Maier 2015, Carney 2016). This non-regulation has directly contributed to the piecemeal development of the nurse practitioner role as illustrated in this study. Some nurses working autonomously with Masters level preparation in an expansive role, some with similar qualifications in a semi-autonomous role with a narrower more prescriptive domain of practice and others in a largely bounded role directed and managed by the requirements of their employing practice.

The rationale for this approach was outlined in a report from the CHRE to the four Health departments of the UK; a report which examined the case for regulation of advanced practice.

> We are unconvinced that much of what is often called 'advanced practice'
> in many professions represents such a significant shift in the nature of
> practice that it is inadequately controlled for through current
> arrangements (p9).

The CHRE explicitly linked the decision not to establish a new regulatory mechanism for nurses in advanced roles to the concept and principles of 'proportionality of risk'; an assessment of the level of risk and impact on public safety compared to the relative cost and restriction of statutory regulation. In the case of nursing, they considered that what they determined was 'advanced practice' CHRE (2009) did not either increase risk to public safety significantly or constitute a new role and therefore a new regulatory framework was unnecessary.

Further justification for this decision came from the Secretary of State for Health, Andrew Lansley, in the document 'Enabling Excellence, Autonomy and Accountability' (DOH 2011). He expressed the government's view that new regulation should only be considered for unregulated professional groups if there was a compelling case on the basis of public safety. He further qualified this stating that centralising responsibility

for the complexity of managing risk in millions of daily interactions between clinician and patient might seem a "tidy solution" (p4) but could never replace individual, team or organisational accountability. Moffat, Martin and Timmons (2014) suggest that the consequence of this is the 'responsibilisation' of autonomous individuals and the encouragement of self-governance. Individuals and collective groups such as GP employers become wholly responsible and accountable for a particular social risk, in this case patient safety. This represents a policy driven process, packaged as personal accountability and responsibility.

In the absence of regulation, governance frameworks, whether through contractual arrangements with employers or voluntary agreements through agencies such as Health Education England (HEE), assume greater importance. Some voluntary governance policies do exist in some areas of the UK. Health Education Yorkshire and the Humber (HEYH 2015), West Midlands (HEE 2015) and East Midlands (Health Education East Midlands 2015) have all developed an advanced practice framework intended for use by clinicians from different professional groups across all sectors of the NHS. It builds on the work of the four countries and the RCN in developing a generic framework for workforce planning and the support of new roles which cross professional boundaries, for example, emergency care practitioners on outreach from emergency care departments, nurses working in advanced roles and radiography practitioners. These guidelines recommend Masters' level qualifications and determine Agenda for Change pay bands for entry and experienced practitioners.

Professional bodies, such as the RCN also have a role to play in governance. Its officers and professional advisors produced a competency framework for advanced practice (RCN 2012b) and are currently engaged in developing a voluntary credentialing structure which will permit nurses who can evidence their academic preparation and their level of practice to apply for benchmarking. This will signal to employers, colleagues and the public that that nurses with RCN credentialing have the skills and educational preparation for autonomous, advanced level practice.

### 10.2.3 *Implications for General Practice*

National centralised regulation is recognised as the best way to ensure public protection and safety. It defines criteria which reflect the minimum requirements for safe and competent practice (Carney 2016). It establishes role clarity so that professionals and the public know what a nurse working at an advanced level can do. It provides workforce statistics which can assist in planning and shaping services to meet demand. In the absence of regulation, governance of the practice of advanced nursing is left to the discretion of individuals, settings and providers, for example, through collaborative practice agreements between nurses and their employers (Maier 2015).

The consequence of an unregulated advanced role in general practice is clear from the narratives. Piecemeal construction of individual roles in individual practices is driven by the needs of the practice; for Mandy this was entirely first contact care; for Naomi a new service for patients with diabetes and Sandra mix of clinical work with administrative and QOF responsibilities. Whilst some of the nurses were occupied with the team, managing rotas or training junior staff, few were involved in the strategic direction of the practice and none in research activities. These pillars of the more rounded advanced practice level framework (DOH 2010) were forgotten or never considered in the need for flexible workers to fill gaps in the workforce. The implication of this for the individual nurse and the patient was never fully considered.

### 10.2.3.1. *Risk to public safety*

One of the distinguishing features of general practice care, compared with secondary care, is the undifferentiated nature of the problems presented by patients (The King's Fund 2010). Patients present to practice with symptoms which are often only partly developed or at an early stage in a disease process. Some of these symptoms may indeed relate to minor illness, but some may not, and it is the detection of the more serious underlying processes which represents the major risk associated with medical and nursing practice.

Minor illness, the demand, definition and management was a presence throughout the interviews. Clare was scathing of nurses who 'only' managed minor illness, others, like Ellie and Dawn recognised it as a major part of their role. Minor illness defines a

multitude of uncomplicated, usually self-limiting illnesses which in most cases would resolve without any intervention. Generally, when the minor illness service is first established GPs and nurses together establish a list of minor ailments which can be booked into a nurse appointment. That list can vary but a common list of presentations as defined by The King's Fund (2010b) is appended (appendix 9). Some of the nurses interviewed felt confident managing all of these, but many did not, for example, Sandra admitted she would not manage any mental health problems but would refer all of these to her GP colleague.

The inherent risk in treating minor illness is that alarm symptoms may be missed. Some of the symptoms presented in appendix nine can herald major disease (for example, cough, abdominal pain or headache). It is the task of the clinician to 'marginalise the danger' (p9) which requires GPs or substituting clinicians to have the skills and experience to separate the minority of patients who actually have acute, threatening illness from the majority who have minor or self-limiting illness (The Kings fund 2010b). Some alarm symptoms also form the basis of the two week rule for urgent referral of patients suspected of having cancer; these may include symptoms such as suspicious changes in a skin lesion, alteration in bowel habit or abnormal weight loss. In addition it is important that the clinician can identify and correctly manage acute exacerbations of long term conditions, for example, breathlessness could be related to an infective exacerbation of COPD but also to heart failure.

The issue of clinical risk here is twofold. Defining minor illness as a separate entity, corralling patients into minor illness clinics and using nurses with in-house or modular training to manage this tranche of acute work is clearly attractive to general practice and has support in the 'hierarchy of expertise' (Charles-Jones et al 2003). Utilising GPs to manage every viral illness, rash or muscle strain which presents to practice appears to be a poor use of their higher order skills. Claire considered it to be a poor use of her skills also and rarely consulted with patients presenting with minor illness, leaving this work to the practice nurses. But the inherent risk, as described above, is that nurses only trained to manage minor illness presentations might miss the alarm symptoms when they present and as a consequence may reassure and discharge patients who have more serious disease.

Inevitably in clinical practice mistakes will be made. Evidence from the Medical Defence Union (MDU), an organisation which provides indemnity for general practitioners and their staff, demonstrates an increase in litigation against nurse practitioners. The MDU report that in 2015 there were 25 allegations of clinical negligence against nurse practitioners with one settled for over two million pounds. Most of the allegations concern missed diagnosis, delay in referral and prescribing errors, all critical aspects of their extended practice. Whilst the number appears small in comparison to claims against GPs, they are rising steeply year on year (MDU 2016). It is an NMC requirement that nurses have indemnity relevant to their scope of practice and traditionally this had been provided by nursing's representative body, the RCN. However in 2012, in a climate of increasing risk and litigation and with unregulated, fluid and far reaching scope of practice the RCN cynically withdrew professional indemnity protection for nurses working in general practice, insisting it was an employer or personal responsibility (Knight 2012).

For practices using NPs in a different way, managing undifferentiated presentations and sharing the workload more equitably as occurred in Gaynor's practice and for Jane, working alongside the GPs in walk-in clinics, the risk may be different. It has been demonstrated in a number of studies that NPs refer more and investigate more than GP colleagues (Venning et al 2000, Horrocks et al 2002), possibly because they do not have the same level of training or are more risk averse. The result of this, other than the obvious increased use of costly resources could be heightened patient anxiety as a result of unnecessary and potential invasive or risky procedures. It should be noted that these studies are dated but research has not revisited this as NPs became embedded in the system and more experienced in managing health problems.

As discussed, working within a defined and regulated scope of practice provides some public protection but working beyond it increases risk to both the public and the practitioner. Issues arose not just because nurses felt they were unable to work to the limits of their training and competency but also because they were asked to work beyond it. Sandra described inherently unsafe practices when she was asked to see additional patients in an afternoon surgery when there was no GP in the building; Barbara and Jane dropping in and out of practice nursing duties as required knowing

this is a highly specialised role requiring current knowledge of policies and treatments and Mandy who remarked on the problem of having patients inappropriately allocated to her instead of the GP when there were no GP appointments available.

### 10.2.3.2. *Lack of role clarity*

Public safety is clearly crucial to the concept of advanced practice but it is not the only aspect of these NP roles affected by the absence of a regulatory framework. A lack of clear definition of the role itself affected how it developed and was enacted in practice. The impact of this lack of role clarity formed a clear thread throughout the narratives, touching their professional relationships with patients, employers and professional colleagues. Even though these nurses were working at different levels of advanced practice they all felt the same frustration when their roles were misunderstood or abused. For Gaynor it translated into irritation that any nurse, whatever her training, could call herself a nurse practitioner. For others it related more to their individual roles with in practice. These and more potential areas of conflict could be resolved if there was a clearly defined scope of practice understood by the public and professional colleagues.

It is so much more difficult to establish clarity in the current miscellany of roles and responsibilities than if a strong governance or regulatory framework had been established when advanced practice was in its early development. Using Plager, Conger and Craig's (2003) model for differentiation of advanced nursing roles, when discussed dispassionately advanced nursing may seem the same, but when viewed through a prism, the role splinters and separates into different roles with some shared functions. This then is the role dissonance which any governance framework must now incorporate. It should still be possible for these roles or levels to have clear and coherent boundaries of practice which define scope, but they do not.

Lack of role clarity impacted upon patients who did not fully understood who they were consulting with and what the NPs' abilities or responsibilities were. Indeed Mandy, Naomi and others reported that patients often called them 'doctor', suggesting that patients were confused perhaps by nurses not in uniform, adopting the language, tools and routines of the medical professional.

Lack of role clarity also affected professional relationships within teams and there was much discussion in the interviews about the resentment and difficulties these nurses had experienced from both medical and nursing colleagues. Barbara felt this keenly when secondary care consultants would not accept referrals from her unless countersigned by a GP. Xyrichis and Lowton (2008) in their review of enablers and barriers to interprofessional teamworking recognised a lack of clear understanding of professional roles as a major factor in conflict within teams. Machin et al's (2012) study supported this view, and it has resonance also amongst other roles and teams across primary and secondary care. Brault, Kilpatrick, D'Amour, Contandriopolous, Chouinard, Dubois, Perroux and Beaulieu (2014) suggest that clearly defining roles and professional boundaries is an effective approach to mitigating power struggles and facilitating the integration of new roles in teams.

Lack of clarity impacted upon the professional standing of and respect for the NP role in general practice. These nurses reported feeling valued by their GP employers, Jane felt that she was valued at least as much as a salaried GP in her practice, Gaynor that her role was even more important when her practice lost a GP partner. Yet their narratives do not suggest GP employers valued them for the role they could deliver but for the role they were prepared to deliver within practice. For Sandra it was evident in the expectation that she would complete monthly prescription claims despite wanting to use her newly acquired clinical skills, for Jane it was being prepared to perform routine nursing duties, "just to be a nurse", when the practice needed this. These nurses wanted professional legitimacy and credibility amongst the public and their peers. They wanted wider recognition of the important role they felt they were fulfilling. But the obvious difficulty here is that no two nurses interviewed conformed to the same role; ten interviews, ten constructs determined by factors other than regulation, governance or scope of practice. It is this which makes the advanced role in general practice vulnerable. This inability to claim a unique professional role and territory, to define who they are and what they do opens the professional arena to other professional groups who can clearly define where they fit into the service, professional groups such as Physician Associates.

