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COMBINING THE BEST OF NURSING AND MEDICAL CARE

Evaluation of the West Yorkshire Nurse Practitioner (Primary Care) Development Programme from 2001 to 2005

Report for Yorkshire and the Humber Strategic Health Authority, the University of
Huddersfield and Leeds Metropolitan University

By

Dr Reg Walker – Elliott Walker Consultancy
Linda Bindless – University of Huddersfield
Fiona Harrison – Leeds Metropolitan University
Susan Michael – Yorkshire and Humber NHS
Jan Firth – University of Huddersfield

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Susan Michael (Chair), Yorkshire and Humber SHA
Linda Bindless, University of Huddersfield
Janet Firth, University of Huddersfield
Fiona Harrison, Leeds Metropolitan University
Lynda Burt, Bradford and Airedale Primary Care Trust
Joanne Crewe, Kirklees Primary Care Trust
Tracy Small, Kirklees Primary Care Trust
Professor Peter Bradshaw, University of Huddersfield
Ann-Marie Bagnall, Leeds Metropolitan University.

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Reg Walker

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1. INTRODUCTION

The West Yorkshire development programme for Nurse Practitioners (NPs) in primary care was designed to address an impending shortage of General Practitioners (GPs) at the turn of the decade and government policy to encourage the development of advanced practitioner roles in nursing and other non-medical professions.

At the initiative of the West Yorkshire NHS Workforce Development Confederation (WYWDC), in 2001 a Steering Group representing the West Yorkshire Primary Care Reference Group, the WYWDC and the Universities of Huddersfield and Leeds Metropolitan developed – in the absence of national guidelines on NP development – an agreed framework for developing the role of Nurse Practitioner in primary care and for commissioning courses and support infrastructures for aspiring NPs. This formed the basis for the commissioning of NP development courses at the two Universities – two-year courses at Masters level leading to a Postgraduate Diploma, with an optional third year leading to an MSc.

So far approximately 200 Nurse Practitioners have completed the programme. This report presents an evaluation of it vis-à-vis the first three cohorts: 2001-3, 2002-4 and 2003-5. The evaluation was commissioned by the WYWDC (now incorporated into the Strategic Health Authority for Yorkshire and the Humber) and the two Universities. It was carried out between mid-2006 and Spring 2007.

2. OBJECTIVES AND METHODS

2.1. Research objectives and purpose of this report

As set out initially, the evaluation had four objectives:

- To examine the commissioning process used to develop the programme and consider its transferability for commissioning future courses
- To evaluate the content of the programme in preparing Nurse Practitioners who are fit for purpose and practice
- To examine the impact of the programme on the students' career opportunities
- To identify the extent to which Nurse Practitioners are able to utilise their new skills and knowledge.

Since the commissioning process took place six years ago, the first of these objectives really translates into evaluating the commissioning strategy. The purpose of this report, therefore, is to assess commissioning strategy and the effectiveness of the education programmes commissioned – specifically in relation to the first three cohorts: 2001-3, 2002-4 and 2003-5.

2.2. Research methods and numbers

The report is based on data drawn from six different perspectives, as follows.

- (1) The thinking that led to the framework produced in 2001.
- (2) Reflections on the commissioning strategy obtained from interviews at WYWDC with Kath Hinchliff, who was responsible for the commissioning strategy, and Susan Michael, who later managed the contract; and interviews also with those who led the programme in the Universities: Fiona Harrison at Leeds Met; Janet Firth and Linda Bindless at Huddersfield.
- (3) A review of the course evaluation reports for the first three cohorts.
- (4) Analysis of responses to a postal survey of NPs who had completed the programme.
- (5) Follow-up interviews with NPs.
- (6) Interviews with some GPs who have acted as tutors and clinical assessors for student NPs.

Numbers

The survey and interview numbers are shown in Table 1. We anticipated a 1-in-3 response to the survey, and that was achieved, giving 35 completed questionnaires, spread across the three cohorts and both institutions. We aimed to interview 10-15 qualified NPs, and in fact interviewed 19. On the other hand, we hoped to interview 10-15 GPs, but only 8 consented to be interviewed and were contactable.

Table 1: Postal survey and interview numbers

	Huddersfield	Leeds Met	Total
NP questionnaires & interview consent forms sent out	56	45	101
Completed questionnaires	17	18	35
NPs who consented to be interviewed & gave contact information	17	14	31
NPs interviewed			19
GPs invited to be interviewed	12	30	42
GPs who consented to be interviewed & gave contact information			8

The postal survey

Because NPs' and GPs' time is at a premium, it was decided to keep both the survey questionnaire and interview schedules as brief as possible, focusing on general issues. The postal questionnaire, which is reproduced in Appendix A, covers the following issues:

- How NPs rate the main parts of the development programme
- In what ways the role is more or less demanding than anticipated
- The extent to which NPs play a lead role in various clinical situations
- Acceptance of the role by various other people
- Satisfaction with the role
- Effects on their career and future prospects
- The impact of having a Masters
- Foreseeable developments
- Suggested changes in the development programme.

The questionnaires were issued with a covering letter from the WYWDC which, among other things, assured anonymity and confidentiality. A letter inviting people to consent to be interviewed accompanied the questionnaire. To safeguard anonymity, separate envelopes were provided for returning the questionnaire and the interview consent form.

The NP interviews

These interviews took place a couple of months after the postal questionnaires had been returned and the initial analysis of the questionnaires helped to frame the interview schedule. Thirty-one NPs consented to be interviewed and supplied contact details, while three others omitted the contact details. Of the thirty-one, nineteen were interviewed: 15 face-to-face; three by phone and one by email.

It took 64 attempts to obtain the 19 interviews. Almost all of the NPs whom we were able to contact directly were in fact interviewed. In the few cases this wasn't feasible because of the practicalities of location or of co-ordinating NP and researcher availability.

The interviews were short, mostly 15-20 minutes. The schedule (see Appendix B) was semi-structured around questions concerning the role of NP, specifically:

- What distinguishes the role of NP in primary care from other clinical roles?
- In practice, how well does the role fit it with how NPs think it should be?
- The parts of the role they feel most and least confident performing
- Aspects of the role that other people are keen, or reluctant, for them to develop
- Improving recognition of the role, and
- Whether they foresee the role changing significantly.

While time-consuming to arrange and get to, the interviews proved particularly useful in giving the researcher a flavour of the calibre of NPs and how they view their emerging role. The face-to-face interviews all took place on practice premises. For reasons of short duration, focus and practical convenience, these interviews were not tape-recorded; instead the researcher took notes which were transcribed soon after each interview took place.

The GP interviews

The interviews with GPs took place when most of the NP interviews had happened and, again, the earlier findings helped to frame the semi-structured schedule for interviewing the GPs. These interviews were all done by phone, with the researcher taking notes which were transcribed soon after each interview. Again, the interviews were short, only 10-15 minutes. The questions (see Appendix C) fell into two groups, as follows.

(A) The GP's own role as in-house tutor and clinical assessor:

- The number of NPs tutored so far
- The benefits and disadvantages of the tutorial role
- Willingness to perform the role again
- How the relationship between GP and NP may have altered since the NP qualified.

(B) The NP's role:

- The GP's experience of working directly with a qualified NP, as distinct from in a tutorial role
- What particularly distinguishes the NP's role from other clinical roles
- How the NP's role affects patient care
- Acceptance and recognition of the NP role
- Hopes and concerns in regard to how the NP role may develop.

2.3. Project oversight

The Chair of the NHS Research Ethics Committee to which the proposal was submitted decided that nothing in it called for REC debate or opinion, and deemed it to be "a very appropriate (and well presented) argument for assessing a course funded by the WDC". The Research Ethics Panel in the School of Human and Health Sciences at the University of Huddersfield – which hosted the project – were also happy with the proposal and raised some practical issues which were addressed.

Apart from the project group representing the WYWDC and the two Universities, there was a Steering Group consisting of representatives of three PCTs and two other University staff which met three times during the fieldwork and drafting of the report.

2.4. The structure of the report

Having described the evaluation objectives and approach, we turn now to reviewing the commissioning framework and the findings vis-à-vis the commissioning strategy, and then – in section 5 – to the Universities' course evaluations. Sections 6 and 7 present the findings from the survey and interviews. The final section pulls together the conclusions and recommendations.

3. THE COMMISSIONING STRATEGY

This section outlines the background to the West Yorkshire initiative and the framework that formed the basis for commissioning the Nurse Practitioner development programme.

3.1. Background to the West Yorkshire initiative

Several factors have been contributing to the development of what are variously called Nurse Practitioner and Advanced Nurse Practitioner roles in both primary and secondary healthcare.

Mainly they reflect a mix of concerns about the supply of doctors, pressures to develop other clinical roles, and government reforms of the NHS. Broadly, the latter are designed to make the NHS more responsive to patients' needs and public health agendas; to make healthcare provision more flexible while also achieving more integration within health services and between health and social services; to achieve more integrated workforce planning; and to make healthcare provision more innovative and more cost-effective – all matters for considerable debate, and beyond our remit.

