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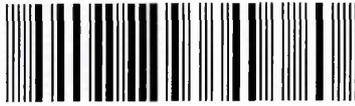
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The Experience of Nurse Partnership in General Practice: A Thematic Analysis

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fulfilment of the requirements of

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Abstract

This research project was conducted within the setting of English General Practice and explored the experience of nurse partnerships; from the perspective of the Nurse Partners and their colleagues. The inquiry was within a social constructionist framework; the research was inductive, emerging and shaped by the researcher's experience. A critical emancipatory perspective fully embraced and exploited the subjectivity of the researcher. Reflexivity is used throughout the report, making visible the researcher's individuality and effect on the research process. It has been possible for nurses to become partners in general practice since 1997. However, it is not possible to determine the exact numbers of nurse partners, as there is no national list or database. There is little published research about Nurse Partners.

A purposive sample of five self-selecting practices was used; geographically spread across England; representing the diversity of general practice. Nineteen in-depth interactive interviews were audiotaped: five GPs; five Nurse Partners; five practice managers and four members of the nursing team.

The data was thematically analysed using the Attride-Stirling method of thematic networks. The web-like networks are an organising principle and representational. Two Global Themes were developed to conceptualise the main argument and assumptions, drawing on ten Basic Themes and four Organising Themes. The Global Theme metaphors became the titles of the interconnected Networks; 'Stepping out the Box' and 'Toe in the Water'. The findings suggest that the Nurse Partners are pioneers; combining professional nursing with an entrepreneurial perspective. However, there remain cultural issues around equality. The research practices have embraced multi-professional working, with the Nurse Partner playing a major role in the senior management team of partners.

The Nurse Partners enjoy an autonomy and independence; are able to show entrepreneurship and demonstrate a commitment to the 'business' of general practice. Nevertheless these nurses have not received the recognition they deserve. It is therefore a concern that Nurse Partnerships are not being considered as part of the solution to the 'crisis' in general practice. The entrepreneurship and expertise demonstrated by these Nurse partners in multi-professional working is vital to the continuation of modern effective primary healthcare.

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**It is in the mood of critical reflection on social reality in
readiness to take action for change that critical
researchers come to the task of human inquiry**

Michael Crotty 2009

List of Abbreviations

ANP	Advanced Nurse Practitioner
APMS	Alternative Provider Medical Services
ATPP	Advanced Training Practices Pilot
BMA	British Medical Association
BNF	British National Formulary
CCG	Clinical Commissioning Groups
CHD	Chronic Heart Disease
CKD	Chronic Kidney Disease
COPD	Chronic Obstructive Pulmonary Disease
GMS	General Medical Services
GP	General Medical Practitioner
GPN	General Practice Nurse
HCA	Health Care Assistant
LTC	Long Term Condition
LMC	Local Medical Committee
MPW	Multi-Professional Working
NHS	National Health Service
NMC	Nursing & Midwifery Council
PBC	Practice Based Commissioning
PCG	Primary Care Group
PCT	Primary Care Trust
PEC	Professional Executive Committee
PFI	Private Finance Initiative
PHCT	Primary Health Care Team
PMS	Personal Medical Services
PNA	Practice Nurse Association
QNI	Queen's Nursing Institution
QOF	Quality & Outcome Framework
RCN	Royal College of Nursing
UKCC	United Kingdom Central Council for Nursing, Midwifery & Health Visiting United Kingdom

Definitions

Multi-professional working; characterised by each discipline within the team working towards discipline-related goals. Team members work within the boundaries of their professional practice; progress is formally discussed at team meetings (Webster 2002).

Inter-disciplinary working; is the ability for practitioners to work holistically while 'blurring' the boundaries of professional practice, the key aim or intention being to best meet client need (Webster 2002)

Inter-professional working; describes occasions when two or more professions come together to learn with, and from, each other with the intention of promoting collaborative practice (Humphris 2007)

Collaborative working; happens when multiple health workers from different backgrounds work together with patients, families, carers and communities to deliver the highest quality of care (WHO Framework for Action on Inter-professional Education & Collaborative Practice)

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Introduction

This research project explores the phenomenon of Nurse Partners in General Practice and their perceived impact on the practices in which they work and also on the wider health community. The findings are derived from the perspectives of the participating Nurse Partners themselves, and those with whom they work closely.

Culture and cultural identity are important concepts for this project; which is about nurses and nursing. Hudelson (2004 p345) defines culture as; '*the shared set of (implicit and explicit) values, ideas, concepts and rules of behaviour that allows a social group to function and perpetuate itself*'. She goes on to suggest that culture is the '*dynamic and evolving socially constructed reality*' that exists in the minds of group members.

Each health care profession has a different culture; including values, beliefs, attitudes, customs and behaviours. Hall (2005 p188) proposes that '*this culture is passed on to the neophytes in the profession, but it remains obscure to other professions*'. Hall goes on to state that nursing has progressed as a profession, such that nurses are now responsible for their own actions and omissions (Nursing and Midwifery Council (NMC) Code 2008). This openly challenges the authority and boundaries of medicine.

Williams (2000) asserts that if the cultural identity of general practice has been created in relation to other medical specialities; the cultural identity of general practice nursing has been created in relation to medicine. It will be seen that this hypothesis of general practice nursing's cultural identity resonates throughout this research project and reaches to the heart of the findings.

Whilst the concept of culture is central to this research project, the methodology employed is however, not claimed to be ethnographic as such, but takes a more general qualitative approach employing thematic analysis as a strategy for managing and interpreting data, which was generated through in-depth interviews with key informants.

A literature search found only one published research paper on Nurse Partners in general practice, indicating that little is known about how Nurse Partners are perceived and operate in the world of General Practice. The scarcity of attention paid to this phenomenon indicated that a qualitative research approach should be used to undertake the study. Denzin and Lincoln (2005 p3) describe qualitative research as:

'a situated activity that locates the observer in the world. These practices transform the world.....At this level, qualitative research involves an interpretative, naturalistic approach to the world. This means that qualitative researchers study things in their natural setting, attempting to make sense of, or interpret, phenomena in terms of meanings people bring to them'

Qualitative research is an inductive process, moving from the details of the experience to a more general picture. Cresswell (2007 p37) states that *'the final written report includes the voices of participants, the reflexivity of the researcher and a complex description and interpretation of the problem and signals a call for action'*

Reflexivity is an important element of qualitative research; the interpretation of the data based on the cultural, social, gender, class and personal politics of the researcher. Finlay (2002a) states that the researcher recognises that she is an integral part of the research process she is conducting and the report is a representation and co-construction of the interactive processes between the researcher and the researched.

The reflexive researcher does not pretend to be detached from the subject of the research, she does not claim to objectivity and discreetly observe the situation from a distance to collect 'pure' data. Rather she recognises that she is an integral part of the research situation in which she is participating.

The epistemology that underpinned this research was social constructionism; a seeking of an understanding of the world in which we work and live, drawn from an assumption that humans build shared meanings about the world through their interactions with it. The objective is to rely on the participants' view of the world that has been formed through interaction with others and through historical and cultural

norms that operate in individuals' lives (Cresswell 2007). The research questions are broad and general, with the participants constructing meaning from a situation. This often involves the processes of interaction between individuals. Researchers also play a part in constructing meanings and need to recognise how their own background, personal, cultural and historical experience shapes their interpretation of the situation.

This researcher, as a Nurse Partner herself, acknowledges her inevitable part in the construction of the meanings that are offered in this study and also her leanings towards postmodernism, as the main theoretical perspective informing the approach to the study. The basic concept of postmodernism is that knowledge claims must be set within the conditions of the world today and in the multiple perspectives of class and gender. These can show themselves as hierarchies, power and control (Cresswell 2007). There was also an influence of a critical paradigm shaped by the researcher's social, political, cultural, economic and gender values, which aimed towards an interest in liberating the study participants by making their voices heard.

Published information about Nurse Partners is scarce; only one published research paper, one unpublished paper and several discussion articles were found during the literature review. The research papers described the personal and professional attributes of Nurse Partners and identified the perceived benefits and challenges of a partnership. The discussion articles debated that: Nurse Partners had an important leadership role for other nurses; brought a different perspective to decision making; improved teamwork and gained greater job satisfaction. Due to this limited information about Nurse Partners, it felt timely that a research project should be undertaken to explore the experience of nurse partnerships in general practice from the perspective of the Nurse Partners and their colleagues. The research questions were;

- What are the experiences of nurses who become partners in general practice?
- Why do nurses become partners in general practice?
- In what way are Nurse Partners perceived to be different to GP (general practitioner) partners?

In order to generate data to address the study's questions; in-depth, interactive interviews were carried out, using an interview schedule that was based on exploring the identified research interests. A purposive sample of Nurse Partners and their colleagues was accessed via the electronic data base held by the Queen's Nursing Institute (QNI). Five Nurse Partners across England agreed to participate and became the 'gatekeepers' for their colleagues. Nineteen interviews were audio recorded and professionally transcribed.

A thematic analysis of the data was undertaken using the Attride-Stirling model (2001) of Thematic Networks. These web-like diagrams are used to summarise the main themes from the data, grouping the information into Basic Themes, then more abstract Organising Themes and finally forming Global Themes, the main representations of the findings of the research.

The report is set out in eight chapters. The first chapter establishes the research context – English General Practice, its historical origins, the significance of its independent contractor status and the key policy milestones that have influenced the business of general practice. This chapter also includes the development of nurses in general practice, from 'handmaidens' to the doctor to a distinct discipline within nursing, with recognisable post registration qualifications. The second chapter introduces reflexivity and how it is presented as an integral part of the research process. The third chapter covers the narrative literature review and the fourth chapter describes the methodology and method of the study. Chapter five explains how the findings are presented graphically, as web-like networks, illustrating the significant themes and the interconnectivity of the themes. The two following chapters present the themes and networks with verbatim data presented to support researcher's interpretations. Chapter eight provides: a summary of the study and its findings; the limitations of the study; the major implications of the work and a number of recommendations arising from the study.

Chapter 1 – The Research Context

This study was conducted within the setting of English General Practice and the delivery of primary healthcare services. Prior to the formation of the National Health Service (NHS) in 1948; low paid working men were provided with the service of a 'panel' doctor in return for a compulsory four pence per week in National Insurance contributions. The employer paid in three pence and the state two pence; this did not provide for hospital care. Higher paid workers, all women and children had to pay to see a family doctor. With the formation of the NHS, the 'General Medical Practitioner' (GP) became responsible for all personal medical services for a whole population and controlled access to specialist hospital care. However, during the turbulence of the emergence of the NHS, GPs chose to remain outside the NHS as independent contractors rather than salaried NHS employees.

Traditionally the GP was the personal doctor working in the community, separated from the physicians and surgeons who specialised in a particular field. Woodroffe (2006) considers three major roles that characterise the traditional model of general practice: seeing undifferentiated health problems and using clinical skills and knowledge as diagnostic and therapeutic tools, within a low technology setting; providing continuous longitudinal relationships with patients and their families and as the 'gate keeper' / advocate for patients who require specialist services.

The independent contractor status is often misunderstood by other healthcare professionals and the general public. This also means that staff employed by GP practices, including nurses, are outside the NHS. Contract negotiations have caused much conflict between successive governments and the GP representatives, the British Medical Association (BMA). These negotiations are often acrimonious and protracted.

In 1966 a new contract improved pay and conditions for GPs, instituting a maximum list size of 2,000 patients per GP and providing resources for professional education, improvement of premises and hiring of support staff, for example receptionists and nurses, many of whom were the GP's wife. These developments saw the beginning

of group practices. At this time the GPs were paid a capitation fee for their registered population and an 'items of service' fee for their services.

The 1990 GP contract introduced greater external management for general practice and established elements of performance-related pay, associated with 'health promotion' activities. This new contract led to a significant increase in the number of nurses employed in general practice, as these 'health promotion' activities could be undertaken by nurses in scheduled 'clinics'.

GP fundholding was introduced in 1991 by the then Conservative government; fundholding was voluntary with the aim to give GPs a financial incentive to manage costs and to apply some competitive pressure to hospital providers. GPs held real budgets to purchase non-urgent elective care and community care for their patients; they were able to keep any savings. Many GP practices formed consortia to purchase secondary care consultant services for their populations; this was the beginning of the commissioner / provider function that GPs and general practices are required to manage today. The Labour government abolished GP fundholding in 1997 but kept the purchaser / provider split. Health authorities were replaced by primary care groups (PCGs) and then by primary care trusts (PCTs). In 2004 the government announced the introduction of practice-based commissioning (PBC), this scheme was not compulsory. Practices which participated were given an indicative budget, accompanied by data on the volume of services their patients used. GPs were allowed to plough back an agreed share of any efficiency savings they made into developing new services.

Another new GP contract was also introduced in 2004 with increased emphasis on performance - related pay; the Quality and Outcome Framework (QOF). QOF rewards GPs for good practice and was intended to improve the quality of general practice. Participation in the QOF is voluntary, but for most practices the QOF is the only area where they can make a difference to their income.

There were four domains: clinical; organisational; patient experience and additional services, with a number of criteria and points allocated for achievement. Some of these domains have now disappeared with the points allocated differently. The clinical domains have points attached to them for achieving specific clinical

indicators; covering the management of most of the long term conditions including asthma, diabetes, chronic obstructive pulmonary disease (COPD), chronic heart disease (CHD), chronic kidney disease (CKD) and some preventative and monitoring measures. These points are attributed to an amount of money, which is given to the practices for attaining certain thresholds within the domains. For a typical practice the payment was £77.50 per point in 2004/5 with subsequent increases over the years. The number of pounds for points is now £124.60.

Each year the British Medical Association on behalf of GPs and the NHS Employers on behalf of the UK government, enter into negotiation around changes in the GP contract and the QOF. There have been several years when agreement has not been reached and the changes have been imposed.

The 2004 contract also changed the patient registration process from being registered with an individual doctor to being registered with the practice as a whole. This was a significant change enabling other professionals to become partners in the practice.

The General Medical Services (GMS) contract remains the most common contract for general practice in England. However, there are two other contracts in use: the Personal Medical Services (PMS) and the Alternative Provider Medical Services (APMS). The PMS contract enables GPs and other NHS staff to enter into locally negotiated (rather than nationally negotiated) contracts with the health service. These contracts allow providers to develop services outside the scope of GMS to meet specific needs of a local population, for example refugee and asylum seekers. The APMS contract allows the commissioning of primary care from commercial or voluntary providers or from foundation trusts.

Helman (2002 p619) suggests that *'from an anthropological view the concept of 'culture' – the shared world-view, beliefs, and practices of a group of people is only partly applicable to general practice.'* The key characteristic of general practice is its huge diversity. General practice does not exist in a vacuum; it is always imbedded in a much wider cultural, political, economic and demographic context (Helman 2002).

Sibbald (2008) states that nurses are competent and capable to undertake the majority of the work in general practice: including preventative health care; management of long term conditions (LTCs); and first contact care for minor illness. Therefore they should be acknowledged to be the true frontline providers of primary care and that GPs should become consultants in primary care receiving referrals from nurses.

Nurses in General Practice

The first nurses in general practice were the GP's wife, often acting as a receptionist and secretary, as well as performing general nursing duties such as dressings and injections. The 1966 GP Charter introduced a major change in how GPs were paid. The new payment system, which became known as the 'red book', allowed doctors to claim back from the NHS seventy percent of their staff costs and a hundred percent of the costs of their premises. This was the turning point for general practice, enabling doctors to improve their premises and to employ clerical staff and nurses (Kmietowicz 2007).

The 1990 GP Contract made further amendments to the system of payments and added incentives, which lead to an expanded role for general practice nurses (GPNs) and an increase in the numbers of nurses in general practice. Much of the work specified in the new contract: immunisations; cervical cytology; child health surveillance; health promotion; long term conditions management; new registration health checks and health assessments of people over 75 years old could be performed by appropriately trained nurses (Atkin & Lunt 1996).

Several Department of Health documents have supported the role of nurses in general practice (Department of Health 1997a; DH 2000; DH 2002) which has ensured the continuing development of the GPN. However, general practices are small businesses, with one 'customer' - the NHS. This puts nurses who work in general practice in a unique position; employed by another healthcare professional, in an organisation subcontracted to the NHS. This has brought the nurses benefits and disadvantages. Nurses have been able to develop their role and become more autonomous, taking on responsibilities for the management of patients with long term conditions, extending their role to become non-medical prescribers and to undertake

first contact care. However, many practice nurses feel isolated with few if any support networks and are sometimes the only nurse in the practice. Their leaders have either been employed and based in the primary care organisations, subject to all the recent changes of policy (DH 2010a), or emerged voluntarily, to lead local forums. In 1997 after much lobbying by the Royal College of Nursing (RCN) Practice Nurse Association (PNA), practice nurses were able to access the NHS pension scheme, but only prospectively. As employees practice nurses have very little control over their workload and have little input into the decision making processes.

Nursing in general practice has developed a long way since the wife of the GP 'handmaiden' role to employed professional nurse, expanding and extending their scope of practice as non-medical prescribers and specialists in LTCs.

A new type of nurse has evolved, operating at the boundaries between medicine and nursing, the Advanced Nurse Practitioner (ANP). This role was introduced from America, as a solution to the shortage of GPs during the 1990's. These advanced practitioners have skills in physical examination, assessment skills and problem solving and are educated at Masters level. The expertise of the ANP in primary care lies in their ability to operate as a 'generalist'; working autonomously, seeing patients, of any age, with undifferentiated health problems and usually completing the episode of care without referral to another healthcare professional. The RCN (2005 p2) states these are 'maxi nurses' not 'mini doctors'.

Modern general practice has become more pressured with high patient demand for appointments, patients living longer with LTCs and needing regular reviews of their medications and GPs being expected to contribute to the commissioning intentions, taking them out of clinical practice. ANPs in general practice are fulfilling the role of the GP in many of the 'on the day' patient contacts, such as telephone triage or consultations, minor illness clinics or first contact clinics and 'drop in' sessions.

Nurses as General Practice Partners

General practice has often been described as a corner shop business, owned by a group of GPs in a legal partnership agreement. Most GP partners also have a share in the premises. Although, over recent years many 'new build' premises have been

developed by private finance initiatives (PFIs) and operated by management companies, with the GP partners paying rent and management fees. Income is from the national contracts, incentive schemes e.g. QOF and enhanced services. After overheads and staff salaries are paid, the remaining income is divided between the GP partners as 'drawings' depending on seniority and share allocation. The value of these drawings can vary from month to month and year on year. Some GPs, especially those newly qualified, do not wish to have the added responsibility of practice ownership and uncertainty of income, become salaried GPs. Salaried GPs are treated as any other paid member of staff, national insurance, tax and pension contributions are deducted at source and a regular amount of money is paid to them monthly.

It has been possible for nurses to become partners since 1997, by taking advantage of the PMS (Department of Health 1997b) contract. This locally negotiated contract with the Primary Care Trust was developed to deliver primary care health services to a local population. However, it was the 2004 GMS contract that 'opened the gates' for non GPs to become partners; this has included practice managers and other healthcare professionals, though nurses have been the largest professional group to achieve partnerships in general practice. This contract is practice based rather than individual GP based and includes a much greater proportion of payments based on quality of care and outcomes for patients. It is generally acknowledged that the majority of the QOF work is undertaken by nurses. This involvement in income generation has been given as one of the reasons that nurses may wish to become profit-sharing partners (Cook 2005).

It is not possible to determine the exact numbers of Nurse Partners. The Queen's Nursing Institution, a national charity for community nurses, did develop an electronic database holding approximately 300 members. Many of these were interested in becoming partners rather than already a partner. Unfortunately, due to lack of funding, the organisation was unable to keep this database 'live'.

An interview with several general practice nurse partners by Robinson (2005) identified the potential benefits of nurse partnerships as: bringing a different professional perspective to decisions on clinical, managerial and business issues; providing an important leadership role for other nurses in the practice; releasing GP

time by taking the lead in delivering the QOF; prompting debates about the contribution of different professionals in meeting the practice's goals; enabling nurses to have an equal say in both strategic and operational decisions and providing a greater degree of job satisfaction and improved teamwork.

The Health and Social Care Act (DH 2012) gave GPs and other clinicians the primary responsibility for commissioning health care for their local population. These Clinical Commissioning Groups (CCGs) consist mainly of GPs supported by senior managers. After much lobbying it was agreed that there would be a nurse on every CCG, however, the nurse could not be employed by any provider unit that the CCG may commission services from, effectively ruling out any practice nurses. Most CCG nurses are from a secondary care or community care background. As self-employed nurses, Nurse Partners are eligible to be members of the CCG. The government allowed the BMA Local Medical Committees (LMC) to organise the selection for membership to the CCGs. It is interesting to note that few if any Nurse Partners were selected.

This chapter has set the context of the study: from the development of general practice at the beginning of the NHS to the commissioning of most of the health care for a geographical population. The parallel development of nursing in general practice has been explored. A critical stance has been taken about the changes that have occurred.

The following chapter discusses how reflexivity can be used to: examine the position, perspective and presence of the researcher; evaluate the research process, method and outcomes and inspire others by opening up a more profound consciousness.

Chapter 2 – Reflexivity

Reflexive research is a method that fully embraces and exploits the subjectivity of the researcher (Rolfe et al 2001). It is an acknowledgement of the role and influence of the researcher on the research project; the researcher is subject to the same critical analysis and scrutiny as the research itself.

As a Nurse Partner I was aware that I would influence the collection, selection and interpretation of my data. Finlay (2002a) suggests that research is co-created, a joint product of the participants and the researcher and that another researcher would produce another 'story.' Freshwater and Rolfe (2001 p526) proposes; *'There is no one way street between the researcher and the object of study: rather, the two affect each other mutually and continually in the course of the research process.'*

Finlay (2002a p532) goes on to define reflexivity as thoughtful, conscious self-awareness and she suggests that reflexivity involves a change in our understanding of data collection from *'something objective that is accomplished through detached scrutiny of 'what I know and how I know it' to recognising how we actively construct our knowledge'*

Finlay states that reflexivity has the potential to be a valuable tool to:

- Examine the impact of the position, perspective and presence of the researcher
- Promote rich insight through examining personal responses and interpersonal dynamics
- Open up unconscious motivations and implicit biases in the researcher's approach
- Empower others by opening up a more radical consciousness
- Evaluate the research process, method and outcomes
- Enable public scrutiny of the integrity of the research through offering a methodological log of research decisions.

Reflection and reflexivity are often used interchangeably; Finlay (2002b) suggests that the concepts are best viewed on a continuum, where both ends are

acknowledged to be important across the stages of the research project. Reflection at one end of the scale, a 'thinking about' process taking place after the event and at the other end of the scale reflexivity, a more immediate, continuing, dynamic and subjective self-awareness.

Freshwater and Rolfe (2009 p527) quote Schon (1987) that '*in the varied topography of professional practice there is a high hard ground overlooking a swamp.*' They state that the 'hard ground' is inhabited by academics that need to push forward qualitative research methodologies to add to the body of knowledge. To achieve this it is essential to '*go down into the swamp where practitioners go about their daily work*'.

Finlay (2002b) presents five 'maps' to negotiate the 'swamp': introspection; intersubjective reflection; mutual collaboration; social critique and discursive deconstruction. Introspection challenges the researcher to '*use personal revelation not as an end in itself but as a springboard for interpretations and more general insight*' (p215). A radical self-reflective consciousness is looked for in the intersubjective reflection where the self in relation to others becomes both the aim and object of focus. Reflexivity as mutual collaboration uses a broad range of methodologies which are linked to the way the researchers enlist participants as co-researchers. Reflexivity as social critique offers the opportunity to utilise experiential accounts while situating these within a strong theoretical framework about the social construction of power. In reflexivity as discursive deconstruction, notice is paid to the ambiguity of meanings in language used and how this impacts on styles of presentation.

In terms of theoretical and methodological commitments, Finlay suggests that the 'social critique' and 'discursive deconstruction' maps are favoured by post-modernists, social constructionists and sociologists and are in opposition to the more personal and individual 'introspective' map.

Research is an interactive and iterative process with particular emphasis on change, which therefore relies heavily on dynamic communicative partnerships between researcher and practitioners (Freshwater and Rolfe 2001).

The interaction between the researcher and the data is now accepted as inevitable in qualitative research and that the researcher's philosophy and beliefs influence the choice of method used. Alvesson and Skoldberg (2009) believe that emotions are a vital part of the researcher's rationale and choice of direction. Nevertheless it is essential that there is an acknowledgement of self and the examination of one's values and beliefs is fundamental to an understanding of reflexivity.

Although this research took a post modernism and social constructionist stance I preferred to use an introspective model of reflexivity. The researcher becomes clearer about the link between knowledge claims, personal experiences of both participant and researcher, and the social context, subsequently turning the research outwards towards the social and political world.

Alvesson and Skoldberg (2009) state there are two basic characteristics in reflexive research; careful interpretation and reflection. All references to the data are the results of interpretation: which is the awareness of theoretical assumptions; the importance of language and a pre-understanding of the research environment. Reflection brings attention towards the person of the researcher, the research community, intellectual and cultural traditions. Alvesson and Skolberg (2009) propose that systematic reflection on several different levels can provide the interpretation with a quality that makes empirical research of value. However, it is difficult for the researcher to explain the taken for granted assumptions and blind spots in her own social culture and language.

Reflexivity implies that the researcher makes visible their individuality and its effects on the research process. There is an attempt to highlight the motivation, interests and attitude which the researcher brings to the research and to reflect on how these have impacted on each stage.

How we write is a reflection of our own interpretation based on the cultural, social, gender, class and personal politics that we bring to the research. All writing is 'positioned' all researchers shape the writing that emerges and qualitative researchers need to accept this interpretation and be open about it in their writings (Cresswell 2007).

Originally this research project was to be about nurse leadership in primary care; with an initial research question as 'what are the characteristics and circumstances needed to achieve effective clinical nurse leadership in general practice?' However, as I presented the first thoughts and ideas to my peers and supervisors; trying to explain primary care nursing, the unique position of nursing in general practice and the phenomenon of Nurse Partners, I was encouraged and challenged to undertake a study of Nurse Partners. This was partly due to the lack of published research on the subject and importantly because of my personal experiences as a Nurse Partner.

The following section describes my professional journey as a nurse leader and a General Practice Nurse Partner. The purpose is to reflect upon and understand my own personal, political and intellectual biography in order to make explicit where I am situated in relation to the research participants (Mauthner and Doucet 2003).

My Professional Journey to Nurse Partnership

I have worked in general practice for 28 years, in the same practice, during which time I have seen and been involved in many changes. I became the nurse partner in the practice in October 2006.

As a nurse leader both locally and nationally I have been influential in the development of primary care nursing and especially practice nursing. As the Chair of the RCN PNA (2002 – 2007) I was part of many national steering groups, boards and committees, undertaking work on topics such as; the new GMS contract, new roles for community nurses, NatPact competences, National Service Frameworks (NSFs) and clinicians who's performance gives cause for concern. I have been a member of the National Association of Primary Care (NAPC) Executive Board and their Nurse Adviser.

I was a member of the Professional Executive Committee (PEC) of the Sheffield Primary Care Trust. (PCT) I served 5 years as a PEC clinician, was a member of the Clinical Governance sub-committee and PEC lead for Training and Education.

In 2009 I was asked to join a high profile national team lead by the National Clinical Director of Primary Care, looking at the access issues arising from the national patient survey. The group's remit was to visit all Strategic Health Authorities collecting information from PCTs and practices to establish best practice and share leading edge performance and learning across the country.