Lack of regulation or clear governance structures creates a barrier for nurses wishing to progress their roles within general practice to the detriment of the practice population. Nurses working at advanced, autonomous levels have the potential to improve health care for communities (Lowe, Plummer, O'Brien and Boyd 2012). Too much of the debate has focused on nurse substitution, on shifting tasks from medical to nursing professional groups, rather than considering what diversification of the workforce could really contribute. Substitution merely replaces one type of professional with another to increase efficiency and reduce costs (Sibbald, Shen and McBride 2004). It is subject to the imposed hierarchy of expertise which has its parallel in the hierarchy of appropriateness (Charles-Jones et al 2003). It remains within the confines of that hierarchy, having tasks and responsibilities delegated by the GP, permanently practising within the shadow of medical colleagues. Rather than substitution, nurse practitioners should be proposing a process of diversification; introducing advanced level nursing roles which widen the range of skills which can be accessed by the public (Sibbald et al 2004). Diversification maintains a unique identity as a nurse, working autonomously and collaboratively within general practice. The broader range of roles seen in this study could then really begin to really benefit general practice.

### 10.2.4. *Value of the unregulated role to general practice*

It is difficult to identify evidence of generic value of the nurse practitioner role to general practice when the roles are so inconsistent. Indeed, Lowe et al (2012) suggest this is *only* possible when roles and functions are clearly defined. It is possible to say that each nurse satisfied unmet needs in her own practice; Mandy improved access for her housebound caseload; Naomi improved routine care for her patients with diabetes and Dawn for patients with minor illness requiring rapid access to services. What is apparent from their narratives is that flexibility is the key value of their unregulated roles to general practice.

Workforce flexibility has been resisted by professional groups' intent on maintaining their own professional status and boundaries. But the need for additional capacity in general practice in the context of increasing demand and a rapidly shrinking GP workforce has legitimised the blurring of these boundaries by promoting vertical

substitution of tasks and duties across disciplines where power is not equal; from GPs to NPs; and horizontal substitution or overlap where tasks are transferred between individuals of similar training and expertise for example between nurses (Nancarrow and Borthwick 2005). These nurse practitioners were subject to vertical substitution, taking on duties and responsibilities including diagnosis and prescribing generally seen as traditional medical tasks and were in many cases working concurrently across nursing boundaries. The value here to the practice is having a clinician capable of working across these boundaries and domains.

This task and role flexibility is a direct consequence of the lack of regulation in the UK and perhaps explains the government's reluctance to establish one. A prescriptive regulatory system risked stifling flexibility and innovation in general practice. It would have prevented nurses being what the practice needed and created a potentially insurmountable gap in service provision. Whilst using nurse practitioners to fill those gaps enabled practices to address the real and current problems of an understaffed and pressured service; capacity and access, it did not address the long-term future of general practice. There was no assessment of what was needed then and what might be needed in the future, rather a presumption that down-grading tasks perceived as lower risk and lower value and shifting them to other clinicians would address demand and meet need.

Whilst there were grumbles about this inappropriate utilisation of their roles and skills, these nurses still expressed a high degree of role satisfaction. Generally they enjoyed the continued patient contact and found the role satisfying and fulfilling. However the professional ceiling has been reached for these nurse practitioners. Whilst there may be opportunities to specialise, as seen in Jane's expanded training to manage long-term conditions and Gaynor's inclusion in strategic planning, any further involvement in the practice could only occur through nurse partnership, and these were few in number and difficult to sustain (Roscoe 2012). It was also demonstrated in Naomi's narrative that NPs were not being replaced when they left their current roles and instead GPs were looking to junior doctors who worked in the practice but were paid by local medical deaneries. In addition the emergence of new clinical roles particularly

the Physician Associate further contests the value and sustainability of the role for nurse practitioners.

This challenge creates a further paradox. Whilst the value of the unregulated nursing role to general practice has undoubtedly been its flexibility, the new role of Physician Associate (PA) has value to a skill-mixed team entirely because of its defined boundaries and inflexibility. They do not challenge practice nursing roles as they cannot cross those professional boundaries, but are intended to manage acute first contact care, a significant part of the role of many of the nurse practitioners interviewed. PAs will manage requests for same day or urgent appointments; they will work alongside their supervising GP with access to him or her for advice and prescriptions (Drennan et al 2015). In addition, shorter fully funded training programmes will lead to their more rapid deployment in practice.

For patients, the nurse practitioner role, whether regulated or not, should have value as an alternative to medical care. Nursing at advanced level in general practice goes beyond traditional nursing and incorporates a commitment to help; not help as in a traditional nursing paradigm but with a dual caring and treatment focus, Watson's (2008) 'carative /curative' focus which offers help traditionally within the sphere of medicine. These nurse practitioners recognised that with time, patients could develop valuable therapeutic relationships with them.

### 10.2.5. *The future of the NP role*

To be able to take advantage of the current workforce shortfalls and climate in general practice, nurses in advanced roles need to be able to clearly articulate that what they do makes a difference. That there is room in general practice for different advanced level roles and that general practice is better for that. Yet the contradiction here is that defining roles also defines territory and perhaps the time has come to shed those traditional claims and enable health care professionals to work collaboratively for the benefit of patients.

Real collaborative working has been glimpsed in the roles of pioneering nurse partners; practice nurses or nurse practitioners who have taken a financial stake in the business of general practice, making strategic decisions collaboratively with their GP

partners (Roscoe 2012). Some pioneering nurses have even taken full responsibility for general practices, working as business directors and clinicians, employing GPs and providing a full range of services for their patient population (Pearce 2016). But these examples are rare. General practice is designed to a medical model; GPs are the employers retaining control of the composition and direction of their lower status nursing teams.

### 10.3. Reflection upon the Research Findings

I embarked upon this project with some preconceived ideas and opinions about what value the nurse practitioner role had for general practice. I already had some notions about where that value lay, and what I perceived the role to be. I found quite early in the process that these had to be revised.

Of all the findings of my study, the one which affected me most and impacted upon my own perception of my profession was the exploration of the scope and boundaries of the nurse practitioner role in general practice. Working in relative isolation, in a small town with no ready access to a local university, as a member of a forum committee where every nurse practitioner works in the same way as I do, it was a surprise to discover how the role had been constructed by other nurses in other practices. And more than this a profound sadness at the way I saw the advanced role being debased and exploited. I saw the lack of uniformity in how the role was delivered as detrimental to the advanced role and felt angry at times when I saw enthusiastic and skilled nurses being used as administrators and practice nurses whenever the practice demanded. And yet each nurse perceived value in their role to their practices and most importantly to their patients. So perhaps the only issue should be matching roles to titles or roles to patient needs and then promoting and celebrating them differently.

I can appreciate now that I was seeking an elusive generic role which could conclusively demonstrate value to general practice. What I discovered was the confusion of clinical practice. These nurses were making a difference to general practice every day; whether through improved access and capacity, the provision of a different clinician, their commitment to understanding disease from the perspective of their patients or offering a different service with a different skill set and orientation.

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Through them I discovered the rich potential for advanced level nursing, not the 'one-size-fits-all' I envisaged, but the value of diversification to provide services tailored to the needs of individual practice populations.

## 10.4. Strengths and limitations of the Study

The study was conducted within a qualitative interpretative paradigm using a social constructionist framework. Social constructionism was utilised because of its ability to interpret and comprehend multiple socially constructed realities. It seemed likely that nursing in advanced practice would be constructed differently across individual practices. This was based on the researcher's experience of working in and knowledge of general practice.

*"When people talk to each other, the world gets constructed"* (Burr 2003 p 8)

Symbolic Interactionism was an important strand in the research approach. The nursing profession has its own deeply held culture, values, rituals, symbols and language. SI acknowledges the importance of symbols, particularly language, within the interaction and construction of meaning. How nurses talked about their patients and their interactions was important within the project as was nursing metaphor, 'hands on nursing'; the therapeutic use of touch, empathy advocacy; all elements of a nursing toolkit.

As a nurse practitioner in general practice, I have current personal knowledge of the subject under scrutiny. It was important that the research approach recognised the value of the position of researcher within the study. The qualitative paradigm recognises the role of the researcher as instrument; the credibility of methods hinges to a large degree on engaging the skill and knowledge of the individual and uses experiences and insights to enhance quality.

The use of thematic analysis as a methodological strategy is controversial. Whilst Silverman (2006) supports the use of a broad qualitative methodological approach or strategy provided it is located within a defined epistemological and theoretical framework, it appears that other researchers and theorists disagree. They suggest that this is an "unfounded leap" and one which should be avoided (Nelson 2008). However

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thematic analysis, which has no fixed theoretical partners, is congruent with the social constructionist perspective of this project. It is also accessible to novice researchers, providing a logical sequence of steps for conducting the study whilst remaining a challenging process requiring active engagement with the data and reflection on emerging themes.

The initial study sample was drawn from individuals who were all members of the RCN and had either attended conference or utilised the discussion zone of the forum website. It could not therefore capture the views of nurses who do not engage with the forum or the RCN and it is not known whether or not their views may have differed from my study sample. However, within a purposive sampling framework I was able to minimise any potential distortion by selecting participants who could offer a broad range of experience, qualifications and practice backgrounds. In addition I actively sought the views of nurse practitioners who had both a clinical foothold in practice and a local or national political profile together with nurses who had left general practice. This enabled me to capture a multi-layered sample of perspectives and experiences.

Semi structured interviews were selected as the best means of generating rich deep information for the study. As a nurse practitioner working in general practice interviewing other nurse practitioners working in the same setting, it was difficult to resist disclosure during the interviews. Whilst co-construction of meaning is recognised as central to social constructionism, I was concerned that my professional voice might influence the responses of my participants. However, as the sole interviewer I was able to maintain consistency and continuity throughout the process and establish a personal connection which encouraged openness. I was able to incorporate insights from the early to the later interviews, exploring key moments in the narratives which might have resonance and meaning.

As with all doctoral studies, the interviews were conducted and the data analysed by a single researcher. Whilst this cannot contribute the multiple perspectives possible within research teams, perspectives which might enhance the findings, it does improve consistency within the interview and coding frame. In addition I shared transcripts and

coding decisions with my supervisory team. Their insights were of great value and strengthened the analysis.

## 10.5. Conclusions and Recommendations

In a healthcare system, funded through taxation, in a climate of austerity and with the increasing demands of an ageing population with complex health needs and indeed, a younger generation wanting rapid access for more minor problems, a new workforce is needed. This may mean that the public cannot have access to GP services in the way they did historically, but it should still be possible to design teams which both meet needs and provide nurses with opportunities to expand their roles.

Part of the professional guidance for leaders in the medical profession is to use health resources judiciously (GMC 2012), and perhaps skill mixed teams are the translation of that ethos into practice. Health care personnel are a precious and increasingly scarce resource and their skills should be deployed wisely. Task-shifting from medical to nursing practitioners, the 'hierarchy of appropriateness' described by Charles-Jones et al (2003), has value but it has raised concerns about patient safety and quality of care which have not been fully explored.