More specifically, interest in the NP role was spurred by the partial reform of primary care general practice through the introduction of Personal Medical Services (PMS) practices – i.e. practices organised in ways that differed from what up to then had been the conventional model of independent GPs and GP partnerships – and pressures from various quarters to recognise untapped levels of ability among nurses and to build capacity for development of their clinical roles, as envisaged in the NHS Plan, particularly in the Chief Nursing Officer's framing of key roles for nurses. Development of advanced practitioner roles in the USA and elsewhere has also been influential.

However, progress towards a national framework for NPs has not kept pace with developments of the role on the ground, or development of educational provision for it around the country, although in 2006 there was progress to the extent that the Nursing and Midwifery Council (NMC) put formal proposals (NMC, 2005) seeking Privy Council approval to amend nursing registration in order to register advanced nurse practitioners – the term it uses, without capital letters – that approval being necessary to pave the way for legislation, though there is no way of knowing at present whether such legislation will be forthcoming.

However, even that was far from being the case at the turn of the decade when the West Yorkshire initiative was started. It was prompted by the mix of factors just described and particularly by the lack of anything approaching national guidelines for NP roles or for education for them.

3.2. Development of the framework

Following the introduction of Primary Care Groups in 1999, the West Yorkshire Education and Training Consortium (i.e. the WYWDC) established a Primary Care Reference Group to facilitate communication between the Consortium and primary care organisations regarding workforce planning and education. This Reference Group set up

a Nurse Practitioner Steering Group with the aim of developing a framework to provide a basis of consistency across West Yorkshire for commissioning courses and infrastructural support for developing Nurse Practitioners.

The group's starting points included the national local drivers of change outlined above and particularly the NHS Plan goal to shatter old demarcations by requiring 'NHS employers ... to empower appropriately qualified nurses, midwives and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, admit and discharge patients, order investigations and diagnostic tests, run clinics and prescribe drugs' (DoH, 2000: 83). The plan also refers to nurses managing patient caseloads, running clinics, performing minor surgery and outpatient procedures, and taking a lead in the way local health services are organised and run (DoH, 2000: 83-4).

The NP Steering Group was multi-professional. It consisted of eleven people representing five primary care interests, two health authorities and NHS Direct, and WYDC and the Universities of Huddersfield and Leeds Metropolitan. Among the agreed objectives, the main ones can be paraphrased as follows:-

- To develop a shared understanding of the NP role in primary care
- To develop and agree a definition for the role of NP in West Yorkshire
- To advise on the competencies and educational requirements for NPs in primary care
- To advise on appropriate supervision and mentorship, and assess the associated financial implications and the capacity within primary care to provide the necessary support
- To develop a framework to support commissioning for NP education.

The workings of this group need not concern us here. What is of interest are the group's working definition of an NP and the associated principles and competencies, and the support infrastructure that the group proposed. These are summarised below, as set out in the group's report to the Primary Care Reference Group in May 2001 (Coombs, May 2001); although a draft, it is in effect the final version.

Definition of NP and competencies

The following is the definition agreed by the Steering Group:-

“A Nurse Practitioner (primary care) is an independent practitioner who is able to demonstrate a high level of defined competencies, which enables the practitioner to manage a whole range of clinical situations. This incorporates diagnostics, therapeutics, decision making and clinical management, which is complementary to other members of the primary health care team” (Coombs, 2001).

In the Leeds Met course handbook (2003-5: 5) this definition is reproduced with the term 'complementary' replaced by the term 'interdependent'.¹

¹ In 2005 the Nursing & Midwifery Council produced a definition of the NP's role, intended for the general public, as follows: “Advanced nurse practitioners are highly experienced, knowledgeable and educated members of the care team who are able to diagnose and treat your health care needs or refer you to an

Underpinning the Steering Group's definition was a long series of principles, namely that NPs should be:-

- First level qualified (Part 1) and registered nurses
- Experienced
- Generalists functioning at a higher level
- Knowledgeable/experienced in primary healthcare
- Independent – autonomous in decision making
- Able to demonstrate competencies in a whole range of areas [as described in the NHS Plan]
- Complementary to ... other professions [in primary care]
- Professionally accountable
- Managerial accountable
- Able to demonstrate Continuing Professional Development (CPD)
- Able to lead developments and manage innovations in practice

'Knowledgeable/experienced in primary care' is clarified as including General Practice, community, accident and emergency services, and fast access primary care such as Walk In centres and NHS Direct.

The group also drew attention to several other aspects of working at a higher level of practice. In addition to providing effective health care and improving health outcomes, these refer to evaluation and research, leading practice development and innovation, developing oneself and others, and working across professional and organizational boundaries (UKCC, 1999).² The group advocated that these be integrated into a competency framework strongly featuring:

- Diagnostics
- Therapeutics
- Consultations and Clinical Decision Making
- Policy and protocol development, including evaluation.

The Steering Group's framework for the role of NP consisted therefore of the agreed definition, the principles listed above, the list of ten key roles for nurses in the NHS Plan and the competencies the group wished to see incorporated in NP development.

The group's principal recommendations were to ask the WYWDC to endorse this framework, and to consider how funding could be secured to reimburse facilitation and mentoring of NPs during development. The latter brings us to the nature of the support infrastructure they recommended and the funding arrangements envisaged.

appropriate specialist if needed" (NMC, 2005). The definition is followed by a clear and rounded statement of what patients, carers and other health professionals can expect an advanced nurse practitioner to be capable of doing.

² The final report on the UKCC higher level of practice project was produced in 2002.

3.3. Support infrastructure and funding arrangements

The Steering Group recognised that without the right level and type of support nurses are unlikely to feel properly prepared for the role, resulting in unnecessary stress or failure to meet required standards. This called for each NP to have a facilitator and a mentor, with specific roles and functions.

Facilitators and mentors

The facilitator would usually be a GP, but as experienced NPs became available they could undertake this. The facilitator's role would be "to provide teaching and establish a conducive learning environment to ensure successful progress of the NP learner" (Coombs, 2001), and also to provide clinical supervision and feedback to course tutors on the developing NP's progress. It was estimated that a commitment of one half day a week would be a minimum for this. The group also suggested that prospective facilitators be assessed to help ensure the right level of competence and commitment. They recommended too that the quality of prospective learning placements be formally assessed by the Universities as part of the process of recruitment to the programme.

The mentor's role would be to encourage personal and professional development, and help with critical reflection on clinical practice. It was suggested that experienced NPs would be best placed to provide this, individually or on a group basis, and that consideration also be given to alternatives such as action learning sets or peer supervision.

Funding arrangements

In regard to funding of the programme by the WYWDC, in addition to payment of course fees the arrangements proposed included 'backfilling' of the nurses' salaries. Furthermore, it was argued that whereas PMS practices might be allocated funding by Health Authorities or PCTs specifically for facilitation and mentoring, as things stood GP practices would not receive such funding and it was "extremely unlikely" that GPs would be prepared to act as facilitators without payment or incentives – especially given the arrangements for funding GPs and their practices for taking medical trainees and students. This would create inequities between nurses in different kinds of practice, so it was "imperative" that the WYWDC provided a consistent approach to funding this aspect of the programme across the board (Coombs, 2001).

3.4. The commissioning process

The proposed framework did indeed serve as the basis for the development programme that was commissioned in 2001. The thrust of the strategy was to provide the educational and support infrastructure for a rolling development of Nurse Practitioners qualified to an advanced level – at least PostGraduate Diploma – and, crucially, to secure funding for the programme by establishing it as a priority for primary care organizations.

Based on the agreed definition of the role and the associated principles and competencies, the Universities of Huddersfield and Leeds Metropolitan were each commissioned to provide a two-year part-time PostGraduate Diploma course at a Masters level of skills and knowledge, for intakes of fifteen students per course

(subsequently increased to twenty).³ Furthermore, the support infrastructure for in-practice learning was put in place – on the basis of one half day per week (term time) protected time for GP-facilitated learning plus the equivalent for self-directed learning – and there was provision for mentoring too. The Universities undertook the oversight of the quality of learning placements, liaison with the GP educators/facilitators, and so on. In addition to the Diploma, which constituted the qualification, there was also provision for optional completion in a third year of an MSc, with some protected time for that but not the facilitated learning built into the first two years.

The funding package covered course fees, the participant nurses' salaries and payment to the support practices for the facilitated learning. The backfilling of nurses' salaries for the two-year course period was generous, covering two days per week throughout the year, not just in term-time. However, this left some ambiguity regarding the 'protected' status of this provision outside of term time. Our survey findings indicate that some practices respected the protected time provision only during term time and tended to disregard it otherwise, while others continued to provide facilitated learning and time for self-directed learning outside of term time.

The programme commissioned

To sum up, the development process commissioned consisted of the following elements:-

- A two-year taught course based on one day per week for the academic year
- Practice-based learning one day per week for two years, split between a half day GP-facilitated clinical tuition and supervision and a half day self-directed learning
- Mentoring by experienced NPs (once enough were qualified)
- Tripartite reviews by the student, clinical educator/facilitator and the course tutor
- Assessment of the theoretical content of each module and of the student's competencies by the University teaching team, coupled with assessment in the practice setting by the clinical educator/facilitator
- Completion of the PostGraduate Diploma
- Option at the end of Year 2 or in Year 3 to complete a MSc dissertation.

3.5. Interim assessment of the strategy

The extent to which the commissioning strategy has succeeded in developing a significant number of NPs who are fit for purpose and practice is the most important factor in evaluating it. That cannot be addressed properly until all the findings have been reviewed, so we will come back to this in the overall Conclusions.