Whilst working on a proposal for a Vocational Training Scheme (VTS) for practice nurses based on the scheme for GP registrars, I was part of a small group of experienced practice nurses who approached the Yorkshire and Humber Associate Postgraduate Dean for help and advice. As a result of this meeting I was asked to join the Advanced Training Practice Project (ATPP) Steering Group, as the only nurse. The aims of the project were;

- To develop the provision of integrated inter-professional learning and working in primary care
- The development of a robust infrastructure, ensuring productivity and sustainability, for the provision of quality assurance placements and training for medical and non-medical students and staff
- To actively demonstrate an integrated learning ethos.

The practices were already training practices for medical students and GP registrars but had no experience of nursing students. There has been a huge learning curve both for the steering group members and the practices, needing to work within the NMC regulations in respect of nurse training and how to embed true inter-professional learning.

I have maintained my clinical practice with the support of my GP partners. There have been some challenging times when discussing skill mix within the nursing team versus more GP time. Agreed outcomes of these discussions have needed compromise on both 'sides'. By being a partner I have felt the responsibility of being the nursing advocate whilst at the same time pointing out the advantages of multi-professional working. The nursing team has definitely benefitted from this approach. Our Health Care Assistants (HCAs) have developed from a unidimensional role as phlebotomists to supporting the registered nurses with long term conditions

management. The registered nurses now undertake all routine LTC management and I have taken on the role of first contact / nurse practitioner and non-medical prescriber. This has enabled the GPs to spend time with the more complex patients.

I approached the senior partner about becoming a partner; he was aware of the concept and favourable to the idea, agreeing to present the suggestion to the other partners. There was a general agreement to explore the idea. There followed two years of discussion and negotiation before this became a reality. Some difficult conversations took place regarding the share of profits (parity), an incremental increase was agreed, but not to full parity with the GP partners. The rationale being that there were some things that GPs do that nurses cannot. However it has to be said that there was a lack of acknowledgement or understanding that there are things that I do that GPs do not.

I am not sure where the idea of becoming a partner came from; it became an ambition early in my practice nurse career, when there didn't seem to be any possibility to attain such a position. I always said that I would know I had 'made it' when my name appeared on the entrance door brass plaque. We don't have a brass plaque but my name is on the door!

After eight years I am still the only Nurse Partner in Sheffield. There have been many occasions where I have 'taken up the gauntlet' to be recognised and accepted as a General Practice Partner by the 'establishment'. Many of my GP colleagues have been supportive and encouraging, recognising my unique position as a senior nurse and a business partner, others have been less accepting.

Undertaking the professional doctoral programme has been a journey, sometimes enjoyable sometimes frustrating but always enlightening. Giving myself the time to study the phenomenon of Nurse Partners in general practice has felt like a reward for all the clinical study I have done in the past in order to progress my career. I therefore need to acknowledge researcher bias within the research process, which inevitably leads to a level of subjectivity. The 'moral integrity' of the researcher acknowledged by Finley (2002a) from Kvale (1996) is crucial for the validity of the project. My values, assumptions, prejudice and influence should be taken into

account; however, my reflections can also be a resource to be integrated into the research.

Woolgar (1988) suggests that critical reflexivity occurs where the researcher identifies and makes public her impact on the data generation within the research field.

Qualitative researchers accept that the researcher is a central figure who actively constructs the collection, selection and interpretation of data and that the research is co-constructed, a joint product of the participants, the researcher and their relationship. As a reflexive researcher I understand that meanings are negotiated within a particular social context so that another researcher will reveal a different story.

In accordance with Hand's (2003) proposal, that reflexivity should be considered at each stage of the research project, with the researcher examining and making explicit the decisions made, I have included reflexivity sections throughout the report.

As recognised earlier there is a lack of published research about Nurse Partners. Therefore the following literature review takes the form of a narrative review rather than a systematic review.

Chapter 3 – Literature Review

Introduction

In keeping with Wolcott's (1990:p17) advice that an introductory literature review in qualitative work should be confined to 'nesting' the research topic, with wider literature being brought to later chapters in the research report, this chapter presents an initial review of literature conducted during 2012. In keeping with qualitative approaches to the literature, further incremental searches took place throughout the conduct of the study to illuminate findings and support discussion. This literature appears in later chapters. The purpose of the review in this chapter was, as described by Hart (1998), to establish the context of the topic of interest of this study: general practice nurse partners. As identified previously, general practice nurse partners are a new phenomenon; and as such there is limited literature about them. However, two research papers investigating Nurse Partners were personally known to this researcher; one had been published (Roscoe 2012) the other was unpublished (Tindall 2008). In view of this it was decided to undertake a wider literature review drawing on the researcher's insider knowledge of nurse partnership and concepts derived from the Roscoe and Tindall papers. Key search terms were used to undertake a search of electronic data bases, resulting in the identification of four themes that were used to organise the review: nurse partners in general practice; advanced nursing roles; multi-professional working and professional identity.

Search strategy

Two search methods were used; electronic databases using all relevant search terms and incremental searching. An incremental approach is said to be particularly useful when investigating a topic in a more specialist field or where there is a limited amount of information available (Crookes & Davies 1998) and involved checking reference lists of papers identified through the electronic search, but not appearing in the electronic search. An unpublished master's dissertation by Tindall (2008) was known to this researcher through personal contact. The electronic databases were those available from the Sheffield Hallam University (SHU) Library Gateway Litsearch and support from the NHS Sheffield Library staff using NHS Athens. The

databases searched were; CINAHL, MEDLINE and BNI (British Nursing Index). The thesaurus option on the electronic database was used to identify all key search words. Key words were: nurse partners; nurse practitioners, nurse consultants; community matrons; inter-professional / multi-professional working; multi-disciplinary teams; doctors and nurses; professional power.

The review presented in this chapter may be described as a narrative literature review and, as previously mentioned, provides a contextualisation of the study.

Cronin et al (2008) provide a useful differentiation between systemic reviews and the more traditional narrative review: as being the systematic review uses a rigorous, closely defined approach to answer specific well focused questions, whereas the narrative review is designed to summarise a body of literature, the selection of which will depend on the study interests. In this review, the selection of literature was as described by (Avegard 2010), more loosely defined than in systematic reviews, the main criterion for selection being relevance as determined by the researcher's insider knowledge. Very little work was found in the specific context of general practice, therefore papers relating to community settings were selected, but papers relating to acute healthcare settings were excluded.

Other criteria applied to the inclusion of literature in the searches were; articles / papers published between 2000 and 2012 and included; original research papers, systematic reviews, discussion documents and opinion papers. The search was limited to papers published in the English language and those relating to the UK primary health care system. The UK primary health care system includes; community pharmacists, community dentists, community nursing as well as general practice. General practice is a unique system, no other country provides; registered population - based primary health care via a multi-disciplinary healthcare team, free at the point of access. Since the publication of the NHS Plan in 2000, primary healthcare and general practice has changed dramatically and continues to evolve, through the commissioner / provider split to clinical commissioning. Therefore documents prior to 2000 will be 'out of date' when referring to strategies and policies or ways of working.

This literature review presents the results of the initial search of the literature in the following four themes: what is known about nurse partners in general practice; advanced nursing roles; multi-professional working and professional identity.

Nurse Partners in General Practice

The initial search for studies into nurse partnerships in general practice revealed several journal articles about: how to become a partner; news articles about nurse partners meeting together to discuss issues; or individual stories about how the nurse became a partner.

The one published research paper on Nurse Partners in general practice (Roscoe 2012) used grounded theory to describe the professional and personal profiles of the '*average*' (Roscoe's word – this researcher's inverted commas and italics) nurse partner and discussed qualities that may influence a successful partnership agreement. Using the QNI electronic database of Nurse Partners she circulated a questionnaire to obtain an '*average*' profile for a nurse partner. The analysis of the answers gave an '*average*' profile for a Nurse Partner as: female; white aged 50 years; with 27 years post registration experience; extensive clinical and academic experience; practice based prior to partnership and length of partnership of 3 years. The use of the word '*average*' in this study does seem surprising, in that the postal questionnaire resulted in 20 replies from an estimated 100 Nurse Partners on the database.

Roscoe went on to interview six nurse partners who had expressed a willingness to be interviewed and who lived within a four hour travel zone of the interviewer. She concluded that personable qualities such as: flexibility; facilitative; credibility and collaborative; in addition to visionary and progressive traits, qualify nurse partners for effective team working and leadership. The weakness of this research is the small numbers involved in the interviews and the self-administered questionnaires.

However, as the only published research relating to nurse partners, it serves to raise the awareness and possibilities of nurse partnerships in general practice.

An unpublished descriptive survey study, using a self-administered postal questionnaire, to identify the perceived benefits and challenges of Nurse Partnership (Tindall 2008) found that the role was: demanding; requiring commitment both personally and financially; allowed for greater levels of autonomy and the

development of a more influential role; and that there was a lack of support available for nurses to help them establish their partnerships.

Again this was a small cohort of participants; Tindall acknowledges that there was only a 27% response rate to the postal questionnaires. Although this is probably what would be expected from a postal questionnaire, it may mean that the sample becomes unrepresentative of the target population and responses received may only be the opinion of a highly motivated section of the sample. The format of questionnaire design makes it difficult for the researcher to examine complex issues and opinions.

However, when combined with Roscoe's study, a description begins to emerge of the type of nurse who aspires to a partnership in general practice. Nevertheless, there is a lack of information as to why nurses become partners, their experiences of being nurse partners or the differences between nurse and GP partners.

In recent years, several advanced nursing practice roles have emerged: ANPs; Nurse Consultants and Community Matrons. Advanced practice has been described as adjusting the boundaries; pioneering and developing new roles responsive to changing needs (UKCC 1994). These new roles highlight the importance of delivering health from a primary care system which highlights personal responsibility, patient participation and teamwork. This literature review will now examine the research that considers these advanced nursing roles.

Advanced nursing roles

In November 2010 the Department of Health published 'A Position Statement' (DH 2010b) describing the level of practice expected of nurses working at advanced level who provide direct care to patients, clients or service users. This was in response to a review from the Council for Healthcare Regulatory Excellence (2009), which concluded that there was a need for a set of national agreed standards for advanced level practice in nursing. The term 'advanced level practice' has been applied inconsistently over many years to a number of roles and there has been much lobbying to have the 'title' regulated. However, this document did not go as far as discussing regulation. Nevertheless, it did provide a benchmark for advanced level nursing; it describes a level of practice, not speciality or role, which should be evident as being beyond first level registration. The benchmark comprises of 28

elements clustered into 4 themes; clinical / direct care practice, leadership and collaborative practice, improving quality and developing practice and developing self and others.

Nurse Practitioners

The role / title of Nurse Practitioner has gradually been adopted by many nurses both in secondary and primary care to describe a higher level of competency in certain areas of practice, for example: emergency nursing; rheumatology nursing and general practice. Those who have undertaken Masters level education have begun to call themselves ANPs. Over the years there has been much lobbying to have the title ANP regulated. The RCN (2012) acknowledged advanced nursing practice was covered by the Nursing and Midwifery Council's code of conduct (NMC 2008) but stated that this was not sufficient in isolation and other checks and controls must be in place. In the absence of national regulation of the title, the RCN document expressed the importance of local governance frameworks to assure fitness for practice and public protection. It was felt that if these processes were sufficiently robust, it would prevent the *ad hoc* development of ANP roles and the use of the title by nurses whose level of clinical expertise could not be verified. However, there are concerns that the independent contractor status of general practice and the 'small business' ethos is a barrier to establishing robust clinical governance structures in respect to this subject.

Many ANPs in general practice have undergone training and education at Masters Level; these programmes have been devised using the RCN's fifteen standards set out in the 2012 document. Also in the document the RCN defines the level of practice within which ANPs work as comprising of the following;

- Making professional autonomous decisions, for which they are accountable
- Receiving patients with undifferentiated and undiagnosed problems and making assessment of their health needs, based on highly developed nursing knowledge and skills including skills not usually exercised by nurses, such as physical examination
- Screening patients for disease risk factors and early signs of illness

- Making differential diagnoses using decision making and problem solving skills
- Working collaborative with other health care professionals and disciplines.

The expertise of the ANP in primary care lies in their ability to operate as a 'generalist'. The ANP provides complete episodes of care for patients of any age and with a wide variety and range of presenting problems and health care needs. This encompasses the provision of evidence-based, high quality care for patients whose issues fall within urgent / acute episodes, long term / chronic conditions health promotion and public health.

Two systematic reviews (Horrocks et al 2002 and Laurant et al 2009) have concluded that ANPs are safe and effective and they provide positive conclusions regarding value of the role and the patient satisfaction that arises from care given by an ANP.

Horrocks' et al (2002) systematic review of randomised controlled trials and prospective observational studies, aimed to determine whether nurse practitioners can provide care at first point of contact equivalent to GPs. They reviewed eleven trials and twenty three observational studies. No differences in health status were found; however, nurse practitioners did have longer consultations and made more investigations than GPs. There were no differences in the number of prescriptions issued, return consultations or referrals. The authors state that quality of care was in some ways better in the nurse practitioner consultations; these included more information to patients, better communication and offered more advice on self-care and management. The limitations of the review were acknowledged as; there were few recent randomised trials and the larger numbers of observational studies were generally of poor quality. Nevertheless, the authors concluded that increasing availability of nurse practitioners in primary care is likely to lead to high levels of patient satisfaction and high quality of care.

The Cochrane review by Laurant et al (2009) sought to evaluate the impact of nurse-doctor substitution in primary care on patient outcomes, process of care and resource utilisation. The review included studies where nurses were providing a similar primary health care service to doctors and included practice nurses, nurse

practitioners, clinical nurse specialists and ANPs. The findings suggested that appropriately trained nurses can provide as high quality care as doctors and achieve as good health care outcomes for patients. However, the conclusions need to be viewed with caution when considering reducing doctors' workload; nurses may be meeting previously unmet need or the presence of nurses generate a demand for care where there was none previously, for example seeing the worried well.

A randomised control trial of nurse practitioner versus general practitioner care, for patients requesting "same day" consultations in primary care, supported the wider acceptance of the role of nurse practitioners in providing care to patients requesting same day consultations (Kinnersley et al 2000).

Numerous studies that demonstrated satisfaction with nurse practitioner care have found significantly longer consultations (Horrocks et al 2002; Kinnersley et al 2000; Venning et al 2000). Seale et al (2005) compared transcripts of audiotaped consultations across eighteen matched pairs of nurse practitioner and general practitioner consultations where 'same day' appointments were sought. It was found that nurse practitioners spent twice as long with their patients and both patients and clinicians spoke more in nurse consultations. Conversation about how to use treatments and discussion of side effects contributed to most of the difference, with nurse practitioners also recommending a greater number of treatments. It was suggested that some of the extra time was spent in getting GPs to approve treatment plans and sign prescriptions. However, this analysis was based on data collected in 1998; there have been some significant changes since then with the previously mentioned documents on advanced level nursing (DH 2010a) and the RCN (2012) competences and more importantly independent nurse prescribing, allowing suitably qualified nurses to prescribe from the whole of the British National Formulary (BNF).

There have been obstacles to ANP introduction and development: organisation of care and funding mechanisms; legislation and regulation of scope of practice and education and training opportunities. Equally, there are certain drivers such as healthcare needs of the population and workforce issues, which support the advancement of ANPs. Haider (2014) suggests that ANPs are change agents for health care and are ideally placed to implement evidence-based practice to change

individuals' behaviour. Workforce planning needs to consider ANPs as part of the solution to the pending GP shortage.

Two other advanced nursing roles have been introduced over recent years, that of nurse consultants and community matrons. It was considered that by reviewing the literature available about these new senior nursing roles, an insight would be gained in regard to the challenges faced by experienced nurses establishing new roles.

Nurse Consultants

Nurse Consultants were introduced in 2000; the role was intended to achieve better outcomes for patients by improving quality and services and to enable experienced nurses to remain in clinical practice rather than move into management. The Department of Health specified that the role should encompass four core functions: expert practice; leadership and consultancy; education and training and service development; research and evaluation (Department of Health 1999). Nurse Consultants were expected to have Masters level education; however there was no explanation as to how these posts differed from the already existing senior clinical roles.

Most of the published research and evaluations have been secondary care based. Abbott (2007) quotes a primary care evaluation undertaken by Guest et al (2004); however this was unobtainable to this researcher. Abbott (2007) states that only 4.5% of known nurse consultants work in community and primary care and that relatively little is known about this group, as they have not been studied separately. His qualitative study explored the emerging role of nurse consultants in English primary care. This case study approach involved: a learning disabilities nurse; a public health nurse; a nurse working in child protection and a nurse working in intermediate care. Although not specifically stated it appears they were all employed by a community trust, general practice was not involved. Abbott found that all the nurse consultants would potentially work with a large number of disciplines, departments and organisations and as a result it took time to identify priorities and build relationships. It was found that two out of the four had made little progress in doing this.

Woodward et al (2005) undertook a qualitative research project involving ten Nurse Consultants working in a variety of settings and specialities in one English region. The analysis used the 'Framework' technique and identified four themes: '*characteristics of the post holder*'; '*role achievement*'; '*support systems*' and '*NHS influences*'. The results were published in two parts; characteristics and role achievement (Woodward et al 2005) and support systems and NHS influences (Woodward et al 2006). The data showed that the nurse consultants varied in terms of their academic background and previous experience; not all had the recommended minimum of Master's degree level and some had limited research experience. The researchers felt that this influenced the degree to which they were able to achieve the four domains of the role.

The paper focusing on nurse consultants' '*characteristics and achievements*' (Woodward et al 2005) indicated that; those who were able to carry out their role successfully were the most experienced practitioners, who had prior knowledge and experience of all four domains before coming into post. The nurse consultants, who were unable to fulfil all aspects of the role, were more likely to be achieving only the basic elements; usually clinical commitments. The authors concluded that new appointments to these roles should only be made when candidates possess the recommended levels of education preparation and professional experience of change management. They also suggest that it is important that there is clarity about the scope of the role, which should not include management responsibilities. Management was not part of the role's core functions specified by the Department of Health but it appears that, due to operational issues, some nurse consultants were being required to undertake these duties with no prior experience or training.

The paper reporting on '*organisational influences*' (Woodward et al 2006) found a major area of contention was how much nurse consultants were expected to take on work previously done by doctors, rather than develop their nursing role. The power base of the NHS was seen by many nurse consultants as a hindrance, with a strong perception that doctors still held the balance of power. '*Most had learned to use 'trade-offs' to get round or compensate for it, although some rejected this approach as not in nursing's best interests and were more confrontational*' (Woodward et al

2006 p278). The researchers suggest that organisational support and commitment are needed if nurse consultants are to maximise the benefits of this new role.

These findings show that new nursing roles are not always easily accepted in multi-professional settings and that holders of such posts need to have the appropriate previous knowledge, skills and personal characteristics, as well as the ability to negotiate their way through organisational influences.

An evaluation of the perceived role of the nurse consultant by McSherry et al (2007) suggests that the role is: significant in contributing to the modernisation of the NHS; future nursing career pathways and professionalism of nursing. However, the authors' state that the process of evaluation should not begin after the person commences the post, but prior to drawing up the business case or personal specification plan.

A mixed method systematic literature review (Kennedy et al 2011) examined the impact of nurse consultant roles in adult healthcare settings, with a view to identifying indicators for demonstrating their impact on patients and professional outcomes. Although the review found that there was limited evidence evaluating the impact of nurse consultants on patient and professional outcomes, it did present some evidence of the range of areas that nurse consultants potentially do influence. This systematic review led onto a series of case studies (Gerrish et al 2011), which found that few of the nurse consultants had made any attempt to capture their impact on patients, healthcare staff and the organisation in which they worked. From this work the authors developed a framework and toolkit to capture the impact of nurse consultants in three domains: clinical significance; professional significance and organisational significance. It is suggested, by the authors, that the framework and toolkit should be used by the nurse consultants in order to help them reflect on their role and evaluate their impact. Nurse Managers should find the framework and toolkit useful when supporting newly appointed nurse consultants, and in guiding the annual review process. Gerrish et al suggest that Nurse Managers may also find the framework useful when undertaking workforce planning. The framework and toolkit

can assist in identifying the unique contribution that nurse consultants make to patient outcomes.

These research studies of nurse consultants have usefully contributed to the knowledge of advanced nursing roles. They have mostly used small cohorts and case studies. However the settings have been local, involving no more than one region; a wider geographical spread may have provided stronger information for the development of nurse consultants nationally. There is little evidence that the role has developed a unique identity from other senior clinical nursing roles.

Community Matrons

The role of the Community Matrons was announced by the Department of Health (2004) as a case management role with specific competencies to support people with LTCs at risk of unplanned hospital admissions. Case management for frail elderly people aims to combine both preventative and responsive care for patients at high risk of deterioration in their health. It includes: defining a target group of patients; individual assessment and care planning; monitoring of patients on a regular basis and intervening when problems arise. Estimates have indicated that 5% of people with LTCs account for 42% of hospital bed use and remain in hospital longer than other patients (Wilson et al 2005). Very high users of services have three LTCs and are more likely to be found among the older population.

There has been significant interest in nurses undertaking clinical focussed case management roles for people with LTC, since the Department of Health funded the Evercare programme; a collaboration with United Health, a United States Health Management Organisation (HMO). This form of case management was introduced in nine pilot PCTs (Colin-Thome and Bellfield 2004). In the United States, Evercare had substantially reduced hospital admissions among nursing home residents, but the US version was markedly different to that introduced in the UK. In the US programme Evercare included intensive domiciliary nursing for patients when they became ill; this did not happen in the UK. In the pilot PCTs patients were initially selected because they had two or more emergency admissions in the previous year, but these criteria were broadened as the pilots developed, often including subjective

judgements made by clinicians. 'Advanced Primary Nurses' (APNs) were employed as case managers.

The final evaluation of the Evercare approach (NPCRDC 2006) found that although there were individual examples of avoided admissions, there was no overall effect on emergency hospital admissions. Despite these results, Community Matrons were given the role of case managing the very high intensity users of healthcare, in an attempt to reduce emergency bed days through preventing admissions; co-ordinating early discharge and through working closely with their patients to develop personalised care plans, which support and encourage patients to take more control of their condition.

Wright et al (2007) undertook a qualitative research project, using semi-structured questionnaires to study the patients' perspective of the Evercare approach. Three interlinking themes were identified: patients felt the community matrons improved their health by understanding them; this enabled a relationship and effective care to be planned; which gave patients confidence and through this increased control over their condition. The authors concluded that, although the study cannot provide evidence that community matrons reduced emergency bed days, it did suggest that the community matrons were meeting their aim of supporting and encouraging patients to take more control of their conditions.

This evaluative study used patient questionnaires, delivered by the community matron who had been visiting them. The questionnaires needed to be completed independently by the patient; there were a total of 100 questionnaires from ten community matrons. The data were collated using Excel and analysed using coding and categorisations. This method of data collection lends itself to bias and therefore some partiality in the results.

Drennan et al (2011) carried out an evaluation of the introduction of Community Matron posts, using a realist, pragmatic research design. They looked at the scheme from different levels: an analysis of national and local strategy and planning documents; a national survey and a stakeholder analysis; the study used semi-structured interviews in three primary care organisation case study sites. The authors determined that the implementation of the community matron role was an example of how a national policy, that valued the clinical skills and expertise of

nurses, was *'reinterpreted to fit with local patterns of delivery'* (p2948). Drennan et al concluded that before new nursing roles are introduced, a better understanding of the local factors that resist or support such changes is necessary.

This study involved the community matrons reflecting on their role and experiences through face to face interviews as well as interviews from the case study sites. The authors conceded that the willing participants from the three case study sites may have only been those with strongly held negative views. Both these studies are evaluations of the community matron role rather than research projects. A literature review of the evaluations of the role of the Community Matron (Lilleyman et al 2009) established that the evidence to support the effectiveness of the role was mainly anecdotal with little evidence-based research. However, Lilleyman et al did recognised that the role continues to develop but at different stages and in different directions across the country.

The Government set a target of 3000 Community Matrons to be appointed by 2007. This number was never achieved. It has been suggested that this was in part due to the lack of local evidence of a causal link between Community Matrons activity and the rate of unplanned hospital admissions, a government key outcome target (Drennan et al 2011).

The roles of Nurse Consultant and Community Matron differ from Advanced Nurse Practitioners in several respects; ANPs have evolved in response to the workforce pressures of primary care and the increased workload expected of general practice. Frequently it is the incumbent practice nurse who undertakes further training and education to become an ANP. This can be seen as a cheaper option to taking on a new GP partner or a salaried GP. ANPs do relieve some of the workload by 'triaging' the demand for 'on the day' appointments and have a role in first contact care. The research into ANPs has showed that with slightly longer appointments, patient satisfaction and outcomes are equivalent to GPs.

The Nurse Consultant and the Community Matron roles were imposed by government, their roles were not always fully defined and a lack of support from management has been reported. Due to the targets set by the government there appears to have been some rushed appointments of applicants who did not fulfil the

job specification, especially for Nurse Consultants. A case management role was already in existence in many community trusts. The research shows that these senior nurses have to repeatedly negotiate and justify their role and purpose. Community Matron and Nurse Consultant roles need on-going research to evaluate how the role develops, how measurable outcomes for patients have been achieved and the extent the roles have fulfilled policy makers expectations.

The delivery of health care is changing rapidly to meet the diverse needs of patients, becoming focused on promoting; a culture of innovation, support and best practice. For this reason, great importance has been placed on the benefits of multi-professional working. To achieve this it is important for primary care practitioners to have a clear understanding of the different types of multi-professional working, the implications of person-centred practice and the potential barriers to multi-professional working.

Multi-professional working

There are many 'labels' for healthcare practitioners working together: multi-professional working; inter-professional working; multi-professional collaboration; multi-disciplinary teams and inter-disciplinary working. Webster (2005) maintains there is a need for practitioners to provide a holistic approach to care and also to blur the boundaries of professional practice for the benefit of the patient. Healthcare practitioners need to be able to think, problem solve and understand key multi-professional issues within the scope of their professional practice. In recent years there has been a push for differing healthcare professions to learn together; Barr and Low (2013) describe multi-professional education as occasions when professions learn side by side for whatever reason; whereas inter-professional education occurs when students or members of two or more professions learn with, from and about each other to improve collaboration and the quality of care. Collaborative working moves healthcare professionals from historical ways of working where; professionals work within their own discipline in a uni-professional way, to a multi-professional way, where professions recognise that other disciplines have an important contribution to make (Kenny 2002).

Challenges and Advantages

Multi-professional working (MPW) has challenges and advantages: several authors (Delva et al 2008, Kvarnstrom 2008, Suter et al 2009) have identified certain difficulties which occur as the result of different professionals working together such as: difficult power dynamics; poor communications; lack of understanding of own and other's roles and responsibilities and conflicts due to various approaches to patient care.

Zwarenstein et al (2009) undertook a Cochrane review to assess the impact of practice-based interventions designed to change inter-professional collaboration (IPC) compared to no interventions, or to an alternative intervention, on one or more of the primary outcomes: patient satisfaction and / or the effectiveness and efficiency of the health care provided. The review describes IPC as a '*negotiated agreement between professionals which values the expertise and contributions that various healthcare professionals bring to patient care*' (p2). Five randomised control trials of practice-based IPC interventions were selected. Three of the studies found that IPC did lead to improvements in patient care, one study found no impact and one study showed mixed outcomes. The authors conclude that due to the limitations in terms of: the small number of studies; sample sizes; problems with identifying multi-professional working; the mix of interventions and settings it was difficult to generalise about the key elements of multi-professional working and its effectiveness. However, there was some evidence that MPW can lead to positive changes in health care but further studies were needed.