Some of those concerns could have been addressed and resolved by the regulation of advanced level practice, thorough registration, unified educational pathways and defined scope of practice. Having failed to do this, nursing at advanced level has been left to develop haphazardly driven by the needs of employers and practices rather than by the vision of the profession. Only now, decades after Stilwell first demonstrated the role could provide an alternative practitioner in general practice is the RCN developing a credentialing framework which will recognise nurses working in truly autonomous roles.

Whilst the chapters demonstrated value in the roles of these individual nurses, value in the domains of role, practice, patient and team; uncovering generic value of advanced level practice has been more difficult. Nonetheless, there is value in the multi-layering of advanced roles. Whilst credentialing will distinguish those nurses working at the higher level, it will offer nothing for nurses providing much needed services but who do not have the qualifications or training to be recognised as advanced nurse

practitioners. Credentialing will not resolve the confusion of role titles. ANP will not be a registerable title with the NMC therefore nurses in general practice can continue to use whichever title they prefer; be that specialist practitioner, nurse practitioner or advanced nurse practitioner. This situation needs to be addressed if nurses are to continue providing services to general practice populations; services which are contributing to the daily health and wellbeing of their patients.

### 10.5.1. Recommendations

The paradox of the advanced nursing role is that the lack of a robust regulatory framework, definition of scope of practice and uniform educational preparation has both hindered and facilitated its development. It has both prevented nurses from providing advanced nursing care in general practice which could benefit the public and made the same public vulnerable as a result of a lack of understanding of the real scope and risks inherent in advanced practice. However as there is no political appetite for regulation and nursing does not have the political strength to make it happen, maximising the effectiveness of the voluntary credentialing process that is currently being developed by the RCN offers the greatest potential for progressing and legitimising advanced practice.

#### 10.5.1.1 Recommendations for nursing's professional body

It seems then that the voluntary credentialing process being developed by the RCN offers the only opportunity for a definition of the profession which will help to ensure safe and competent practice and provide nurses working at an advanced level with professional credibility. Whilst this process has not yet been completed or released for wider professional scrutiny it is anticipated that it will require evidence of Masters' level qualifications and demonstration of practice at advanced level. My concern is that as a professional body representing all nurses, the RCN will hesitate, will recoil at the prospect of alienating those nurses using the title 'nurse practitioner' who have not achieved this level and cannot demonstrate autonomous practice. I perceive the general practice workforce can accommodate the differentiation of roles presented in figure 7. My recommendations therefore are;

- Masters' level entry for nurses working in those highly autonomous extended roles as defined in figure 7. Non-medical prescribing is an essential element of this role.

- The creation of a voluntary register, held by the college, for nurses who have reached the standards for autonomous, advanced level practice.

- The voluntary register should be available via the RCN website for employers to confirm that a potential employee has the relevant qualification and can demonstrate advanced level practice before being appointed.

- Recognition and professional pathway for nurses working in expanded roles in general practice who do not want to extend into the more independent role.

### 10.5.1.2 Recommendations for Clinical Commissioning Groups

Currently GPs make decisions about who they employ and in what role but the landscape of general practice is evolving. Those Clinical Commissioning Groups who wish to take on greater responsibilities for general practice could, in the future, dictate workforce decisions. If, as some predict, there is progression to a salaried GP service their role in determining skill mix in practices would become even more important. Until then, the CCGs do retain some responsibility for workforce training and my recommendations are;

- Ensure all CCGs have a strong, contemporary and informed nursing presence on their governing body.

- Primary care workforce planning in partnership with NHS England should address the ageing demographics of GPs nationally, local health needs and should identify, commission and frame opportunities for nurses working in advance roles.

- When an Advanced Nurse Practitioner is recruited, credentialing and inclusion on the voluntary register should be a condition of employment.

- The CCG should identify how many nurses are working in advanced roles within their locality.

- Establish a nurse practitioner forum within the CCG locality which can raise awareness of individual roles in practice and provide a network for nurses working in more isolated roles.

- Identify shared learning opportunities for nurses working in advanced roles in practice to through protected learning times or prescribing support initiatives.

- Workforce planning should include the commissioning of Masters' level training places for nurses who wish to access this. This might need to include secondment opportunities between practices or identification of funding streams and clinical placements.

- Explore and frame opportunities for nurses who want to extend their roles into management of long term conditions or minor illness but do not want to undertake Masters' level academic qualifications.

- Deliver specific training for these nurses locally and by a central team.

### 10.5.1.3 Recommendations for General Practice

Collaborative working is generally viewed as a future imperative for the health service and general practice specifically. Teams will need to be designed to meet the increasingly complex needs of patients, to align with social care, and to reflect the diverse skills required to care for patients in the community setting. This will take further organisational change at a time when experienced clinicians have already struggled under the pressure of decades of continual change. It will take realignment of general practice hubs with named community nurses, health visitors and social care staff. It will demand a reintegration of staff removed from the GP team to serve geographical communities rather than individual practices. The benefits of closer working for any practising clinician are clear; sharing space with their clinical colleagues, communicating easily with a named professional, serving a common community. This would take political will which at present seems focused more on cost containment than quality of service.

General practice can affect this process by;

- Ensuring clinical teams meet on a regular basis, as general practice hubs and as wider teams serving the practice population. This should include district nurses, Macmillan nurses, community therapists, community midwives, local leaders of social care

- Patient Participation Groups based in individual practices should be utilised to inform the wider practice population of new clinical roles and feedback experiences of teamworking.

- Where recruitment of an Advanced Nurse Practitioner is being considered the GPs should make explicit the requirement for the individual to have undergone the RCN credentialing process and be included on the voluntary register.

### 10.5.1.4. Recommendations for higher education institutions

Collaborative working could be improved easily and quickly by a greater understanding of each other's roles and contributions to the service of those communities. This is not just the responsibility of individual clinical teams but could be influenced by greater emphasis on multidisciplinary working at undergraduate and postgraduate levels.#

Recommendations in this area are;

- Build opportunities for different professional groups to train together at undergraduate level to counter the negative impact of ethnocentric practice.

- Multidisciplinary post graduate degrees are well placed to promote greater understanding of collaborative practice.

- Shared clinical placements; medical students, nurse practitioners, community practitioners, physician associates would enhance collaborative practice in all areas of the NHS.

### 10.5.1.5. Recommendations for future research

Patient demand for services has a direct impact on the design of teams in general practice. Local and national commissioners have used a variety of services to try and meet this demand; NHS walk-in clinics, the 'Darzi centres' of the noughties, were established to meet demand and divert patients with minor illness from Accident and Emergency Departments. As seen in this study, general practitioners provided

enthusiastic practice nurses with additional in-house and modular training to meet the demands placed upon practices. All of these have been reactive policies without any attempt to determine why patients are reluctant or unable to manage these predominantly self-limiting illnesses. My recommendation for further research in this area would focus on;

- Qualitative studies to explore further how patients manage minor and self-limiting illnesses and what influences their decision to seek medical help and intervention. This would directly impact on design of services to address the real health needs of the population.

New clinical roles, such as the Physician Associate, have certainly developed because of a lack of general practitioners, but also because nursing at an advanced level has not been able to stake a claim for professional territory in general practice. All of the issues around non-regulation have contributed to this and the champions of the new role have learned from it. PAs will have a national qualification and a voluntary register, and whilst exactly where the role fits into general practice is still uncertain, there is no doubt it will be integrated because it has political and professional support. Nurses need to become more visible within the general practice workforce, to raise awareness of what it is they do and offer. This would not only inform professional colleagues but influence the public perception of nurses and encourage patients to use the full skills offered by the general practice team. This could be achieved by;

- Dissemination of these research findings on a national platform through,
  - Royal College of General Practitioners Foundation programme
  - Royal College of Nursing national conference
  - Royal College of Nursing International Research Conference
  - Application for publication in British Journal of General Practice together with nursing press.

Much of the evidence around the ability of nurse practitioners to substitute for doctors, the integration of the role into teams and the acceptability of the role for patients dates from the early introduction of the nurse practitioner role into pilot sites and teams. This could and should be revisited.

- Further clinical research should be commissioned to examine into how nurse practitioners are enacting their roles *now* rather than relying upon dated research to inform change. This should include research into patient perception of the acceptability of the nurse practitioner role.

- The nursing consultation offers a rich source of data and further research could continue to explore how it can be used more effectively for the benefit of patients and delivery of general practice services.

- General practice teams are changing and the body of knowledge around the NP and other roles needs to grow. The influential study by Charles et al (2003), the 'hierarchy of appropriateness' could be used as a foundation to re-examine how skill-mixed teams are constructed now and the impact of redistribution of medical and nursing work affects teams and patients.

- As the credentialing project and the register embed in practice research should explore how it is populated and utilised by the nurses and their prospective employers and the impact it has on the general practice workforce.

This study has been an important professional and personal journey for me. It may not have demonstrated value as I anticipated it to be; rather it provided glimpses of real value in the narratives of patient satisfaction, of improving professional relationships, of value to the general practice team. The NP role should not be valued because of its flexibility, because nurses in those roles are willing and able to respond to any call from any source. It should be valued because of its unique ability to bring together some parts of a medical toolkit and a nursing perspective grounded in the best traditions of the profession. These are the areas which should direct further research; what is it about a nursing consultation that patients value and what this new uniquely nursing role can bring to teams focused on delivering care for their diverse local communities.

# References

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Addicott R; Ham C. (2014) <u>Commissioning and funding general practice; Making the case for family care networks</u>  Kings Fund  London

Al-Yateem N.  (2012) The effect of interview recording on quality of data obtained: a methodological reflection  <u>Nurse Researcher</u>  **19**(4) pp  31 - 35

Ashforth B.E.  (2001)  <u>Role Transitions in Organisational Life: An identity-based Perspective</u> pp 131 - 148 Routledge  New York and London

Atkin K; Lunt N.  (1996) Negotiating the role of the practice nurse in general practice <u>Journal of Advanced Nursing</u> 24 pp 498  - 505

Attride-Stirling J. (2001)  Thematic networks: an analytic tool for qualitative research <u>Qualitative Research</u>  **1**(3)  pp 305 - 405

Auerbach C. F; & Silverstein L. B. (2003) <u>Qualitative Data: an introduction to coding and analysis</u>  New York University Press  New York

Ball J. (2005)  <u>Maxi nurses. Advanced and Specialist Nursing Roles</u> Royal College of Nursing  London

Barton T.D; 2006  Nurse practitioners − or advanced clinical nurses? <u>British Journal of Nursing</u>  **15**(7) pp 370 - 376

Basford L; Slevin O.  (2003) 2<sup>nd</sup> edition <u>Theory and Practice of Nursing: an integrated approach to nursing practice</u>  p. 1 Nelson Thornes  Cheltenham

Baumann Z.  (2007)  <u>Liquid Times: Living in an Age of Uncertainty</u> Polity Press  Cambridge

Beauchamp T.L; Childress J.F  (2008)  <u>Principles of biomedical ethics</u> 6<sup>th</sup> edition Open University Press  Maidenhead

Benner P.  (1984)  <u>From Novice to Expert Excellence and Power in Clinical Nursing Practice</u> chapter 2 pp 13 − 38 Addison-Wesley  Menlo Park

Berger P.L; Luckmann T.  (1966)  <u>The Social Construction of Reality: A treatise in the sociology of knowledge</u>  Doubleday  New York

Bergin M (2011)  NVivo 8 and consistency in data analysis: reflecting on the use of a Qualitative data analysis program  <u>Nurse Researcher</u>  **18** (3) pp 6 − 12