However, it is appropriate at this point to take note of what made this commissioning process different, and to ask how the prime movers in the commissioning process now regard what was done. The cost of the initiative also has to be considered.

³ This reflected their experience in providing programmes for Health Visitors and District Nurses.

An unusually cohesive approach

It is worth noting that NHS educational programmes at postgraduate level usually are commissioned in three ways that notionally are different but tend to overlap. They come about: (i) through Trusts and/or Universities instigating a course to meet local or national needs or perceived demand; (ii) through professional bodies and networks responding to developments in clinical standards that generate the need for new or different training courses; (iii) through WDCs bringing people together to develop responses to particular needs.

Elements of all three played a part in the commissioning of this Nurse Practitioner programme but the approach to it in West Yorkshire was underpinned by certain factors. First, the need was clear; some parts of the region were seriously un-doctored, particularly in areas of high deprivation. Secondly, some ground-breaking efforts to address that problem by developing advanced nurse practitioners were going on, but with big discrepancies between local solutions. So the breakthrough was to seek and pave the way for a common approach. Thirdly, a group representing the main interests was brought together and they succeeded in agreeing a framework for addressing all the main issues – and support for that framework was gained from all fifteen PCTs in West Yorkshire, including ones which needed to change what they were doing in order to align themselves with the common approach. Fourth, the two Universities were committed to the agreed framework and had real grounds for confidence in developing their courses and their links with primary care providers. Fifth, the prime movers at the WYWDC managed to secure Board approval of sufficient funding for the initiative and to have it ring-fenced. All told, this was an unusually cohesive process of purposeful co-operation.

To find out how they now regard it with all the benefit of hindsight, the key people in the WYWDC responsible for commissioning the programme were interviewed on two occasions, and the people who led the programme at the two Universities were also interviewed.

How the WYWDC and Universities regard the process

From the WYWDC's perspective there were two outstandingly positive aspects of the process. One was the clear focus on the specific need to remedy the shortage of GPs by developing advanced nurse practitioners, and to underpin that development by consistency of approach. The other outstanding factor was the quality of partnership working harnessed by the Steering Group, which paved the way for the agreed framework to be endorsed across the board and funded on a sustained basis. Yet if there had not been a recognized shortage of GPs in deprived areas it would have been much harder to get the initiative off the ground. On the other hand, the WYWDC has been able to apply a similar model of commissioning in other areas – specifically occupational health and Community Matrons – although without the in-practice facilitation which is a particular feature of the Nurse Practitioner programme.

In regard to feedback from various quarters, the WYWDC has had very positive feedback from the primary care members of its Management Board, from the Universities' course evaluations, and from employer networks. Furthermore, NPs continue to be in demand.

On their part, the University programme leaders highlight several factors that made the commissioning process particularly effective-

- the advantages of being given a 'steer' by the WYWDC and assurance of its support so long as the Universities made a good job of delivering the course;
- the quality of support from the GPs on the Steering Group;
- the opportunity to really think things through, coupled with the fact that the situation called for a united approach, without the usual vying between interests;
- the commitment to positive funding, covering not only course fees but relatively high 'backfill' and GP-facilitation costs;
- the quality of liaison with the WYWDC and the efficiency of its payment system.

Of course there were the usual frustrations in getting complex things done, and some disappointments too. For instance, some of the GP facilitators chosen by students were "*just not committed to the role*", as one person put it – something that surfaces several times in survey responses and NP interviews, as will be seen. In contrast, some GPs were exceptionally committed to their role as facilitators.

Leaving aside for now the problem of variable quality, the nature of the support infrastructure for NP development brings us to the relative cost of the initiative.

3.6. The relative cost of the initiative

The financial arrangements underpinning the Nurse Practitioner programme were – and in mid 2007 still are – essentially no different to those for training Health Visitors or District Nurses. The WDC pays the course fees and reimburses practices for the notional costs of replacing people while they are attending courses (full time or part time) or otherwise engaged in professional development, i.e. salary 'backfill' as is called.

The backfill costs of programmes like these account for most of the expenditure – as much as 75% to 80%. In addition, for the NP programme payment for GP facilitation was part of the proposed framework, and for NPs going on to do the MSc a small amount was provided to ensure some protected time for their dissertation. Clearly, the amount and quality of practice support for NP development should be commensurate with the level of salary backfill and additional payment for facilitation, so it is regrettable that some of our respondents experienced shortcomings in that regard.

The backfill arrangements make it very costly to run programmes like these, but in terms of relative cost two points are worth making. First, the cost per student of the Nurse Practitioner programme is only 10 per cent higher than the full cost of training District Nurses or Health Visitors, i.e. when travel expenses for DNs/HVs are taken into account. Moreover, that 10% is mostly due to salary differentials. In real terms, therefore, the cost per student for the Nurse Practitioner programme is much the same as for other programmes at a less advanced level.

Secondly, there is a big difference between funding a standard programme of professional training and investing in an initiative to develop a new kind of practitioner at a higher level of clinical ability, in this case one that has the advanced nursing and clinical skills to practice alongside doctors. It is to the provision for developing those skills that we now turn.

4. THE DEVELOPMENT PROGRAMME

This section outlines the structure of the two University courses and associated aspects of the development programme, gives the number of NPs who have been through the programme, and summarises the Universities' own course evaluations. This refers to the first three cohorts, 2001-3, 2002-4 and 2003-5.

To re-cap, the Postgraduate Diploma course is a two-year part-time programme which combines university-based taught modules, practice and assessment; facilitated taught practice in primary care settings; self-directed learning, mentoring and portfolio development. There is then an option to complete an MSc dissertation.

While both courses reflect the working definition of an NP, and the principles and competencies in the agreed framework, the taught modules on the two courses are quite different. The WYWDC regards this difference as good because the complexity of primary care calls for some diversity in advanced nursing expertise, and because it gives students and employers a choice between different approaches.

4.1. The Huddersfield course

	Module	Assessment
<i>Year 1, semester 1:</i>	Clinical Sciences and Clinical Skills for NPs – 1	Practice component, case studies & reflective journal
	Health Professional Accountability	Essay
	Clinical Practice and/or Mentor groups	Practice component, case studies & reflective journal
<i>Year 1, semester 2:</i>	Clinical Sciences and Clinical Skills for NPs – 2	Practice component, case studies & reflective journal
	Public Health Policy and Practice	Needs analysis & justification
	Clinical Practice and/or Mentor groups	Practice component, case studies & reflective journal
<i>Year 2, semester 1:</i>	Clinical Sciences and Clinical Skills for NPs – 3	Practice component, case studies & reflective journal
	Mental Health and Mental Illness	Case study
	Clinical Practice and/or Mentor groups	Practice component, case studies & reflective journal
<i>Year 2, semester 2:</i>	Consultation, Communication and Change	Patient Simulated Surgery
	Methods for Inquiry	Project proposal & justification
	Directed study/Mentor groups	Practice component, case studies & reflective journal
<i>Throughout</i>	1 day per week in the practice setting split between GP-facilitated taught practice and self-directed learning, with summative assessments by the clinical educator.	
<i>Year 3</i>	individual tutorials, research and Masters dissertation	

4.2. The Leeds Metropolitan course

	Module	Assessment
<i>Year 1, semesters 1 and 2:</i>	Professional Development (1 module)	Professional Portfolio
	Human Health and Disease (1.5 modules)	OSCE* Competence Profile Critical Analysis assignment
	Health Assessment (1.5 modules)	OSCE Competence Profile Critical Analysis assignment
<i>Year 2, semester 1:</i>	Pharmacology (1 module)	Case studies
	Skills for Evidence-based Practice (1 module)	Staged assessment focusing on qualitative and quantitative approaches
<i>Year 2, semester 2:</i>	Option to complete Masters (3 modules)	
<i>Throughout</i>	1 day per week in the practice setting split between GP-facilitated taught practice and self-directed learning, with summative assessments by the clinical educator.	
<i>Year 3</i>	individual tutorials, research and Masters dissertation	

* OSCE = Objective Structured Clinical Examination: a circuit of assessment stations where a range of practical skills are assessed against pre-determined criteria

Other elements

- In addition to the forms of assessment listed above, on both courses tri-partite meetings between student, course tutor and clinical educator take place three times during Years 1 and 2, or more often if necessary.
- From 2003 arrangements were made to ensure that all the NPs were qualified for Extended Nurse Prescribing (now Independent and Supplementary Nurse Prescribing) when completing or within a short period of completing the course.

4.3. Numbers of students and successful completions

The breakdown for each University of the numbers for each cohort of applicants, students and successful awards of the Postgraduate Diploma – i.e. the basis of NP qualification in this programme – and of MSc degrees is set out in the Table overleaf.

Huddersfield has attracted higher numbers but the Leeds Met numbers climbed steadily, and in both cases the numbers that were commissioned increased year by year. Ninety-five percent of those who were selected for the programme completed it to the point of being awarded the PgDiploma; only five did not complete. Fifty-eight per cent went on to complete their dissertation and be awarded the MSc, and subsequent completions will have increased that number, while some others already had Masters degrees. A notable feature in that regard is that most of those achieving this MSc were on the Huddersfield course (50 out of 58).