Teamwork

None of the previous cited studies were undertaken in primary care / general practice. Richards et al (2000) reviewed the literature on workload in primary care; attitudes to delegation; multi-professional and inter-professional relationships. There was no search criteria given; however, by reading the reference list, it was found that the review was undertaken on; research papers, government documents and expert opinion articles during the period of 1989 and 1999. Literature was reviewed from both nursing and medical publications. The authors found that in order to deliver a primary care led NHS; meet health care needs of users, address the inevitable

anxieties of GPs and emancipate the professional aspirations of nurses and other healthcare professionals, the requirement is for multi-professional health care teams to share decision making and that mutual respect is a core value. Ownership of care rests with the whole team rather than being confined to the medical profession.

Freeman et al (2000) used a case study design to explore the issues around professional interaction which inhibits or supports team-working. Using grounded theory they identified three philosophies of teamwork; '*directive*' based on an assumption of hierarchy where one person would take the lead by virtue of status and power and direct the actions of others. This has been the traditional way of working of the medical profession. The second philosophy was '*integrative*' in that there was a commitment to the practice of collaborative care and therapy; attention to being a team player; recognition of different levels of role understanding and their importance in the development of negotiated role boundaries. This philosophy was identified most frequently in the nursing and therapy professionals. Lastly, there was the philosophy of '*elective*', essentially a system of liaison; professionals who preferred to operate autonomously and referred to other professionals as and when they perceived there was a need. It was found that those working in mental health were most likely to hold this philosophy.

The researchers found that only those professionals who held '*directive*' and '*integrative*' philosophies related well to teamwork; those who held an '*elective*' philosophy tended to view teamwork as a threatening concept. In the context of role understanding and role valuing, both the '*directive*' and '*integrative*' philosophies presumed an understanding of other professional roles and of valuing those roles. However, for those operating within a '*directive*' philosophy this meant they understood others' roles more in terms of tasks. The teams studied were not specifically based in primary care, but the different philosophies can be identified within primary health care teams (PHCT), especially the *directive* and *integrative* philosophies. Freeman et al have shown that professionals in PHCTs should have a certain level of understanding of team work processes to be able to challenge and discuss their differences and negotiate a way forward for multi-professional working.

The introduction of the PMS contract represented a radical change from the old model of primary care. A qualitative study undertaken by Riley et al (2003) explored

the influence of the new PMS contract on the dynamics of multi-professional relationships. The study used in-depth interviews, conducted on site with 'key informants' from 13 locations, providing a range of different organisational models of PMS. These included; NHS Trusts, GP led and a charitable Trust. The interviewees included; nurse practitioners, salaried GPs, GP and managements leads.

Using a thematic analysis method; four themes were devised relating to multi-professional care: '*professional boundaries*' as represented by the extended role of the Nurse Practitioners; '*collaboration for overall health promotion rather than medical care*' opportunities for practices to continue with strategies and models of preventative healthcare; '*organisational and cultural practices*, the perceived changing nature of the organisation of primary care and the professionals within it, evidenced by innovative approaches.

The authors acknowledged that, as with all large scale organisational changes that challenge long established working practices, it remains to be seen whether the impact of PMS on patients and health care providers is sustained over time. They also noted that the positive aspects of multi-professional care were hampered by '*political cohesion*', identifying the contentious issue of the role of the health authorities in supporting PMS practices. Nonetheless the introduction of PMS has enabled an improvement of cultural values within primary care, not least the hierarchical dominance of GPs over nursing staff within the PHCT.

Traditional hierarchies

There remain separate ideologies and subcultures of GPs, nurses and managers. Elston and Holloway (2001) conducted a study to compare the perspectives of health professionals concerning the impact of the formation of PCGs on professional roles and inter-professional collaboration. GPs, nurses and practice managers from three practices within PCGs located within a 20 mile radius and working with the same health authority. The practices had similar numbers of GPs and nurses with similar practice populations. In-depth semi-structured interviews were analysed through the constant comparative method and the grounded theory approach of Strauss and Corbin (1998). The researchers identified that professional identities and the traditional power structure generated some conflict between the GPs, nurses and practice managers and was perceived to have affected collaboration. Interestingly, the study revealed that it was not that the medical profession wished to exercise

more power, but that GPs were fearful of losing to other professions the power they already held; *'nurses acknowledged the blurring of boundaries while GPs feared it.'* (p21) The authors concluded that for the changes to work it would require a shared philosophical stance and balance between professional self-interest and focus on patients which could be difficult to achieve.

Based on these findings it was suggested that it would probably take a new generation of health professionals to bring about a multi-professional culture in the NHS.

An ethnographic study of primary care organisation and practice conducted within nine general practices in the North West of England (Charles-Jones et al 2003), reported on the redistribution of medical work within primary care teams. Semi-structured interviews were undertaken with GPs, practice nurses and practice managers in the individual practice premises; the interviews took place between August 2000 and June 2001. Discourse analysis (Silverman 1993) was used to construct a hierarchy of appropriateness in which different patients and problems are attributed to different professional values especially in how 'on the day' appointments are managed. The authors argue that transferring the 'on the day' appointments to nurses, reinforces the GP as the person at 'the top of the hierarchy', this then identifies the GP as the consultant in primary care within a hierarchy that resembles that found in hospitals. It can be argued that a similar mirror hierarchy has occurred within the practice nursing team; with nurse practitioners, long term condition specialist nurse, practice nurses, treatment room nurses and healthcare assistants. Through their accounts of how work is distributed between different kinds of health care professionals a reinforcement of the hierarchies of knowledge and expertise takes place particularly between doctors and nurses.

A study of patients' accounts of the differences in nurses' and GP roles (Redsell et al 2006) again appears to reinforce the traditional hierarchies in primary care. Semi-structured interviews were conducted with 28 adults attending general practice for urgent 'same day' appointments during 2004. Participants were interviewed prior to their consultation with either the nurse or GP. The study took place in two large general practices. The constant comparative analysis found that patients preferred to consult with a GP if they perceived their symptoms to be serious and with nurses

for minor symptoms or reassurance. The participants thought the nurses had more time for them and were more compassionate. Since this study was undertaken the workload in general practice has increased significantly and the role of advanced nurse practitioners in undertaking first contact / minor illness work has become much more familiar. It is widely implied that this innovation gives GPs the time for patients with co-morbidities and complex needs.

Over the past twenty five years the NHS has changed dramatically, successive governments have felt the need to make changes in the way healthcare is managed and delivered to the population (Department of Health 2001; DH 2002, DH 2010a, DH 2012), leading to major developments in primary care and general practice. There have also been two 'new' GP contracts that have changed the nature of the clinical care provided by general practices: from reactive medicine to more proactive preventative healthcare for well people with the anticipation of keeping them well; routine management of long term conditions and minor illness / first contact care. These developments have necessitated a change in the primary care workforce and the need to work more collaborative in multi-professional teams.

The literature shows that there remain many challenges to multi-professional working; the need to understand each other's roles and responsibilities and finding new ways of working including skill mix and role substitution. However, the traditional hierarchies and the power dynamics between nurses and doctors remain an obstacle.

Over the last few years, there has been a transformation of existing professions and the introduction of new disciplines into primary care. These changes are partially due to the workforce pressures on nursing and medicine, but also take into account the needs of service users rather than the needs of the professional groups.

Professional Identity

Historically nursing has found it difficult to define its professional identity; the role has changed over time, from hand maiden to the doctor to autonomous practitioner. Several authors have suggested that the conclusive recognition of nursing as a

profession was the moving of training from the hospital apprentice model to the tertiary sector (Willettts and Clarke 2013). Others maintain that the evolution of nurses' professional identity should be understood alongside the social development of the female identity (Ohlen and Segesten 1998). Traditionally, within healthcare there has been a gender division; men predominately occupied the higher status, higher pay profession of medicine; whereas women have assumed the more support roles such as nursing. Davies (1996 p670) quote included here due to her seminal work on gendering of profession - states:

'Autonomy stands at the very heart of both cultural concepts of masculinity and of professions. It is also important to recognise that professions can represent themselves as autonomous only by ignoring or misrepresenting the work of others.'

Davies goes on to argue that occupational cultures draw directly upon ideologies of gender and gender imagery, to explain the relations between 'professional' work of men and the 'supportive' activities of women. She contends that this has been shown in the case of nursing.

Over the years nursing has striven for independent status; demanding the rights and privileges of a full and independent profession. The recognition of independent roles and functions for nurse practitioners and others with advance training suggests some success in the achievement of some degree of independence for some members of the nursing profession, in some settings.

Pullon (2008) undertook a qualitative study to explore the attitudes and perceptions about the roles of, and relationships between, individual nurses and doctors currently working in primary care settings. Eighteen in-depth interviews were undertaken with equal numbers of nurses and doctors. A mixed method of analysis was used; following the principles of naturalistic (inductive) enquiry, where units of useful information are identified and gradually categorised.

The findings indicated that effective multi-professional relationships between individual doctors and nurses can and often do exist, although not universally. The development of trust came from the identification and separation of vocational and

business roles and the development of professional identity. Professional identity was found to be related to the demonstration of professional competence, which in turn related to the development of mutual inter-professional respect and enduring inter-professional trust. Shared values and commitment to primary health care were recognised. Pullon concluded that, inter-professional relationships between doctors and nurses in primary care are characterised by trust and are forged in a sequential way between individual people. Where nurses and doctors competencies have been demonstrated and have been well understood and are mutually respected resilient trust has been developed.

Although this study was undertaken in New Zealand there are similarities to the situation in the UK; the New Zealand primary health care system has undergone as many changes as the UK and is now based on a population-based funding strategy much the same as the UK. Therefore Pullon's findings that; professional identity is related to demonstration of professional competence which in turn is related to development of mutual inter-professional respect and trust can be extrapolated into the UK primary healthcare system.

Nancarrow and Borthwick (2005 p898) write that the '*UK healthcare workforce has undergone considerable change in the past century, with neo-liberalism leading to the breakdown of traditional workforce hierarchies and the distribution of resources on the basis of achievement rather than undisputed professional status*'.

There is considerable literature on the socially constructed and contested nature of professionalism and professional boundaries in the primary care workforce (Charles-Jones et al 2003, Leese 2007, Grant et al 2009) emphasising that the implementation of national policy depends on the reconfiguration of small multi-professional teams. Charles-Jones et al (2003) state that policy changes have resulted in clinical work being distributed amongst increasingly complex primary healthcare teams. They suggest clinical work has become increasingly geared towards nurse-led chronic disease management and that general practice work is being reduced to a set of delegated medical tasks within a biomedical model of primary care gradually replacing the previous biopsychosocial one.

Wynd (2003) suggests that as experienced nurses acquire a sense of heightened professionalism they are able to develop an enhanced partnership with medical staff

that can only improve communications towards shared goals of high quality patient care.

In Summary:

Over the last 20 years the emphasis on a more independent and autonomous patient has led to changes in the role of the nurse in primary care. Most GPs now recognise the expansion of the nurses' role and the devolvement of clinical responsibility across the whole of the primary health care team and that the emphasis should be on continuity within the primary health care team not on an individual practitioner. Evidence suggests that, in many clinical areas, roles undertaken by doctors can be successfully transferred to nurses (Kernick and Scott 2002). Nurse-led PMS pilots have demonstrated that nurses can also lead the delivery of primary care (Kings Fund 2001).

It is recognised that doctors and nurses are not the only professionals in the healthcare team. However, the status of medicine and the size of the nursing workforce will continue to ensure that any successful model of service delivery relies upon the effective collaboration of these two professional groups. The literature shows that collaboration between nurses and doctors does work to break down barriers, facilitate communication and create the conditions for a seamless delivery of care.

Many of the papers reviewed were small qualitative research projects, using grounded theory or mixed methodology. These papers were often undertaken in specific locality or PCT area with small numbers of participants. There were four systematic reviews, of which two were conducted within the Cochrane Collaboration. There was one randomised control trial involving 1368 consultations.

The two papers relating to Nurse Partners suggest that the pioneering role of the General Practice Nurse Partner has not been analysed and there are no published descriptions regarding the effectiveness of nurses in what has traditional been a doctor's domain (Roscoe 2012). Partnerships have been considered to provide the opportunity for nurses to be involved in shaping the future and really make a difference at local and national level (Tindall 2008 unpublished).

This chapter has provided an overview of how general practice is evolving to cope with the volume of work generated by the government policy of moving secondary care work into primary care. Multi-professional working leads to; the breakdown of barriers, facilitates communication and creates the conditions for a seamless delivery of care. Inter-professional relationships between doctors and nurses remain problematic; there needs to be an understanding of each other's roles and responsibilities to find new ways of working including skill mix and role substitution. New nursing roles are not always easily accepted in multi-professional settings and holders of such posts need to have the appropriate previous knowledge, skills and personal characteristics. However, the literature has shown that these are pioneering roles; opening up new areas of development and venturing into unknown territory. More research is needed to explore multi-professional teams, using the potential of nursing and nurses and how nurses can achieve a place in the decision making processes at the highest level.

The findings of this narrative review indicate that further research into the phenomenon of Nurse Partners in General Practice is needed to raise awareness of the possibilities and to encourage other senior nurses in general practice to aspire to the role.

Chapter 4 – Methodology and Method

This research project explores the experience of nurse partnership in general practice and the perceived impact of Nurse Partners on their organisations, from the perspective of the Nurse Partners and their colleagues. It considers the opportunities and challenges and the power relationships within the world of nurse partnership.

This chapter will present the theoretical underpinnings of the research, the data generation process and the thematic analysis approach that was used.

Theoretical Perspectives

The research project took a qualitative, interpretative approach, one which is concerned with understanding the meanings people attach to phenomena, i.e. actions, beliefs, decisions & values within their social worlds. Ritchie and Lewis (2009) highlight the key elements that are commonly agreed to give qualitative research its unique character: aims that provide in-depth and interpretive understanding of the social world of the participants; small samples purposively selected; data collection methods involving close contact between researcher and participants, which is very detailed, information rich and extensive; analysis that is open to emergent concepts and ideas and outputs that focus on interpretation of the social meaning of the social world of the participants.

The interpretative approach

The interpretative approach '*looks for a culturally derived and historically situated interpretation of the social life world*' (Crotty 2009 p67). Crotty proposes that Interpretivism is usually linked to the work of Max Weber, who suggested that social sciences were about understanding, in contrast to the natural sciences' focus on explaining. Therefore social science and natural science should have different methods of investigation. Dilthey cited by Ritchie and Lewis (2009) stressed the importance of studying and understanding peoples' 'lived experiences' that occurs within a particular historical and social context. Ritchie and Lewis (2009) explain that the researcher and the social world impact on each other and those findings are influenced by the researcher's perspective and values. The researcher, as the

interpreter, interacts with the study participants who are also interpreters. This leads to an understanding of the participants' views, in the context of the conditions and circumstances of their lives. Interpretation of the generated data, rather than the representation of reality, is then the central element.

The social sciences are embedded in a political and ethical context; what is studied and how it is studied cannot avoid either supporting or challenging existing social conditions. Therefore the interpretations are not neutral but are part of, and help to construct political and ideological conditions.

The theoretical perspective of interpretivism is often aligned to social constructionism as an epistemology (Crotty 2009). This epistemological perspective considers that the knowledge sought is based on the subjective views of the participants; formed through interaction with others and through historical and cultural norms that operate in individuals' lives. Individuals create their reality but this reality in turn creates the individual (Alvesson and Skolberg 2009). This happens through socialisation and the social influence through which individuals internalise social norms and knowledge.

Social constructionism can be seen as a sociological theory; a theory of knowledge; a theory of reality and can take a critical perspective (Alvesson and Skolberg 2009). A critical perspective in research terms concerns the uncovering of power relationships within societies and looks at how these are perpetuated. In particular it addresses inequities of power. Illich (1975) discusses in particular, how the power and influence of health care professionals enable them to dominate health care. The notion of professional power within the health service resonates with the interest of this research project, that can be seen as taking a critical perspective, in that it is concerned with; exploring the power dynamics and special interests present in the health service and particularly in general practice, where GPs as independent contractors employ nurses. Critical forms of research, informed by what is termed 'Critical Theory' (Alvesson and Skolberg 2009) involve questioning existing beliefs and challenge conventional social structures.

Critical Theory

Critical Theory is characterised by an interpretive approach combined with a distinct interest in critically disputing actual social realities (Alvesson and Skolberg 2009). It

is sometimes referred to as critical hermeneutics; the driving principal is an emancipatory interest in knowledge. Habermas, a key figure in critical theory, states that emancipatory knowledge involves reflection and awareness, which empower people to assert themselves and take control of their lives. In an ideal world communication would involve spontaneous unlimited discussion among free and equal people (Habermas 1984).

Critical Theory provides '*guidelines and ideas about how the ideological-political dimension of social research can be made subject to reflection and awareness in empirical work and the production of texts*' (Alvesson and Skolberg 2009 p145). The primary function of Critical Theory is to create emancipatory change. Rose and Glass (2008 p13) propose '*emancipatory research has the intent to challenge inequalities and disturb the status quo where necessary. It has oppression as its central focus, and social change as a key objective*'. They quote Henderson who suggests that knowledge is '*socially constituted, historically situated and valuationally based*' (Henderson 1995 p58).

Research using Critical Theory must include self-reflection and avoid the natural tendency to interpret existing social reality from a taken for granted cultural stance. Such critical awareness can make it more likely systems, goals, procedures, reforms, controls and ideas are not taken for granted but are reflected upon and may therefore work more positively. Kincheloe and McLaren (2005) describe critical researchers and theorists as people who use their work as a form of social or cultural criticism and accept certain assumptions:

- That all thought is essentially mediated by power relationships that are social in nature and historically constituted
- That facts can never be isolated from values or removed from philosophical ideas
- That certain groups in any society are privileged over others establishing an oppression that is forceful when subordinates accept their social status as natural, necessary or inevitable
- That the relationship between concept and object and researcher and participant is never stable or fixed.

- That mainstream research practices are generally associated, often unwittingly, in the reproduction of systems of class, race and gender oppression.

Researchers need to acknowledge their own power, engage in dialogues and use theory to interpret social action (Madison 2012). Thomas (1993 p18) refers to Critical Theory as 'intellectual rebellion';

'The roots of critical thought spread from a long tradition of intellectual rebellion in which rigorous examination of ideas and discourse constitute political challenge.....The act of critique implies that by thinking about and acting upon the world, we are able to change both our subjective interpretations and objective conditions'

Although this study did not take an overtly phenomenological approach, Gadamer's hermeneutic philosophy influenced the interpretation of the data. One of the main principles is that understanding is not conceived in the traditional way as an act of human subjectivity but rather as 'being in the world'. A second principle is related to the idea of pre-judgements; Gadamer (1989) believes that pre-judgements or prejudices have an importance in interpretation. Prejudgements are more than merely the person's judgements; they are also their historical reality. Prejudgements are not something that must be or can be disposed of; they are the basis of being able to understand history. Because interpretations are always being made they will always be in the light of anticipatory pre-judgements and prejudices. These prejudgements are always changing, in the course of history, our understanding of the meanings given to situations and events. Gadamer believes that meaning and understanding are interconnected, that the researcher must have some pre-understanding of the subject and situation. This is the hermeneutic circle; a process of 'coming into being' moving between a background of shared meaning (the whole) and a more finite focused experience within it (the part).

Critical hermeneutics

Critical research can be described as a kind of triple hermeneutics; the first order hermeneutics consists of the interview participants' own understanding of their reality, which already exists in their lived self-interpretations. The research interviewer then undertakes a second hermeneutical interpretation of the interviewees' first order meanings this is double hermeneutics. The triple

hermeneutics of Critical Theory contains the double hermeneutics and a third element; the critical interpretation of ideologies, power relationships and other expressions of dominance. This includes the favouring of certain interests over others, within the essentials of understanding, which appear to be spontaneously generated. Critical interpretation involves a '*shift in focus, so that the balance between what appears self-evident, natural and unproblematic on the one hand and what can be interpreted as the freezing of social life, irrational and changeable on the other, moves in favour of the second thus enabling it to become the object of further scrutiny*'. (Alvesson and Skoldberg 2009 p176) Understanding then becomes a development of what is already understood, with this developed understanding returning to illuminate and enlarge the starting point. Another way to conceptualise the hermeneutic circle is to talk of understanding the whole through grasping its parts, and realising the meaning of the parts through discovering the whole. Other authors have transformed the circle into a spiral. Cautiously relating to the whole, on which new knowledge is gained and from here return to the part studied.

Kincheloe and McLaren (2005) maintain that critical hermeneutics ground critical qualitative research and raise questions about the purposes and procedures of interpretation. The purpose of hermeneutical analysis is to develop a form of cultural criticism revealing power dynamics within social and cultural texts. Critical hermeneutics take seriously the reflective critique of the interpretation applied by the researcher and so offer insights about how understanding takes place. Harvey and Myers (1995) point out critical hermeneutics require the researcher to become aware of her own historicity. The critical researcher is essentially situated in history, the history of the situation and of the interpretation and is also part of a wider set of social, economic and political relationships.

The process of interpretation

Hermeneutics does not involve any step by step method, but some criteria of interpretation have been developed by Kvale and Brinkmann (2009), which they believe may serve to clarify issues raised by multiple interpretations of interview texts. The first involves the continuous back and forth process between parts and the whole, which follows from the hermeneutic circle. Starting with a vague and intuitive understanding of the text as a whole, its different parts are interpreted and

out of these interpretations the parts are again related to the totality. The second criterion is that interpretation of meaning ends when one has reached a 'good Gestalt' an inner unity of the text that is free from any logical contradictions. A third criterion is the autonomy of the text; the text should be understood on the basis of its own frame of reference by explaining what the text itself states about a theme. A fourth criterion is that an interpretation of a text is not without assumptions, the interpreter cannot 'jump outside' the tradition of understanding she lives in, however, the interpreter attempts to make her assumptions explicit. The fifth criterion states that every interpretation involves innovation and creativity.

Critical inquiry cannot be viewed as a discrete piece of action that achieves its objectives and comes to a close; with every action taken the context changes and assumptions must be critiqued again;

'As researchers we need to contextualise our own positionality, making it available, transparent and vulnerable to judgement and evaluation. In this way we take ethical responsibility for our own subjectivity and political perspective. Undertaking this type of research is a personal experience, our intuition, senses and emotions are strongly woven into and inseparable from the process. We are attracting an ethics of accountability by taking the chance of being proven wrong' (Thomas 1993)

This qualitative inquiry was within a social constructionist framework. The research was inductive, emerging and shaped by the researcher's experience. It took a critical emancipatory perspective and the data were interpreted within a process of critical hermeneutics. The inductive approach allowed the findings to emerge from frequent, dominant or significant themes inherent in the raw data. The reasoning that this researcher followed was that, information was generated from the ground up, rather than handed down from a theory. Inductive approaches are intended to aid an understanding of meaning in complex data, through the development of summary themes or categories, into a model or framework that captures key themes, associations and concepts. A thematic analysis was developed at the emergent interpretive level, identifying and examining the underlying ideas, assumptions and conceptualisations, rather than simple description.

Method

Data Generation

In-depth interactive interviews were used for data collection. Kvale and Brinkmann (2009 p48) describe two images of an interviewer: as a miner or a traveller. In the miner metaphor, knowledge is '*waiting in the subject's interior to be uncovered, uncontaminated by the miner*'. The traveller metaphor is within the constructionist model in which knowledge is not given but is created and negotiated. The interviewer is seen as a traveller, journeying with the interviewee interpreting the interviewees' 'stories'. Thus, the interviewer leads the subject to new insights, resulting in a transformative component to the journey (Ritche and Lewis 2009). This investigative, discovery approach emphasises the personal experience of the interviewer, and sees the process of interviewing as collaboration between researcher and participant, sharing reflection and enquiry.

In-depth interviews

Ritchie and Lewis (2009) identify five key elements of in-depth interviews: combination of structure with flexibility; interactive in nature; the researcher uses a range of techniques to achieve depth of answers; the interview is generative and interviews are face to face. These individual interviews provide an undiluted focus on the interviewee, providing the opportunity for a detailed investigation of the interviewees' personal perspectives and context within the research area. Individual interviews are ideal for research that: requires an understanding of deeply rooted or delicate phenomena or responses to complex systems, processes or experiences; because of the depth of focus and the opportunity they offer for clarification and detailed understanding; whilst remaining within the interviewer's own interpretation. The in-depth interactive interviews conducted in this study used an interview guide to steer the discussions. The guide combined the general principles of interviewing suggested by Ritchie and Lewis (2009) with the linguistic form of questions of Kvale and Brinkmann (2009) (Appendix 1). A good interviewer knows the topic; is proficient in language and understands her subjects' linguistic style; should have a sense for good stories and be able to assist the interviewee in telling their story (Kvale and Brinkmann 2009).

The conduct of the interviews was conversational. This was assisted by the researcher's insider knowledge enabling her to meet the Kvale and Brinkman's criteria above. None of the participants were known personally to the researcher and so some time was spent in explaining the study, ensuring consent and establishing rapport. The interviews tended to begin with asking the participant about their experience working in the practice in terms of length of service and role, and the researcher took the opportunity to explain her interest in the topic of the interview. These opening questions were intended to put the participant at ease and to start the interview on areas that could be easily responded to. Some interviews seemed to flow freely and naturally, this was particularly noted in the nurse partner interviews where common ground was quickly established. In others the conversation seemed more difficult to initiate and sustain, had a greater reliance on drawing on the interview guide and although rich data resulted the process felt quite different to other interviews in terms of fluency and free-flow of conversation. A number of these interviews were shorter and were a feature of some of the practice manager and employed nurse interviews. The interviews with GPs (all partners) tended to be focussed very closely on the questions raised, rather than, more generally conversational as experienced with the nurse partners.

Data collection

Nineteen interviews were audio recorded. Five GPs and five Nurse Partners were interviewed for approximately one hour; five practice managers were interviewed for about forty minutes and four members of the nursing team were interviewed for around thirty minutes. The interviews concluded naturally; when both the interviewee and the interviewer felt that there was nothing else to add, this accounts for the time differential between the interviews. An arranged meeting with a nurse from the first practice was cancelled due to family illness.

The interviews took place on the practice premises in an allocated private room.

The recordings were transcribed by a professional transcriber; who is registered for data protection at the Information Commissioner's Office, works alone at home and has a password protected computer. The audio recordings were transferred electronically via Dropbox technology and the transcriptions returned in the same

way. All transcripts were stored electronically on a password protected, personal computer with anonymous identification codes.

Sample

A purposive sample was used, defined by Ritchie and Lewis (2003 p108) as '*sample units selected on the basis of known characteristics.....units are chosen to represent and symbolise prescribed groups and to reflect the diversity of the study population as fully as possible.*' After discussions with the supervisory team it was felt that five practices would be a manageable cohort. Contact with the practices was initially made via the Nurse Partner, from a request through the QNI nurse partner network and through personal knowledge. From those who replied further information regarding the research was sent to the Nurse Partner with follow up correspondence to arrange a suitable date to visit. The five practices chosen were able to have: a GP; the practice manager; and a member of the nursing team as well as the Nurse Partner herself available sometime during the one day visit. The practices were geographically spread across England and showed the diversity of general practice in England; Practice L and K are single site practices; Practices T, B and C are much larger group practices with several sites. The Nurse Partner acted as the gatekeeper to other members of the practice team, with the practice manager making the practical arrangements. . Practice L is situated in a large tourist area with 5,500 registered population; Practice K is a village practice with approximately 6,000 registered population; Practice T is a merger of three practices with a total registered population of 18,300 in one of the most deprived areas of the country; Practice B is located in a large Northern city with high deprivation rates; based on three sites and has a registered population of 22,000 and Practice C has had four mergers of partnerships in recent years and now consists of five sites, the practice is situated in a market town with a registered population of approximately 23,000 patients with mixed social and healthcare needs. See Table 1 (p51) for details of staff members and numbers.

It is acknowledged that, due to the almost self-selection of the study population, other types of practice have been missed out, for example APMS or rural practices.