Bleakley A,  (2013) Working in "teams" in an era of "liquid" healthcare: What is the use of theory?  <u>Journal of Interprofessional Care</u>  **27**(1)  pp 18 − 26

Blumer H. (1979)  Symbolic Interactionism Perspective and Method  University of
        California Press  London

Bochner A.  (2000) Criteria against ourselves  Qualitiatve Inquiry  **6**(2)  pp 266 - 272

Bonsall K; Cheater F.M. (2008) What is the impact of the advanced primary care
        nursing roles on patients, nurses and their colleagues? A literature review
        International Journal of Nursing Studies **45**(7) pp 1090 – 1102

Booth A.  (1996)  In search of the evidence: informing effective practice
        Journal of Clinical Effectiveness  **1**(1)  pp 25 – 29

Boyatzis R.E.  (1998)  Transforming Qualitative Information: Thematic Analysis and
        Code Development  Sage Publications London

Braddock C.H; Snyder L. (2005) The Doctor Will See You Shortly: the ethical significance
        Of time for the patient-physician Relationship Journal of General Internal
        Medicine 20 pp 1057 - 1062

Branson C; Badger B.  (2008)  Skill mix in general practice: patients', professionals' and
        managers' perspectives  Primary Health Care  **18**(1)  pp 35 – 39

Brault I; Kilpatrick K; D'Amour D; Contandiopolous D; Chouinard V; Dubois C.A;
        Perroux M; Beaulieu M.D.  (2014)  Role Clarification Processes for Better
        Integration of Nurse Practitioners into Primary healthcare Teams: A
        Multiple-Case Study  Nursing Research and Practice
        http://www.hindawi.com/journals/nrp/2014/170514/

Braun V; Clarke V.  (2006)  Using thematic analysis in psychology
        Qualitative Research in Psychology  **3**(2) pp 77 – 101

Braun V; Clarke V. (2013) Successful Qualitative Research: a practical guide for
         Beginners  chapter 9 pp 201 – 222  Sage Publications Ltd  London

Bunn F; Byrne G; Kendall S. (2009)  The effects of telephone consultation and triage on
        healthcare use and patient satisfaction: a systematic review  British Journal of General
        Practice  55  pp 956 – 961

Burr V.  (2003) 2<sup>nd</sup> edition Social Constructionism  pp 1 – 27  Routledge  Hove

Caldow J; Bond C; Ryan M; Campbell N; San Miguel F; Kiger A; Lee A,  (2007) Treatment
        of minor illness in primary care: a national survey of patient satisfaction,
        attitudes and preferences regarding a wider nursing role Health Expectations
        **10** (1) pp 30 - 45

Campbell J; Fletcher E; Britten N; Green C; Holt T; Lattimer V; Richards D, Richards S; Salisbury C; Calitri R; Bowyer V; Chaplin K; Kandiyali R; Murdoch J; Roscoe J; Varley A; Warren F; Taylor R, (2014) Telephone triage for management of same-day consultation requests in general practice (the ESTEEM trial): a cluster-randomised controlled trial and cost-consequence analysis The Lancet 384 pp 1859 – 1868

Campbell S.M; Kontopantelis E; Reeves D; Valderas J.M; Gaehl E; Snall N; Roland M.O. (2010) Changes in Patient Experiences of Primary Care during Health Service Reforms in England between 2003 and 2007 Annals of Family Medicine 8(6) pp 499 – 506.

Carney M. (2016) Regulation of advanced nurse practice: its existence and regulatory dimensions from an international perspective Journal of Nursing Management 24 pp 105 - 114

Carr J; Armstrong S; Hancock B; Bethea J. (2002) GPs' perceptions of the nurse practitioner role in primary care British Journal of Community Nursing 7(8) pp 408-413

Carr J; Bethea J; Hancock B. (2001) The attitudes of GPs towards the nurse practitioner role British Journal of Community Nursing 6(9) pp 444 – 451

Castledine G. (2002) The development of the role of the clinical specialist in the UK British Journal of Nursing 11(7) pp 506-508

Castledine G. (2003) The Development of Advanced Nursing Practice in Advanced Nursing Practice 2nd edition editors McGee P: Castledine G. Blackwell Publishing Oxford

Chapman J; Zechel A; Carter Y.H; Abbott S. (2004) Systematic review of recent Innovations in service provision to improve access to primary care British Journal of General Practice 54 pp 374 -381

Charles-Jones H; Latimer J; May C, (2003) Transforming general practice: the Redistribution of medical work in primary care Sociology of Health and Illness 25(1) pp71-92

Charlton R. (2010) General Practice Clinical Medicine December pp 600 - 604

Charmaz K. (2006) Constructing Grounded Theory: A practical guide through Qualitative Analysis Sage Publications Ltd London

Corbin J; Strauss A. (2008) Basics of Qualitative Research techniques and procedures for Developing Grounded Theory 3rd edition Sage Publications London

Council for Healthcare Regulatory Excellence (2009) Advanced Practice: Report to the four UK Health Departments CHRE London

Creswell J.W. (2014) 4th edition Research Design, Quantitative, Qualitative and Mixed Methods Approaches  chapter 9 Qualitative Methods
Sage London

Critical Appraisal Skills Programme (2013)  Appraising the Evidence
http://www.casp-uk.net/#!appraising-the-evidence/c23r5

Crookes P; Davies S.  (2004) Editors Research into Practice: Essential Skills for Reading and Applying Research in Nursing and Health Care  p 232
Balliere Tindall London

Crotty M. (1998a)  The Foundations of Social Research: Meaning and Perspective in the Research Process  pp 1 – 17  Sage  London

Crotty M. (1998b)  The Foundations of Social Research: Meaning and Perspective in the Research Process  pp 52-57 Sage  London

Currie G; Finn R; Martin G.  (2008)  Accounting for the 'dark side' of new organisational forms: The case of healthcare professionals  Human Relations  61(4)
pp 539 – 564

Cutliffe J.R.  (2003)  Reconsidering reflexivity: Introducing the case for intellectual entrepreneurship Qualitative Health Research  13(1)  pp 136 - 148

Dayan M;  Arora S; Rosen R;  Curry N. (2014) Is General Practice in Crisis?
Policy Briefing#1 Nuffield Trust London

De Maeseneer J; Willems S; De Sutter A; Van de Geuchte I; Billings M (2007)
Primary Health Care as a strategy for receiving equitable care:
a literature review World Health Organisation Geneva

Denzin N.K; Lincoln Y.S.  (1998) Entering the field of qualitative research in Denzin N.K
and  Lincoln Y.S. editors Strategies of Qualitative Inquiry  pp 1 – 34
Sage Thousand Oaks CA.

Department of Health (1990) The NHS and Community Care Act
http://www.legislation.gov.uk/

Department of Health (1992) Medicinal Products: Prescription by Nurses etc. Act
http://www.legislation.gov.uk/ukpga/1992/28/section/1

Department of Health (1997a) The new NHS; Modern, Dependable
HMSO  London

Department of Health (1997b) Personal medical services pilots under the NHS (Primary Care) Act 1997 a comprehensive guide  HMSO London

Department of Health (1999) Making a difference: strengthening the nursing,
Midwifery and health visiting contribution to health and healthcare
HMSO London

Department of Health (2000) The NHS Plan; a plan for investment, a plan for reform
HMSO London

Department of Health (2001) Shifting the balance of power in the NHS: Securing
Delivery HMSO London

Department of Health (2002) Liberating the Talents: Helping Primary Care Trusts
and nurses to deliver the NHS Plan HMSO London

Department of Health (2003) Modernising Medical Careers
http://www.sehd.scot.nhs.uk/publications/ModernisingMedicalCareers.pdf

Department of Health (2004) The NHS Improvement Plan: Putting People at the
Heart of Public Services HMSO London

Department of Health (2006) Our Health, Our Care, Our Say A new direction for
community services HMSO London

Department of Health (2008) High Quality Care for All
HMSO London

Department of Health (2010) Advanced Level Nursing: A Position Statement
HMSO London

Department of Health (2011) Enabling Excellence, Autonomy and Accountability
for Healthcare Workers, Social Workers and Social Care Workers
https://www.gov.uk/government/uploads/system/uploads/attachment_data/fi
le/216580/dh_124374.pdf

Department of Health (2012) Health and Social Care Act
http://www.legislation.gov.uk/ukpga/2012/7/contents

Department of Health (2013) Care in local communities; a new vision and model for
district nursing Department of Health London

Department of Health (2014) Advanced Nursing Practice Framework: supporting
advanced nursing practice in health and social care trusts
http://www.dhsspsni.gov.uk/advanced_nursing_practice_framework.pdf

Department of Health and HM Treasury (2015) Spending review and autumn
statement (policy paper) HM Treasury London

Department of Health and Social Security (1986) Neighbourhood Nursing: A Focus for
Care (Cumberledge Report) HMSO London

Department of Health and Welsh Office (1989) General practice in the National Health
        Service: a New Contract  HMSO  London

Daly W.M; Carnell R.  (2003)  Nursing roles and levels of practice; a framework for
        differentiating between elementary, specialist and advanced nursing practice
        Journal of Clinical Nursing 12 pp 158 - 167

Drennan V; Goodman C; Manthorpe J; Davies S; Scott C; Gage H; Iliffe S.  (2011)
        Establishing new nursing roles: a case study of the English community matron
        initiative  Journal of Clinical Nursing  20 pp 2948 - 2957

Drennan V; Halter M; Joly L; Gage H; Grant R; Gabe J; Brearley S; Careneiro W;
        De Lusigan S. (2015) Physican associates and GPs in primary care: a comparison
        British Journal of General Practice 65(634) pp 344 – 350

Duffield C; Gardner G; Chang A.M; Catling-Paull C.  (2009) Advancing nursing practice;
        a global perspective  Collegian 16(2)  pp 55 – 62

Dworkin G.  (1988) The Theory and Practice of Autonomy  Cambridge University Press
        Cambridge

Edwards M; Bobb C; Robinson S. (2009)  Nurse practitioner management of acute
        in-hours home visit or assessment requests: a pilot study
        British Journal of General Practice  59(558) pp7–11

Fielding N; Lee R.  (2002) New Patterns in the adoption and use of qualitative software
        Field Methods 14(2) pp 197 - 216

Fielding S; Porteous T; Ferguson J; Maskrey V; Blyth A; Paudyal V; Barton G; Holland R;
        BondC; Watson M.  (2015)  Estimating the burden of minor ailment
        consultations in general practices and emergency departments through
        retrospective review of routine date in North East Scotland  Family Practice
        32(2) pp 165 – 172

Finlay L. (2002)  Pearls, pith and provocation. 'Outing' the researcher: the provenance,
        process and practice of reflexivity  Qualitative Health Research
        12(4) pp 531 – 545

First Practice Management (2015)  FPM Staff Pay and Ratios Survey 2014/15 results
        http://www.firstpracticemanagement.co.uk/blog/posts/fpm-staff-pay-and-ratios-
        survey/

Fontana A; Frey J.H  (2008)  in Denzin N.K; Lincoln Y.S editors Collecting and
         Interpreting Qualitative Materials 3rd edition  pp 115 - 160  Sage  London

Freeman G; HorderJ.P;  Howie J.G.R; Hungin A.P; Hill A.P; Shah N.C; Wilson A.  (2002)
        Evolving general practice consultation in Britain: issues of length and context
        British Medical Journal  324 pp 800 – 882