These levels of retention and successful completion point to high standards in the approach to selection and how the courses were run.

Table 2: Distribution of student numbers and successful completions by University and cohort

Cohort	No. of Applicants	No. of Students	No. awarded Postgrad. Dip.	No. awarded MSc
University of HUDDERSFIELD				
2001-3	25	17	17*	18*
2002-4	35	20	19	17
2003-5	35	21	19	15**
Sub-totals	95	58	55	50
LEEDS METROPOLITAN University				
2001-3	22	13	13	4
2002-4	26	16	15	2
2003-5	32	18	17	2
Sub-totals	80	47	45	8
Totals	175	105	100	58

* Another one was accredited through APEL and then completed the Masters.

** Two others already had Masters degrees and two more were due to complete subsequently.

4.4. University course evaluations

Both Universities evaluate their courses through a combination of student and staff evaluation of modules and annual reports by an external examiner, whose report covers the course as a whole. Fortunately, the external examiner reports for each course the years in question were all done by the same person, so there is continuity from year to year and the course leaders can see exactly what has been achieved and what needs to be done.

The Huddersfield external examiner's reports are very thorough and go into a range of matters. From the reports for the years 2001-5 some salient points for the purposes of this report are:-

- that in general the modules were rated highly by students, and where problems were identified (such as a particular module falling below par or expectations not being made clear) they were usually resolved;
- that there were on-going issues about how to enable students to observe and practice clinical skills outside of actual practice settings, and related issues about assessing competence objectively;
- that some students struggled to relate theory to practice; and

- that while most students gained tremendously from the GP-facilitated learning sessions, some students regarded the quality of facilitation as being poor.

These points are singled out as being worth highlighting because they are relevant for any programme of this kind. Similarly, salient points from the external examiner reports for the Leeds Met course in 2003-5 are:-

- that the approach to assessing students' work was suitably rigorous but also helpful;
- that the combination of one day in University and the equivalent in practice with their GP facilitator provided the essential link for developing clinical skills and confidence;
- at the same time, lack of national standards for NP competencies creates grey areas in the assessment of students' professional development portfolios.

While these evaluation procedures provide the Universities with feedback on a module and yearly basis, the postal survey for this evaluation reveals how their former students rate the development programme from the perspective of having performed the role, and their views about the realities of being an NP. The next section deals with those findings.

5. SURVEY FINDINGS

Thirty-five survey questionnaires were completed and returned, a response rate of one in three. The spread across the three cohorts that we are concerned with is shown below. This section summarizes a detailed analysis of the findings. The questionnaire is reproduced as Appendix A.

Table 3: No. of respondents by year awarded the NP Diploma (n=35)

	2003	2004	2005	Response unclear
Huddersfield	5	8	4	
Leeds Met	3	5	8	2
	8	13	12	2

5.1. Context of experience gained as NP

In most cases – 29 out of 35 – these NPs have worked mostly or exclusively in GP practices (augmented in a couple of cases by Out of Hours work elsewhere), the other six having been employed directly or indirectly by PCTs.

5.2. How NPs rate the development programme

The NPs were asked to rate four main aspects of the programme on a scale of 1 (low) to 10 (high). Table 4 shows the mean average rating for each factor, and also the range. In round figures, the average ratings for the four aspects range from 7.5 to 8.5, within ranges from 10 down to 2. The factor rated mostly highly (8.5) is the weekly GP-supervised clinical practice.

The frequencies of the ratings are not particularly informative, except that far more NPs rated the GP-facilitated sessions at 9 or 10 than for any other factor. Despite complaints, only one person rated this factor at 2 and the next lowest rating is 5.

Table 4: How the NPs rated four main aspects of the programme (with 1 low and 10 high)

<i>Aspect of the programme</i>	<i>Mean average rating</i>	<i>Range</i>
The university-based taught modules	7.83	3 to 10
Weekly supervised clinical practice with the GP	8.51	2 to 10
Project work, portfolio development, and suchlike	7.46	3 to 10
Mentoring, individually or in groups	7.79	4 to 10

5.3. How has the role been more or less demanding than anticipated?

Respondents were asked to say in what ways (if any) the role as actually experienced is more demanding or less demanding than the course prepared them for.

For those who felt experienced enough to comment, the ways in which the role has been more demanding than anticipated are mostly to do with getting used to dealing with complex cases and conditions, the pressures of coping with the volume of work and decision making, and the need to keep learning. *“Textbook cases rarely present”*, as one person says. Other typical comments refer to *“the constant variety of patient conditions”*; *“learning to deal with prescribing issues”*; *“dealing with uncertainty”*; *“GP expectations”* and being *“acutely conscious of my lack of experience”*. Three more quotes sum up the demands of the role:

“Nothing can quite prepare you for a full-time clinical role where you are no longer a student.”

“Having overall responsibility for making diagnoses is sometimes daunting”

“The programme provides the fundamental skills/competencies, but the demands of the role require you to constantly develop them.”

Only seven people commented on the role being less demanding than anticipated. A couple refer to GPs being available for advice, and to the role becoming easier with experience. Less satisfactorily, two people say that they are having to do lots of things below their skill level; a third is actually working as a Community Matron, and a fourth is mentoring practice nurses.

5.4. Clinical responsibilities

To establish the extent to which NPs perform certain clinical responsibilities, question 4 asked: How often as a Nurse Practitioner do you play a lead role in the following clinical situations? – followed by a list of ten activities and frequency options ranging from ‘routinely’ to ‘never’. Table 5 shows the distribution of responses. One of the 35 respondents is in a mentoring role with no direct clinical responsibilities.

Table 5: Frequency that NPs perform certain clinical responsibilities (n=35)

	Routinely	Fairly often	Occasionally	Seldom	Never
Taking medical histories	34				
Dealing with	33	1			
Making diagnoses	34				
Undertaking full medical	30	4			
Initiating investigations	30	2	1		
Initiating treatments	32	2			
Referring patients to other professionals	28	3	3		
Prescribing medicines	33				
Prescribing non-medicinal	26	4	3		
Managing on-going care	28	4	1	1	

Apart from the one who had no clinical responsibilities, most of the respondents routinely perform the ten listed activities, although it is less frequent in some cases. It is also important to know that in the pattern of responses on this there is very little difference between graduates of the two different courses.

Two conclusions can be drawn from these findings. First, that the ten activities listed constitute the core of the NPs clinical role. Secondly, that the content of development programme is closely aligned with what most NPs routinely do.

As implied, some NPs carry other responsibilities. The one with no direct clinical role is nonetheless involved in teaching clinical skills, clinical supervision and mentoring. The other routine activities mentioned by a few other respondents are: reviewing treatments, interpreting investigations, reviewing test results, home visits (all mentioned once) and chronic disease management (mentioned twice). Two other 'fairly often' activities were mentioned: teaching, and monitoring care for older people at an intermediate care hospital.

5.5. Acceptance of the NPs role

The next question probed the extent to which the Nurse Practitioner role is accepted by patients, carers, and other healthcare workers. Table 6 shows the distribution of responses, including a few additions (in italics) to the list we provided. The higher the numbers in the left-hand columns, the greater acceptance there is among those categories of people, and vice versa. The higher the numbers in the middle and right-hand columns, the more doubtful NPs are about acceptance of their role in some quarters, and vice versa.

Table 6: Others' acceptance of the NPs' role (n=35)

	Fully	Largely	Somewhat	Not much	Don't know
Patients	15	18	3		
Carers	11	20	4		
PCT Managers	8	9	9	3	6
General Practitioners	16	16	3		
Practice Managers	13	18	4		
Practice Nurses	19	13	3		
Reception staff	22	12	1		
District Nurses	13	15	5		2
Health Visitors	10	12	9		3
Allied Health Professionals	5	13	15	1	1
Hospital Consultants	1	11	17	5	1
X-ray personnel	3	3	17	10	1
Laboratory personnel	7	17	6	4	1
<i>Hospital nurses</i>				1	
<i>Junior hospital doctors & registrars</i>			1		
<i>Ultrasound personnel</i>				1	

Unsurprisingly, the overall pattern is that acceptance of the role is strongest among patients, carers, and others closely involved in general practice, with less acceptance among AHPs and colleagues in secondary care. The spread of responses in regard to PCT managers indicates variable acceptance of the role there too.

5.6. Satisfaction with the role, and causes of dissatisfaction

Twenty-five of the 35 respondents say they are very satisfied with their role, and six are fairly satisfied. Four are quite dissatisfied.

The following give the flavour of the main causes of satisfaction:-

“Love the job, especially the autonomy, seeing patients recover from my diagnoses & treatments”

“Support from other professionals”

“Able to make autonomous decisions & manage treatments”

“Autonomy. Pushing the boundaries”

“The ability to complete an episode of care”

“Constant challenge/variety”

“Holistic care. Able to offer different style of consultation”

“Being able to provide total management of my patient from diagnosis through to treatment”

“Mentally stimulating & rewarding”

In contrast, the following convey the main causes of dissatisfaction:-

“Expected to take on the role of being a doctor”

“Lack of regulation to protect title”

“Not properly remunerated”

“Lack of recognition by [other] health professionals”

“Local hospital will not, on the whole, accept referrals from NPs”

“Lack of understanding of the role outside general practice”

“Lack of resources”

“Frustration having to get x-ray requests countersigned”

“Sick notes” [i.e. NPs not being entitled to issue them]

“Pay compared to GPs”

“Pressure to achieve QOF targets at all times”

“Patients who start the consultation with ‘I wanted to see the doctor but ...’ ”

“Having to constantly promote & market the role”

“PCT not recognising NPs at all!”