To maintain anonymity the participants have been given pseudonyms beginning with the first letter of the practice. To identify the individual disciplines in the interview extracts, letters have been used after each participant's pseudonym: D for a GP; NP for a Nurse Partner; PM for a Practice Manager and N for a member of the nursing team. (Table 2 p 51)

Table 1

	Practice L	Practice K	Practice T	Practice B	Practice C
Number of GP partners	3	4	10	7	5
Number of ANP (inc NP)	2	1	5 (NP not ANP)	9	3
Number of salaried GPs	0	0	13	4	6
Practice population	5,500	6,000	18,300	22,000	23,000
Number of sites	1	1	3	3	5
Number of practice nurses	2	1	12	13	8
Number of HCAs	0	2	8	10	7

Table 2

	Practice L	Practice K	Practice T	Practice B	Practice C
Doctor (D)	Lynda	Kim	Tom	Bridget	Connie
Nurse Partner (NP)	Louise	Karen	Theresa	Brenda	Christine
Practice Manager (PM)	Laura	Kate	Tony	Brian	Claire
Nurse (N)	Lily	Kelly	Tina	Betty	Carol

Analysis

The analysis of the data generated through the interviews commenced by listening to the recorded interviews whilst reading the transcripts, to identify issues from the dialogue. This process was repeated several times. Following this data immersion, sections of transcripts with identified issues were highlighted to be coded (see Appendix 3 p xxvii-xxiv for an example of coded data). The codes were devised from recurring issues in the text; these were written on 'post-it' notes to be grouped together into emerging themes. Following the Attride-Stirling model of thematic analysis the themes were processed further to ensure they were specific enough to be distinct but broad enough to summarise a set of issues identified in the text segments. These themes became the Basic Themes (Table 1 p xvii-xix).

Further interpretation took place: by arranging the Basic Themes into clusters based on larger shared concepts; these clusters were named, and the underlying issues were identified and analysed. These became the Organising Themes (Table 2 p xix). Global Themes were then devised summarising the main argument and assumption of the Organising Themes and became '*the core principle metaphor that encapsulates the main points of the text*' (Attride-Stirling 2001 p393). These Global Theme metaphors then became the titles of the networks. It is acknowledged that much of the clustering overlaps and that the selection and interpretation of the data by this researcher has been vital to the significance given (Figure 1 p63???)

Thematic Analysis

Cresswell (2007) suggests that a thematic analysis, conducted within a constructionist framework, seeks to theorise the sociocultural contexts and structured conditions of the participants. Thematic analysis tries to discover the themes significant in a text at different levels. The interview questions are open-ended, addressing the processes of interaction amongst individuals, focussing on the specific context in which people live and work, in order to understand the historical and cultural setting of the participants. The researcher recognises that her own background shapes the interpretation and she 'positions herself' in the research, to acknowledge how her interpretation flows from her own personal, cultural and historical experiences. Consequently, presenting a co-construction of the findings. Braun & Clarke (2006) describe the process by imagining the data as a three

dimensional, uneven blob of jelly, a descriptive approach would describe the surface of the jelly its form and meaning, whilst the emergent approach would seek to identify the features that gave it that particular form and meaning. Therefore the development of the themes involved interpretation and were theorised within the constructionist paradigm.

Boyatzis (1998 p1) states that '*thematic analysis is a way of seeing.*' He suggests that thematic analysis moves through three phases of inquiry: recognising an important moment (seeing); encoding the moment (seeing it as something); which then leads to the third phase of interpretation. Thematic analysis is a process for encoding qualitative information that forms a list of themes; these may be initially generated inductively from the raw information or generated deductively from theory and prior research. Others argue that thematic analysis should be considered a methodology in its own right, claiming that it is compatible with both essentialist and constructionist paradigms (Braun and Clarke 2006). The essentialist method reports experiences, meanings and the reality of participants, whereas from the constructionist perspective, meaning and experience are socially produced and reproduced. Thematic analysis conducted within a constructionist framework therefore does not focus on motivation or individual psychologies but attempts to theorise the sociocultural context and the structural conditions present.

According to Boyatzis (1998), the analysis is helped if the researcher has knowledge and understanding of the arena in which the study is being conducted. This will provide some insight about where to look in readiness to 'see'. The ability to 'see' and 'to see as' consistently is the coding of the data stage. Developing proficiency in coding is the next stage and the final stage is interpreting the themes in the setting of a contextual framework and contributing to the development of knowledge.

This research project was investigating a phenomenon that has received little attention - nurse partners in general practice. Thematic analysis was used to provide a rich thematic description of the entire data set, focusing on what the experiences, events and social interactions look like to the nurse partners and their colleagues. The themes were identified by an inductive or data-driven approach, a process of coding the data without trying to fit it into a pre-existing coding frame.

Braun and Clarke (2006 p 84) recognise that '*researchers cannot free themselves of their theoretical and epistemological commitments and data are not coded in an epistemological vacuum.*'

As a Nurse Partner, this researcher recognised her own history and accumulated knowledge, as well as the intuition that drew her to this topic, it was also acknowledged that the processes of the study were influenced and shaped by the interpretive lens of the researcher. These issues have been explored in the reflexivity sections throughout this report.

Thematic networks are presented graphically, removing any impression of hierarchy, '*giving fluidity to the themes and emphasising the interconnectivity throughout the network*' (Attride-Stirling 2001 p 389). The next step in the analysis is to describe and explore the networks, identifying the patterns that underlie them. This requires returning to the original text and using segments to support the analysis. Each network is then summarised, beginning to make explicit the patterns emerging. Once all the networks have been summarised the aim is to pool the key conceptual findings together into a cohesive story, relating back to the original study questions and the theoretical grounding of the research.

Ethical considerations

In any research it is important to ensure that the benefits of the research outweigh any risk to the participants. Informed consent must be obtained and participation voluntary, thereby supporting the ethical principle of respect for autonomy. Streubert Speziale and Carpenter (2011) suggest that 'process informed consent' is more appropriate for qualitative research. This requires the researcher to re-evaluate the participants' consent at various points of the project; especially when or if unexpected events or consequences arise. This would include the output stage where protecting the integrity of the participants and the sites is most important. As the process encourages mutual participation there should be due regard to the participants' feelings and a chance to discuss any concerns they may have.

The principle of beneficence; doing good and preventing harm, applies to the researcher being alert to unanticipated reactions due to the dynamic processes

involved in qualitative research. It may become necessary to stop the interview and offer support. Confidentiality and anonymity also cover the principle of beneficence; it is not always possible to guarantee this in small sample sizes and thick description data. Robley (1995 p48) highlights that a thick description is particularly important to the meaning of qualitative research and suggests a solution: *'if the narrative requires it, retain it and return to the respondent for permission, verification and justification'*. There were no unanticipated reactions during the interviews and therefore there was no need to return a transcript to a respondent. When the interviewees were asked, no-one requested a full transcript of their interview to review.

Participants in the research project were fully informed about the research and received a participant information sheet before being requested to give written consent. (Appendix 2 p xxiii-xxiv) A participant information sheet was e-mailed to the practice prior to the interview date, for circulation to all interviewees. Another participation information sheet was offered to each interviewee prior to them signing the consent form. I stated that confidentiality and anonymity will be maintained wherever possible and if not will be sent back to the participant for discussion. Kvale and Brinkmann (2009) maintain that the integrity of the researcher, her knowledge, experience, honesty and fairness is the decisive factor in maintaining an ethically sound research project.

An enquiry to the National Research Ethics Service (Appendix 3 p xxv-xxvi) stated that this research project did not require ethical review by a NHS Research Ethics Committee. The Research Ethics Committee at Sheffield Hallam University reviewed the study proposal and approved the research.

Reliability and validity are used to determine rigor in quantitative research, however these concepts do not directly transfer to assessing rigor in qualitative research. McBrien (2008 p1286) states that: *'the abstract and subjective nature of the human experience and qualitative inquiry make it difficult to adhere to rigid mechanisms of achieving validity'*. Lincoln and Guba (1985) have translated the concepts of internal and external validity, reliability and objectivity into the alternative criteria for qualitative research: credibility, dependability, transferability and confirmability. Collectively these concepts are classed as *'trustworthiness'*.

Trustworthiness

The goal of rigour in qualitative research is to accurately represent the participants' experiences (Streubert and Rinaldi Carpenter 2011). There is no one set of criteria that can be expected to 'fit the bill' for every research project and ultimately our decisions regarding rigour amount to a judgement call (Emden and Sandelowski 1999). For the purpose of this project the Lincoln and Guba (1985) concept for trustworthiness will be used: credibility; dependability; confirmability and transferability.

Credibility – includes activities that increase the probability that credible findings will be produced. This can be by checking whether the participants recognise the findings of the study to be true to their experiences. This can be done by returning the findings to the participants, referred to as 'member-checking'. McBrien (2008 p1287) states; *'member checking can provide correlating evidence to support the truthfulness and consistency of the findings; however, on the other hand, an over reliance on member checking can potentially compromise the significance of the research findings.'*

Peer debriefing has been suggested as another method of improving the credibility of the findings Lincoln and Guba (1985). The drawback to this method is that an independent colleague will have had less contact with the study participants, consequently less able to judge the competency of the interpretation. However, McBrien (2008 p1287) suggest that the process; *'may enable the researcher to make reasoned methodological choices and can ensure that emergent themes and patterns can be substantiated in the data'*.

For this research project the initial thematic networks were sent to the study Nurse Partners with a request to pass to the other interviewees in their practice to see if they recognise the findings of the study to be true to their experiences. This 'member checking' resulted in no replies, it is hoped this was because there was no disagreement from the participants. However, in retrospect this should have been followed up by a phone call. Regular supervision sessions facilitated discussions on the interpretation of the findings, assisting the validation of the analysis.

Dependability – this is a criteria met once researchers have demonstrated the credibility of the findings (Streubert and Rinaldi Carpenter 2011), the question to ask is how dependable are these results? Lincoln and Guba (1985) assert there can be no dependability without credibility.

It was not possible to conduct a triangulation of methods in this research project, as is often suggested in the literature, to demonstrate a degree of reliability. However, some of the results are similar to those presented in Roscoe's (2012) grounded theory research.

Confirmability – the objective for this criteria is to illustrate the evidence and thought processes that have led to the conclusions as clearly as possible. This can be difficult; another researcher may not agree with the conclusions developed by the original researcher. Sandelowski (1993) argues that; only the researcher who has collected the data and been immersed in them can confirm the findings.

The data for this research was collected by this researcher, who was immersed in the data and is able to illustrate the evidence and thought processes that have led to the conclusions thus confirming the findings.

Transferability – refers to the probability that the study findings have meaning to others in similar situations. However, the expectation for determining whether the findings fit or are transferable rests with potential users of the findings and not with the researcher (Streubert and Rinaldi Carpenter 2011).

Nurse Partners are a unique group of healthcare professionals; the transferability of the findings may have meaning to other Nurse Partners and their colleagues and possibly to those experienced practice nurses who, based on specific personalities, aspire to become partners in general practice.

Irrespective of the methodological approach used, the goal of data analysis is to illuminate the experiences of those who have lived them. The researcher has the responsibility of describing and analysing what is presented in the raw data to bring to life particular phenomena (Streubert and Rinaldi Carpenter 2011).

'Stories illuminate meaning, meaning stimulates interpretation and interpretation can change outcomes' Krasner (2001 p72)

Streubert and Rinaldi Carpenter (2011) describe the data analysis process as the centre of qualitative research. It is the stage when the researcher is able to put into words her conceptualisations of the shared experiences. Through the active process of intuiting, synthesising, analysing and conceptualising the researcher distils and then illuminates the experiences that have been part of the research.

Reflexivity on Methodology and Method

Qualitative researchers understand that the researcher is a central figure who influences the collection, selection and interpretation of data. The researcher's behaviour will always affect the participants' responses and affect the direction of the findings. Meanings are negotiated between the researcher and the researched within a certain social context so that another researcher in a different relationship will tell the story from a different perspective (Finlay 2002b).

Methodology

At the proposal presentation for approval of this research project I was asked why I was not using a phenomenological approach to this research project.

Reflecting on the theoretical perspective of phenomenology Crotty (2009) suggests there are two clear characteristics of phenomenology: it has a note of objectivity, it is searching for objects of experience rather than a description of the experiencing subject; secondly it calls into question what we take for granted. Phenomenology is usually seen as a study of people's subjective and everyday experiences; it is geared towards collecting and analysing data in a way that does not prejudice the participants' subjective character. It also puts in place a number of procedures to minimise the effect of the researcher's presuppositions and construction on the data, by 'bracketing' the researcher's own knowledge.

Heidegger (1962) argues that each person will perceive the same phenomenon in a different way; each person brings his or hers lived experience, specific understanding and historical background. Social constructionists draw on the beliefs of reflexivity to explain how individuals make sense of the social world and their place in it. Habermas focuses on the capacity of humans to be reflexive agents and on how through reflecting on our own history, as individuals and as members of larger societies, we can change the course of history. He argues that the more we can understand how structural forces shape us the more we can escape from those constraints (Finlay 2002a).

It would have been impossible for me to 'bracket' my knowledge and experience as a Nurse Partner. My interest was in the culture of general practice and if having a nurse partner changes that culture. Crotty (2009 p53) maintains that '*without culture we could not function; as a direct consequence of the way humans have evolved we depend on culture to direct our behaviour and organise our experiences*'. Therefore I felt applying a social constructionism framework within a critical emancipatory perspective to be the most appropriate approach for the research project.

Emancipatory research methods should integrate inter-subjectivity and reflexivity as essential processes (Rose and Glass 2008). Rose and Glass describe inter-subjectivity as enhancing the mutuality between the research participant and the researcher to generate meaning from the data gathered.

I spent a considerable amount of time at the beginning of the project exploring critical ethnography as a research method; Madison (2012) describes critical ethnography as disrupting the status quo and disturbing neutrality and the taken for granted assumptions by, exposing the underlying and obscure operations of power and control. Whilst an ethnographic study was appealing, because of its emphasis on understanding culture, it would have been impractical for two reasons; the time needed to be 'in the field' and the fact that no two general practices have the same ethos or organisational structures.

However, the 'intellectual rebellion' of critical theory and the type of reflectivity used for philosophical hermeneutics did influence the interpretation of the data. Critical hermeneutics combine Habermas' critical philosophy which regards knowledge as

active and entrenched in a socio-political context with Gadamer's interpretive philosophy.

Finlay (2002a) describes reflexivity as exploring the dynamics of the researcher – researched relationship and how research is co-constituted. She suggests it can be used at different levels: at a minimum it means acknowledging the presence of researcher bias and openly locating the researcher within the research process; at a more dynamic level it involves the assumption of subjectivity, by using researcher's / co-researcher's reflexive insights.

Method

Conducting the interviews

Sandelowski and Barroso (2002) state there is a difference between data collection and data generation. They suggest that data collection implies an independent existence for data, whereas data generation implies that data have no independent existence apart from the researcher who decides some things and not others will become data for the study. Finlay (2002a) suggests that the sharing of personal and social experiences between the researcher and the respondent results in a developing relationship.

During the interviews, I was mindful that I should not be drawn into expressing personal opinions or experiences; however this was difficult during the Nurse Partner interviews as they were interested in my journey to partnership and the common issues we all encountered.

The GP interviews were mixed; Lynda was very chatty, in fact her transcription was the longest of all by several pages; however she did not always answer the question and I often found it difficult to 'get her back on track'. This may have been partially due to the fact we were sitting outside in the sunshine and I do not think she had a clinical session afterwards. Whereas Kim was very short and to the point; she was running late and had kept me waiting such a long time I was beginning to think she was avoiding me! It was difficult to achieve a rapport with Kim; it may have been that my anxieties were reflected in my interview technique. There was very little of her transcript that I could use. On the other hand, Tom was very eloquent, had a very

good insight into Theresa's role and challenges and had some interesting theories about the difference between nursing and medicine.

The practice managers were mixed; two male and three female; their insight into the experiences of the Nurse Partner tended to vary; depending how long they had been with the practice, whether they were also partners or had joined the practice after the nurse became a partner. Some of the practice managers viewed the Nurse Partner as an ally in some of the negotiations with the GP partners; some thought the Nurse Partner gave a certain 'normality' to the partnership meetings without 'a hidden agenda'.

Unfortunately most of the nurse team members were HCAs, the only registered nurse was newly qualified and new to the practice. It was more difficult to engage the nursing team members in a conversation; this may have been because they were being cautious with me, despite reassurances of anonymity.

Data analysis

Having rejected a phenomenological and ethnographic methodology, I struggled with how to present the data I had collected. Many qualitative research papers present themes supported by quotes from participants' transcripts as the primary form of analysis and reporting of their data (Bazeley 2009). However, it is expected that qualitative researchers should be clear about what they did, why and how they did the analysis. A strong analysis requires using the data and the ideas generated from the data to build an argument that establishes the points that need to be made.

I found thematic analysis met my needs for a 'framework' to work with; a method for identifying, analysing and reporting patterns (themes) within data, which then can be taken further and used to interpret various aspects of the research topic (Boyatzis 1998). Thematic analysis can be used as a constructionist method, examining the ways in which events, realities, meanings, experiences are the effects of a range of discourses operating within society (Braun and Clarke 2006). The method searches for certain themes or patterns across the entire data set. Attride-Stirling's thematic networks attracted me; with web-like non-hierarchical networks that provided a visual representation of the data analysis.

Practically this meant: reading & re-reading the transcripts of the interviews whilst listening to the interview recordings; highlighting themes within the transcripts; repapering the walls of the study with pinkish cartridge paper covered in different coloured highlighted segments of text from all the transcripts, to enable coding to take place; then the use of coloured post-it notes to arrange the basic, organising and global themes. There were several iterations before the final labelling of the thematic networks. This process may have been 'simplified' by the use of a storage and data management computer programme; however, I felt it was necessary to be fully immersed in the data, rather than grappling with technology.

Thomas (1993) states that undertaking this type of research is a personal experience, our intuition, senses and emotions are strongly woven into and inseparable from the process. The first attempts to devise the thematic networks were very descriptive and bore no resemblance to the final result. However, by using intuition, exploration, and an ongoing reflexive dialogue with my supervisory team I was challenged to be bolder in my analysis and the titles of the themes became more abstract and refined, thus developing the concepts and ideas of the basic and organising themes and producing the metaphoric global themes of 'Stepping out the Box' and 'Toe in the Water'.

The following chapters introduce the research findings; describe and explore the two interconnected Global Themes that have been constructed from the data.

Chapter 5 - Introduction to the Findings

The findings of this study are derived from interviews that used Ritchie and Lewis' (2009) investigative, discovery process with Kvale and Brinkmann's traveller metaphor. It is acknowledged that this method emphasises the personal experience of the interviewer, and sees the process of interviewing as a partnership between researcher and participant, sharing thoughts and learning. The findings are presented as web-like networks illustrating the significant themes; with a double-headed arrow between the networks to demonstrate the interconnectivity between the two networks.

Using the Attride-Stirling model of thematic analysis ten Basic Themes were identified (Table 3 p viii-xx). Following further interpretation these basic themes were clustered based on larger shared concepts, to become the four Organising Themes. (Table 4 p xx). The two Global Themes were developed to conceptualise the main argument and assumption of the Organising Themes. The Global Theme metaphors then became the titles of the networks (Figure 1 p 67). Quotes are used selectively to give voice to the participants and to illustrate the meanings.

It is recognised that the selection and interpretation of the data, leading to the development of the themes, has been influenced by this researcher's knowledge and experience of nurse partnership. Regular supervision sessions enabled clarification and meaningful analysis by challenging the rational and formation of the basic and organising themes. At the beginning of the process these were very descriptive, for example: 'Practice Culture'; 'Being Valued'; 'Professional Identity'. It took several iterations to conceptualise the themes and devise the metaphors for the two global themes.

The Thematic Networks

Two interconnected Global Themes were constructed from the data; the first recognising the uniqueness of Nurses Partners was labelled – 'Stepping out the Box' and the second describing aspects of culture and environment of the practices in which they work was labelled – 'Toe in the Water'. (Figure 1 p 66)

Global Theme - 'Stepping out the Box'

This Network explores the individual characteristics and the development of the Nurse Partners, which has led them to 'stepping out' of the nurse 'box'. It comprises two Organising Themes (bold and underlined) and five Basic Themes (italics and underlined) (Figure 2 p 67).

Organising Theme – 'Nursing Differently' – 'Stepping out the box' involves the Nurse Partners **nursing differently** by *managing risk and uncertainty* in both their clinical and partnership roles.

The Nurse partners were innovative and motivated, revealing personal characteristics of *being entrepreneurial*.

Organising Theme – 'Being Influential' – 'Stepping out the box' involves the Nurse Partners **being influential** through *advocating for nurses* by supporting the nurses in the team.

The Nurse Partners *widened perspectives* in the partnership through being patient focused and by having a different point of view in the decision making process.

A professional identity of *being a nurse* enabled the Nurse Partners to function at an advanced level, to be influential within the practice and to some extent in the wider primary care community.

Global Theme - 'Toe in the Water'

This Network examines how the practices have cautiously accepted a nurse as a partner by putting a 'toe in the water' and treading carefully with this change in organisational culture and environment. It comprises two Organising Themes (bold and underlined) and five Basic Themes (italics and underlined) (Figure 3 p 85).

Organising Theme – 'Multi-professional working' – 'Toe in the water' is characterised by these practices' alignment to contemporary drivers for **multi-professional working** and being aware that the Nurse Partner was *adding nursing value* and developing a different perspective within the team, resulting in a more cohesive workforce with greater satisfaction and ultimately better patient care.

The Nurse Partners were taking a lead in changing the culture of their practice to a multi-professional, highly skilled team.

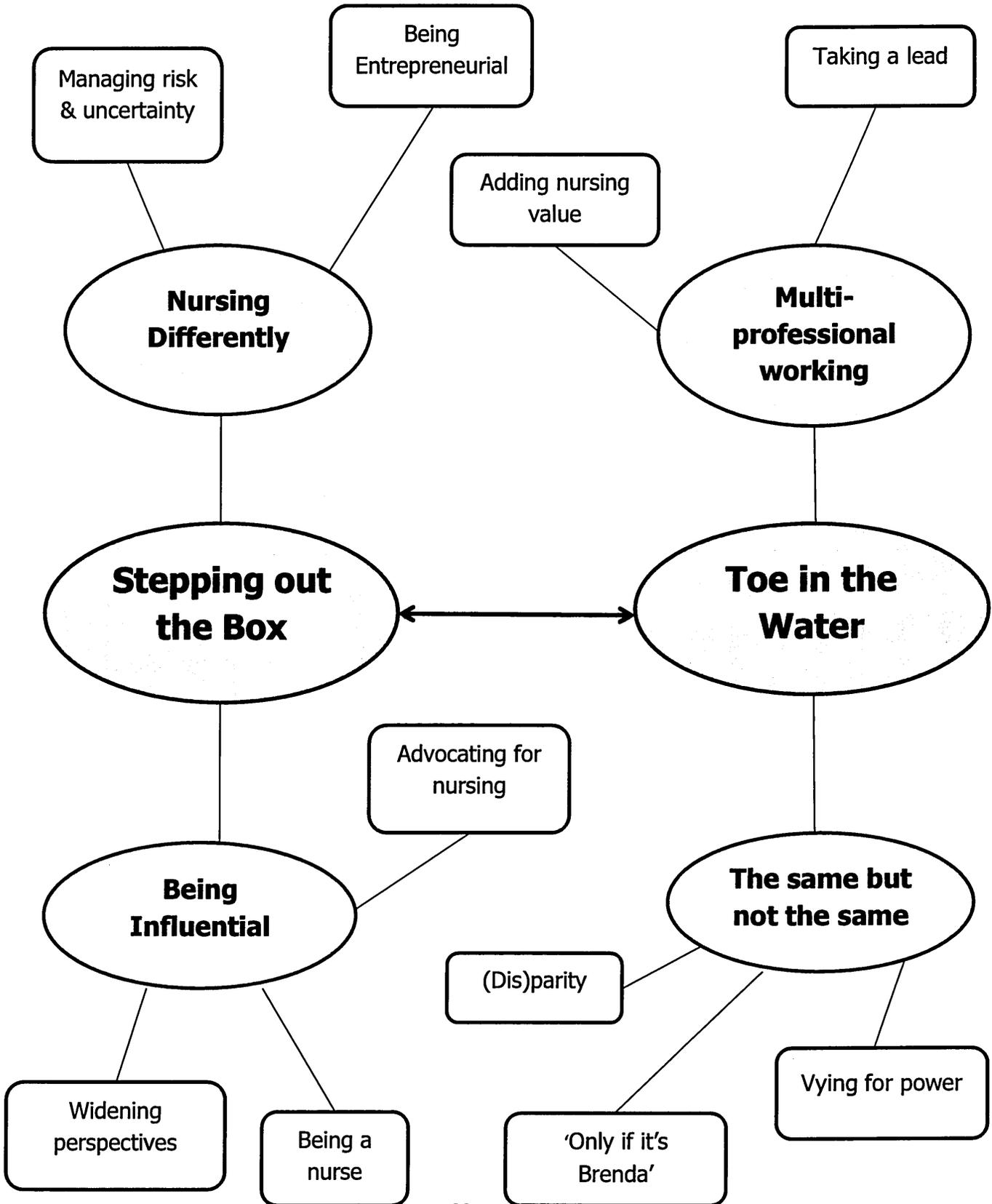
Organising Theme – ‘The Same but not the Same’– The ‘Toe in the Water’ metaphor however, also illustrates the caution that the GP partners viewed a Nurse Partner in respect of equal shares of the ‘profits’. The Nurse Partner **was the same but not the same** in terms of (dis)parity.

There remained an element of vying for power within the partnerships.

‘Only if it’s Brenda’ captures treading carefully, and only putting a ‘toe in the water’ when considering whether to have an additional or replace a retiring nurse partner.

Figure 1

Interconnected Global Themes



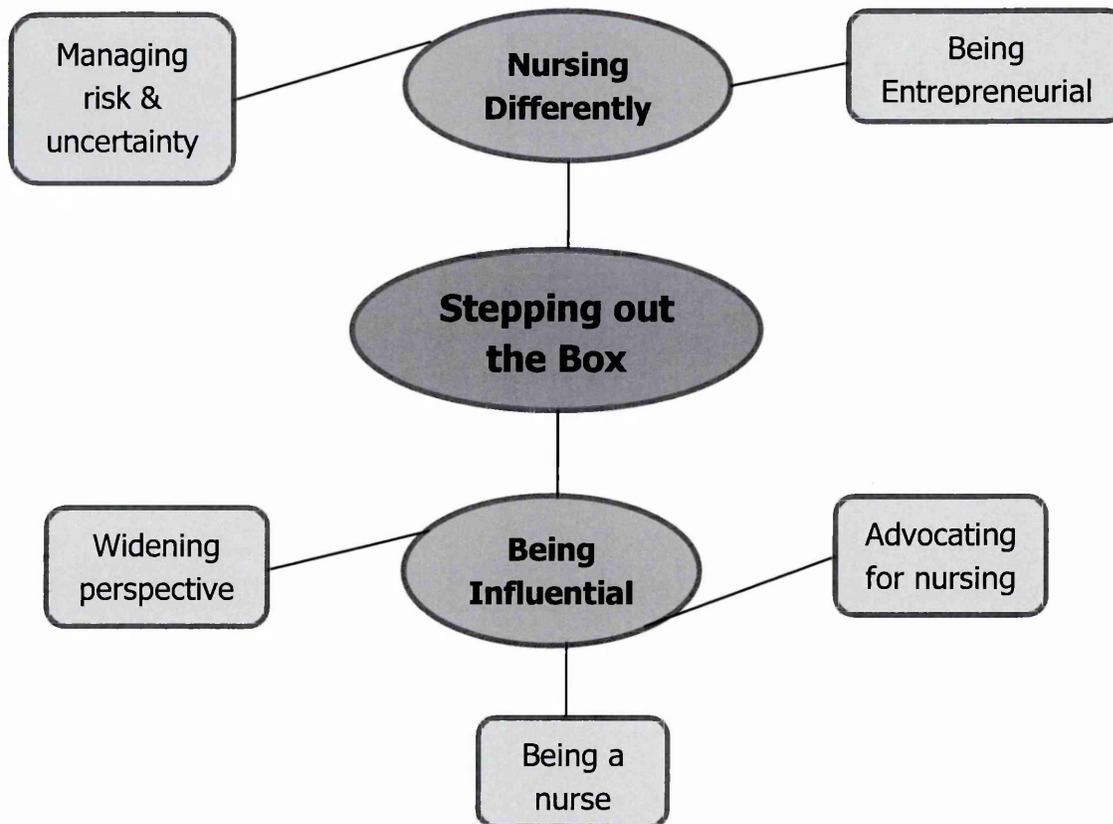
Chapter 6 - Thematic Network: 'Stepping out the Box'

This Network explores the individual characteristics and the development of the Nurse Partners, which has led them to 'stepping out' of the nurse 'box'. It consists of the two Organising Themes; that the Nurse Partners are 'nursing differently' and that they are 'being influential' especially within the practice organisation.