Freeman G; Hughes J.  (2010) <u>Continuity of care and the patient experience:</u>
<u>An Enquiry into the Quality of General Practice in England</u>
The Kings Fund London

Freund T; Everett C; Griffiths P; Hudon C; Naccarella L; Laurant M.  (2015)
Skill mix, roles and remuneration in the primary care workforce: who are the
healthcare professionals in the primary care teams around the world?
<u>International Journal of Nursing Studies</u> 52 pp 727 - 743

Friedson E.  (1984) The Changing Nature of Professional Control  <u>Annual Review of</u>
<u>Sociology</u> 10 pp 1 - 20

Gallagher M; Drinkwater P; Pearson C; Guy J.  (2001) Managing patient demand: a
qualitative study of appointment making in general practice
<u>British Journal of General Practice</u>  51 pp 280 – 285

General Medical Council  (2012)  <u>Leadership and management for all doctors</u>
General Medical Council  Manchester

Gergen K.J.  (2009)  <u>An Invitation to Social Construction</u> 2<sup>nd</sup> edition  pp 1 – 30
Sage  London

Gergen M; Gergen K.J.  (2003) editors <u>Social Construction A Reader</u>  Part One
pp 1 – 10  Sage London

Guest G; Bunce A; Johnson L. (2006)  How many interviews are enough?
An Experiment with Data Saturation and Variability <u>Field Methods</u>
**18**(1) pp 59 – 82

Guest, G;  MacQueen K.M;  Namey  E.E.  (2012) <u>Applied  Thematic  Analysis</u>.
Sage  Thousand Oaks  California

Gulliford M; Fiqueroa-Munoz J; Morgan M; Hughes D; Gibson B; Beech R; Hudson M.
(2002)  What does 'access to health care' mean?  <u>Journal of Health Service</u>
<u>Research Policy</u>  7**(3)**  pp 186 – 188

Hammersley M. (1998)  <u>Reading Ethnographic Research: A Critical Guide</u>
Chapter 5 pp 78  – 110  Routledge  London

Hammersley M. (2010) Reproducing or constructing? Some questions about
Transcription In social research  <u>Qualitative Research</u> **10**(5)  pp 553 – 569

Heale R; Buckley R. (2015) An international perspective of advanced practice nursing
regulation  <u>International Nursing Review</u> **62**(3)  pp 421 – 429
Health Education England (2015) <u>Advanced Clinical Practice Framework for the West</u>
<u>Midlands</u>
<u>https://www.hee.nhs.uk/sites/default/files/documents/ACP%20Framework%2</u>
<u>0for%20the%20WM.PDF</u>

Health Education East Midlands  (2014)  East Midlands Advanced Clinical Practice
Framework
https://hee.nhs.uk/sites/default/files/documents/East%20Midlands%20Advanc
ed%20Clinical%20Practice%20Framework.pdf

Health Education Yorkshire and the Humber  (2015)  HEYH Advanced Practice
Framework    https://www.hee.nhs.uk/sites/default/files/documents/HEYH-AP-
Framework-Final-V1.pdf

Hicks C; Hennessy D. (1999)  A task-based approach to defining the role of the nurse
practitioner: the views of UK acute and primary sector nurses
Journal of Advanced Nursing  29(3) pp 666 - 673

Hill A.P; Freeman G.K.  (2011) Promoting Continuity of Care in General Practice
Royal College of General Practitioners  London

Hollinghurst S; Horrocks S; Anderson E; Salisbury C. (2006)  Comparing the cost of
nurse practitioners and GPs in primary care: modelling economic data from
randomised trials  British Journal of General Practice 6(528) pp 530 - 535

Holyoake D.D.  (2011)  Is the doctor-nurse game still being played?  Nursing Times
107(43) pp 12-14

Horrocks S; Anderson E; Salisbury C.  (2002) Systematic review of whether nurse
practitioners working in primary care provide equivalent care to doctors
British Medical Journal  324 pp 819 – 823

International Council of Nurses' Nurse Practitioner/Advanced Practice Nurse Network
(2001) Definition and Characteristics of the Role
https://international.aanp.org/Practice/APNRoles

International Council of Nurses' Nurse Practitioner/Advanced Practice Nurse Network
(2014) Advanced Practice Nursing Network Country Profiles
http://international.aanp.org/content/docs/countryprofiles2014.pdf

Irving G; Holden J.  (2012) Calling time on the ten minute appointment
British Journal of General Practice  62(598)  pp 238 - 239

Jiwa M; Bakewell J; Foster S; Gerrish K. (2001) Primary care visits out of hours. The case
for skill mix? Journal of Community Nursing 15(11) pp 4 - 6

Joffe H.  (2012) Thematic Analysis in Harper D; Thompson A. Qualitative Research
Methods in Mental Health and Psychotherapy: A Guide for Students and
Practitioners pp 209 – 223  Wiley-Blackwell Chichester

Jones T.L.  (2010)  A Holistic Framework for Nursing Time: Implications for Theory,
Practice and Research Nursing Forum 45(3)  pp 185 – 195

Kant I. (1996)  Groundwork of the Metaphysics of Morals translated Gregor M.
    4: 400 Cambridge University Press  Cambridge

Karatas-Ozban M; Murphy W.D. (2009)  Critical Theorist, Postmodernist and Social
    Constructionist Paradigms in Organisational Analysis: A Paradigmatic Review
    of Organisational Learning Literature  International Journal of Management
    Reviews 12 pp 453 – 465

Kearley K; Freeman G; Heath A.  (2001)  An exploration of the value of the personal
    doctor-patient relationship in general practice
    British Journal of General Practice 51  pp 712 – 718

Kinnersley P; Anderson E; Parry K; Clement; Archard L; Turton J; Stainthorpe A;
    Fraser A; Butler C; Rogers C. (2000)  Randomised controlled trial of nurse
    practitioner versus general practitioner care for patients requesting 'same day'
    consultations in primary care  British Medical Journal  320(7241)
    pp 1043 - 1048

Kleiman S.  (2010) Josephine Paterson and Loretta Zderad's humanistic nursing theory
    In Parker M.E; Smith M.C. editors Nursing Theories and nursing practice
    3rd edition  pp 337 -350  F.A. Davies Co  Philadelphia

Knight J.  (2012)  Who has got you covered?  Nursing Standard  26(18)  p 61

Kuhn T.S.  (1962)  The Structure of Scientific Revolutions  University of Chicago Press
    Chicago

Kvale S; Brinkmann S.  (2009)  Interviews Learning the Craft of Qualitative
    Research Interviewing  2nd edition  Sage  London

Laird S.  (2004) First Contact MedEconomics  25(9)  pp 42 - 43

Lau R; Cross W; Moss C; Campbell M; De Castro M; Oxley V.  (2014)
    Leadership and management skills of practice nurses; experience or education?
    International Journal of Nursing Practice 20(6) pp 655 - 661

Laurant M; Reeves D; Hermens R; Braspenning J; Grol R; Sibbald B.  (2004)  Substitution
    of doctors by nurses in primary care  The Cochrane Collaboration
    John Wiley & Sons Ltd  London

Leary A; Crouch H; Lezard A; Rawcliffe C; Boden L; Richardson A.  (2008) Dimensions
    of clinical nurse specialist work in the UK  Nursing Standard 23(15)
    pp 40 - 44

Lincoln Y. S; Guba E. G. (1985) Naturalistic Inquiry Sage Beverly Hills, California

Long A; McCann S; McKnight A; Bradley T.  (2004)  Has the introduction of nurse
practitioners changed the working patterns of primary care teams?
A qualitative study  Primary Health Care Research and Development
5 pp 28 – 39

Loudon I.  (2008)  The principle of referral: the gatekeeping role of the GP
British Journal of General Practice **58**(547)  pp 128 - 130

Loveland P.  (1992)  The New Deal: an account of progress in reducing junior hospital
doctors' hours in England  Health Trends  24**(1)**  pp 3 – 4

Lowe G; Plummer V;  O'Brien A.P; Boyd L.  (2012) Time to clarify – the value of
advanced practice nursing roles in health care  Journal of Advanced Nursing
**68**(3) pp 677 -685

Lowry. S (1992) What's wrong with medical Education in Britain?
British Medical Journal  **305** pp 1277 - 80

MacBride-Stewart S.  (2012)  The effort to control time in the 'new' general practice
Sociology of Health and Illness 35**(4)** pp 560 - 574

MacDonald C. (2002) Nurse Autonomy as Relational  Nursing Ethics
**9** (2) pp 194 - 201

Machin A.I; Machin T; Pearson P.  (2012) Maintaining equilibrium in professional
role identity: a grounded theory study of health visitors' perceptions of their
changing professional practice context  Journal of Advanced Nursing
**68**(7) pp 1526 - 1537

Madill A; Sullivan P.  (2010)  Medical training as adventure-wonder and adventure-
Ordeal: a dialogical analysis of affect-laden pedagogy
Social Science and Medicine **71**(12) pp 2195 - 2203

Maier C.  (2015)  The role of governance in implementing task-shifting from
physicians to nurses in advanced roles in Europe, U.S., Canada, New Zealand
and Australia  Health Policy  119 pp 1627 - 1635

Matthews-King A.  (2016)  Hunt says there will be 'flexibility' in the 5000 target Pulse
http://www.pulsetoday.co.uk/home/new-deal-2015/16/hunt-says-there-will-
be-flexibility-in-5000-gp-target/20010310.article

Mays N; Pope C. (2000) Assessing quality in qualitative research
British Medical Journal  **320** (7226) pp 50 - 52

McGee P; Castledine G.  (2003) 2nd edition  Advanced Nursing Practice
Chapter 3 pp 17 – 30  Blackwell Publishing Ltd  Oxford

McGhee G; Marland G.R; Atkinson J. (2007) Grounded theory research: literature
Reviewing and reflexivity Journal of Advanced Nursing **60**(3) pp 334 – 342

McGuire P; Pitcheathley C (2002) Key communication skills and how to acquire them
British Medical Journal 325 pp 697–700

McKenzie R. (2002) in Freshwater D. editorTherapeutic Nursing; Improving Patient
Care through Self Awareness and Reflection chapter 2 pp 22 – 38
Sage Publishing Ltd London

Mclaren P. (2005) The Evolution of the Nurse Practitioner Role
Evidence-based Healthcare & Public Health 9 pp 265 - 266

McParland J; Scott P.A; Arndt M; Dassen T; Gasull M; Lemonidou C; Valimaki M;
Leino-Kilpi H. (2000) Autonomy and clinical practice: identifying areas of
concern British Journal of Nursing 9 pp 507 - 513

McWhinney I.R. (1998) Primary care core values. Core values in a changing world
British Medical Journal 316 pp 1807 – 1809

Mead G.H. (1934) Mind, Self and Society From the Standpoint of a Social Behaviorist
The University of Chicago Press London

Medical Defence Union (2016) Nurse Practitioners at increased risk of claims and
complaints warns MDU
http://www.themdu.com/press-centre/press-releases/nurse-practitioners-at-increased-risk-of-complaints-and-claims-warns-mdu

Mercer J. (2007) The challenges of insider researcher in educational institutions:
Wielding a double edged sword and resolving delicate dilemmas
Oxford Review of Education **33**(1) pp 1 - 7

Ministry of Heath, Scottish Home and Health Department (1966) Report of the
Committee on Senior Nursing Staff Structure: The Salmon Report
HMSO London

Moffatt F; Martin P; Timmons S. (2014) Constructing notions of healthcare
Productivity; the call for a new professionalism?
Sociology of Health and Illness **36**(5) pp 686 - 702