“Barriers and red tape within PCT/hospital trusts”

“Lack of recognition & barriers to autonomy”

To sum up, the causes of satisfaction are mainly to do with the challenges and rewards of having a degree of autonomy in developing a substantial clinical role and being able to provide [more] complete patient care. The causes of dissatisfaction arise mainly from lack of understanding and acceptance of the role, and unfair pay differentials. And the next set of findings underline the fact that the respondents have experienced mixed fortunes as NPs.

5.7. Effects on career and future prospects

In regard to concrete effects on their career so far as a result of being an NP, respondents cited various factors, mostly to do with improving personal and job satisfaction, gaining of confidence, opening of doors to further experience and skills development, job promotions, pay increases, or simply achieving a career ambition.

“Gained confidence, extended my skills, more autonomous”

“A confidence boost. I feel respected by the patients and practice nurses”

“Have had some good pay rises. Feel a valued member of the team”

“Appointed nurse consultant”

“Appointment as Nurse Director and to the GP partnership”

“Has increased my options”

“It has fulfilled my professional career as I always wanted to be nurse practitioner”

“Enhanced pay, more job satisfaction”

“Higher level of thinking – able to manage a lead role in non-med prescribing”

“Large financial gain – more autonomy – more job satisfaction – better service for patients”

“Grade increase from G to H (whoopie!)”

“Respect from colleagues, GPs and practice nurses”

“Increased salary, status & satisfaction (in no particular order)”

“Clinical skills vastly improved”

“Not sure, too early to tell”

Views regarding likely effects on future prospects tend to swing between, on the one hand, being fairly sure of role development and further advancement, including practice partnership possibilities, and, on the other hand, quite a degree of uncertainty about future prospects. It is a question to which several people gave no answer. The fact is

that some NPs are brimming with confidence, while others are quite unsure about their prospects.

“Would like to be considered to be a partner and then practice where I work”

“Possible offer of partnership in GP practice”

“I think I will continue in this role to retirement”

“Likely to explore potential of nurse-led services”

“Unsure at the moment as my job may be replaced by salaried GP”

“Probably make me a more attractive option [for other employers] – depends on their opinion of advanced nurses”

“Enables me to work in a variety of roles & settings”

“Don’t know”

“Hopefully will enable me to find work elsewhere easily as my skills & experience are in demand”

“Unsure”

“Optimistically, will have increased my options when new service providers come into the NHS”

“Has opened doors, e.g. practice partnership”

“Unsure”

“Don’t know yet”

“Uncertain future – NMC have not agreed competencies for the title. DoH seem to favour Physician’s Assistants. NPs are finding it difficult to get jobs after qualifying”

“More of the same (increased salary, status, satisfaction)”

“Further training for specialist skills & services”

“Become a valued member of the team”

“Hopefully will enable me to become partner in practice.”

5.8. Having a Masters

We asked those who have a Masters degree to what extent does it affect them vis-à-vis their confidence in the role of NP, others' acceptance of the role, and their actual competence. Table 7 shows the distribution of responses (omitting two who hadn't yet completed at the time).

Table 7: Effects of having a Masters (n=22)
(type of effect by extent)

	A little	A lot	Hard to say
Your confidence in your role as NP	4	15	3
Others' acceptance of the role	2	16	4
Your actual competence	9	9	4

Two-thirds of our 35 respondents had a Masters at the time of the survey. While that appears to be a higher proportion than among the three cohorts overall, where the figure is 58%, one more person with a Masters in the overall numbers would make the proportions the same, so our sample is not particularly biased in that direction.

In any case, among those who do have a Masters (this MSc or in one case an MBA), in most cases they say that it enhances their self-confidence a lot and also others' acceptance of their role, but the perceived impact on actual competence is much less clear. These factors are reflected in the fact that opinion is divided on the importance of formally having the Masters qualification as distinct from the Postgraduate Diploma at a Masters level of study. For some, the issue is about NPs' professional standing rather than additional competence.

5.9. How NPs intend to develop their role

In regard to how the NPs intend to develop their role in the foreseeable future, the responses tend to cluster around consolidating a general role or developing a specialism, simply keeping up to date, or aiming at partnership possibilities. The following quotes show the range of their intentions.

“Currently setting up and leading a nurse-led service and general practice”

“Become a partner in GP surgery hopefully”

“Spend time settling into role, improving, learning and then move on to develop a specialist role”

“Continually update my skills ... Would love the opportunity to mentor a student NP”

“To become a clinical lead in current PCT practice”

“Would like to extend my clinical skills – minor surgery, joint injections, managing complex cases”

“Just plan to get better at what I do”

“Explore nurse-led services”

“Intend to consolidate for the next year. Would like to develop the mental health services offered by the practice”

“Develop the role by showing other GPs, practices & the PCT the value of NPs. I intend to do this by auditing my surgeries and presenting to the GPs and PCT, hopefully to prove what we actually do!”

“Complete MSc ... Setting up multidisciplinary teamwork to reduce admissions and chronic disease management issues”

“Completing the Masters with a view to changing practice [in order to be better placed to] address patient needs & provide enhanced services”

“To consolidate knowledge & skills – To specialise in paediatrics”

“To keep up to date and ensure I do my job as well as possible.”

5.10. Suggestions for changing the development programme

Considering how the NP role is developing in general, respondents were asked what changes they would make to the development programme. The range of responses is quite broad and not readily summarized, so a representative cross-section of the comments and suggestions is given below, leaving aside topics which have already been covered.

Clinical skills development

“More of the basics of anatomy & physiology”

“More clinical [practice] and keep it at higher level”

“Somewhat less theoretical assignments, more examination-type assessment (not oral) and more time practice-based”

“Perhaps more emphasis on the psychological aspects of health and illness”

“X-ray training – more clinical lectures & treatments – sick notes – less writing useless essays and more clinical skills”

“Some chronic disease mgmt. Very difficult not be involved in this in general practice”

“More clinical teaching in hospital, [similar to what] we had before OSCEs”

“More hands-on experience. Time spent with hospital doctors. I spent time in A+E which has a good fast turnover of learning opportunities”

“Formal assessment of NP role, i.e. assessment in clinical practice”

“Amalgamate the prescribing qualification into the programme”

“More joint training & development with doctors”

“Updates on enhanced services”

“Perhaps follow-up study days around clinical examination ... as the [course] presents a very steep learning curve and a ‘drip feed’ of each system ... after qualifying would be helpful”

NP involvement

“Involve qualified NPs more in mentoring and supervising students”

“More exposure to other NPs working in various fields”

Professional and career development

“Tutors to recognise that we have [already acquired] some of the theoretical professional development in previous roles”

“Encourage NP to look outside practice settings”

“More managerial/business skills & leadership skills”

One person called for “greater support for students who do not have experience in general practice before entry to the programme”. Some of the NPs interviewed believe that it is quite essential for someone wishing to practice as an NP in primary care to have prior experience in general practice, and not just in other spheres of primary care or in A+E.

5.11. Other views

The opportunity to add anything else at the end of the questionnaire yielded some views that sum up a lot – and in some cases are quite salutary. They lead naturally in to the interview findings which come next.

“Course excellent, support excellent”

“[We need] pay on equitable terms with GPs. The public image is still that NPs are a poor substitute as they are worth less. Also clarification on titles. NPs in 2ndary care do not have the same level of training in this country. And access to same services as new GPs - e.g. mentoring, 360 appraisal.”

“The plan for utilising qualified NPs was poorly thought-out in our PCT as there were no jobs for the majority of us. Despite this, other nurses have been allowed to continue to ... to apply to train. The work I undertake out of hours is [outside Yorkshire] as that has been the only place I have been able to find a suitable position ... to utilise my skills ... Knowing what I know now, would I still have undertaken the programme? Most definitely!”

“The role is fantastic. Having MSc has given me the clinical skills and confidence to practice as a safe, competent consultant.”

“Regulation needed so nurses cannot use term NP unless assessed to Postgrad or MSc level

“I would question the motives of GPs who agree to undertake a GP facilitator role. Is this financial? In my experience it definitely is the case, as they are reluctant to acknowledge the NP on qualification and award the appropriate remuneration etc. I feel strongly that GPs are only willing to offer facilitation/supervision for their own financial rewards. This needs serious consideration as it affected my morale and status at the time I was employed by GPs. However, as a PCT employee ... I am [now] thriving”

“I am convinced that having a MSc greatly enhanced my chances of securing well-paid employment when I relocated to [...]. It is the best career decision I have made even though it was a lot of hard work.”