(Figure 2 p 67)

Figure 2

Thematic Network – Stepping out the Box



This Thematic Network represents patterns in the data that suggest the Nurse Partners were not perceived as 'ordinary' nurses. Whilst keeping their perspectives

firmly aligned to nursing, they had nevertheless 'stepped out the box' to become something different.

The five Nurse Partners had been in general practice for many years and most had been in the same practice a long time before becoming a partner. Four of the Nurse Partners were ANPs. ANP carry an expanded and extended role at the 'cutting edge' of nursing practice; which has resulted in the phrase 'maxi-nurse not mini-doctor' (RCN 2005). These nurses are often mistaken for doctors by patients, in that they are able to prescribe and refer patients to other healthcare professionals.

Two of the ANPs approached the GP partners regarding a partnership; one was asked to put the request in writing stating what difference she would make to the partnership; the second was offered a partnership a short while after the initial approach. Another ANP requested an increase in hours and salary or she would look for a new job; she was offered a full time contract with an option of a partnership in a year, within days of the request. The other ANP was asked to apply for the partnership vacancy along with a salaried GP; the selection process involved a two hour interview, with a PowerPoint presentation on why the practice should have a nurse partner and why that nurse partner should be her. The GP applicant went through a similar process. The fifth nurse, who is not an ANP, had been a partner for 14 years, long before it was legally possible for non GPs to be partners. To enable this to happen it was arranged that she was informally accepted as a full partner within the decision making process, remained salaried and take a percentage bonus for financial arrangements. This nurse had been very involved in developing the practice from an organisation with one GP and a very small team to the large multi-professional, multi-site practice it is today. The proposal of a partnership was unexpected; she felt it was offered in recognition of the work she had done and the continuing involvement she was expected to have in the proposed future developments of the practice.

The nurses were recognised by the GP partners to be an asset to the practice, but several of them were required to identify and justify what added value they could bring to the partnership, during the partnership negotiations. This may have been due to the fact that in four of the practices there was no partner vacancy and therefore the decision to have a nurse partner had financial implications for the

existing partners. The usual practice when a vacancy occurs in a partnership is for it to be advertised and interviews will take place to appoint a successor.

This 'Stepping out the box' Network considers the uniqueness of Nurse Partners; their willingness to accept risk and uncertainty within their clinical and partnership roles; and their interest in developing the business side of general practice. The Network also explains how the Nurse Partners have been influential within their practices through the position of being a nurse and by advocating for nursing whilst providing a different perspective to the partnership.

Organising Theme – 'Nursing Differently'

This Organising Theme has two Basic Themes; *managing risk and uncertainty* and *being entrepreneurial*.

Whilst one of the Nurse Partners in the study did not have an Advanced Nurse Practitioner role all were highly experienced and skilled professional nurses. 'Nursing differently' concerns the expertise generally associated with the role of the ANP, that in primary care is seen as their ability to operate as a 'generalist,' providing complete episodes of care for patients of any age, making professionally autonomous decisions, for which they are accountable. (RCN 2012) This includes the provision of evidence-based, high quality care for patients whose problems fall within: urgent / acute episodes; long-term conditions; health promotion and public health. The knowledge, skill, competence and confidence that ANPs acquire from their training and experience equips them to manage risk and uncertainty. This aspect was shared by Theresa (not an ANP), who was a nurse manager with many years of practice nurse experience and had been involved in all the developments of the practice, from a small traditional medical practice to the large multi-site community orientated primary care organisation it is today. This 'on the job' experience enabled her to 'step out the box' into the Nurse Partner role.

Castledine (1998) suggests that individuals who are dedicated to their profession take much of their personal identity from their work and consider it a part of their lives. It has always been a puzzle to this researcher, is it the person or the nurse

that takes that step out of the box? There were certain personal characteristics identified by some interviewees that were thought to contribute to the nurse becoming a partner, but many found it difficult to isolate the person from the profession;

Karen (NP) 'a lot of my philosophy is nurse but obviously a lot of my personality and character come into that, so I might not be the same as another nurse'

Tom (D) 'decisions have been taken differently because Theresa is a partner, so I don't know how much of it is Theresa's personality and how much of it is the fact that she's a nurse'

Lynda (D) 'and so things that she says in partners meetings which may well influence ultimate decisions but they're because she's Louise'

Roscoe (2012) identified certain personal qualities of Nurse Partners, including;

- Credibility; vast clinical experience and responsibility, impressive academic achievements with qualifications gained whilst working
- Grounded; not financially motivated, pride in nursing values, not impressed with status – everyone of equal value
- Supportive; wanting to be there for colleagues, aware of staff personnel issues.
- Progressive; dynamic, rising to the challenge, influential
- Personable; effective communicator, approachable, conscientious.

These findings are reflected in this study. All the Nurse Partners showed the personal quality of credibility; most had post registration qualifications in long term conditions, four had a Master's degree in Advanced Nursing Practice and one had a Doctorate in Nursing Practice, all achieved whilst in clinical practice. Four of the nurses, were adamant that accepting a partnership was not financially motivated. Karen was within a few years of being able to retire and therefore was more focused on financial security;

Brenda (NP) 'the money side of it didn't bother me, I mean obviously it did because I still wanted to get a salary, but I didn't come into it thinking well I'm going to be partner I'm going to earn mega-money, because I don't earn mega-bucks, I earn what the practice chooses to do'

Karen (NP) 'I said at my appraisal I'm looking for one full-time job, clinical, and I'm being head-hunted and I'll go to the highest bidder because it's about money at this stage of my life'

All the other personal qualities identified by Roscoe (2012) were also identified in this study. However, a number of the interviewees highlighted another quality that was not included in Roscoe's list that of career trajectory and the experience gained before joining general practice;

Louise (NP) 'In my role as a partner that's a bit more blurry and I'm not sure how much of me is the nurse and how much of me is, you know, just other experiences in life and understanding about organisational change and all that sort of thing which has come from other parts of my life'

Bridget (D) 'I think it was quite specific to her and her skills and we knew her quite well it's something about Brenda and her particular sort of career and experience'

The Nurse Partners were nursing differently in that while they upheld the values, ideals and beliefs of their profession, they embraced the enterprise culture, being creative and imaginative for the benefit of the practice population and the business. They were prepared to take risks and not only 'think out of the box' but also take steps to develop solutions to problems.

Managing risk and uncertainty

The ANP Nurse Partners recognised that their training enabled them to manage ambiguity within their clinical practice, which has equipped them to manage risk and uncertainty in a general practice partnership. Their autonomous clinical role has given them the confidence to initiate changes and accept responsibility for the outcomes. The risk taking was not only centred on the clinical risk management that was a strong feature of the ANP partners but for all the nurse partners. Theresa, the non ANP partner did not appear any different from the ANP partners in respect of taking responsibility for and managing risk and uncertainty; this may have been due to her long standing responsibilities as a nurse manager and her long association with the practice.

Theresa (NP) 'I think people have to be prepared for the buck to stop with them'

Louise (NP) 'A partner needs to be prepared to go out on a limb sometimes and take risks in all sorts of ways and can live with that.....I think if you're a nurse practitioner possibly you're a bit more used to having that responsibility that you've made that decision and it's yours and you have got to live with it'

There are considerable risks associated with nurses becoming partners, both financially and professionally. Most of the Nurse Partners had less partnership shares than the GPs, therefore less take home money. Some of the practices have had 'lean years', when the income has been reduced and the Nurse Partner could have earned more as an ANP than she took home as a partner. In one practice the partners did not have any drawings for a month. This parity and equality theme will be further developed in the thematic network 'Toe in the Water'. Here, however the focus is on risk;

Karen (NP) 'I am a percentage partner, not an equal partner and I feel that as we take equal risk we should have equal partnership shares, but I'm only one nurse partner and there are four GP partners, I am never going to win that argument'

Christine (NP)'I think you have to be very committed to be a partner, I could earn more as a salaried nurse practitioner, a salaried GP will earn more without any of the risk, so how you compensate that, I don't know, because we don't get more time off and we don't get more holidays'

Some practices had not given staff a pay rise for several years and some have had to make staff redundant, these have been hard decisions for all the partners;

Theresa (NP) 'We went through a very bad patch financially two or three years ago and we were very restricted in what we could do and we lost some nurses, not necessarily as a result of that but we lost them and I couldn't recruit'

Christine (NP) 'we've had to make people redundant, we've had to make some very difficult decisions that I don't think sit easily with anyone to be fair to any of my partners, and normally I don't have to do that kind of thing'

General Practice partners are self-employed and have legal partnership agreements. These legal documents cover buying into the property and how issues such as disputes among the partners, or if it is felt a partner is under-performing, will be handled. These are difficult situations, which can have long reaching effects on the practice and the individual partners. The Nurse Partners were unprepared for these dilemmas;

Theresa (NP) 'opened my eyes into really what went on and how much work there is being a partner and taking that responsibility for staff, for buildings, that comes with talking about all the governance arrangements around that and all the liabilities associated with that'

Most of the Nurse Partners felt the benefits of a partnership outweighed the risks but there were doubts expressed by Christine who had been through four partnership changes since becoming a partner. These changes were due to the merging of smaller practices into her larger practice. Christine felt the partners of the smaller practices were unhappy with having a nurse as a partner and did not understand the difference it made to the partnership and the practice;

Christine (NP)'I've never been sure that I did the right thing, and I never will know, for GPs it's a very natural progression to become a partner, for us it's not, and I think you have to really think about what you want out of it, don't go into it thinking that you're going to make lots of money, don't go into it thinking that you're going to be able to change the world..... don't be naive about it and be aware of your limitations'

Christine also thought it is more difficult to make a difference as a partner now than in the past, with all the recent NHS changes and the perceived constraints on innovation within primary care. She felt the only way forward for nurse partners was to set up a practice and employ GPs. This would then be a truly nurse-led service.

Christine was referring to the nurse-led primary care PMS pilots (Kings Fund 2001); the pilots facilitated opportunities for nurses to work in new ways. However, the nurse leads within these pilots have encountered issues and frustrations with this new way. In particular, in being able to push back the professional boundaries and establishing new models for multi-professional working. These problems have a resonance in the responses from the Nurse Partners in this study.

However, another participant believed that the opportunities for nurses in primary care were still there;

Theresa (NP) 'I think we may come to a position where there's so much more coming out to primary care that actually nurses would excel in doing for their patients and creating the right environment, right sort of practices, the right sort of organisations that would manage this.....long term conditions and everything else.....encouraging people to have

courage and have a go is the kind of support we should be offering nurses that are interested in doing it'

These findings support the 2005 RCN survey which highlighted that nurses working in extended and expanded roles have a huge potential to contribute positively to service delivery and quality of patient care. These Nurse Partners are not 'mini-doctors' but are 'maxi-nurses' (RCN 2005), their training has enabled them to manage risk and uncertainty in their clinical work and also their partnership role. This ability to assume risk associated with uncertainty, to be innovative and responsive to opportunities characterises the Nurse Partners as being entrepreneurial.

Being entrepreneurial

An entrepreneur possesses the capacity and willingness to develop, organise and manage a business venture along with any of its risks. An entrepreneurial spirit is characterised by innovation and risk taking with an ability to succeed in an ever changing environment (businessdictionary.com). There is very little literature regarding UK nurses being entrepreneurial. Most of the research is from the USA, Australia and New Zealand where primary care is delivered differently.

Specific characteristics in nurses, recognised by Collinson (2000) as being entrepreneurial are; being risk takers, have autonomy and control, being creative, innovative, optimistic and motivated. The data from this research project indicated that all the Nurse Partners demonstrated a need to achieve, driving them to engage in activities that have a high degree of individual responsibility for outcomes. They were prepared to use their own judgement and take a risk. An entrepreneurial activity is a function of opportunity, structure and carried out by motivated entrepreneurs with access to resources (Shane et al 2003). Many of the innovations undertaken in the research project's practices have been either initiated or created by the Nurse Partners. For example, developing new services for the practice population, and as income generation for the practice. Practice B set up a warfarin monitoring clinic; this needed special equipment and the nurses who were to run the clinic needed training, this took time and caused frustration amongst the GP partners. Brenda insisted that these should be in place before the service was

introduced. She had doubts that this would have happened if she was not at the 'top table';

Brenda (NP) 'a new Warfarin testing clinic, one of the GPs came back and said well we could do that..... I break that down straight away, have we got the nurses, have they got the qualifications to do it, and they hadn't..... we had to make sure we'd got the correct clinical governance around what they were doing and I think that is part of what they would like to say, there you go Brenda, that's yours'

This practice has also developed a private travel clinic; the nearest clinic is ten miles away and so this local provision was of benefit to the population. Likewise, however, this innovation took time to set up, the nurse selected to run the clinic had to undertake a Travel Health diploma course. Without the experience of the Nurse Partner it is unlikely this requirement would have been recognised and the nurse would not have been in a position to provide recognisably safe practice; a situation potentially hazardous for patients and for her professional integrity.

Practice C tendered to provide health services to a deprived area within the town; if successful they could fund a large new building to replace their existing listed, and therefore less than ideal, premises. Christine was instrumental in developing the bid on the basis of a predominately nurse led service;

Christine (NP) 'we had to go to tender to win the contract to supply the health services for here, so I was quite important in that process and you know, sort of wanted to make it a nurse led service initially, so there's a SureStart building down the road, so I went and did some clinics in there'

It was the Nurse Partners who took the initiative on these developments, creating and implementing new ideas. By having an understanding of the capabilities of the nursing team, the Nurse Partners could make the strategic decisions to develop the new services. Stevenson (2006 p5) states '*critical to the success of the entrepreneurs is knowledge of the territory they operate in.*' The Nurse Partners recognised that by using the nursing workforce differently there was an opportunity to improve services for the practice population and to increase the practice income.

By being entrepreneurial the Nurses Partners were taking a lead in developing the practice – a theme from the 'Toe in the Water' network. Thus illustrating the

interconnectivity of the Networks; the importance of having a lead nurse, ('Toe in the Water') who is able to manage risk and uncertainty to develop a different way of nursing in primary care ('Stepping out the Box').

This confidence to act and to maintain focus enabled the Nurse Partners to become influential within the partnership.

Organising Theme – 'Being Influential'

This Organising Themes consists of three Basic Themes; advocating for nursing, widening perspectives and being a nurse.

Being influential describes how all the Nurse Partners shared the goal of providing quality patient care and brought a breadth and depth of skills, knowledge and experience to the partnership, from many years in general practice but also from previous nursing experience. These nurses have developed an understanding of themselves and their own professional identity. Tindall (2008 unpublished) describes several benefits of being a Nurse Partner including; the professional aspect of being more autonomous and being able to be influential both within the practice and externally.

Being influential within the practice was an important incentive for the nurses in becoming a partner;

Louise (NP) 'I couldn't be in the organisation without being a Nurse Partner.....it's difficult for me not to want to try and influence processes and procedures and the way the organisation is it's just the way I am, so no, I would find it difficult to do anything else'.

Theresa (NP) 'I would also say it's fantastically rewarding and you know to be able to influence the development of a practice and the way that it cares for its practice population, the way it cares for a community, that's a tremendously satisfying thing to do, and at the end of the day there's a real feel good factor about feeling that you've made a difference somewhere'

Brenda (NP) 'I think they find it quite challenging at times because what I could never understand in general practice was GPs or practice managers made decisions for nurses without consulting nurses.....and I still firmly believe doctors don't know what nurses do or what capacity they can work at'

It seems Brenda was very influential when her practice was looking at expanding the clinical team. She worked with the practice manager to devise a different model of working, which resulted in the nurse practitioner team increasing to eight nurses and the salaried GP team remained at eight doctors. Other practices had similar examples of the Nurse Partner's influence in the type of clinical model they wanted to develop and the type of skill mix needed to deliver the ever increasing workload of general practice, especially in long term condition management and first contact work;

Theresa (NP) 'We have a very well developed nursing team which includes health care assistants and phlebotomists,, I was instrumental, in developing that team, challenging the GPs can manage everything, looking at the requirements of the population and making proposals about a different skills set and moving the nurses on to proper pay scale'

Christine (NP) 'they're aware that health care assistants don't just take blood now that they do the flu jabs and they do a lot of the LTC'

Louise (NP) 'we've gone from a position where we had three Practice Nurses working in the treatment room and another Practice Nurse doing some chronic disease management and the nurse practitioners also doing chronic disease management.....and then the phlebotomist wanted to become a Health Care Assistant, she now does dressings, ear syringing'

These skill mix initiatives, emerging from the nurse partners being influential, have resulted in the nursing team members working to their skills and potential, allowing the Nurse Practitioners to use their advanced skills to relieve some of the workload from the GPs, giving them the time to spend with the more complex cases.

By virtue of their position as a partner and the specific knowledge and experience they brought to the position, the Nurse Partners were able to influence the development of the practice and the practice team by being a nurse; advocating for nursing; and widening the perspectives of the partnership.

Advocating for nursing

The World Health Organisation (2003 p222) states that to be able to '*meet the challenges of their profession, nurses need to be clear about why they think and act as they do and they need to perceive themselves as empowered*' Many of the

interviewees felt that the Nurse Partner acted as an advocate for nursing and nurses in the practice;

Louise (NP) 'because of my knowledge of the way nursing works and about skill mix, I've really put a lot of effort into changing the skill mix, in trying to work with people to develop their roles..... look at where we are now to where we were 5 years ago there's been a big change, and that's the nursing team, and I think that's happened because I'm a nurse'.

Laura (M) 'I think it sort of empowers the other nurses a little bit as well.....helped gel everything together a little more, and I suppose shows the other nurses how much nurses are valued within the practice'

Carol (N) 'Christine is big influence because she's with the other partners and she can voice the nursing team's opinions you know and put new ideas forward'

By being 'at the top table' the Nurse Partners were seen as a conduit between the nurses and the GPs in respect of skills and expectations. They were influential within the decision making processes and able to advocate for the value of the nursing team;

Brenda (NP) 'we've got a team of highly skilled nurses with the nurse practitioners and the practice nurses and actually at any point if you didn't have me as the middle man, they could turn round and say, well I'm not doing that, I can't do that, I haven't got the skills to do that, and the GP would be, what do you mean, whereas I can challenge that.....I'm almost like a pot where everybody throws stuff in'

Louise (NP) 'I see my role as almost being the cement between the partners and the rest of the staff'

Carol (N) 'Because they can bring what's going on, on nursing side to the GPs.....if you've got a nurse partner on board then it is far better for the nurses'

Many of the GPs commented on how supportive Nurse Partners were towards other members of the team;

Lynda (D) 'say what she thinks in a very diplomatic way, you know she lets others have their say but she will certainly disagree with them and usually, often that means standing up for somebody'

Connie (D) 'Christine worked very closely with that particular partner and was very good at enabling him to let off steam but steering him forward in the direction that everybody else had taken'

A major part of being influential within the practice team is supporting and developing the nurses to achieve their individual potential, and recognising the importance of nursing to challenge the traditional hierarchy of general practice. This challenge when linked to the 'Stepping out the Box' Organising Theme 'Nursing Differently', leads the way to the possibility for nurse-led and owned general practices. It can be argued that these practices were not typical general practices, as they had put a 'toe in the water' by having a nurse as a partner; however this was a very cautious move and will be further explored in Chapter 6.

Widening perspectives

Most of the interviewees thought the Nurse Partner brought a wider perspective to the partnership; this was variously described as; 'bringing a balance' by 'avoiding group think' from an all medical point of view and 'being patient focused.' The discussions within the partnership and the decision making processes were believed to be different because of the presence and influence of the Nurse Partner;

Louise (NP) 'one of the partners suddenly sat back and said "It's really good having you here because you've got a different perspective"..... the whole lifetime thing of being in a different culture of nursing, brings a different view to the decision making process and all that sort of thing, and it's not necessarily always in agreement but it's just a different way of looking at things and helps avoid group think'

Tom (D) 'I think the partnership is very different with a nurse partner, I think it's very enriched, it gives a different perspective because although as doctors we're all different from each other, I think nurses are also quite different from doctors and the perspectives they bring on patient care, the perspectives they bring on processes'

Brian (M) 'I think having that different voice and that different experience on the leadership table is good, That's one problem with many GP practices is that the board of directors, the group of partners are all of the same skill, if you look at any organisation you know PLCs or companies or whatever, then the board isn't made up of everyone with the same skill, there's a skill mix on there and a range of views and a range of opinions so it's good to have that'

This different perspective was considered important in management issues and the Nurse Partner input was particularly valued by the practice managers;

Laura (M) 'she has a more realistic approach to things and sort of handling of staff issues. She understands, sort of the, legal aspects a little more and so it's another voice of reason'

Tony (M) 'Theresa volunteered to be the partner who would lead on the HR stuff. Now that, I think, was quite important and she very consciously did that because she wasn't a GP and she felt that she could sit in a more representative place in the organisation as a whole as the partner who was the HR lead'

This widening perspectives theme illustrates the culture of nursing. This culture of 'compassionate care' described as the '6 Cs' by the Chief Nursing Officers (Compassion in Practice 2012) puts care as the core business of delivering help to individuals and improving the health of the community.

There is an element of nursing / nurse in almost everything to do with general practice. The contribution of a nurse at the highest level is essential to the decision making processes;

Kelly (N) 'she can actually make a difference and we know if the doctors at their meetings are saying well perhaps we should do this, we should do that, we know Karen will soon say, yes or no to that idea'

Laura (M) 'because she's a nurse, she came at it from a different point of view..... she was keen to get it and was also supporting the nurses and because she was a partner she was able to have that bit more clout than I would, the difference being that she has the clinical input.....she drove it through, and I think had we not had her, the nurses would have come to me, I would have taken that to the GP's and the GP's would have probably said oh I don't think we need it' (*a new piece of expensive equipment*)

The Nurse Partners used their experiences of skill mix within the nursing team to influence the perspectives of the partnership team; they were viewed as being more patient-orientated and often had an alternative approach to their medical partners. General practice is moving from being 'the gatekeeper' to specialist care to being the 'navigator' that steers patients to the most appropriate care and support (Kings Fund 2011). This will need the expertise of a multi-agency team of which healthcare is only a part. In bringing a wider perspective to the partnership team, the data

suggests that the Nurse Partners have shown the value of a having a nurse presence in the decision making processes.

Being a nurse

A positive and flexible professional identity is essential for nurses to function at a high level and benefits not only nurses themselves but also patients and other healthcare workers. Wynd (2003) suggests that as experienced nurses acquire a sense of heightened professionalism they are able to develop an enhanced partnership with medical staff that can only improve communications towards shared goals of high quality patient care.

The Nurse Partners felt their nursing background brought something different to the partnership;

Theresa (NP) 'reason I was offered partnership was that it was felt really important to publically acknowledge the value and contribution that non-GPs can make to a partnership because it isn't just about clinical work; it's about the whole running of the organisation'

However, many of the GPs thought that there was something about the nurse herself that influenced them to offer a partnership;

Connie (D) 'she sticks up for the service that we're offering to our patients I think that's a huge thing that she's brought to the partnership, before a nurse partner, partnership meetings I don't think we very often mentioned patients'

The Nurse Partners in this study have received an advanced education but have struggled to develop a unique professional identity, falling between the nurse and doctor role. Although the nurse-doctor relationship has altered in these practices the change has been by the nurses becoming more like doctors;

Connie (D) 'it's a lot to do with personality, that makes a difference you know, and maybe it's also to do with how much, how close they are to doing what a doctor does as well in order to be able to accept somebody as a partner'

How nurses think and feel about themselves changes throughout their lifetime, but the years of education and training are central in shaping the direction and nature of their professional identities. Johnson et al (2012) states there are many factors that

can alter the formation of nurses' professional identity from macro level culture change to the micro level of individual expectations and experience. Ohlen and Segesten (1998) suggest that the professional identity of the nurse is integrated with the personal identity of the nurse. It consists of the person's feelings and experience of herself as a nurse, the subjective part and other people's image of the person as a nurse, the objective part.

It was difficult to determine how much influence the Nurse Partners had outside the practice, within the wider healthcare community. Although Theresa did identify the need for nurse partners to become more involved externally;

Theresa (NP) 'we've got CCGs now I think there's a huge amount of input that nurses can have into commissioning and I think if nurses are to have a real impact it will be great to have more nurse partners who really had a voice then in the clinical commissioning groups'

CCGs are a core part of the government's reforms to the health and social care system. In April 2013, they replaced primary care trusts as the commissioners of most services funded by the NHS in England. They now control around two-thirds of the NHS budget and have a legal duty to support quality improvement in general practice. (The King's Fund 2013). All practices are legally obliged to be members of a CCG and the governing body must have a majority of GPs on the Board. After 'a pause' and a national consultation period the government agreed that the CCGs should also have a nurse on the Board. None of Nurse Partners in this study were members of their CCG; Brenda did try to apply but was rejected.

All the research practices had at least one GP involved at CCG level, one as the Chair of the Governing Body. Theresa, the Nurse Partner at this practice was involved at a 'network of practices' level.

Brenda disclosed that she had been asked by other practices for advice on nursing issues and was being used as an informal nurse adviser and therefore had some influence locally on the practice nurse workforce in her area.

Most of the Nurse Partners felt frustrated with the lack of acknowledgement and acceptance of the Nurse Partner role both locally and nationally;

Theresa (NP) 'why are nurse partners being treated any differently from any other partner, there is no reason why, so that's something that we've got to raise because it's just constant barriers, there's this lack of full acceptance as a nurse partner that you have to face, and sometimes you just hold your hands up and go, I'll just get on with my job OK, but actually these battles are worth fighting'

Many of the interviewees recognised the barriers that Nurse Partners encounter both from within the practice and from the wider primary healthcare setting;

Tom (D) 'she probably had her own battles and I think she had some battles with some of the nursing team as well over time, but I don't think with anybody else. The external battles she still faces all the time'

Theresa shared a frustrating experience, which illustrates the difficulty of being accepted by an external organisation. All general practices had to be registered by the Care Quality Commission (CQC) by April 2013; the paperwork was completed by the practice manager including CRB (Criminal Records Bureau) checks for the partners. For the GPs their GMC (General Medical Council) number and a standard CRB check was sufficient, however, the CQC would not accept her NMC number and she had to have an enhanced CRB check before the practice could be registered. This entailed completing a three page form on line, printing off the completed form and taking it with all required documents to a 'special' post office. This meant a 24 mile round trip for Theresa and a payment of £64.

This example and the fact that none of the Nurse Partners were members of their CCGs; signifies the lack of recognition of their status, as independent contractors and equal to GPs.