Molleman E. (2009) Attitudes Toward Flexibility: The Role of Task Characteristics
Group and Organisation Management **34**(2) pp 241 – 268

Molleman E. (2000) Modalities of self-managing teams International Journal of
Operations and Production Management 20 pp 1837 – 1858

Monitor (2014) Walk-in centre review: final report and recommendation
www.monitor.gov.uk#

Morris C.J; Cantrill J,A; Weis M.C.  (2001)  GPs' attitudes to minor ailments
         Family Practice  **18**(6)  pp 581 - 585

Nancarrow S.A; Borthwick A.M.  (2005)  Dynamic professional boundaries in the
         Healthcare workforce  Sociology of Health and Illness  **27** (7) pp 897 - 919
National Leadership and Innovation Agency for Healthcare (2010) Framework
         For Advanced Nursing, Midwifery and Allied Health Professional Practice in
         Wales NHS Wales Lanharan

National Statistics Online (2010) Population Trends 1984-2034
         http://www.statistics.gov.uk/cci/nugget.asp?ID=949

Nelson A.M. (2008)  Addressing the threat of evidence-based practice to qualitative
         inquiry through increasing attention to quality: a discussion paper
         International Journal of Nursing Studies 45 pp 316 – 322

Neuwelt P; Kearns R; Browne A.  (2015) The place of receptionists in access to primary
         care: challenges in the space between community and consultation
         Social Science and Medicine 133 pp 287 – 295

NHS England (2014)  Five Year Forward View
         https://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

NHS England (2015) GP Patient Survey – National Summary Report
         Ipsos Mori  London

NHS England and NHS Clinical Commissioners (2014) Next Steps Towards
         Primary Care Co-commissioning
         https://www.england.nhs.uk/commissioning/wp-
         content/uploads/sites/12/2014/11/nxt-steps-pc-cocomms.pdf

NHS Federation (2011)  The Legacy of Primary Care Trusts
         NHS Federation  London

NHS Scotland (2008) Advanced Practice Toolkit
         http://www.advancedpractice.scot.nhs.uk/

Nuffield Trust (accessed 2014)  The history of NHS reform
         http://nhstimeline.nuffieldtrust.org.uk

Nursing and Midwifery (2002) Report of the Higher Level of Practice Pilot and Project
         NMC  London

Nursing and Midwifery Council (2004)  A framework for the standard of post-
         Registration nursing  http://www.nmc.org.uk

Nursing and Midwifery Council (2009)  Regulation of advanced nursing practice
 www.nmc-uk/org/About-us/Policy-and-public-affairs/Politics-and-parliament
 PMs-commission-on-the-future-of-nursing-and-midwifery/Regulation

Nursing and Midwifery Council (2012a)  Changing priorities at the NMC
 www.nmc-uk.org/Press-and-media/Latest-news/Changing-priorities-at-the-
 NMC

Nursing and Midwifery Council (2012b)  The Code: Standards of conduct, performance
 and ethics for nurses and midwives
 http://www.nmc-uk.org/Publications/Standards/The-code/Introduction/

Nursing and Midwifery Council (2016)  Recordable qualifications
 https://www.nmc.org.uk/registration/staying-on-the-register/adding-
 qualifications/

Offredy M. (2002) Access to primary care: decision-making by GP receptionists
 British Journal of Community Nursing  7 (9) pp 480 – 485 2015

Osborn J; Thompson M.  (2014) Management of same day appointments in primary
 care The Lancet  384 (9957)  pp 1828-1829

Orem D.  (1985) 3<sup>rd</sup> edition  Nursing concepts of practice McGraw-Hill  New York

O'Shea R.A.  (2013) The regulation of advanced nursing practice  PHd Thesis
 Glasgow Theses Service  http://theses.gla.ac.uk/4283/

Oxford Dictionary (2016) http://www.oxforddictionaries.com/definition/english/value

Parle J; Ennis J.  (2015)  Physician associates: the challenge facing general practice
 British Journal of General Practice  65 pp 224 - 225

Paterson J.G; Zderad L.T.  (1976)  Humanistic nursing  John Wiley  New York

Pearce L.  (2016) Nurse-led general practice blazes a trail  Nursing Standard
 30(26) pp 22 -23

Perry C; Thurston M; Killey M; Miller J.  (2005) The nurse practitioner role in primary
 care: alleviating problems of access? British Journal of Nursing  14 (5)
 pp 255 -259

Phillips C.  (2009) What is cost effectiveness?  What is?...series: Health Economics
 http://www.medicine.ox.ac.uk/bandolier/painres/download/whatis/Cost-
 effect.pdf

Plager K; Conger M; Craig C.  (2003) Education for differentiated role development for
 NP and CNS practice Journal of Nursing Education  42(9) pp 406 - 415

Polit D; Beck C.T.  (2010) Generalisation in quantitative and qualitative research: myths and strategies  International Journal of Nursing Studies  **47**(11) pp 1451 - 1458

Por J.  (2008)  A critical engagement with the concept of advancing nursing practice  Journal of Nursing Management  16 pp 84 - 90

Price A; Williams A.  (2003)  Primary care nurse practitioners and the interface with secondary care; a qualitative study of referral practice Journal of Professional Care  **17**(3)  pp 239 - 250

Radcliffe M.  (2000) editorial  Doctors and nurses: new game, same result  British Medical Journal  320  p 1085

Rashid C.  (2010)  Benefits and limitations of nurses taking on aspects of the clinical role of doctors in primary care: an integrative literature review  Journal of Advanced Nursing **66**(8) pp 1658 – 1670

Redsell S; Stokes T; Jackson C; Hastings A; Baker R.  (2007)  Patients' accounts of the differences in nurses' and general practitioners' roles in primary care  Journal of Advanced Nursing  **57** (2)  pp 172 - 180

Reedy B.L; Phillips P.R; Nevell D.J.  (1976)  Nurses and nursing in primary medical care in England  British Medical Journal  2  pp 1304 - 1306

Reedy B.L.  (1978)  The new health practitioners in America: a comparative study  Pitman Medical Publishing  London

Reveley S.  (1998) Role of the triage nurse practitioner in general medical practice: an analysis of the role  Journal of Advanced Nursing  **28**(3)  pp 584 – 591

Richards A; Carley J; Jenkins-Clarke S; Richards D.A.  (2000) Skill-mix between nurses And doctors working in primary care - delegation or allocation: a review of the literature International Journal of Nursing Studies **37**(3)  pp 185 -197

Roberts A; Marshall L; Charlesworth A (2012) A Decade of Austerity? The funding Pressures facing the NHS from 2010/11 to 2020/11 The Nuffield Trust London

Robson C; McCartan K.  (2016a)  Real World Research  4th edition chapter 2 pp 14 – 40  John Wiley and Sons  Chichester

Robson C; McCartan K.  (2016b) Real World Research  4th edition chapter 11  pp 243 – 279 John Wiley and Sons Chichester

Rolfe G.  (2014)  Understanding advanced nursing practice  Nursing Times  **110** (27) pp 20 - 23

Rollnick S; Seale C; Rees M; Butler; Kinnersley; Andersen L. (2001)  Inside the routine
general practice consultation: an observational study of consultations for sore
throats Family Practice  **18**(5)  pp 506 – 510

Roper N; Logan W.W; Tierney A.J.  (2000) The Roper-Logan-Tierney Model of Nursing:
Based on Activities of Living  Churchill Livingstone/Elsevier  Edinburgh

Roscoe F.  (2012)  Nurse Partners in General Practice  Journal of Community Nursing
**26**(1) pp 17 – 19

Rowe J.  (2010)  Commentary on Skar R (2010) The meaning of autonomy in nursing
practice  Journal of Clinical Nursing  19 pp 2662 - 2663

Royal College of General Practitioners; NHS Alliance (2004) The future of access to
General practice-based primary medical care: informing the debate
RCGP  London

Royal College of General Practitioners  (2005) European definition of General Practice
and Family Medicine
http://www.rcgp.org.uk/policy/rcgp-policy-areas/european-definition-of-
general-practice-and-family-medicine.aspx

Royal College of General Practitioners (2007)  The Future Direction of General Practice:
A roadmap  RCGP  London

Royal College of General Practitioners (2008a)  Primary Care Federations: Putting
Patients First
http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-
policy/Primary_Care_Federations-document.ashx

Royal College of General Practitioners  (2008b)  Good Medical Practice for General
Practitioners  RCGP  London

Royal College of General Practitioners  (2012) Medical Generalism: why expertise in
wholeperson medicine matters  RCGP  London

Royal College of General Practitioners; General Practice Foundation (2012)
General Practice Nurse Competencies  RCGP  London

Royal College of General Practitioners (2013) The 2022 GP: A Vision for General
Practice in the future NHS  RCGP  London

Royal College of General Practitioners (2014)  Put Patients First
http://www.rcgp.org.uk/policy/put-patients-first.aspx

Royal College of General Practitioners: Nuffield Trust (2015)  Collaboration in general practice: surveys of GPs and CCGs http://www.rcgp.org.uk/news/2015/december/~/media/Files/CIRC/Federations/RCGP-National-survey-results-slide-set-2016.ashx

Royal College of Nursing (RCN) (2005) Defining Nursing  RCN  London

Royal College of Nursing (2012a) Nurse Prescribing in the UK  RCN London

Royal College of Nursing (2012b)  RCN Competences. Advanced nurse practitioners; an RCN  guide to advanced nursing practice, advanced nurse practitioners and programme accreditation  Royal College of Nursing  London

Rubin G; Bale A; George A; Shackley P; Hall N.  (2006)  Preferences for access to the GP: discrete choice experiment  British Journal of General Practice 56  pp 743 - 748

Schmalenberg C; Kramer M; King C; Krugman M; Lund C; Poduska D; Rapp D.  (2005)  Nursing through Evidence: securing collegial/collaborative nurse-physician relationships, part 1  Journal of Nursing Administration  35(10) pp 450 - 458

Schwandt T.A. (2001)  Dictionary of qualitative inquiry  2nd edition  p110-111 Sage Publications Thousand Oaks  California

Scottish Executive (2006)  Modernising Nursing Careers: setting the direction http://www.gov.scot/resource/doc/146433/0038313.pdf

Seale C; Anderson E; Kinnersley P.  (2006)  Treatment advice in primary care: a comparative study of nurse practitioners and general practitioners Journal of Advanced Nursing  54(5) pp 534 – 541

Shenton A.  (2004) Strategies for ensuring trustworthiness in qualitative research Projects Education for Information  22 pp 63 - 67

Shiner A; Ford J; Steel N; Salisbury C; Howe A.  (2014) Managing multimorbidity in primary care http://ino.sagepub.com/content/early/2014/09/22/1755738014549756.full

Shum C; Humphreys A; Wheeler D; Cochrane M.A; Skoda S; Clement S.  (2000) Nurse management of patients with minor illnesses in general practice: multicentre randomised controlled trial British Medical Journal 320 pp 1038 – 1043

Sibbald B; Shen J; McBride A. (2004) Changing the skill-mix of the health care workforce Journal of  Health Service Research Policy 9 (Suppl 1): 28–3

Silverman D.  (2006) 3rd edition Interpreting Qualitative Data: methods for analysing talk, text and interaction  chapter 1 pp 1 – 33  Sage  London

Silverman D (2013)  Doing Qualitative Research  chapter 9  pp 141 - 158  Sage London