“I found the course very demanding, felt I had made enormous professional development and earned my Masters. I am using all the knowledge and skills developed ... I feel the NP qualification as a Postgrad Diploma is satisfactory, but NPs should be encouraged as much as possible to complete the Masters degree to reinforce our ‘advanced’ practice”

6. THE NURSE PRACTITIONER INTERVIEWS

This section presents the findings from the interviews – mostly face-to-face – with nineteen Nurse Practitioners. Because of the way the research was structured, all had already completed the postal questionnaire, and then consented to be interviewed as a distinct step. Mindful of the potential overlap, the interview schedule was designed to minimize any sense of repetition, and the fact that there was an interval between questionnaire completion and interview helped in that regard too. In effect, therefore, the interviews give fresh perspectives on how NPs view their role.

The profile of the 19 interviewees in terms of basic data is as follows.

- All three cohorts were represented, with half of them being from the 2002-4 cohort. Six were awarded the PgDiploma in 2003, nine in 2004, and 4 in 2005.
- Thirteen have gained their experience as NPs in GP practices, another three in a combination of GP practice and PCT or other setting, one in a PCT setting, and one is leading a PCT-financed nurse-led practice.
- Thirteen had a Masters (one prior to this programme), and another five had submitted or were about to.
- All but one of the interviewees is female.

What follows is meant to convey the range and weight of responses to the main questions asked, drawing from different interviewees across the range of issues. Unless shown in quotation marks and italicised, these are not strictly quotations, but they do accurately reflect what the interviewees said, and the range of views expressed.

6.1. Distinctive features of the Nurse Practitioner role

The first substantive question asked what is it, based on their experience, that particularly distinguishes the role of Nurse Practitioner in primary care from other clinical roles.

> *“More autonomy to work as a health professional – more interesting work – expanded knowledge – working more independently”*

> *“The standout point is that we are seeing people with undifferentiated diagnoses.”*

> The level at which you're working. Taking on part of the GP's role, as a nurse with enhanced diagnostic skills, and not limited to specific illness, more generic.

> Little distinction from GP's role. From other nursing roles: much more extended, in terms of taking full responsibility from the first point of contact with the patient through to eventual treatment.

> Very similar to a GP, however you use nursing skills, and additional skills to nursing skills, to provide a total package of care.

> *“Approaching illness and health from a nursing model rather than disease/medical model”*

6.2. How the role compares with what they expected

How well, in general, does the role as the NPs have experienced it fit in with how they think it should be? Most of the interviewees said that it is pretty much or exactly as they expected, in terms of what the course prepared them for. On the other hand, some had less satisfactory experiences.

> Exactly as expected. *“The ... course prepared us brilliantly.”*

> *“The course prepared us pretty well for how the role has developed.”*

> *“Yes. It’s the kind of role that develops as you get into it.”*

> *“I’ve made it my role – set it up for what I wanted it to be.”*

> At first the role was very frustrating, because you couldn’t prescribe. Now have the confidence to see people from start to finish. It’s becoming a really fulfilling role. Also, patients are increasingly inclined to see the NP as a link person, someone familiar.

> [Having moved to a nurse-led practice] *“Now doing what I hoped to be doing, and more.”*

> Some of the theoretical content (e.g. on accountability) seemed beside the point when we wanted to be doing more clinical stuff, but in fact that professional stuff is critical and was well covered. The course is well aligned with the actual job.

One NP describes a situation where several people’s hopes have been dashed:-

> In this PCT, a lot of nurses went on the course when there were no jobs for them [as NPs]. Out of 8 people, only one is working in the PCT full-time as an NP, while two are in GP practices; two went elsewhere, and the others had to revert to their previous roles. The PCT hasn’t the money to pay NPs – even though they’re paid only one-third of what GPs are - and managers have no clear idea what the role is about. So, some people have been very disappointed.

6.3. What they are most confident about

The question was: Which aspects of the role – as it is – do you feel most confident in performing? Three people found this hard to answer:-

> *“It gets a bit nervy sometimes! [i.e. leading a practice] ... You can’t get [afford to get] too over-confident.”*

- > Hard to answer – *“you never know what’s going to come through the door”*.
- > Hard to separate out – you become more familiar with certain physical systems, the ones that present most often.

The following represent the majority of responses:-

- > History taking, doing physical examinations, prescribing, health promotion. Working to a nursing as well as medical model.
- > The skills learned on the course, particularly patient assessment and diagnosis.
- > *“Diagnostic skills – and I know my limitations. That’s really important.”* (This NP has a lot of responsibility for chronic disease management, particularly diabetes.)
- > I feel more confident with physical things, or distinct diseases, compared with psychological problems.
- > Respiratory medicine, women’s health, self limiting illness

6.4. What they don’t feel comfortable doing

This question – Are there any aspects of the role that you don’t yet feel comfortable doing? – prompted some particularly candid responses.

- > *“Not really. The things I don’t like doing (e.g. men’s health), I just refer them to someone else.”*
- > *“Eyes! – just can’t do it”*
- > *“Examining men”* – lets the GP do this! A matter of familiarity rather than technical ability.
- > Most things I can deal with – and support is readily available. You develop the role according to your competencies anyway, but I see people with totally undifferentiated diagnoses.
- > *“I hate people who come in with headaches or dizziness!”*
- > Complicated medical cases with a history of chronic disease
- > *“I’m fuzzy about a lot of mental healthy problems”*
- > Mental health and neurological conditions.

6.5. Aspects of the role that other people are keen for NPs to develop

This question drew some rather disparate responses, such as the following.

- > Women's health & mental health – though she is encouraged to develop in whatever way she feels comfortable with.
- > *“No, I don't want to develop [the role] beyond what I feel comfortable doing – and I need to be careful not to do that.”*
- > Prescribing, particularly in her new role in palliative care. Advanced clinical skills and diagnosing.
- > Doctors keen that she extends the role to full capacity and take on anything they need to do a lot of (e.g. blood pressure treatments). In effect, they try to off-load onto her ... Also, she's keen to keep dealing with common ailments, not get drawn into complex disease management.
- > Colleagues: diabetes & chronic disease mgmt. Also kidney disease. And there's a move afoot to get her involved in practice-based commissioning.
Patients: the ones who come to her for chronic disease tend to also come for everything else too.

6.6. Aspects of the role other people are reluctant to let NPs develop

Thirteen of the nineteen interviewees say that they have not met any, or any significant resistance to what they are trying to do, and several talk of positive support. Which is not to say that there are no pockets of resistance (or worse)

- > Some GPs don't welcome it. Not in this practice, but elsewhere some GPs were all for it while she was in training – because of the financial benefits – but don't want to know once she qualified.
- > Has always felt well supported but never pressurised – although in another practice there was some consternation at first, but it settled down.
- > Hasn't come across any yet – apart from the hospital's refusal to accept referrals from NPs [though this doesn't happen in another place where she works as an NP].
- > *“Because it's a new role [in regard to palliative care], we're advancing slowly.”* More generally, she reckons other NPs may experience problems, particularly if they've moved from Practice Nurse to NP. She hasn't had any such issues, and had no problems with any of her medical colleagues – all supportive.
- > “No. Such a shortage of GPs [here] that there has been great support.” Still can't refer for x-rays but other test results and pathology come direct to her. Opposition to radiology referrals by NPs needs to be cracked at national level. Interestingly, when she's doing OOH work at the hospital [i.e. & dealing with the same radiology dept.], the problem doesn't arise at all.

- > *“One or two GPs were disgruntled because of what we’ve done but most are encouraging, and the PCT is very encouraging. You have to build up trust with [medical] colleagues; e.g. by putting your hand up when you reach your limitations.”*
- > *“No, not at all. If I wanted to do anything, they’d say ‘fine’.”*
- > She’s reluctant herself to develop chronic disease mgmt, since practice nurses do that. No point in duplicating others’ expertise. Can’t sign medical cert’s. Can’t sign death cert’s in care homes, GP has to, even though she has been treating the people. Can refer to 99% of consultants, but the consultants usually write back to the GP – because of insurance protocols, presumably - so sometimes she’s not always fully in the picture.
- > *“Anything I’ve wanted to do, if we can prove a case for it, it has been supported.”*
- > A bit of wariness from GPs, unsure how far the role should go. And nurses are a bit apprehensive about what she might be taking over from them.
- > Don’t think so. GP very good, and the PCT too [where she has worked for about 14 years]. *“I’ve been very lucky really.”*
- > No problems – apart from not being able to sign sick notes.
- > *“No. Very lucky being in a nurse-led, PCT-funded practice – not controlled by a group of partners with their own agendas.”*

6.7. Improving recognition of the role

It hardly needs saying that a lot of hopes are pinned on the role of NP being accorded national recognition. Without labouring the point, the following gives the flavour of what interviewees think could be done at PCT or SHA level to improve recognition of the role – and the scepticism of some in regard to the likelihood of anything being done.

- > *“The NMC is dragging its heels. While ... the role isn’t formally recognised, anyone can call themselves an advanced nurse practitioner – with all the knock-on effects that has in regard to pay-scales and so on.”*
- > So long as there’s no national recognition, the PCT would happily have NPs with just minimal training ... The role will be lost if the course is stopped and replaced by minor ailment courses.
- > Protecting the title – PCTs and Trusts need to agree baselines.
- > *“NPs are no longer flavour of the year. GP leads can build recognition. But mainly it’s a matter of ploughing their own furrow”*
- > PCT’s know very well that we fill the role of doctor, while not trying to be one. But we’re a threat to some doctors, and they try to put us down. I don’t know what more we can say or do.