The Nurse Partners do have influence within their practice, but their specific set of characteristics, strengths and potential contributions remain largely unrecognised by the wider primary care organisations.

Summary of Thematic Network – 'Stepping out the Box'

The Nurse Partners interviewed for this research are nursing differently and being influential. They have shown they are able to manage risk and uncertainty and that they are entrepreneurial, by being independent and using their own judgement to the benefit of the patients and the practice. These nurses have stepped out of the nurse 'box' to become advocates for nurses and patients and have demonstrated the

credibility and clinical capability to overcome organisational and occupational hierarchies.

Wynd (2003 p259) concluded that;

'Nurses must avoid the passivity and subservience of the past that characterised early development of the profession and they need to participate by demanding a place at the decision-making tables, emphasising their value and worth to society and accepting the associated responsibilities and obligations that accompany true professionalism'

Nurse Partners have no 'collective voice'. The QNI database is no longer active and there is no interest from the RCN. However, Ohlen and Segesten (1998) contend that interaction with others and internalisation of the knowledge, skills, norms, values and culture of the nursing profession are acquired by the process of socialisation. Without a national organisation to support networking, these unique individuals will remain isolated and have difficulty developing as a strong force for nurse-led primary healthcare.

The Nurse Partners have shown they have the professional knowledge and skills and the self-confidence to 'step out the box' of traditional primary care nursing. This confidence allows them to position themselves to influence decisions and resource allocations within the practice. This unique role of professional nurse combined with an entrepreneurial characteristic gives them the power to shape the culture and organisational structure of the practice.

Multi-professional teamwork is the only way in which primary care will meet the challenges and demands facing general practice today. A multi-professional partnership will ensure that the skill-mix of the team will be able to deliver high quality care to the practice population

The following 'Toe in the Water' chapter, will consider the partnerships and the practices that have enabled the pioneering role of Nurse Partner to develop by putting a 'toe in the water' and cautiously accept a nurse as a partner but are treading carefully by appointing a known experienced nurse.

Chapter 7 - Thematic Network: 'Toe in the Water'

This Network considers the issues faced by those nurses who have 'stepped out the box' and become partners in general practice. The challenges they have faced by being pioneers of a cultural change, within an established healthcare delivery model. Multi-professional working has been used to describe the way the practices have embraced a collaborative way of working and have enabled nurses to gain almost equality. The 'toe in the water' metaphor signifies the cautious acceptance of a known experienced nurse as a partner, with the reluctance to take 'the plunge' of full equality.

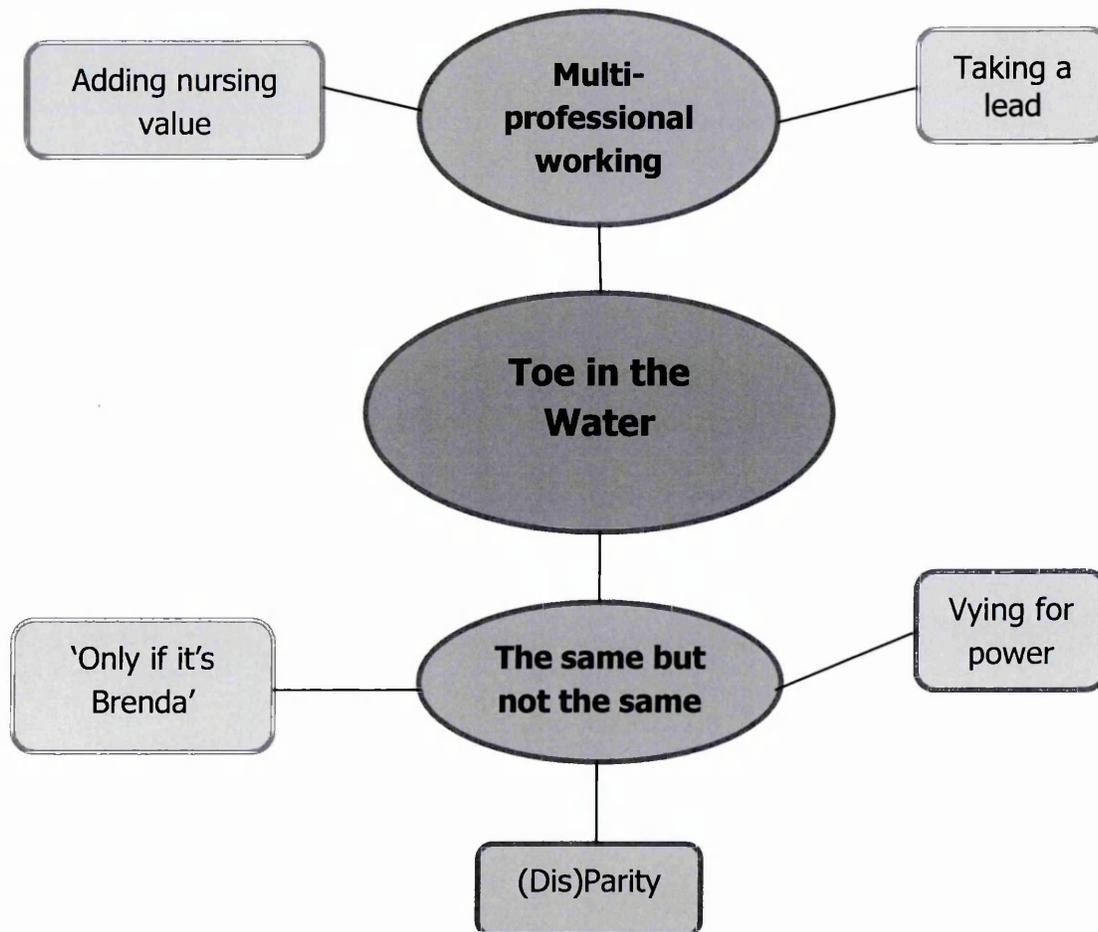
The Network consists of two Organising Themes;

The practices do embrace multi-professional working however, there are concerns with regards to equality - 'the same but not the same' of the Nurse Partner.

(Figure 3 p 85)

Global Theme – Toe in the Water

Figure 3



General practice partnerships are very different from other business partnerships. As sub-contractors to the NHS they basically have only one 'customer' – the NHS; there are some limited opportunities to undertake private work although most practices do not. The partners 'buy into' the business and usually the property, the 'profits' are taken as drawings by the partners in different share percentages. Traditionally, there has been a 'senior partner' usually the one that has been in the practice the longest who is the decision maker. Practices advertise and interview for new partners as a vacancy arises. With recent NHS changes it has become more common for smaller practices, especially single-handed practices, to merge. This has happened in three of the study practices.

Many GPs have found it difficult to be business minded, they are trained to be doctors and nothing in their training equipped them to run a business. More recently the GP Registrar training scheme has included elements of practice finances, where the money comes from and management and leadership skills. Nevertheless many GPs will admit to not being 'business' orientated, the more enlightened ones employ qualified managers to manage finances, staff and the business, especially in larger practices. Smaller practices have managers who frequently have been 'promoted' from receptionists.

A general practice partnership was described by one interviewee as being like an 'arranged marriage'; often the individuals do not know much about each other until they come together in a legal arrangement. With GP partners there is a shared education and career pathway giving a certain insight about the individual who is joining the partnership. When considering a nurse partner, the sociological power and status issue between nursing and medicine becomes evident.

The key characteristic of general practice is its huge variety: each practice has its own unique assumptions; expectations and behaviour patterns; attitudes to patients; internal organisation and ways of delivering health care to its population. This diversity and the way practices adapt and reflect their local communities is a source of strength not weakness.

Organising Theme – ‘Multi-professional working’

This Organising Theme has two Basic Themes *adding nursing value* and *taking a lead*.

Multi-professional working requires individuals to contribute to a common goal and share in the responsibilities for outcomes. Borrill et al (2000) showed clear evidence that effective multi-professional team working; improves communication; cost effectiveness and efficiency of care; and outcomes for people. Supporting the point that, it is the differing perspectives of the various members of the team, that makes collaborative work more powerful than working separately. Working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience (Davies 2000). The elements for effective multi-professional working are shaped by the individual philosophies of the healthcare professionals; the need for a shared vision; what constitutes effective communication and role understanding; and how role contribution is valued (Freeman et al 2000).

The participants in this research felt the Nurse Partners demonstrated an ‘integrative’ philosophy; *‘committed to being a team member and the practice of collaborative care, equal value assigned to each professional’s contribution, wide discussion and negotiation and that professionals learn skills and knowledge from each other’* (Freeman et al 2000 p241) and they were instrumental in developing a multi-professional team approach to the delivery of services in their practices;

Laura (M) ‘I mean she’s very good at pulling a team together, and that has certainly helped, certainly when we were merging and moving, she had the understanding of the needs of the staff and trying to pull the two teams together, and so she was very supportive and came up with some good ideas in that’

Brenda (NP) ‘there’s a lot around the team, around personalities and who you would have in that team and who you wouldn’t have....does that person fit personality wise with us, have they got the same ethos as us

Tony (M) ‘we’ve had a number of conversations about the sort of clinical model that we are trying to develop and thinking about type of skill mix that we have across the organization’

In Freeman's 'integrative' philosophy there is equal value assigned to each professional's contribution and it is assumed that they will learn from each other. Having a nurse at the 'top table' shows that primary health care nursing has evolved as a profession and as such nurses have become responsible for their own actions and are valued as important members of the multi-professional team.

Adding nursing value

Value indicates what is important, worthwhile and worth striving for. Horton et al (2007) suggest that values influence job satisfaction; motivation and commitment and that consciously or unconsciously, values affect the way people act in their personal and professional lives. Individual values in the workplace are shaped by the position and responsibilities held. Sullivan et al (2002) suggest that the most influential value factors are; integrity; respect; patient focus; quality; innovation; accountability and fairness.

The Nurse Partners give the impression that they have added nursing value to the practice and the partnership by understanding the health needs of their patient population and by being role models for their nursing colleagues. They have initiated skill mix and workload shift, in the nursing team to be more cost effective;

Lynda (D) 'she is more knowledgeable about nursing type stuff so that's very helpful, especially when we come to rejigging the nursing teams or educating Health Care Assistants and all that sort of stuff'

Kelly (N) 'in modern general practice you've got to have that skill mix which is, you know, the GPs have got to let go of some stuff for the nurses, the nurses then have to let go of some stuff for the health care assistants.'

Several of the practices had undergone mergers with other practices; with the Nurse Partner being instrumental in developing the skill mix model for the merged nursing teams;

Brenda (NP) 'I was one nurse practitioner and wanted to build the nursing team so we took on another two nurse practitioners, that was a big decision and now we are a team of eight Part of my role is monitoring the whole team of nurses...I have two band 7 nurses, one manages what I call the HR rota type issues, the other one manages the management of

LTC...we're looking at cost effectiveness at the moment – who's doing what, is the right person doing it are we doing too much of the things that we don't really need to be doing.....the nurse practitioners take a lead in one area, they all have their specialist area'

Christine (NP) 'they had a clinical mix of health care assistants, nurses, RGNs and nurse practitioners, my brief when we merged was to sort the nurses out in effect, and really, the nurses had never had any clear input or direction, they were just turning up and working by rote in effect and they were very unhappy and we had a big turnover of staff'

There was recognition that having a nurse at partnership level was important in respect to the large nursing team and workload distribution;

Tom (D) 'how much of it is the fact that she's a nurse, but obviously there's always that voice when we're talking about recruitment, you know, there's always that voice about balancing the clinical team and HCAs, nurse practitioners, nurses, which perhaps the rest of us wouldn't quite have enough at the forefront of our mind all the time'

Brian (M) 'I think they realised how much work the nursing team did here and how the powerful positive effect that would have on the practice nursing team to know they had a voice at all levels'

Theresa (NP) 'the advantages of having a nurse there is that I can speak for the nursing team and for nursing and nursing's contribution to general practice, which is incredibly important'

Practice T had spent some time considering a shared vision and a set of values for the practice;

Theresa (NP) 'I think there is something really important about bringing it back to sometimes about a patient focus. And I think one of the things we've done in our practice is spend some time thinking very carefully about our mission, our vision and our values, and I have to say I think that we all buy into that and it's a very kind of holistic, inclusive, supportive, encouraging kind of view that we all share'

Tom (D) 'I'd like to think that if there are still people making decisions about policies and protocols and you know, on the big level about values and vision and mission statements and that nurses are going to be part of that'

All the participants agreed that there was something different about the practices; several were attracted to apply for advertised jobs because of the perceived uniqueness. Although the presence of a Nurse Partner was not necessarily the

reason for this difference, it appears that there was a certain work ethic and culture in the practices that encouraged a more inclusive holistic way of running the business.

Being valued was a consistent topic identified by the respondents. The Nurse Partners did have a personal sense of having an impact on the practice, although this varied and was dependent on the extent of the amount of changes the partnership had undergone. It sometimes felt that feedback from the team was lacking, the team participants valued the Nurse Partner but she was often unaware of this. Anecdotally, the patients appeared to be unaware of the different status of the Nurse Partner. Public recognition, from the local primary health care community was minimal.

These practices demonstrate an integrative philosophy of teamwork by '*working with rather than working for other professionals*'. (Freeman et al 2000 p244) By being seen to support the nursing team and by championing nursing within the practice the Nurse Partners have shown the added value of nursing. However, by using the title 'Nurse Partner' it could be argued that the positional status is not helped; one of the participants did state that she avoids using 'nurse' and introduces herself as a partner of the practice.

Taking a Lead

Clinical leaders are seen to be effective and respected because they have a belief in themselves and are able to stand up for what they believe. (Stanley 2006) The characteristics and qualities associated with clinical leadership are identified as: clinical competence; clinical knowledge; effective communication; empowerment or motivation; openness and approachability.

All the Nurse Partners were respected and seen as effective leaders;

Brian (M) 'it helps me do my role to have someone that understands nurses who can be at times a difficult group of individuals to manage, compared to admin staff or secretarial staff, and I think having that slightly different working relationship with Brenda makes it easier'

Kelly (N) 'she's sort of a middle stepping stone for us she can take it to the meetings and to the partners it's not just paying lip service to her, she can actually make a difference'

It was apparent that most of the Nurse Partners were also seen as managing the nursing team. Two of the Nurse Partners had originally been employed as Nurse Practitioners to manage the nursing team;

Brenda (NP) 'they asked me if I would apply to take on the management of the team as well..... We introduced a number of initiatives at that time, different roles and dynamics within the practice nurse team and started to develop their work. They were doing what I would class as very basic nursing duties at that point so we skill mixed and introduced more healthcare assistant time'

Connie (D) 'we were looking to improve our work base really, our clinicians and we were looking at cheaper ways of working, this was before health care assistantswe didn't want a nurse practitioner because she was cheaper but we wanted somebody who could lead a nursing team and improve our existing nursing team which was old and set in its ways'

It was recognised that GPs lack the managerial skills that the Nurse Partners had gained from experiences prior to entering general practice;

Christine (NP)'I don't think doctors have any real management skills as in running a ward and being able to look after different levels of staff so I think they find it difficult, well why hasn't it been done, they don't think through actually the process for that to be done'

Bridget (D) 'Brenda has a lot of managing people skills that she has developed through her career, she's been used to managing throughout her career as a senior nurse, whereas we haven't'

The Practice Managers acknowledged the management and leadership role of the Nurse Partner as key to managing the larger nurse teams;

Laura (M) 'I personally feel my job has got easier because she is who she is and what she brings to the partnership.....they're very forward thinking and very good but it has had a change, sometimes they've had to have a change of working and thinking because they've now got a Nurse Partner'

Christine had been involved in four practice mergers in recent years and was responsible for managing and developing very dysfunctional groups of nurses;

Christine (NP) 'they weren't considered in the partnership or any clinical team at all.....I'd like to think that the nurses are happier and feel that they've got more of a voice in the practice than they ever had and you know, things have improvedI'd like to think the nurses have a better working life, and I've made some changes to patient care and how we do things'

A leadership role was mentioned by most interviewees, mainly in respect of the nursing team but also being a leader within the partnership;

Theresa (NP) 'the place got filled up with GPs and I'm now just trying to re-establish the nursing team as a strong workforce and that's proving really difficult, actually to persuade the GPs they are doing a stack of work that could be delegated to other members of the team'

Laura (M) 'I think she is very good mediator.....I mean sometimes GP's can all pull in different ways, and she's very good at talking to them all individually and bringing them in.'

Brian (M) 'we've as many nurse practitioners as we have salaried GPs, so again them feeling like they've got someone who's championing their cause, and again their needs are slightly different to those of a GP at partner level'

In the main the Nurse Partners balanced the role of a manager with that of a leader. Most of them were day to day managing the nursing team; rotas, who will run which clinics at which sites, appraisals and working alongside the practice manager on HR issues. Their leadership role was across the practice team and was of a transformational leadership style. Day et al (2000 p15) states that '*transformational leaders not only manage structure but they purposefully impact upon the culture in order to change it.*' Transformational leadership is described as a process that changes and transforms individuals (Northouse 2001). It involves: emotions; motives; ethics; long-term goals and a unique form of influence that enables followers to achieve more than is usually expected of them. This involves: setting directions; establishing a vision; developing people; organising and building relationships. It is unclear whether the Nurse Partners see themselves as this type of leader; although some of their colleagues felt they were;

Brian (M) 'I think it's good for the whole team and I think it's good for the balance, I think having that different voice and that different experience on the leadership table I think is good'

Tom (D) 'the partners have a much more overarching role now; I suppose a strategic role and much more about the kind of the ethos and the values of the practice rather than the day to day running. So Theresa's very much a part of those conversations'

Nurses are being expected to become more involved in multi-professional work and in strategic work to implement national and local policy. Primary care is at the forefront of many changes, which requires primary care nurses to become more 'political'. One of the Nurse Partners summed this up as;

Theresa (NP) 'nurses traditionally have not been very political and actually I have been around long enough to think, I'm not sure that this is ever going to quite happen, we've tried a number of strategies over the years, I think there will always be a huge number of nurses that don't want to engage, sadly, and few that do, and so in terms of nurse leadership it's really important that nurse partners are there with the other nurse leaders'.

The research practices demonstrated multi-professional team working; a collaborative approach to patient care, with the nursing team taking a lead in long term condition management and some 'on the day' work (Reeves et al 2008, Price et al 2014). This Organising Theme again illustrates the interconnectivity of the Global Themes; the Nurse Partners' advocacy for nursing ('Stepping out the Box') by taking the lead in the multi-professional working ('Toe in the Water'). By championing multi-professional working the Nurse Partners have been explicit about their professional philosophy and have shared their values beyond their professional boundary ('Toe in the Water').

However, these practices were unique in their CCG area and the Nurse Partners, even though being pivotal to enabling multi-professional working approaches and symbolic of collaboration between nursing and medicine, were not fully accepted as equal to GP partners in the wider primary care community or as leaders in primary care.

Organising Theme – ‘The same but not the same’

The title of this theme is a metaphor that describes being a partner in *the same way* as the GP partners but actually not really perceived *as the same* as the other partners.

This Organising Theme has three Basic themes; (dis)parity, vying for power and ‘only if it’s Brenda’

The theme covers the issues of not being treated the same in respect of partnership shares (parity / disparity) and the difference in power and status between nurses and doctors, linking with ‘only if its Brenda’

Four of the Nurse Partners were ANPs; these nurses had at least five years post registration experience, were educated at Masters Level and practised autonomously. They were trained to see patients with undifferentiated health problems, to take histories, undertake physical examinations, to diagnose and to treat. If necessary they are able to refer to secondary care services. In many ways they were working in the same way as their GP colleagues. The Nurse Partner who was not an ANP had many years of primary care nursing experience with management and leadership expertise.

McMurray (2011 p814) suggests that ANPs employed by GPs can be a source of value in terms of lower costs and workload; *‘as an income generating employee they do not pose a competitive threat, and do not disturb the good order of traditional inter-occupational relations based around medicine’s domination.’* However, this order is disturbed when, as Nurse Partners the ANPs claim equality with their GP partners in respect of parity of partnership shares and as employers of the salaried GPs.

Williams et al (1997) suggested that the difference between GPs and nurses working in general practice is that GPs are holistic in terms of overall medical status of the patients whereas nurses are holistic in terms of dealing with patients’ emotions and social needs. The participants in this study identified the different perspectives the

nurse brought to the partnership as; being patient focused and giving a different point of view in the decision making process.

All the GPs declared that the Nurse Partner was equal within the partnership in relationship to decision making processes, but some of the Nurse Partners had doubts. One GP participant (Connie) suggested that the Nurse Partner did not perceive herself as equal which was different from whether she was an equal within the partnership. The answer the Nurse Partner gave to the question 'do you feel equal to the GP partners?' was;

Christine (NP) 'no I would say, I think it probably always will be, I think it's not anything that I can't deal with, but sometimes I do find it particularly annoying, and I've had to learn to be a lot more political as I've got older and matured as a person and you know, being a partner for a longer period of time'

Whilst most of the interviewees stated that the Nurse Partner had equality in the partnership and had equal voting rights if ever a decision came to a vote, the 'elephant in the corner' was whether there was parity or more often disparity of drawings ('salary')

Connie (D) 'she is an equal partner as far as our partnership agreement goes she is absolutely an equal partner for her sessions, she works one session less than me but that doesn't matter when it comes to vote you don't have half a vote because you work part-time so it is all equal'

Theresa (NP) 'It went from salary and profit share to profit share but not at the same rate, and then went up to full parity. In terms of parity of decision making and responsibility that was the whole way through'

Laura (M) 'I think it takes a certain type of practice to do it, and I think in other practices it wouldn't work because maybe they wouldn't accept the Nurse Partner as an equal, within this practice Louise is'

Tindall (2008 unpublished) was concerned that many of the nurse partners she interviewed felt isolated and lacked support for their role. The Nurse Partners in this research when asked, did express feelings of isolation, being the outsider and felt that they were not considered equal within the partnership. Most were the only Nurse Partner in their area and no practice had more than one Nurse Partner.

General Practices are independent businesses contracted to the NHS, as such the legal partnership agreement states how the 'profits' will be divided between the contract holding partners. Traditionally these were equal shares, as all partners worked full time. In more recent times more GPs, especially female doctors, are working part-time. Therefore share income is calculated on the number of sessions worked. When the Nurse Partners joined the partnership they all accepted a lower percentage per share, some as low as fifty percent less than a GP partner for the same number of sessions. This inequality was a particularly sensitive issue with all the participants, most of the GP Partners felt that there should be a differential between the Nurse Partner and the GP Partners, citing length of training, clinical responsibility and clinical liability. However, there was no real consideration of the amount of work the Nurse Partners were undertaking, both clinically and as a partner. All the Nurse Partners felt this workload more than balanced out against the clinical responsibilities and liabilities claimed by the GPs.

(Dis)Parity

This basic theme focuses on the issue of lack of equality in remuneration between the GP partners and the Nurse Partners. All the study practices had different ways of negotiating the issue of partnership shares or parity, from looking at the nurse's existing salary and adding more, to full parity over varying timescales.

Only two of the Nurse Partners had equal shares within the partnership, for one it took approximately eight years to reach this position. New GP partners usually join a partnership on 70% parity during a probation period typically of six months and will then be on full parity. Christine, the nurse who replaced a GP partner, was not dealt with in this way. The other Nurse Partners were offered partnerships, although there was not a vacancy, which meant a reduction in income for the existing partners;

Lynda (D) 'whether she would come in as a parity partner or non-parity partner, and that, in a sense has been a bigger issue..... of course she should have a share, and you look at what her salary is and you work out what share that salary would be and then you add a bit, you add a generous bit really, which we did, but it wasn't a parity partner'

Louise (NP) 'My proposal right at the beginning was that I thought with my skills and everything that I should be paid on the same level as a Nurse

Consultant and so we looked at that, which was about £50k, and that was about half the salary of the partners at the time'

Brian (M) 'A GP partner who left was half time so I suggested that we used that money to bring Brenda onto the partnership team which was equal money in terms of what half a GP costs and it cost us the same for Brenda to be full time on the team and then we could re-use that money to buy a bit more salaried GP time'

Louise and Theresa attended a national nurse partner workshop organised by the QNI where the topic of parity was discussed and partnership shares were compared. This empowered them to negotiate full parity over a period of time with their GP partners;

Louise (NP) 'then I went along to the Queen's Nursing Institute nurse partners group.....they (the GPs) asked me outright what are other Nurse Partners being paid..... I said I was being paid the lowest of everybody in the room and that several of them are on parity with their partners, and to be fair, my partners said well we want to do what's right but, because I wasn't replacing a partner when I joined them that meant, a big hit. So what we came up with was a plan over five years where bit by bit I increased my profit share and now I am on full parity'

All the participants found these negotiations difficult, the GPs felt there should be a differential because of the legal responsibilities that GPs have, for example certification of death, completing insurance forms and signing fitness to work notes. However, it was acknowledged by some interviewees that the Nurse Partners did other things within the partnership that counterbalanced this;

Connie (D) 'the most difficult thing was trying to negotiate a fair deal for a partner who isn't a doctor and that was traumatic I think for everybody and actually it would seem on reflection recently that it still isn't right'

Christine (NP) 'I came in as a salaried partner because obviously there are things that I cannot do, I cannot be on-call, some of the paperwork and things I can't, legally so I came as a salaried partner to start with for a couple of years. I wished I'd stayed as a salaried partner, financially I'd be much better off, but I really felt that I should be taking the risk as well as taking the benefits, so about three years ago now I went in as a share partner. I take home £12,000 a year less because I don't do on-call'

Theresa (NP) 'I got a profit share based on my hours, but it wasn't the same as the GP partners' drawings..... I suppose as the organisation was growing and developing and I realised what level of responsibility I was being asked to take without being recompensed in the same way as

the partners, I realised that it was something that I wanted to fight for, and it wasn't just about me, it wasn't just about the money, it was actually about saying publically, you can't expect people to take on the same level of responsibility for running an organisation and then expect them to take home less money for it'

The Nurse Partners, who now have equal shares in the partnership, had to negotiate an incremental increase over several years with no recognition of the back years being reimbursed. Two Nurse Partners felt there were still underlying issues with their partnership shares;

Karen (NP) 'they did suggest that I should reduce my income to pay for an incoming nurse and I said, absolutely not. I already work more hours than any GP in this building for a smaller percentage and I am not cutting my income, part of my income goes towards locum costs, which are massive and I object to paying for GP locums'

Theresa (NP) 'If I'd said yes I'll take on all this responsibility and continue to contribute in the way that I'm doing, just like you are, but take less money, I wonder what the response would have been. I felt that I was contributing absolutely equally and I always have had an equal vote, and have had all the responsibility, you know in the partnership agreement, I bore all the full responsibility for the organisation, all the liabilities that any of the other partners would'

There was a lack of understanding that ANPs practising at advanced level carry the same professional responsibility and liability for their decisions and omissions as GPs. A deep seated belief that doctors are worth more than nurses existed even among the most enlightened GPs. Davies (2000) suggests that this belief originates from the profession of medicine creating doctors who are self-reliant and independent, emphasising expertise, autonomy and responsibility, more than interdependence, deliberation and dialogue. Whereas nursing traditions have emphasised hierarchy and bureaucratic rule following. Although these traits have lessened, she suggests that nurses still work 'around' others. Ponte et al (2007) observed that the power of the nurse lies in her knowledge and expertise related to the technical, analytical and interpersonal domains of nursing.

Parity / disparity was a major topic with both the Nurse Partners and the GPs in the research project; all the GPs felt uncomfortable with the negotiations but seemed adamant that a differential was necessary. This is a complex issue; relating to social

background, gender issues and professional power, which remains despite the professionalisation of nursing and the advanced clinical skills of the ANPs.