Singh D. (2006) Making the Shift: Key Success Factors A rapid review of best practice in
        shifting hospital care into the community University of Birmingham
        NHS Institute for Innovation and Improvement  Birmingham

Skar R.  (2010) The meaning of autonomy in nursing practice Journal of Clinical Nursing
        19 pp 2226 - 2234

Slevin O.  (2003) in Basford L; Slevin O. editors Theory and Practice of Nursing: an
        integrated approach to caring practice  pp 363 – 374  Nelson Thornes
        Cheltenham

Smith P.  (1991)  The nursing process: raising the profile of emotional care in nurse
        training  Journal of Advanced Nursing  16  pp 74 - 81

Snape D; Spencer L (2013) Foundations of Qualitative Research in Ritchie J;
        Lewis J. editors Qualitative Research Practice:A Guide for Social Science
        Students and Researchers  pp 1-23  Sage Publications Ltd  London

Soldana J.  (2009)  The Coding Manual for Qualitative Researchers  Sage London

Stein L.  (1967)  The Doctor-Nurse Game  Archives of General Psychiatry
        16(6) pp 699 - 703

Stein L; Watts D.T; Howell T.  (1990)  The Doctor-Nurse Game Revisited
        The New England Journal of Medicine  322 pp 546 - 549

Stilwell B.  (1988)  Patients attitudes to a highly developed extended role: the nurse
        Practitioner  Recent Advances in Nursing  21 pp 82 - 100

Taylor S.  (2001) Discourse as data: A guide for analysis
        Sage Publications  London

The King's Fund (2010a)  Have targets improved NHS performance?
        http://www.kingsfund.org.uk/projects/general-election-2010/key-election-
        questions/performance-targets

The King's Fund (2010b)  Managing Acute Illness  King's Fund  London

The King's Fund (2011)  Improving the Quality of Care in General Practice
        Chapter 2  pp 13 – 23 King's Fund  London

Thompson C; Dowding D.  (2001)  Responding to uncertainty in nursing practice
        International Journal of Nursing Studies  38  pp 609 – 615

Tracy S.J. (2010) Qualitative Quality: Eight "Big-Tent" Criteria for Excellent Qualitative
        Research Qualitative Inquiry  16(10) pp 837 – 885

Turner C; Keyzer D; Rudge T. (2007) Spheres of influence or autonomy? A discourse analysis on the introduction of NPs in rural and remote Australia Journal of Advanced Nursing 59(1) pp 38 – 46

Ulin P; Robinson E; Tolley E. (2005) Qualitative methods in public health: A field guide for applied research Jossey-Bass San Francisco

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) Project 2000: a new preparation for practice UKCC London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1992) The Scope of Professional Practice UKCC London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1994) The Standards for Post-registration and Education Project UKCC London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997) PREP - Specialist Practice: Consideration of Issues Relating to Embracing Nurse Practitioners and Clinical Nurse Specialists within the Specialist Practice Framework UKCC London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1997b) UKCC Position on Advanced Practice. (Press Statement 9/1977) UKCC London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1999) A Higher Level of Practice. Report of the Consultation on the UKCC's proposals For a Revised Regulatory Framework for Post-Registration Clinical Practice UKCC London

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (2002) Report of the Higher Level of Practice Pilot and Project UKCC London

Vaismoradi M; Turenen H; Bondas T. (2013) Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study Nursing and Health Sciences 15 pp 398 - 405

Vandenhouten C; Peterson M. (2012) Watson's Theory of Transpersonal Caring Holistic Nursing Practice 26(6) pp326 -334

Venning P; DurieA; Roland M; Roberts C; Leese B; Venning C. (2000) Randomised Controlled trial comparing cost effectiveness of general practitioners and nurse practitioners in primary care British Medical Journal 320(7241) pp 1048 – 1053

Vidall C; Barlow H; Crowe M; Harrison I; Young A. (2011) Clinical nurse specialists: Essential resource for an effective NHS British Journal of Nursing 20(17) Oncology Supplement S23 - 27

Wade D.  (2009)  Holistic Health Care What is it, and how can we achieve it?
http://www.ouh.nhs.uk/oce/researcheducation/documents/HolisticHealthCare
09-11-15.pdf

Watson J.  (2008)  The Philosopy and Science of Caring  University Press of Colorado
Boulder, Colorado

Watton R.  (2013) The loss of multidisciplinary primary health care teams is bad
for patient care British Medical Journal
http://www.bmj.com/content/347/bmj.f5450

Wetherell M; Taylor S; Yates S.J.  (2001)  Discourse as Data; a Guide for Analysis
The Open University  Milton Keynes

Wilkinson C.  (2008)  Junior doctors' working hours: perspectives on the reforms
International Journal of Nursing Practice  14  pp 200-2014

Williams A; Jones M.  (2006)  Patients' assessments of consulting a nurse practitioner:
The time factor  Journal of Advanced Nursing 53(2) pp 188 – 195

Williams A; Sibbald B.  (1999)  Changing roles and identities in primary health care:
exploring a culture of uncertainty  British Medical Journal  322 pp 1522-1524

Willig C.  (2008) 2nd edition  Introducing Qualitative Research in Psychology
pp 1 - 35   Open University Press  Maidenhead

Wilson A; Pearson D; Hassey A.  (2002) Barriers to developing the nurse practitioner
role in primary care – the GP perspective  Family Practice  19(6)  pp641 - 646

Wilson A; Williams M; Hancock B.  (2000)  editors Research Approaches in Primary
Care chapter 2  pp 23 – 52 Radcliffe Medical Press Ltd  Abingdon

Wilson T.  (2013) At the heart of change: What primary care needs to address
to support the NHS at 75 Quality in Primary Care 21 pp 329 331

Woncaeurope  (2011) The European Definition of General Practice/Family Medicine
p 8  www.woncaeurope.org/

Xyrichris A; Lowton  K. (2008) What fosters or prevents interprofessional teamworking
In primary and community  care: a literature review
International Journal of Nursing Studies  45(1)  pp 140 - 153

Yardley L. (2000) Dilemmas in Qualitative Health Research Psychology and Health
15 pp 215 - 228

**Appendices**

Statement by the International Council of Nurses' Nurse Practitioner/Advanced Practice Nursing Network (2001)

http://international.aanp.org/Practice/APNRoles

A Nurse Practitioner/Advanced Practice Nurse is a registered nurse who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped by the context and/or country in which s/he is credentialed to practice. A master's degree is recommended for entry level.

## Educational Preparation

- Educational preparation at advanced level
- Formal recognition of educational programs preparing nurse practitioners/advanced nursing practice roles accredited or approved
- Formal system of licensure, registration, certification and credentialing

## Nature of Practice

- Integrates research, education, practice and management
- High degree of professional autonomy and independent practice
- Case management/own case load
- Advanced health assessment skills, decision-making skills and diagnostic reasoning skills
- Recognized advanced clinical competencies
- Provision of consultant services to health providers
- Plans, implements & evaluates programs
- Recognized first point of contact for clients

## Regulatory mechanisms – Country specific regulations underpin NP/APN practice

- Right to diagnose
- Authority to prescribe medication
- Authority to prescribe treatment
- Authority to refer clients to other professionals
- Authority to admit patients to hospital
- Legislation to confer and protect the title "Nurse Practitioner/Advanced Practice Nurse"
- Legislation or some other form of regulatory mechanism specific to advanced practice nurses
- Officially recognized titles for nurses working in advanced practice roles

North East England

Newcastle
Gateshead
Sunderland
Carlisle
Durham
North West England
Middlesbrough
Yorkshire and the Humber
Lancaster  Harrogate  York  Hull
Bradford
Leeds
Blackpool
Preston  Oldham
Manchester
Liverpool  Sheffield  Torksey
Stockport  Lincoln
Nottingham
Trent  Derby  East Midlands
Repton
Stafford
Shrewsbury  Leicester  Stamford  Norwich
Wolverhampton
West Bromwich  Birmingham  Cambridge
West Midlands  Coventry
Warwick  East of England
Stratford  Luton  Ipswich
Worcester
Hereford
Oxford
Gloucester
Swindon  Reading  LDN  Southend-on-Sea
Bristol  London
Bath  Canterbury
Dover
Folkestone
Salisbury  South East England
South West England  Southampton
Bournemouth  Portsmouth  Brighton
Poole
Exeter
Plymouth
Truro

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**Introduction**

1. **Express thanks for taking part in the study**

I would like to thank you again for agreeing to take part in my study. As I have explained in the literature I sent to you, this forms the basis for the final project for my Doctorate in Professional Studies at Sheffield Hallam University.

2. **Explain the parameters and purpose of the study**

The purpose of my study is to explore what Advanced Nurse Practitioners see as their role in and value to general practice in the United Kingdom. I particularly want to explore what contribution you feel you make beyond the day to day management of patient presentations to your practice. Finally, I would also like to talk about nursing in these advanced roles, and what nursing specifically adds and means.

3. **Explain the right to withdraw from the study**

Could I first confirm that you have received the participant information and consent form. Do you have any questions about this? There is no obligation upon you now or in the future to remain in the study. If you do feel uncomfortable at any time during the interview, please tell me and we can stop.

The information you give is completely anonymous, if you do mention any names during the interview I will remove them.

The interview will be recorded. This is for me, so that I don't have to scribble notes and miss anything you have to say. My papers are just prompts should I lose the thread of what I want to say and I may refer to them during the interview.

Prompt: mobile phones, might they have to leave at any point for calls etc.

**Interview**

1. <u>**Introductory section and personal information**</u>

   i)     First, could I ask you to outline briefly how long you have been qualified, what your qualifications are and what experience you had before becoming a nurse practitioner?

   ii)    And how long you have been a Nurse Practitioner in general practice?

   iii)   Now about the practice, could I ask you to briefly outline the number of staff you have, the size of the practice and type of area it serves?

   iv)    What broadly does your role involve in the practice?

       a. **Prompt -** Do you have any specific responsibilities ie management, chronic disease, triage, housebound visiting?

v)     Did you undertake any specific training to support your role?

       a. **Prompt –** Academic? RCN approved? In-house?

## 2. Thinking about the advanced nursing role in general practice...

i)     What do you think the advanced nursing role contributes to the practice?

       a. **Prompt –** alternative clinician? Female?

## 3. Thinking about what value that role might have...

i)     Do you think the advanced nursing role adds value to general practice?

ii)    In what way?

       a. **Prompt –** do you think patients value this?

       b. **do you have any examples of this from practice?**

## 4. Thinking about how the advanced nursing role affects other roles within the team

i)     Do you feel the nurse practitioner role impacts upon the role of other team members?

       a. **Prompt –** on practice nurses, community staff,

       b. What is your impression of the impact the role has on general practitioners?

       c. **do you have any examples of this from practice?**

## 5. Extending the same issue to the wider nursing profession..

i)     In terms of professional development, what effect do you think the advanced nursing role has on the wider nursing profession?

       a. **Prompt –** is this positive or negative?