> “Yes [PCTs and/or SHA can help], by insisting that people doing the role have the appropriate level of training. Particularly in hospitals, where there are lots of people saying they’re NPs but without the right level of training.”

> Pressure from PCTs and the powers that be ... “We owe it to our patients to have a recognised standard ... it’s a clinical governance issue.”

6.8. Do they see their role changing significantly?

The short answer is No, and it is a fair reflection of the consensus on this, although it is tinged by concern that the role will be changed by default unless steps are taken to protect the title.

6.9. CPD priorities

The level of opportunities for further professional development varies quite a lot, some practices being much more supportive of it than others. Apart from extending their clinical skills, some of the NPs are keen to acquire business know-how in order to equip themselves for developing practice partnerships.⁴

> Like to do business studies. “Professional development is fine, but you need to understand the business side too.”

> “I wanted to do a specialist module on women’s health, but it’s expensive and the practice won’t pay ... GPs only want to train other GPs.” However the practice does give her a half day per week for CPD, and not every practice does that.

> Just keeping up to date, which she does by doing Prescribing Centre courses and weekly clinical supervision with a GP

> “The West Yorkshire [NP] Forum is great. They do master classes – just great, because they’re organized by NPs for NPs.”

Earlier in the interviews, two or three people called for CPD for NPs to be aligned with that for GPs – an arrangement that does exist apparently in a small number of practices, and must surely be cost-effective.

⁴ Overall, our findings on CPD-related matters are in line with the review of CPD needs among NPs in primary care done for the WYWDC in 2003, except that there is now more awareness of the need for business know-how.

6. 10. Other views

The final question, inviting interviewees to add anything else, drew comments reinforcing the fact that the NP programme is generally held in high regard, but also underlined concerns about current developments as they are perceived.

- > *“The LMU course was superb – really prepares you for the job”*
- > *“The course at Hudds was absolutely fantastic – especially the clinical skills development”*
[This respondent was critical about another part of the course that has since been replaced.]
- > *“It’d be a shame if we lose the momentum for the role. But it’s not clear where the jobs will be.”*
- > *The NP course has changed into a more loosely-based multi-disciplinary type of programme*
- > *“I have a problem with there being different levels of NP, and ones calling themselves NP when they’re not fully qualified.” This person went on to say that “There’s a sense of achievement in what an ANP can do, but also a feeling of being used and abused. We’re not getting paid for this!”*
- > *The practice facilitation should be done by a GP, not another NP, because of the relative depth of experience – “it takes nine years to become a GP”*
- > *GPs who actually employ NPs do understand the role very clearly, but not all practices employ NPs ... “I think it’s a fantastic job, but I don’t want to be a doctor”. [This NP went on to say that she’s surprised how quickly patients have worked out what she does.]*
- > *“The NP course is really exceptional.” But she is concerned that some nurses are picking the prescribing and certain clinical modules, and moving into the arena of advanced nursing “but without the broader thinking that the NP programme gives you. And NPs should be working at Masters level, even those qualified at BSc level. As more and more nurses are graduates, to be an advanced nurse you’ll have to be more qualified than the baseline.”*
- > *“I don’t think that someone without comprehensive experience can do the role. You do learn the skills on the course, but you need the background to apply them ... Comprehensive? Just five years, say, on a surgical ward wouldn’t make a good general practice NP. In general practice you see things you’d never see in a hospital, because people don’t go to hospital with them. So there’s a lot in primary care that others don’t experience. The main thing is to learn how to deal with uncertainty.”*

Enthusiasm for the role and some concerns regarding the ambiguity around it both surfaced in the interviews with GP facilitators/mentors too. The dual term is used here because the GP educators who facilitate the in-practice development of NPs tend to

refer to themselves as mentors. We turn now to how they view their role and NP development generally.

7. INTERVIEWS WITH THE DOCTORS

As mentioned earlier, eight GP facilitators/tutors/mentors were interviewed by phone to find out how they view their own role in the development process and how they regard NP development generally. Again, their views are represented by a mixture of quotes and paraphrased comments. Appendix C contains the interview schedule.

Of the eight doctors, five have tutored only one NP so far (i.e. as of March/April 2007), and including current students two had tutored two NPs and one had tutored four.

It has to be borne in mind that these are the views of a small number of doctors from forward-looking practices that employ or actively support the development of NPs, and are unlikely to be representative of the wider profession – and particularly not representative of practices that have little or no direct experience of NPs.

7.1. Pros and cons of being a tutor/mentor

“It keeps you on your toes” and *“it keeps you up to scratch”* is typically how the doctors view the benefits for themselves in acting as tutor/mentor for a student NP. They find it stimulating to revise and update their own knowledge and having to think about how they articulate what they have learned. At the same time, it is *“a two-way process”* which *“helps to cement relationships”*. Along with the professional fulfilment and satisfaction of helping someone to develop their abilities and confidence as clinicians, the GPs learn to appreciate the extent and limitations of the NP’s capabilities.

As regards disadvantages in taking on the role, six of the eight doctors identify the time commitment (directly or in travel time) as a problem – but say that otherwise there is no downside. As one of them notes, the time commitment lessens as the NP’s skills and confidence develop, and another says that the benefits outweigh the disadvantages. On the other hand, one of the eight admits to finding the tutorial role rather daunting and worries that the student is getting the best out of it.

Asked if anything would make them less willing to take on the role again, the possibility of the time commitment becoming problematic is mentioned a couple of times or partners not agreeing to it. *“I wouldn’t consider it if we weren’t paid and the NP was from outside the practice”* is one doctor’s view. Another says that it is important for practical and developmental reasons that student and tutor are both in the same practice. One GP regards it as important for the NP to have a six-month commitment to the practice after training, while another doctor has happily taken on the role again and looks forward to employing the qualified NP.

7.2. Post-qualifying relationships

Asked about how relationships may have altered since the NP got their advanced qualification, the doctors interviewed mostly see a process of continuing development, with the NP becoming more independent, taking more cases or developing their specialism, and contributing more to practice development. A couple of the doctors talk of growing respect for NPs, while another says that the NP has *“grown in stature”* but become *“more pompous”*.

7.3. The doctors' views of the NP role

Only two of the eight doctors had much experience of working with qualified NPs. In most cases tutoring/mentoring this was the doctors' first and only direct association with the role.

As with the NPs, we asked the GPs too what particularly distinguishes the NPs' role. Compared with practice nurses, NPs are described as working autonomously rather than being task-oriented, taking clinical responsibility for undifferentiated cases, making diagnoses, managing cases, being able to make referrals and perhaps developing areas of special interest. They can do a lot that doctors can do – *“she works very much the same as us”* – but have less knowledge and experience when it comes to complicated cases – although, as one GP put it, *“I’m not saying that this can’t be developed, and otherwise [the roles are] very similar”*. Indeed, *“you wouldn’t know she isn’t a doctor”*, except for the fact that NPs still have longer appointments than doctors, perhaps due to a difference in perspective or because doctors are quicker because they are more experienced.

One doctor described NPs as *“neither fish nor fowl”*. The following are some other responses on similar lines.

> She’s a strange ‘hybrid’. She sees unselected patients, does triage and prescriptions ... Like us she works in the consultation rooms and has a medical bag similar to the GP’s, has own prescription pad ... does some visits ... sees both acute and chronic patients.

> It’s in the middle somewhere. She has the qualities and skills of a nurse with the knowledge and skills of a doctor ... *“It’s a complete package of care rather than a snap-shot.”*

> *“It’s taking the best of medical and nursing facets”* ... A hybrid between the two ... [Patients] find it easier to forge a relationship with a nurse.

Obviously, all this has implications for the quality of patient care.

7.4. Quality of patient care, and acceptance of the NPs' role

While one is non-committal on the point, seven of the eight doctors commend the quality of patient care by the NP(s) they know and six of them are sure that NPs have enhanced the quality of care – by improving access, giving patients an alternative to seeing the doctor which puts some people more at ease, and freeing up doctors for the more complex cases. Overall, *“it improves [the quality of patient care], it’s as simple as that”*.

The GPs' views on acceptance of the NPs' role by patients and other clinicians are worth conveying in detail, as follows.

> In our practice she is one of the team and there is not much distinction. [As regards patients] *“the word has got round that she is very good”*.

> Patients accept it quite happily. Some won't go to an NP ... We gradually point them in the right direction [i.e. to the NP]. The clinicians within the practice have come to recognise her, [partly because] I had a great deal of respect for her. The other GPs were not quite so convinced but I was certain that this was the direction the practice needed to take and now they see her as one of us, and know her limitations.

> Patients still "*see them as nurses that know a bit more*". [Patients] don't understand the level of [NPs'] expertise, which is not fair, despite what we say. GPs don't have a problem [with NPs] but some consultants don't accept referrals from them.

> The clinicians in our practice accept her, so she can go to anybody when I'm not around if she needs to discuss cases. Some consultants struggle because they aren't aware of [NPs'] knowledge.