Vying for Power

The difference in power and status between doctors and nurses has been a topic of sociological debate over many years. There are two main issues in this debate; the overall societal hierarchy in which the professions are located, and the relationship between the two professions. Currie et al (2008) refer to the societal hierarchy between the professions as paternalistic and authoritarian, with medicine at the apex of the organisational pyramid. The gender issue between the mainly male-dominated profession of medicine and the mainly female-dominated profession of nursing is also significant, although arguably less so now than in the past.

The British Medical Journal (BMJ) and the Nursing Times collaborated in 2000 to explore the Doctor – Nurse relationship. The joint editorial in both journals stated that the relationship between doctors and nurses has never been straight forward;

‘The differences of power, perspective, education, pay, status, class, and – perhaps above all – gender have led to tribal warfare as often as peaceful co-existence’
(BMJ 2000 p1019)

Nurses have been seeking to create a professional identity away from medicine and the bio-medical model of care, by using social psychology, sociology and social policy, to develop a nursing model that is both reactive and proactive to the needs of the patient. The 1992 changes to the UKCC Code of Conduct provided a basis for independent, professional judgement. An evaluation of nurse practitioners pilot studies (Touche Ross 1995) found that nurse practitioners working in primary care tended to work more like doctors than other nurse practitioners.

DeWitt and Baldwin (2007) imply that power in general means that one party has the ability or means to influence or affect the attributes of the other. They suggest a linear model to describe the progress of an individual, group or profession from dependence to independence to interdependence. Medicine is essentially independent with autonomy and privileges but has failed to progress to interdependent; whereas Nursing continues to push toward recognition of an independent status, free of control and direct supervision of medicine. It could be

considered that ANPs in primary care are an example of achieving independence and those who have become partners could be supposed have progressed to interdependence.

All participants recognised the unique role of the Nurse Partner; some acknowledged there were occasions when collective partnership decisions have led to certain power struggles;

Theresa (NP) 'I think there was a lot about the power, you know sharing power, I think there was a lot about status and they weren't all young GPs there was an experienced GP amongst them, some of her comments were actually quite challenging. I recognised then that she really didn't see nurses as having the same status or contributing in the same way to the partnership.I suppose people feel unsure about sharing full status and sharing full power but interestingly it was more the newer incoming partners rather than the existing partners'

Brenda (NP) 'there's a lot around the team, around personalities, at the end of the day they're your business partners, luckily we all get on and it works well, we did have a problem with one of the partners and unfortunately he did have to leave but we discussed it, there was a very open discussion within the team, around how we would manage it, what would we do, why we were doing it'

Tony (M) 'it's not entirely uniform across the partners, but I think it's uniform across the partnership, the partnership is I think very strongly supportive and respectful of Theresa's position as a partner, a couple of partners are perhaps a bit wobbly about it, but then they are wobbly about other things'

Christine (NP) 'I was the only one that didn't want to merge and obviously it's got to be unanimous and I was put under a lot of pressure to merge and I agreed to. If I'd got my time to go again, I would have stuck to my guns and said, well this is my time to leave the partnership I can't move forward with this and you need to do this separately as a different group'

McMurray (2011) proposed a form of 'ordinal switching' of the nurse – doctor relationship when nurses become partners, claiming equality with their GP partners and managerial authority over salaried GPs. The Nurse Partners in this research project were aware of a power struggle within their partnerships but did not mention any issues regarding being the employer of GPs.

There were some issues external to the practice, when it became known that there was a nurse partner at the practice, this seems to have been around power sharing with other professions. Practice K had a practice manager partner and a nurse partner; the practice received a certain amount of criticism from neighbouring practices;

Karen (NP) 'the GP partners here took a lot of flak from other GPs. How could you offer that nurse a partnership, they're all going to want that.....they stuck to their guns in credit to them, it mustn't have been easy'

Kate (M) 'I know one of the Practice Managers who'd been in the NHS a lot longer, was told, don't get any ideas, you know that type of thing. And, so she never did become a partner, she's retired now'

Another practice expected other nurses to request a partnership;

Tom (D) 'we thought that when Theresa became a partner it would open the floodgates, you know, people would come and expect or request, but we haven't had a single nurse actually come up and say look, I've been here a long time, when am I going to be a partner'

Most of the Nurse Partners were conscious of a certain amount of anxiety from certain GP partners, especially those who had been affected by mergers. The 'new partners' had obviously not been involved in the initial decision to have a nurse partner;

Christine (NP) 'I think not being disrespectful to my newest set of partners, the newest mix, they certainly wouldn't have had a nurse as a partner, and you know, it makes it very difficult when I'm saying well, I think actually I'm not a mini doctor, I'm a maxi nurse and I do lots of things that you don't do that you never think about because it never gets to your door. I have to tread very carefully with my new set of partners'

Brenda (NP) 'now that we're taking on new GPs that are at the novice end, but they're going straight in at the fully fledged membership, so I think it is a discussion that we have to have with the partnership'

Brenda was highlighting the fact that after the initial probation period, new GP partners had equal partnership shares and voting rights, whereas although she had equal power within the partnership she only receives 50% of the shares.

This 'vying for power' theme identifies that although the Nurse Partners were considered equal within the partnership agreement and had the same power as the

GP partners in the decision making processes and as an employer, there were some subtle and some not so subtle inequalities that were not being addressed. How much authority did the Nurse Partners have over the salaried GPs clinical practice and why did the shares subject remain an issue?

'Only if it's Brenda'

When asked the question regarding replacing the Nurse Partner if she left, most of the GPs thought they would consider another Nurse Partner, but they were aware that their opinion was biased by the incumbent nurse, the most common comment was 'we'd have ours';

Tom (D) 'I think we're extremely lucky because Theresa is fantastic, which colours my opinion about nurse partners. I don't know whether therefore every partnership should have a nurse partner, I think if every practice had a nurse like Theresa then every practice should have a nurse partner.'

Kim (D) 'we've been lucky in that way absolutely and I don't know if they would then go out and say we are looking for a nurse partner to employ to replace Karen probably not'.

There was something about knowing what they were getting with a doctor partner; the individual will have undergone the same education and training and be from a similar socioeconomic background. Whereas nurses can have had a varied education, advanced diploma, graduate or post graduate; will have had different post registration experience before their primary care role. There is more of the unknown with a nurse partner;

Lynda (D) 'I would have thought, just like you and Louise have done, you want to be in a partnership which is perhaps unfair because you've had to prove that you can do it.....you've got to demonstrate that you're worthy of being a partner'

Tom (D) 'I suppose it's about breaking that stereotype and Theresa's done that really successfully to prove to the rest of us that, well of course this isn't an issue and we never would have doubted that nurses become partners, but I wonder if we never would have doubted it because of what we've learnt and we've seen since'

Several GPs and practice managers thought they would advertise for a nurse practitioner with a view to a partnership, much the same as when advertising for a

salariied GP. Those practices with a team of advanced nurse practitioners thought they may consider offering a partnership to one of them;

Bridget (D) 'I think we probably would yes, we've got quite a few advanced nurse practitioners, I suppose maybe some of them are sort of 'junior Brendas' I could see being useful nurse partner but others I could see no chance, but again, I think it's personalities as well as the skills.'

However, one of the practices was advertising for new partners yet the adverts were only placed in the medical press. Until challenged, this incongruity had not been recognised;

Christine (NP) 'we're looking for two partners now because we've got two retiring, and it's open to medics. It's advertised in the BMJ, the usual circles, I'd love another nurse partner, but I don't know if my partners would'.

Connie (D) 'we're looking at advertising for a partner and nobody has suggested we look for anybody other than a doctor.....think if I said shall we have a nurse practitioner as a partner, they'd all go, nooooo'.

The Nurse Partners were unsure whether they would be replaced if they left.

Several felt it was a financial consideration, income is reducing and it was felt that the GPs would be reluctant to take the 'risk' of a nurse partner;

Brenda (NP) 'I would like to think that when I leave they'd put another nurse in, that would upset me if they didn't, because by not doing it, they're actually saying, well actually we can manage without a nurse.....I've got to get a nurse partner pushed in here for when I leave, and nobody else seems to be recruiting and I'm sure it's because of the money side of partnerships'

Karen (NP) 'I very much doubt that they would replace me with someone of similar qualifications or offer them a partnership, I think their pockets will take priority'

Most participants felt there would not be an active recruitment process for a replacement or a second Nurse Partner. If it was felt appropriate to have another Nurse Partner it would be an internal appointment;

Laura (M) 'I suspect, they wouldn't necessarily look for another Nurse Partner, and I think that comes down to the individual, possibly the Nurse Partners that there are, are because of who they are'

All the Nurse Partners had been recruited internally and had a 'track record' within the practice. Only one nurse had been appointed to replace a GP partner, the others were an addition to the partnership. In three of the practices the ANP had approached the GPs, the concept of a Nurse Partner had not been considered and it was the personal knowledge of the nurse that persuaded the GPs to agree to a partnership. The other two nurses had been employed by the practice for many years before being offered a partnership; they considered it 'a reward' for their contribution to the development of the organisation, rather than the 'rite of passage' a GP would expect.

This Basic Theme illustrates the caution that the GPs showed when considering a Nurse Partner; they gave the impression they were comfortable with offering a partnership to a longstanding loyal employee but were wary about taking on an unknown nurse.

Summary of Thematic Network – 'Toe in the Water'

This Network has explored the cautious acceptance of a Nurse Partner in general practice. The practices have embraced multi-professional working with the Nurse Partner as the lead for the nursing team, who also played a full role in the senior management team of partners. Nursing is seen as being valuable to the business of providing primary care services to the practice population.

The GP Partners have put a 'toe in the water' by appointing a nurse as a partner; however the nurse was a known entity and brought specific skills to the partnership of extended and expanded clinical competence and knowledge, with managerial and leadership experience.

There remain cultural issues around equality between the medical and nursing profession and the perceived remuneration value of Nurse Partners. Whilst the nurses have reached interdependence within the partnership most did not have full parity and therefore complete equality.

The diversity in the way practices reflect and adapt to their local communities enables them to be effective and influential. The latest health 'reforms' of the Health and Social Care Act (DH 2012) established CCGs and put GPs in the 'driving seat' for commissioning healthcare services for their population. None of the Nurse Partners were members of their CCG, although some were involved with sub-committees of their CCG.

The unique and relatively rare arrangement of Nurse Partnership in general practice tends to be unknown outside the local health community. This situation is likely to continue in the current financial constraints, where practices are not replacing retiring GPs and practice mergers and federations are being encouraged. These new organisations will need to be led by a 'Board of Directors' with multi-professional competencies. Nurse Partners are ideally placed to represent primary care nursing at this executive level.

Summary of the Findings

The thematic analysis of the findings resulted in two interconnected Thematic Networks given metaphorical titles. 'Stepping out the box' describes the individual characteristics and the development of the nurses who have become partners in general practice, by 'stepping out' the nurse 'box'. 'Toe in the Water' depicts the cautious acceptance of a nurse partner by the GP partners who were treading carefully with the perceived radical change in organisational culture and environment.

Within each of the Thematic Networks there are organising and basic themes that although discussed and analysed separately are interrelated. The 'Stepping out the Box' Network described how the Nurse Partners were nursing differently and being influential within their practices; they were able to manage risk and uncertainty and were being entrepreneurial. These nurses have progressed from traditional primary care nursing and developed a unique role as a professional nurse combined with an entrepreneurial characteristic, capable of taking advantage of the changing climate

of primary care. However, these pioneering nurses have 'played it safe' by remaining within the traditional model of general practice. There are very few examples of nurses creating a new enterprise to delivery primary care to a population. Until this happens doctors will continue to hold the power.

The 'Toe in the Water' Network explored the cautious acceptance of a known experienced nurse as a partner who brought a specific skill set to the partnership. The Nurse Partners facilitated multi-professional working by adding nursing value and taking a leadership role. However, there remained issues in regard to equality both in remuneration and power sharing. The future of Nurse Partners is uncertain; the research practices were hesitant to commit to further Nurse Partners or to replace their existing one if she left the practice.

The research questions were:

- What are the experiences of nurses who become partners in general practice?
- Why do nurses become partners in general practice?
- In what way are Nurse Partners different to GP partners?

In answer to the research question, 'why do nurses become partners in general practice?' it emerged that certain experienced and established nurses were ready for the next challenge. They wanted the increased autonomy and responsibility that ownership of the practice could give them. It was never about the money, although maybe it should have been, at least partly about the money, in that it remained 'the elephant in the corner' for those Nurse Partners who were less than parity partners. The Nurse Partners were able to demonstrate the value of a nursing input at all levels of the organisation.

For the question 'in what way are Nurse Partners different to GP partners?' it was found that they brought a more holistic approach to primary health care, used their knowledge and skills to help patients to manage their long term conditions, supported preventative health care and self-care. They had a team work philosophy; having learnt throughout their career to work within a team, to collectively work out

problems and are effective and efficient in exchanging information to ensure continuity of patient care.

The experiences of the Nurses Partners were in the main positive; they all enjoyed the autonomy and independence, being able to influence the direction of the organisation and advocating for patients and the nursing team. There remained unresolved issues for them all; the lack of equity within the partnership; the need for a change in the nurse – doctor relationship and a wider acceptance of the status of nurse partners.

Reflexivity on the Findings

Findings are partly composed of the knowledge, beliefs and inclinations of the researcher, meaning everything the researcher is and brings with them to the project (Sandelowski and Barroso 2002). Reflexivity entails the ability and willingness of the researcher to acknowledge and take account of the many ways they themselves influence the research findings. Alvesson and Skolberg (2000) state that it is the capacity to reflect inward towards oneself as an inquirer; outward to the cultural, historical, political and other forces that shape everything about the inquiry and in between researcher and participant to the social interaction they share.

Mauthner and Doucet (2003) maintain that researcher, method and the data are reflexively interdependent and interconnected and that the interpretation of the data is a reflexive exercise through which meanings are made rather than found.

Reflecting on how my values and views influenced the findings adds credibility to this research. For example; in common with the Nurse Partner participants, I was asked what 'added value' I could bring to the partnership. Considering I had held a senior position within the practice team for many years; attending management meetings but not partnership meetings. This was a difficult question to answer not knowing how partnership issues and decisions were handled. However, having been involved with interviewing for replacement GP partners where the question was asked of them, I felt it was a legitimate question to ask. My response was that I would bring a different perspective from my extensive nursing experience both in

primary care and from previous posts in secondary care, managing a department and a specialist ward. I also felt that my knowledge of health service strategy and policy would benefit the partnership; as none of the GP partners were involved in healthcare activities external to the practice.

Gadamer (1989) states reflexivity involves a positive evaluation of the researcher's own experience in order to understand something of the merging of perspectives between subject and object.

I did not fully understand the implications of Theresa's story about CQC registration until a few weeks after the interview; when I received a phone call from the CQC registration department with the same issue. The person calling was very officious and had no understanding of the concept of partners other than GPs. For a fleeting moment I felt guilty that I was holding up the registration process! Then I became frustrated, that I was also going to have to go through the whole bureaucratic process of presenting documentation to a 'special post office.'

The level of frustration this incident provoked in both of us was immeasurable and gave us a sense that Nurse Partners must become more visible and vocal to educate the 'establishment' that general practice is not just doctors.

Following the Health and Social Care Act (DH 2012), CCGs are obliged to tender out primary care services if a practice is unable to continue to deliver a service due to retirement. This has led practices to merge or federate to 'protect themselves' from larger private providers bidding for the contract. This has been the case with several of the project practices; I had a similar experience, although with not such a successful outcome. Less than two miles away from my practice is a single handed GP practice; which has historically struggled to retain practice nurses, had difficulty maintaining income and many of the patients were requesting to register with our practice. The practice Business Manager and I developed a business plan to amalgamate this practice with ours. The single GP was open to the suggestion and willing to enter negotiations; however, this practice would require a great deal of input from our practice and partnership to improve the standards of care for the registered population. Disappointingly, unlike Christine and Brenda, we were unable to convince the GP partners that this was a good idea and would protect our practice from any outside private provider.

Gough (2003) advocates that; recognition of the personal dimension to research is heralded as enriching and informative. During the literature review I discovered the work undertaken by Freeman et al (2000) on the philosophies of teamwork and the implications on multi-professional practice; including the quote of '*working with rather than working for other professionals*'. I have always had an issue when hearing a GP say 'my' practice nurse, implying 'ownership' of another professional. Gough suggests that researcher subjectivity facilitates insights into: the context; relationships and power dynamics relevant to the research setting and as such the personal is celebrated as a strength and a resource to be used in order to enrich the quality of analysis.

Researchers should take responsibility for making intelligible interpretations rather than exclusively concentrating on participants accounts. But researcher involvement should be examined critically, reflexively so that analysis is not overdetermined (Gough 2003).

The interviews were intended to explore the lived experience of the interviewee and to interpret the meaning of the central theme of the life world of the Nurse Partners and their colleagues. Nevertheless, there were times when it became more of a conversation than an interview, especially with the Nurse Partners. Demonstrating the dual position of '*both cultural member and cultural commentator*' (Braun and Clarke 2006 p94).

Chapter 8 – Discussion and Conclusions

This chapter provides a brief summary of the research project; the findings and the limitations. The major implications of the work will also be discussed and recommendations with respect to these implications will be offered.

The purpose of this qualitative research project was to explore the experience of the inclusion of a Nurse partner in general practice. A critical emancipatory perspective was taken to; explore why nurses become partners and in what way Nurse Partners are perceived by themselves and colleagues to be different to GP partners. A thematic analysis process was used to analysis the data, resulting in two thematic networks; 'Stepping out the Box' and 'Toe in the Water'

The project's key findings were:

- The Nurse Partners have specific personal qualities and characteristics, along with skills, knowledge and competences; that enable them to enjoy the autonomy and independence of being a partner in general practice.
- The Nurse Partners are able to be entrepreneurial and influence the direction of the business.
- Inequalities were perceived to be barriers to true partnership; the professional boundaries and the traditional hierarchical system between nurses and doctors, was shown to continue in general practice. The resultant lack of parity / equity of the Nurse Partner compared to the other (medical) partners was of particular concern.
- The Nurse Partners were seen to have championed and promoted multi-professional working.

Limitations of the Research

As mentioned above, the processes of the project were all influenced and shaped by the interpretive lens of the researcher. It therefore cannot be claimed that a different researcher would generate the same findings. Additionally, this study cannot claim to be representative of general practices with Nurse Partners; therefore generalisations cannot be drawn from the findings generated.

By using the Kvale and Brinkmann (2009) traveller metaphor for the in-depth interviews, a collaborative process between the participants and the researcher was established. However, it was at times, difficult to maintain an element of objectivity as many of the interviewees were interested in the researcher's own experiences, thus highlighting that any qualitative research is a co-created account. The use of a single interviewer could be viewed as limiting; since the single interviewer inevitably brought a particular perspective to the research process. Though the counter argument is that; the single interviewer achieved considerable consistency between interviews and data analysis.

The project sample was self-selecting; the Nurse Partners responded to a group e-mail request for participants in the research project. They were then asked to act as the 'gatekeeper' to the other team members willing to be interviewed. This process was felt to be the most appropriate avenue to pursue as it is extremely difficult to access general practice and its workforce for research purposes. By establishing the personal contact of Nurse Partner to Nurse Partner it became easy to gain access to the other staff members.

This researcher had not considered the number of salaried GPs now employed in general practice; it would have been interesting to explore the perceptions of being employed by a nurse from this occupational group. Due to the scope of the study, the patients' voice was not heard. This would have provided an interesting added dimension to the impact of Nurse Partners on the experience of patients of the practice.

Rigour of this Research Project

Interpretative research requires a trail of evidence throughout the process to demonstrate credibility or trustworthiness (Fereday and Muir-Cochrane 2006). These authors describe rigour as demonstrating integrity and competence within a study.

In qualitative research rigour involves in-depth planning, careful attention to the phenomenon under study and productive, useful results.

The 15 point checklist developed by Braun and Clarke (2006) is used here as a guide to demonstrate rigour in this research project.

Process of transcription and coding

The data was transcribed verbatim by a professional transcriber. The researcher read the transcriptions through several times whilst listening to the interview recordings, to ensure accuracy.

The coding process followed the Boyatzis (1998) method. The codes were used to organise the data, to identify and develop the themes. The identified 'issues' were collected on post-it notes, which were then grouped together as 'codes'.

The process of coding and developing themes was an iterative and reflexive process. Continuous re-reading of the transcripts and initial post-it 'issues' was undertaken to ensure that the developing themes were grounded in the original data. For example, a theme was labelled 'everyone should have a Brenda' however, after returning to the data it was recognised that a more accurate description of the theme was 'only if it's Brenda'. Also the theme (dis)parity was originally labelled 'parity' but it became evident that the data was suggesting that there was no parity.

Process of analysis

The Thematic Networks were constructed by an iterative process with several re-arrangements of themes, after probing and deliberations with supervisors.

Participants' comments were linked to the analytic narrative throughout the presentation of the findings. There was a balance of extracts from each discipline involved; Nurse Partner, a GP, Practice Manager and nursing team member. The extracts were congruent with the analytic claims.

An extensive amount of time was spent on analysing the data and devising the themes so that they were specific enough to be discrete and broad enough to encapsulate a set of ideas contained in numerous text segments. This required a significant amount of interpretative work, with several iterations before all the themes 'felt right'.

Process of preparing the written report

Consistency has been shown between the method and the construction of the report. The epistemological position is clearly made in the relevant parts of the report. The researcher, as the interpreter, interacted with the interviewees leading to a co-created account of their lived experiences. The investigative discovery approach emphasised the personal experience of the interviewer and gave the Nurse Partners an emancipatory voice.

Implications of the Findings

The findings suggest that Nurse Partners are 'special' or pioneers, combining professional nurse with an entrepreneurial perspective. However, there remain cultural issues around equality between the medical and nursing profession and the perceived remuneration value of Nurse Partners.

The research practices have embraced multi-professional working with the Nurse Partner as the lead for the nursing team. These 'special' nurses played a major role in the senior management team of partners. In these practices nursing is seen as being valuable to the business of providing primary care services to the practice population.

Nurse Partners as pioneers

The findings could suggest that the nurses who aspire to be and become a partner in general practices are 'special'. On the other hand, there is a question of whether they are in fact 'special', or is it that they have seized an opportunity to develop their autonomy, which their advanced clinical skills have given them, in a different direction.

This research project identified that a major difference between the Nurse Partners and other senior clinical nursing roles is the entrepreneurship they demonstrate.

These Nurse Partners have shown they are entrepreneurial, often more so than their GP partners. McMurray (2011 p801) states *'that the executive authority that comes with entrepreneurial ownership can bolster professionalising claims, disrupting and reversing hierarchical organised professional divisions.'* The Nurse Partners have shown an ability to act in a short time frame and to chase an opportunity quickly. They are prepared to take risks, are able to manage resources and have a strong

self-image and self-confidence. Some of these findings were similar to Tindall (2008 unpublished), she recognised the entrepreneurial aspect of being a partner with the autonomy to push the boundaries and being influential in how services were provided for a patient population. Supporting the findings of this research, she also noted that a cultural divide still exists between nurses and doctors.

Cultural Barriers to Nurse Partners being equal

If it is accepted that nurse partners have an element of 'specialness', even within the pioneering practices that were part of this research project, there remains cultural barriers around equality between the medical and nursing profession. The difference of power, perspective, education, pay status, class and gender has, historically, made the relationship between nurses and doctors complicated.

Despite the progress over several decades of women achieving equal access to general practice training, medicine continues to be viewed as being masculine and nursing as being feminine. The latest national statistics show that for the first time there are more female GPs than male GPs (Health and Social Care Information Centre 2013). Of the GP Partners interviewed for this study there was only one male doctor, this may have been due to availability or willingness to participate as there were a number of male doctors in the partnerships. This research has shown that there needs to be a willingness by the GP partners to accept the shift in the traditional hierarchy between nursing and medicine and that the Nurse Partners need to recognise and accept the power they hold.

Hall (2005 p189) suggests that; '*Boundary-work heightens the contrast between rival professions.....promoting expansion of the profession's authority*'. It is this boundary work that Nurse Partners are undertaking. The increasing demand for managed care especially for people with long term conditions and the elderly has presented new opportunities for primary care nurses; the expectation that the GP is the right health care professional for this is being challenged. By advocating for nursing, the Nurse Partners in this study were having some success in being influential in this important area of healthcare. However, this influence did not extend beyond the practice to the wider healthcare community and the policy, strategy and decision making organisation of the CCGs. Theresa had engaged with her local commissioning processes but was not part of the Governing Body. Brenda

did attempt to be accepted by her CCG but was rejected. This 'locking out' of senior primary care entrepreneurial nurses from the decision making process, is a demonstration of the continuing medical hierarchical power and the lack of acceptance that nursing should have a place at the highest level of decision making.

The most prominent aspect of inequality between the Nurse Partner and the GP partners was the disparity in percentage drawings that was accepted or tolerated by the Nurse Partners. The findings of this research project demonstrate that even these arguably courageous 'toe in the water' practices, that had incorporated a Nurse Partner, were not willing to fully acknowledge the equality of nursing with medicine. Neither did they appear to accept that the Nurse Partners' entrepreneurial and accountability position warrants parity with GP partners.

The development of multi-professional working within practices

The Nurse Partners were instrumental in developing a multi-professional team approach to the delivery of services in their practices. This was most evident within the nursing team where the Nurse Partners demonstrated the clinical leadership qualities of; clinical competence and knowledge, empowerment and motivation. However the Nurse Partners did not appear to recognise this in themselves and did, at times, struggle with some of their GP partners. This struggle perhaps masking their ability to fully acknowledge the gains they had achieved.

Teamwork enables innovative solutions to challenging problems. Nevertheless, the history of professional cultures has traditionally cultivated a hierarchical power structure which tests the multi-professional team process. Reeves et al (2008 p1) suggest that '*the carefully negotiated historical territory of doctor-nurse relations let alone the pillars of professional autonomy and responsibility clearly impede the simple transition from professionally anchored care to collaborative care.*' The practices in this research project have shown, by having a nurse at the 'top table,' willingness to multi-professional working, nevertheless some evidence was found that professional stereotypes and perceived inequalities in status are hindering the process.

The long-established model of general practice is changing from the three traditional roles of: using clinical skills and knowledge as diagnostic and therapeutic tools for the undifferentiated nature of the problems presented in primary care; providing continuous longitudinal relationships with patients; and as gatekeeper / advocate for patients requiring specialist services; to the increasingly important role of co-ordinating care and working in partnership with people living with co-morbidities who require support with self-management. Evidence shows that appropriately trained nurses are well able to undertake the management of long term conditions and first contact work (Laurant et al 2009; Redsell et al 2006), enabling the GPs to have more time for those patients with complex needs. This research project has shown that having a Nurse Partner, who understands the importance of skill mix and a well-trained nursing team, can improve the quality and efficiency of general practice. By being entrepreneurial the Nurse Partners were able to spot the opportunities to change traditional ways of working.

Larger multi-professional primary care organisations or networks have been highlighted as more suitable to care for older people and those with complicated or multiple illnesses (see Five Year Forward View below). It will be vital that these larger primary care organisations have a strong multi-professional leadership that includes nurses; the Nurse Partners in this study have shown the ability to take on this role.

The new care delivery options revealed in the recent 'Five Year Forward View' (NHS England 2014) are an opportunity for Nurse Partners to demonstrate their entrepreneurial expertise in multi-professional working and leadership. There are two options: one will authorise groups of GPs to combine with nurses, other community health services, hospital specialists and possibly mental health and social care to create integrated out-of-hospital care – the 'Multispecialty Community Provider' (MCP); the other option will be the integrated hospital and primary care provider – 'Primary and Acute Care Systems' (PACS), combining for the first time general practice and hospital services. These new organisations will be the opportunity for Nurse Partners to show the value of nursing and challenge many of the inequalities between Nurse Partners and GPs.