## 6. Finally...I wanted to ask about nursing in this advanced role...

i)     Do you still feel like a nurse?

ii)    What do you think your nursing skills add to the role?

iii)   Do you feel this role in practice should be uniquely nursing?

| Codes | Participant | Candidate Themes | Themes | Overarching Theme |
|---|---|---|---|---|
| Look at patient holistically | Gaynor | | | |
| Health promotion model | Naomi/Jane | Recipe for consultations? | Nursing or Medical Model | |
| Can use the medical model | Barbara | | | |
| Nursing orientation | Naomi | | | |
| Holistic approach | Gaynor | Kaleidoscope of care giving? | | |
| Looking at the whole | Ellie | | | |
| Dip in and out of both (medical and nursing) | Mandy | | | |
| Different approach | Mel | | | |
| Nursing toolkit | Barbara | | | |
| Backpack of nursing skills | Barbara | | | |
| Partnership | Naomi | | | |
| "I don't just give a prescription" | Claire | | | |
| "Look outside the box" | Ellie | | | Keeping it Nursing |
| "Bring a human side to practice" | Mel | | | |
| Doctors blinkered | Gaynor | | | |
| | Gaynor | | | |
| Caring | Sandra/Naomi | | | |
| Compassionate | Barbara | | | |
| Sympathy | Barbara | Demonstrating nursing characteristics? | Personal or professional attributes | |
| "sorry you feel so poorly" | Naomi | | | |
| Holism | Mel/Gaynor | | | |
| | Claire/Sandra | | | |
| | Claire | | | |
| I genuinely care | Barbara | | | |
| Sympathy | Claire/Naomi | | | |
| I listen | Naomi | | | |
| Empathy | Sandra | | | |
| Humanism | Dawn | | | |
| Negotiating | Naomi | | | |
| Taking them seriously | | | | |
| Nurses seen as caring "choosing a nurse rather than doctor" | Dawn (extract) | | | |
| Doctors are caring too | Barbara | | | |

**centre for
health and
social care**
research

21 January 2011

Julie Hall
65 Leaburn Road
Messingham
W Lincs
DN17 3SR

Dear Julie

This letter relates to your research proposal
**Advanced Nurse Practitioners' Perceptions of their role in General Practice**

This proposal was submitted to the Faculty Research Ethics Committee for ethics and scientific review. It has been reviewed by two independent reviewers and has been passed as satisfactory. The comments of the reviewers are enclosed. You will need to ensure you have all other necessary permission in place before proceeding, for example, from the Research Governance office of any sites outside the University where your research will take place. This letter can be used as evidence that the proposal has been reviewed ethically and scientifically within Sheffield Hallam University.
The documents we reviewed were:

| Name | Size KB | Date Modified |
|---|---|---|
| Denyse Hodgson CV.doc | 94 | 18/01/2012 12:01 |
| DPS1(2011-12).docx | 149 | 23/01/2012 15:38 |
| DPSEthics (2010-11).doc | 274 | 07/01/2012 21:39 |
| Gant Chart 12.2011.docx | 14 | 07/01/2012 21:39 |
| patient participant form.doc | 142 | 18/01/2012 21:58 |
| reseach and interview schedule.docx | 15 | 07/01/2012 21:39 |

Good luck with your project

Peter Allmark
Chair Faculty Research Ethics Committee
Faculty of Health and Well-being
Sheffield Hallam University
32 Collegiate Crescent
S10 2BP
0114 225 5727
p.allmark@shu.ac.uk

**Sheffield
Hallam University**

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# *Sheffield Hallam University*

## Participant information sheet

| Study title: | Nurse Practitioners' perceptions of their role and value in UK General Practice |
|---|---|
| Chief investigator | Julie Hall |
| Telephone number | 07713585059 |

**Study Sponsor: Sheffield Hallam University**

I would like to invite you to take part in my research study. Before you decide I would like you to understand why the research is being done and what it would involve for you.

Much of the existing research into the role of the nurse practitioner in general practice has understandably focused on the ability of nurses to take on some part of the medical role, in effect to "substitute" for doctors. And whilst this has demonstrated that the service provided by nurse practitioners is safe and broadly acceptable to stakeholders, there is a paucity of research into the role itself, what meaning it has from the nurse's perspective and what nursing itself contributes to service delivery.

I want to explore this aspect of the service by talking to nurse practitioners involved in delivering the service.

This research project forms part of a course of study for a Doctorate in Professional Health Studies.

Participant name:

You will be given a copy of this information sheet to keep

**1. What is the purpose of this study?**

The purpose of this study is to explore, from the nurse practitioner's perspective the value and meaning of their role in UK general practice.

**2. Why have I been invited?**

I have invited you to take part because, as a nurse practitioner in general practice, you have a personal view of the role, what it involves, what it means to you and what value you think it has to the service.

**3. Do I have to take part?**

Your decision to take part in this study is entirely voluntary. You may refuse to participate or you can withdraw from the study at any time. Your refusal to participate or wish to withdraw would not lead to any adverse opinion or reflect badly in any way.

**4. What will happen to me if I take part?**

If you participate in the study it would initially involve one interview, at your workplace or other agreed site at a time convenient for you. Following transcription of your interview I would like to send you my analysis of the discussion for your further review and comment.

**5. Expenses and payments**

**6. What will I have to do?**

If you agree to take part in the study I will contact you to arrange a convenient date and site for the interview.

**7. What are the possible disadvantages and risks of taking**

There are unlikely to be any risks of disadvantages to taking part in the study. There may be questions which cause you some mild distress, perhaps recalling incidents which you do not feel went well or caused potential or real harm to you or your patients.

**8. What are the possible benefits of taking part?**

I hope that the results of this study will contribute to a body of knowledge around the nurse practitioner role. As a participant you contribute to this process and your views and values are given voice and significance.

**9. What if there is a problem or I want to complain?**

If you have any queries or questions please contact:

Principal investigator: Julie Hall
julie-hall3@sky.com

Mobile contact no. 07713585059

**Alternatively,** you can contact my supervisor by e-mail

Dr H. Piercy : h.piercy@shu.ac.uk

Sheffield Hallam University, Faculty of Health and Wellbeing

Contact no 0114 225 5704

If you would rather contact an independent person, you can contact Peter Allmark (Chair Faculty Research Ethics Committee) p.allmark@shu.ac.uk; 0114 225 5727

## 10. Will my taking part in this study be kept confidential?

The interview will be recorded and then written up word for word. As the sole researcher I will be responsible for checking that the digital recording and the written transcript are the same. The transcript will be kept on a password-protected computer. Identifying details will be taken out of any final report and any publication so people reading these will not be able to identify you. The written transcripts will have all links to you removed at the end of the study and will then be kept for as long as they might be useful in future research. In practice, it is anticipated that this will be for a minimum of five years.

It might be that in the interviews something of concern arises relating to patient care. If that happens, I will consult with my supervisor to discuss what to do. I will act in accordance with my professional Code of Conduct.

The documents relating to the administration of this research, such as the consent form you sign to take part, will be kept in a folder called a site file or project file. This is locked away securely. The folder might be checked by people in authority who want to make sure that researchers are following the correct procedures. These people will not pass on your details to anyone else. The documents will be destroyed three years after the end of the study.

## 11. What will happen to the results of the research study?

The final project will be lodged in the faculty of health and wellbeing, Sheffield Hallam University. Some of the results will be presented for publication in nursing and health journals. The results will also be presented at the national conference for Advanced Nurse Practitioners.

## 12. Who is sponsoring the study?

The sponsor of the study has the duty to ensure that it runs properly and that it is insured. In this study, the sponsor is Sheffield Hallam University.

## 13. Who has reviewed this study?

All research based at Sheffield Hallam University is looked at by a group of people called a Research Ethics Committee. This Committee is run by Sheffield Hallam University but its members are not connected to the research they examine. The Research Ethics Committee has reviewed this study and given a favourable opinion.

## 14. Further information and contact details

Please see section nine for contact details of the researcher and research supervisor.

# Sheffield Hallam University

## Participant consent form

| Study title: | Nurse Practitioners' perceptions of their role and value in UK General Practice |
|---|---|
| Chief investigator | Julie Hall |
| Telephone number | 07713585059 |

| Participant name | |
|---|---|

| | **Please read the following statements and put your initials in the box to show that you have read and understood them and that you agree with them** | **Please initial each box** |
|---|---|---|
| 1 | I confirm that I have read and understood the information sheet dated **date** for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. | |
| 2 | I understand that my involvement in this study is voluntary and that I am free to withdraw at any time, without giving any reason without prejudice. | |
| 3 | I agree to take part in this study | |

**To be filled in by the participant**

I agree to take part in the above study

| Your name | Date | Signature |
|---|---|---|
| | | |

**To be filled in by the person obtaining consent**

I confirm that I have explained the nature, purposes and possible effects of this research study to the person whose name is printed above.

| Name of investigator | Date | Signature |
|---|---|---|
|  |  |  |

Filing instructions

1 copy to the participant
1 original in the Project or Site file

| Participant | Years since qualification | Qualification | Previous experience | Years as an NP | Size of practice | Acute first contact care | Long term conditions | No of NPs in practice |
|---|---|---|---|---|---|---|---|---|
| 1. Dawn | 30 | BA (composed of stand-alone modules) Prescriber | Staff Nurse Practice Nurse | 10 | 16,000 | Yes 80% of workload | Yes 20% of workload | 2 |
| 2. Mandy | 24 | Post-graduate diploma Prescriber | Staff Nurse Sister NHS Direct | 11 | 4,500 | Yes 95% of workload | Yes Small housebound caseload | 1 |
| 3. Ellie | 31 | BA (stand-alone modules) Prescriber | Staff Nurse Practice Nurse | 9 | 10,000 | Yes variable | Yes Small housebound caseload | 1 |
| 4. Naomi | 23 | MSc Prescriber | Staff Nurse Practice nurse | 3 | 3,300 | Yes 50% of workload | Yes 50% of workload | 1 |
| 5. Sandra | 30 | BA (stand alone modules) Prescriber | Staff Nurse Practice Nurse | 8 | 17,500 | Yes 30% of workload | Yes 70% of workload | 1 |
| 6. Gaynor | 20 | MSc Prescriber | Staff Nurse Education Practice Nurse | 5 | 7000 | Yes 100% of workload | No | 1 |

| Participant | Years since qualification | Qualification | Previous experience | Years as an NP | Size of practice | Acute care | Long term conditions | No of NPs in practice |
|---|---|---|---|---|---|---|---|---|
| 7. Barbara | 27 | MSc | Staff Nurse Practice Nurse | 2 | 3000 | Yes 50% of clinical workload | Yes 50% of clinical workload | 2 |
| 8. Claire | 36 | MSc | Staff Nurse Practice Nurse | 11 | 13,500 | Yes 100% of clinical workload | No | 2 |
| 9. Jane | 35 | BA Advanced Nurse Practitioner | Staff nurse Ward Sister Practice Nurse Emergency care practitioner | 10 | 14,000 | Yes 50% of clinical workload | Yes 50% of clinical workload | 3 |
| 10. Mel | 41 | MSc | Staff Nurse Emergency care practitioner Nurse practitioner ANP in unscheduled care | 15 | 14,000 | Yes 100% of clinical workload | No | 2 |

**Minor acute illnesses**

| | |
|---|---|
| Musculoskeletal | Minor traumatic or degenerative disorders, aches and pains, backache, gout |
| Respiratory | Viral upper respiratory tract infections, coughs and colds, earache, sore throat, dizziness |
| Gastrointestinal | Nausea, dyspepsia (abdominal discomfort, distension, belching, regurgitation), infective diarrhoea and vomiting, acute abdominal pain, constipation |
| Neurological | Tingling, dizziness, headaches, lassitude |
| Dermatology | Rashes, cysts, warts, itching, allergy (urticaria) |
| Cardiovascular | Irregular heartbeat (palpitations), cold extremities, musculoskeletal chest pain, ankle swelling, varicose veins |
| Mental health | Anxiousness, low mood, bereavement and other situational reactions, minor phobia |

King's Fund 2010 (p 8)