This research has highlighted the necessity for CCGs to recognise Nurse Partners as equal to GP partners and accept their unique value to the process of commissioning healthcare for their populations. Nurse Partners need to be more assertive, to breakdown the traditional barriers between nurses and doctors. The skills, knowledge and competences of the Nurse Partners will be crucial for implementation of the 'Five Year Forward View'. Their entrepreneurial skills should ensure that, whichever option their local health economy undertakes, there are nurses at the forefront.

All the Nurse Partners were adamant that prior knowledge of the issues they had encountered would not have deterred them from becoming partners. They all enjoyed the freedom and self-determination of being able to influence the direction of the organisation and advocating for patients and the nursing team.

There are reports that some practices are faced with closure, and many others, working with reduced numbers of GPs, are struggling to meet the growing demand on reduced budgets (The Nuffield Trust 2014). Health Education Yorkshire and Humber data (2014 – personal contact) suggest that 22% of GPs and 23% of Practice nurses are 'at risk' of retiring in the next few years.

Although health spending has risen by 22% in the last seven years (The Nuffield Trust 2014), funding to general practice has lagged behind funding to secondary care. Capitation fees for the practice population vary from £65 per patient to £125 per patient; the higher figure is for PMS practices. The Government has given notice that this variation will be evened out to £78 per patient over the next five years. These statistics could be seen as supporting the cry that general practice is in crisis. A re-configuration of the general practice workforce can be a solution; nevertheless, it will need recognition of the contribution that Nurse Partners can provide.

The implications of this research are that Nurse Partners have been shown to be pioneers and entrepreneurial within their own practices. However, the cultural barriers between medicine and nursing still exist and prevent these 'special nurses' being considered equal to their medical colleagues. Nevertheless, the Nurse

Partners have been instrumental in developing multi-professional working within their practices.

Reflexivity

Until I started this research project I had not thought of myself as being entrepreneurial but I knew I was a pioneer. Stevenson (2006) describes entrepreneurship as a set of behaviours: commitment to opportunity; strategic orientation; a concept of control over resources and a concept of management. She states that critical to the success of entrepreneurs is knowledge of the territory they operate in. It is clear that the Nurse Partner participants in this study had a huge amount of territorial knowledge. On reflection, my 28 years of nursing in general practice alongside my experience in primary care health policy and strategy, did in fact enable me to be entrepreneurial. Kanter (1985) suggests that entrepreneurs are people who test limits and create new possibilities for organisational action by pushing and directing the innovative process. I now realise and accept that, as with the research Nurse Partners, I am an entrepreneur.

McMurray (2011 p801) states *'that the executive authority that comes with entrepreneurial ownership can bolster professionalising claims, disrupting and reversing hierarchical organised professional divisions.'* Unfortunately it feels that there is still a long way to go until this becomes true in general practice.

The concept of nurse entrepreneurs was first suggested in 2003, (quoted in Faugier 2005) by the then Secretary of State for Health John Reid, in a speech to the chief nursing officers' conference:

'Being an entrepreneur means being prepared to take risks. Nurses who will on every occasion, at every time, recognise that this person is different from the last patient and needs something different that will ensure better care. The characteristic of these entrepreneurial nurses is that they take the initiative, creating and implementing new ideas'

This was in the context of nursing care rather than in a business sense. Becoming a Nurse Partner is much more to do with the need to achieve and a perceived locus of control. Nurse Partners have the attitude, initiative and ability to recognise opportunities and the confidence to make the most of them. However, time and

again they have encountered resistance or negativity from their colleagues. Being a partner in a small business that is general practice is risky but can also be very satisfying; having the independence and capacity to generate ideas and take opportunities when they become available.

Rindova et al (2009 p478) view entrepreneurial projects as; '*emancipatory efforts that focus on understanding the factors that cause individuals to seek to disrupt the status quo and change their position in the social order in which they are embedded*'. This disrupting of the social order and status quo could be the emancipatory change that the Nurse Partners need to pursue opportunities and overcome perceived limitations within their practices. These limitations could be institutional, economic, social or cultural.

Even before I became a partner in the practice I was interested in health policy and strategy; my part-time role at the Health Authority gave me an insight into how policy making happened and the importance of influencing and networking. Debra Meyerson (2001) identified certain professionals who work quietly to challenge established wisdom and gently cause their organisational cultures to adapt. She calls them tempered radicals. Meyerson suggests that these tempered radicals are 'organisational outsiders'; they want to succeed in an organisation yet want to live by their values and identity, they walk a fine line without selling their souls. This everyday leadership is the quiet catalyst which pushes back existing norms to create learning and lays the groundwork for slow but on-going organisational and social change. Meyerson (2001 p29) states that; '*if you want to push important cultural changes through your organisation without damaging your career step softly*'. Tempered radicals work to effect change in moderate ways. I think I have always seen things in a different way and have tried to work quietly to challenge established practice.

My position as a partner in general practice 'entitled' me to selection / election for the various executive committees formed during the 'primary care led NHS' reforms and more recently the clinical commissioning groups. However, the entrenched hierarchical dominance of the medical profession made this difficult and there were many 'behind closed doors' discussions before this was recognised. I think one of

my greatest achievements was to have the wording of a memorandum of understanding changed throughout the document from 'GP' to 'partner'; thus enabling Nurse Partners and management partners to be involved in the decision making processes. This influencing outside their practice is vitally important if Nurse Partners are to achieve recognition.

As discussed in the recommendations section there is a need to actively disseminate the career pathway for nursing in general practice and for support and encouragement for senior experienced practice nurses to become leaders in primary care. My work to devise a VTS (Vocational Training Scheme) type programme for nurses new to general practice resulted in the 'General practice nursing work-based learning induction and preceptorship programme' run by the University of Sheffield. I deliver a session on the programme twice a year, where I emphasise the opportunities and possibilities available for nurses in general practice; these new to practice nurses are surprised to hear that nurses can achieve ownership of the business and always want to know how and why I did it.

Fear et al (2006) claim that tempered radicals operate on a fault line constantly pulled in opposing directions; towards conformity and towards rebellion. Fear et al further suggest that tempered radicals and the work they do are located at the margins of their institutional and professional cultures.

Meyerson (2001) states that organisations change in two ways: through drastic action and through evolutionary adaptation. The power of the evolutionary approach is making a difference in small but steady ways and setting examples from which others can learn. These changes are so incremental that they are often barely noticed; which according to Meyerson is why they work so well.

The evidence from my personal experiences and those of the research project Nurse Partners suggests that Nurse Partners can be described as tempered radicals; they genuinely like their jobs and want to continue to succeed in them, to effectively use their differences as an impetus for constructive change.

Recommendations

The findings of this research project give rise to a number of recommendations:

- It is essential that Nurse Partners are more widely recognised; thereby inspiring innovative and experienced general practice nurses to contemplate a partnership. A support network similar to the Queen's Nursing Institute database should be available to; enable existing Nurse Partners to network and receive support and those experienced and motivated primary care nurses considering partnerships would be able to access help and advice. The few research studies that have been undertaken around Nurse Partnerships need to be disseminated extensively, especially in the medical press rather than just the nursing press.
- There are projected shortages in the general practice workforce; GP partners are retiring early, newly qualified GPs are reluctant to become partners, preferring to be salaried and there are fewer doctors training to be GPs. Many practice nurses are reaching retirement age. Although general practice nursing is recognised as a discipline in its own right, many student nurses have little experience of primary care nursing during their training and therefore are unlikely to apply for posts after registration. A career framework for general practice nursing was devised by the Working in Partnership Programme (WiPP) several years ago; which did include Nurse Partners, but is no longer available. However NHS Education for Scotland (2009) does have a 'Career and Development Framework for general practice nursing'; this should be updated to include Nurse Partners and be disseminated across the whole of the UK. This would raise the awareness of the possibilities for nurses of a career in general practice and the potential to become owners of the business.
- There needs to be greater opportunities to increase the general practice workforce. A good example of how this can happen is the Advanced Training Practices scheme funded by Health Education Yorkshire and Humber; this initiative provides general practice training placements for student healthcare professionals, enabling them to develop the competencies needed to work effectively in primary and community care settings. The scheme has an ethos of

embedding inter-professional learning and working in primary care, so that the future workforce will have a greater understanding of the roles of colleagues. This will ensure an appropriately trained workforce for the implementation of services to support national policy and demographic trends. More practices should be encouraged and supported to be involved.

- Consideration should be given during post graduate education to equipping healthcare professionals with the skills and attributes of entrepreneurship to enable career progression to partnerships. GP Speciality Training Programmes should include recognition that the primary care workforce can usefully include partners from other disciplines.
- General practice is under great pressure from reduced income. There has been a real terms fall in practice income, while expenditure, which consist of practice staff salaries, tax and insurance, utilities, equipment and building costs has risen. The abolition of the Minimum Practice Income Guarantee (MPIG) could lead to practice closures, especially in deprived areas. The MPIG was introduced in the 2004 GP contract to ensure that the basic income of a general practice would never fall below its level before the introduction of the 2004 contract. There is evidence that NHS England has needed to 'bail out' some small practices, when partners have decided to leave and it has not been possible to recruit replacements. Nurse Partners have the skills to help improve this 'crisis in general practice'; this research project has shown they are active in cost saving and income generation initiatives. This skill base should be recognised and utilised.
- Further research is needed: for example a more in-depth study of the skills and attributes needed by nurses to be a partner; a comparative study of a 'toe in the water' practice with a practice without a Nurse Partner or an ethnographical study of a practice with a Nurse Partner. It is essential that more is known about the concept of Nurse Partners, nurse entrepreneurship and gaining equality with the medical profession without challenging its integrity.

Conclusions

This study advances our understanding about the types of practices that put a 'toe in the water' of having a Nurse Partner or why nurses 'step out the box' to become partners. As an explorative project this research has raised the profile of Nurse Partners and the practices within which they work; and contributed to a change process by making the nurse partner position visible.

The key findings from the research have shown that the Nurse Partners enjoy an autonomy and independence that would be impossible if they were employed by the practice. They are able to show entrepreneurship and demonstrate a commitment to the 'business' of general practice. Nevertheless, these nurses have not received the recognition that they deserve. CCGs have failed to acknowledge that these unique roles and skills are essential to the commissioning process, especially in respect to LTC management and the care of the elderly services. The Nurse Partners' knowledge and capability of working with a multi-professional team would be invaluable to the CCG in its legal duty to support quality improvement in general practice. However, equality, especially in respect of drawings, was of particular concern. This key finding is a barrier to nurses and doctors creating true partnerships.

The services being provided now and in the future by general practices will need the skills, knowledge and expertise of the wider clinical team. The Nurse Partners in this research project have proven the need for nurses to be considered as equals in planning, organising and providing primary healthcare to the registered population.

It is of concern that Nurse Partnerships are not being considered as part of the solution to the 'crisis' in general practice. The entrepreneurship and expertise demonstrated by these Nurse Partners in multi-professional working, is vital to the continuation of modern effective primary healthcare.

General practice is changing; the 'corner shop' business model is becoming less and less viable. The new care delivery options will involve more integrated working, federations or merging of practices and will need to incorporate multi-professional

working. Sibbald (2008) asserts that GPs have yielded considerable ground to nurses in the interests of improving the quality and efficiency of primary care. She states that it is time to acknowledge that nurses are the true frontline providers of primary care. They are able and capable to undertake the bulk of the work, including preventative health care, the management of long term conditions and first contact for minor illnesses. If this is so, then nurses need to be members of the 'Board of Directors' of the business that is general practice.

'I think the only way really forward is for nurse partner only practices that employ salaried GPs, I think then you might see some true changes'

(Christine Nurse Partner participant)

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Table 3

Issues	Codes	Basic Themes
<ul style="list-style-type: none"> • Different roles & responsibilities • Being different – thought patterns • Thinking differently • Nurses work to protocols • Maxi nurse not mini doctor • Expanded professional role • Being a role model • Having a role model • Driver / diplomatic / mediator / approachable / facilitator • Experienced nurse working at advanced level of practice • Voice of reason 	<ul style="list-style-type: none"> • Individual • Individual characteristics 	<p>Being a Nurse</p>
<ul style="list-style-type: none"> • Things doctors can do that nurses can't • Proving work / value / ability • Responsibility of partnership • Innovative partnership • Shows practice is progressive • Treated as equal – financially & in decision making 	<ul style="list-style-type: none"> • Doctors & Nurse • Recognition 	<p>Vying for power</p>
<ul style="list-style-type: none"> • Like being married to a stranger • Outsider / being alone in partnership / isolation • Commitment to the partnership • Conflict • Political – internal & external • External lack of acknowledgement & acceptance of nurse partners • Obstacles & barriers– internal & external 	<ul style="list-style-type: none"> • Partnership dynamics • Power & status 	
<ul style="list-style-type: none"> • Managing uncertainty • Clinical responsibility • Cutting edge • Taking risks • Personal risk • Risk to other partners • Equal risk – equal shares 	<ul style="list-style-type: none"> • Risk & uncertainty • Decision making • Process 	<p>Managing risk & uncertainty</p>
<ul style="list-style-type: none"> • Partnership roles & responsibilities – business / clinical • Looking for future opportunities • Innovative partnership • Financial issues / knowledge • Partnership role 	<ul style="list-style-type: none"> • Make a difference 	<p>Being entrepreneurial</p>

Table 3 (continued)

Issues	Codes	Basic Themes
<ul style="list-style-type: none"> • Business responsibilities • Strategic insight / vision 	<ul style="list-style-type: none"> • Make a difference 	<p>Being entrepreneurial</p>
<ul style="list-style-type: none"> • Nursing perspective • Culture of nursing brings different viewpoint • Workload shift • Teamwork / team development • Skill mix • Being valued as a nurse / person 	<ul style="list-style-type: none"> • Value of nursing 	<p>Adding nursing value</p>
<ul style="list-style-type: none"> • Nurses need encouragement & motivation • Champion for nursing team • Proving worth of a nurse / value / ability • Positive affect on the team • Developing nursing • Nurse-led work • Stepping stone between nurses & GPs • Being a balance 	<ul style="list-style-type: none"> • Advocate • Voice of nursing • Conduit between partners & staff 	<p>Advocating for nursing</p>
<ul style="list-style-type: none"> • Thinking differently • Stepping / thinking outside the box • Nursing perspective on decision making 	<ul style="list-style-type: none"> • Different Perspective • Different Approach • Philosophy of the practice • Practice culture • Internal influence • External influence • Networking 	<p>Widening perspectives</p>
<ul style="list-style-type: none"> • Leadership & management of nursing team • Team development • Nurse Partner leads on development • More approachable generally than doctors 	<ul style="list-style-type: none"> • Leadership & management • Workforce planning • Team development • Skill mix 	<p>Taking a lead</p>
<ul style="list-style-type: none"> • Salaried v percentage partner • Difficult negotiations • Negotiating parity • Fairness • Equal risk – equal shares 	<ul style="list-style-type: none"> • Equality & Parity 	<p>(Dis)Parity</p>

Issues	Codes	Basic Themes
<ul style="list-style-type: none"> • Unlikely to have another nurse partner • Being a balance • Being valued as a nurse / person 		Only if its Brenda

Table 4

Basic Themes	Organising Themes	Global Themes
<ul style="list-style-type: none"> • Managing risk & uncertainly • Being entrepreneurial 	Nursing differently	STEPPING OUT THE BOX
<ul style="list-style-type: none"> • Being a nurse • Advocating for nurses • Widening perspectives 	Being Influential	
<ul style="list-style-type: none"> • Adding nursing value • Taking a lead 	Inter-professional working	
<ul style="list-style-type: none"> • Vying for power • (dis)parity • Only if its Brenda 	The same but not the same	

The Experience of Nurse Partnerships in General

Interview Guide

Kvale & Brinkmann Linguistic forms of questions

- Can you describe it to me? What happened?
- What did you do? How do you remember it? How did you experience it?
- What do you feel about it? How was your emotional reaction to this event?
- What do you think about it?
- What is your opinion of what happened? How do you judge it today?

Introduction

Background to project – exploring the experience of nurse partnerships in general practice

- Brief background from interviewee
- Description of the practice organisational structure pre & post becoming a partner
- How do things work around here?
- What is the usual decision making process in the partnership?

Interviewee's personal experience of becoming a nurse partner – how it came about, who initiated, how long did it take

- Were there obstacles – what / who
- Differential in drawings?
- How were these dealt with?

Core part of Interview

Can you describe a time when being a nurse partner has made a difference to a decision or to the practice?

- How did you feel? How did your GP partners react?
- How equal do you feel? / do you feel like a partner?

Can you describe a difficult situation with your partners?

- What did you do? How did you feel? What do you think about it now?
- What issues did it raise?

How do you think things have changed within the practice since you became a partner?

- How would you describe the relationship between the partners?

What do you think makes nursing distinctive from medicine – especially at this level of practice?

Winding down

How do you see the future for nurse partners?

What advice would you give to a nurse considering a partnership?

Knowing what you know now would you still become a partner?

Was there anything else that you thought I would ask but didn't or that you want to add?



Sheffield Hallam University

Participant information sheet

Study title:	The Experience of Nurse partnerships in General Practice: a Thematic Analysis
Chief investigator	Sue Nutbrown
Telephone number	0114 236 3627

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. Talk to others about the study if you wish. Ask me if there is anything that is not clear.

This research is part my studies for a Doctorate in Professional Studies (Health and Social Care)

A literature review found no published research on general practice nurse partners. This study aims to explore the experiences of nurse partnership. The new Health and Social Care Bill will mean huge changes and opportunities for the primary care workforce. Through this research I hope to empower experienced practice nurses to consider becoming a general practice nurse partner.

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 the experiences of nurse partners in general practice in England. This study will examine the new phenomenon of nurse partners, their understandings and views, the importance they give to certain issues and events from their perspective. The study will involve exploring issues of power, empowerment, medical dominance, equality and equity

This research is part of my studies for a Doctorate in Professional Studies (Health and Social Care

2. Why have I been invited?

As a nurse partner / GP with a nurse partner / someone who works with a nurse partner, you have a unique perspective of this new role, how it works in practice and the impact it has had on the practice.

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 without giving a reason.

4. What will happen to me if I take part?

If you participate in the study I would interview you about your experiences of working with / as a nurse partner. The interview will take approximately 1 hour & be audio taped. Ideally I would like to be able to undertake the

interview in your workplace. If this is not convenient, I'm happy to meet you somewhere of your choosing.

5. Expenses and payments

You will not be paid for taking part in this study.

6. What will I have to do?

If you agree to take part in the study the interview will be arranged at a mutually convenient time and place.

7. What are the possible disadvantages and risks of taking part?

The interview may identify sensitive or confidential issues. You are entirely free to discontinue your participation at any time or to decline to answer particular questions.

8. What are the possible benefits of taking part?

The aim of the project is to raise the awareness of the potential of general practice nurse partners, leading to more experienced general practice nurses being empowered to consider becoming a partner in a practice.

9. What if there is a problem or I want to complain?

If you have any queries or questions please contact:

SueNutbrown 0114 236 3627
sue.nutbrown@nhs.net

Sheffield Hallam University, Faculty of
 Health and Wellbeing

Alternatively, Prof. Frances Gordon
 0114 225 4360
f.gordon@shu.ac.uk

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. I will
 check that the recording and the
 written transcript are the same. I will
 then erase the recording. The written
 transcripts will be kept for as long as
 they might be useful in future
 research. Confidentiality and
 anonymity will be maintained
 wherever possible and if not will be
 sent back to you for discussion. 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 the NMC 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
 project file. This is locked away
 securely. The folder might be checked
 by people in authority who want to
 make sure I am 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 results will presented as part of
 the DProf project report. It is
 expected that the results of the study
 will be published in well read primary
 care nursing journals and
 disseminated via presentations and
 posters at established conferences

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

SueNutbrown 0114 236 3627
sue.nutbrown@nhs.net

Alternatively, Prof. Frances Gordon
 0114 225 4360
f.gordon@shu.ac.uk

Sheffield Hallam University, Faculty of
 Health and Wellbeing



*Sheffield
Hallam University*

Participant consent form

Study title:	The Experience of Nurse Partnership in general practice: A Thematic Analysis
Chief investigator	Sue Nutbrown
Telephone number	0114 236 3627

Participant name	<input style="width: 450px; height: 30px;" type="text"/>
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	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 7.2.12 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	<input style="width: 100px; height: 30px;" type="text"/>
2	I understand that my involvement in this study is voluntary and that I am free to withdraw at any time, without give any reason.	<input style="width: 100px; height: 30px;" type="text"/>
3	I understand that my information will be treated confidentially and will be anonymised. Data will be kept electronically on a password protected, personal computer with anonymous identification codes.	<input style="width: 100px; height: 30px;" type="text"/>
4	I agree to take part in this study	<input style="width: 100px; height: 30px;" type="text"/>

To be filled in by the participant
I agree to take part in the above study

Your name	Date	Signature
<input type="text"/>	<input type="text"/>	<input type="text"/>

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
<input type="text"/>	<input type="text"/>	<input type="text"/>

Filing instructions

- 1 copy to the participant
- 1 original in the Project or Site file
- 1 copy in the medical notes (if applicable)

National Research Ethics Service**FW: Ethics advice**

Allmark, Peter [P.Allmark@shu.ac.uk]

Sent: 04 April 2011 15:20

To: Nutbrown Sue (SHEFFIELD PCT)

Dear Sue

This answers your query, I think. You can include it as an appendix in your DPS1 as evidence that NHS REC approval is not required; you'll have SHU ethics approval instead. The link on here didn't work for me but try this one instead:

<http://www.nres.npsa.nhs.uk/applications/guidance/research-guidance/>

Best wishes
Peter

From: NRES Queries Line [mailto:queries@nres.npsa.nhs.uk]

Sent: 04 April 2011 15:09

To: 'Allmark, Peter'

Subject: RE: Ethics advice

Your query was reviewed by our Queries Line Advisers. Our leaflet "Defining Research", which explains how we differentiate research from other activities, is published at:

<http://www.nres.npsa.nhs.uk/rec-community/guidance/#researchoraudit>

Based on the information you provided, our advice is that it does not require ethical review by a NHS Research Ethics Committee. If you are undertaking the project within the NHS, you should check with the relevant NHS care organisation(s) what other review arrangements or sources of advice apply to projects of this type. Guidance may be available from the clinical governance office.

Although ethical review by a NHS REC is not necessary in this case, all types of study involving human participants should be conducted in accordance with basic ethical principles such as informed consent and respect for the confidentiality of participants. When processing identifiable data there are also legal requirements under the Data Protection Act 2000.

When undertaking an audit or service/therapy evaluation, the investigator and his/her team are responsible for considering the ethics of their project with advice from within their organisation. University projects may require approval by the university ethics committee.

This response should not be interpreted as giving a form of ethical approval or any endorsement of the project, but it may be provided to a journal or other body as evidence that ethical approval is not required under NHS research governance arrangements.

However, if you, your sponsor/funder or any NHS organisation feel that the project should be managed as research and/or that ethical review by a NHS REC is essential, please write setting out your reasons and we will be pleased to consider further.

Where NHS organisations have clarified that a project is not to be managed as research, the Research Governance Framework states that it should not be presented as research within the NHS.

If you have received advice on the same or a similar matter from a different source (for example directly from a Research Ethics Committee (REC) or from an NHS R&D department), it would be helpful if you could share the initial query and response received if then seeking additional advice through the NRES Queries service.

However, if you have been asked to follow a particular course of action by a REC as part of a provisional or conditional opinion, then the REC requirements are mandatory to the opinion, unless specifically revised by that REC. Should you wish to query the REC requirements, this should either be through contacting the REC direct or, alternatively, the relevant local operational manager.

Regards

Queries Line
National Research Ethics Service
National Patient Safety Agency
4-8 Maple Street
London
W1T 5HD

Extract of Coded Data - Practice T Nurse Partner Theresa

Comments	No's	Transcript	Themes
	1.1 (SN)	Can you give me a short background of how you became a nurse partner and how long you've been a nurse partner?	
Partnership suggested by GP In practice a long time	1.2 (T)	Sure, I joined this practice in 1990 when it was very small and was very much involved in the development of the practice, ...and founding partner suggested to the other partners that myself and the practice manager at the time be made partners in recognition of the work that we'd done within the practice and what with the proposed developments. .	Make a difference Individual characteristic:
	1.3 (SN)	And how did you think that went?	
Sharing power	1.4 (T) they were very keen two of the newer GP partners weren't desperately keen to share their power..	Power and status
	1.5 (SN)	You would have liked to have been a fly on the wall.	
Difficult negotiations	1.6 (T)	I gathered that there may have been some fairly strong opinions against us becoming partners,	Power and status
	1.11 (SN)	And how does this partnership work in decision making processes or, yeah basically how does it work?	
Being a balance Skill sets Valuing nursing	1.12 (T)	one of the reasons that I was offered partnership in the first place was that it was felt that it was really really important to publically acknowledge the value and contribution that non GPs can make to partnership because it isn't just about the clinical work, it's about the whole running of the organization and obviously other people can bring you know, huge skill sets to the partnership to make it, you know, to contribute to its running,	Making a difference Adding nursing value Widening perspectives
	1.13 (SN)	have there been any conflicts in the partnership that have needed to be resolved and how have those been resolved?	
Conflict External	1.14 (T)	Yeah, there have been conflicts within the partnership, and we have had rather tense meetings at times, not regularly, I	Partnership dynamics

facilitator		think we all get on reasonably well..... There have been moments in partnership meetings that have got very heated and very tense, we have had, but I have to say rarely..... we've had facilitators at those that have helped us look at the way we operate and how we might get the best out of each other	
	1.21 (SN)	Do you think there was an element of threat there, did they feel you were threatening to?	
Power sharing Responsibility	1.22	I think there was a lot about the power, you know sharing power, I think there was a lot about status and there was actually they weren't all young GPs there was an experienced GP amongst them, and you know, some of her comments were actually quite challenging. And I recognised there that she really didn't see nurses as in, having the same status or, or contributing in the same way to the partnership so that was interesting, but yeah, a lot about status and power sharing, and money, of course	Power and status Parity
	1.31 (SN)	is there an incident that you can describe where being there as a nurse partner has made a difference to how it developed or how it went on?	
Developing nursing team Management issues Thinking differently	1.32 (T)	one particular one would be about workforce planning and nursing contribution in the practice. We have a very well developed nursing team which includes health care assistants, phlebotomists, I was instrumental, in developing that team, challenging the you know, the GPs can kind of manage everything..... making proposals about a different skills set and moving the nurses on to proper pay ...that was something that would have gone very differently if I'd have not been, not had the power in the partnership to make that decision. Other people have been for the different skill mix	Different approach Advocate Team development and And skill mix
	1.41 (SN)	Do you find your view is heard accepted and actioned on?	
Demonstrating value of nursing	1.42 (T)	Yes, I do, , but as I said I do feel a bit on the back foot at the moment because	Voice of nursing

Speaking up for nursing team and its contribution to the practice		we had a very strong nursing team, we had those financial pressures, lost some nurses and now actually feel the need to kind of demonstrate the value of them and keep pushing it. And so that makes, I'm conscious of that during partnership conversations	Workforce planning Value of nursing
	1.49 (SN)	is there a distinction between nursing and medicine or nursing in general practice and GPs and what makes that distinction?	
Team work Team development	150 (T)	I think there is something really important about bringing it back a patient focus.... we've spent some time thinking very carefully about our mission, our vision and our values, I think we all buy into a holistic, inclusive, supportive, encouraging kind of view that we all shareI think we have a more even spread of business acumen, and financial awareness and the more holistic kind of thinking ...strategic capability scoping, you know, we've got a whole mix across all of the partners.	Doctors and Nurses Equality Being entrepreneurial