> One or two consultants are reluctant to accept referrals from NPs, although this is improving. "*From the patients there is nothing but a positive response, which is overwhelming. It's a service they wouldn't otherwise have.*"

> Patients at first didn't understand role but have come to accept it. With nurses there was some difficulty initially ... but now they accept it is a different role. [As regards doctors], within the practice it's fine. There was one who was not sure about the whole thing but he has left now. [With clinicians outside the practice], "*we have had one refusal of a referral from a neurologist and generally the referrals are accepted but they tend to go back to the doctors. One other frustration is that she is not allowed to sign x-ray forms.*"

> Within the practice the clinicians accept the role. Outside there are those who don't realise or understand the level of qualification. With patients recognition has improved ... In some ways they're seen as better than a GP and now patients ask to see the Nurse Practitioner.

Most of these doctors are in favour of formal recognition of the role and protection of the title – "*That would hold a lot of sway. A lot of people don't realise the training that they do.*" One GP links this with having done the MSc, but it's not clear what particular level of qualification the others have in mind. In any case, some of those who favour protecting the title are doubtful about it being 'Nurse Practitioner' – "*because of the 'nurse' in the title people just see a nurse*" – though perhaps, on the other hand, people will simply get used to it.

7.5. Development of the role

In regard to how they would like to see the NPs' role developing, the trend of the doctors' views favours letting NPs find their niche, with developing specialisms if they wish. While looking towards expansion of the role, they reject the idea of NPs as a 'cheap' alternative to doctors. Rather, they see it more as a new kind of role, one which may evolve into a new type of general practice, with NPs taking over much of what has been the GP's role and doctors becoming more akin to consultants.

Rather than further development of the NPs' role, one doctor urges "*a period of consolidation ... A new professional group needs time to be accepted. My view is that it takes many years to become an experienced practitioner and they then will be the trainers of the future.*" Another doctor points out that the rationale which first drove the initiative – a shortage of doctors – no longer holds, so while the role should develop alongside general practice, the duration of NP training should be reconsidered and perhaps extended. Another GP remarks that "*the standard of education must be kept as high as possible*", particularly in relation to the clinical content. On that note, while the doctors were not asked to comment directly upon the two University courses, three of them did so, two of them strongly favouring the clinical content of one course while the third strongly favoured the other course – but this was not explored further.

The doctors voiced only a few concerns about how the NP role might develop, and they have mostly been covered already. Particular concerns mentioned are that NPs should not be pressurised into taking on clinical work for which they aren't fully trained, and that doctors themselves might be more challenged if they could not rely upon the high standards of nurse prescribing.

One doctor sums up all this nicely, seeing the development of NPs as "*a great step forward, although it's a double-edged sword*" – because it raises questions about the nature of general practice which need to be asked, while also providing a way for it to develop.

8. CONCLUSIONS AND RECOMMENDATIONS

The objectives of this evaluation were as follows:-

- To examine the commissioning process used to develop the programme and consider its transferability for commissioning future courses – which in effect means evaluating the commissioning strategy
- To evaluate the content of the programme in preparing Nurse Practitioners who are fit for purpose and practice
- To examine the impact of the programme on the students' career opportunities
- To identify the extent to which Nurse Practitioners are able to utilise their new skills and knowledge.

The purpose of this report, therefore, is to assess commissioning strategy and the effectiveness of the education programmes commissioned – specifically in relation to the first three cohorts on the programme (2001-3, 2002-4 and 2003-5).

The commissioning strategy and the programme have been assessed from a number of different perspectives: the thinking that led to the framework produced in 2001; the views of the prime movers in the commissioning process, and of the course leaders; the course evaluation reports for the first three cohorts; the responses to a postal survey of NPs who have completed the programme, and follow-up interviews with some of them; and interviews with some GPs who have tutored student NPs.

The weight of evidence from all these perspectives leads to five main conclusions.

8.1. Main conclusions

First, the whole approach to commissioning for this initiative was underpinned by the development of a framework agreed between the WYWDC, all the West Yorkshire PCTs and the Universities of Huddersfield and Leeds Metropolitan (Leeds Met). That framework and agreement was produced by an unusually cohesive process of purposeful co-operation and partnership that is greatly to the credit of everyone involved. The approach has already been transferred to other contexts in modified form, so its value in that regard has been thoroughly proven.

Secondly, the effectiveness of the courses has been probed from several different angles. All the indications are that course graduates are indeed fit for purpose and practice, and that the content of the courses is well aligned with what most NPs from these cohorts actually do.

Thirdly, the impact of the course on career opportunities is generally positive, but quite variable. Most of the NPs surveyed or interviewed view the course as a step-change in their development, one which many find deeply fulfilling – despite objections to the extent of pay differentials between doctors and themselves. On the other hand, a minority of the graduates have had to revert to their former nursing roles, apparently because their employers do not want to develop the potential of NPs. In contrast, quite a few of our respondents are confidently aiming at practice partnerships or nurse-led practices – already achieved in a couple of cases.

Fourth, while a minority of graduates in these cohorts have been stymied in regard to using their advanced skills and knowledge, most of the NPs have been able to do so successfully, with commensurate gains in self-confidence and the respect of colleagues. Indeed, the NPs who have found a way to **make their own of the role** are gaining recognition as clinicians of a high calibre. With both patients and practice colleagues, the hallmark of success for NPs is their ability to combine the best of nursing and medical care.

That said, the one area where there appears to have been a significant gap in clinical development for the NPs in these cohorts is in relation to mental health.

Fifth, overall therefore, the West Yorkshire initiative and commissioning strategy has been a considerable success. From 2001 to 2005 it has produced 100 Nurse Practitioners qualified to Postgraduate Diploma level, at least 58 of whom also have the MSc or another Masters degree. Furthermore, while the initiative has required substantial investment – mainly because of ‘backfill’ payments to practices – the cost per student for the NP programme and support infrastructure is much the same as for other primary care nurse training at a less advanced level.

8.2. Comments on other issues

The Nursing & Midwifery Council have produced a simply-worded statement of what patients, carers and other health professionals can expect an advanced nurse practitioner to be capable of doing. They define the role as follows:-

“Advanced nurse practitioners are highly experienced, knowledgeable and educated members of the care team who are able to diagnose and treat your care needs or refer you to an appropriate specialist if needed.” (NMC, 2005)

The definition is followed by a statement of capabilities that makes it quite clear that advanced nurse practitioners have certain levels of expertise that other nurses don’t have. While the formal status of NPs remains to be resolved, using the term Advanced Nurse Practitioner might reduce some of the uncertainty about their level of capability, particularly if it were tied to the standard of professional development that has been reviewed here.

However, government policy is pushing for the development of practitioners with advanced skills, regardless of what they are called, and the courses at Huddersfield and Leeds Met are becoming more multidisciplinary in response to pressures in that direction, and also because concerns about the shortage of GPs have subsided. This broadening of the qualification worries some of the NPs surveyed or interviewed, who fear that they may have got the benefit of the programme at its best but that the value of the qualification is now being diluted, and is further endangered by the emergence of Physician’s Assistants trained to lower skill levels. Such fears might be alleviated if the recently-created SHA can let people know more about its strategy for advanced practitioner development.

Furthermore, if there are no insurmountable problems in identifying NPs who are working in parallel with GPs, aligning CPD for NPs more closely with CPD for GPs might also help to sustain the momentum of development for NPs, while also making a valid

distinction between advanced nurse practitioners as the NMC describe them and other types of clinician.

Finally, it is clearly the case that – in combining the best of nursing and medical care – advanced nurse practitioners are in effect practicing preventative medicine and integrated healthcare more comprehensively than GPs have generally sought to do. Some NPs have begun auditing their own practice and producing evidence of the concrete benefits of their interventions. Given the whole thrust of government policy from *The NHS Plan* (DoH, 2000) through to last year's White Paper, *Our Health, Our Care, Our Say* (DH, 2006), and the scale of resources invested in public health campaigns, it is remarkable how little research has been done in this country on the cost-effectiveness of preventative medicine.

8.3. Recommendations

This project is primarily retrospective in orientation. Since the project started, Workforce Development Confederations have been amalgamated into the new Strategic Health Authorities which cover much larger areas than the previous SHAs, the new SHA for Yorkshire and the Humber being created as a result.

In a parallel restructuring, PCTs have been merged to form more powerful new ones that are charged specifically with: (a) following through on the policy of practice-based commissioning; (b) making primary care provision more patient-responsive and more cost-effective; (c) integrating health and social care and putting more resources into preventative healthcare; and (d) moving treatment of long-term conditions away from acute hospitals and into intermediate and community-based facilities (DH, 2005, 2006). The combined effect of these radical changes in primary and community care will create a new culture of provision in which advanced nurse practitioners can flourish, because their combining of the best of nursing and medical care is particularly suited to it.

In the light of these developments, three recommendations are appropriate, all addressed to Yorkshire and Humber SHA.

- That the SHA should build on the success of the West Yorkshire Nurse Practitioner initiative to promote recognition across Yorkshire and Humber of the role and potential of advanced nurse practitioners, taking account of the main findings of this research and the conclusions and comments above.
- That the SHA should consider developing a course for experienced advanced nurse practitioners to learn the business side of practice development.
- That the SHA should also set about developing a robust approach for evaluating the cost-effectiveness and social benefits of integrated primary care as practised by advanced nurse practitioners. The success of the West Yorkshire NP initiative would provide unusually favourable conditions for research of such real significance for the future of health and social care.

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APPENDIX A: SURVEY QUESTIONNAIRE

Evaluation of the West Yorkshire primary care Nurse Practitioners development programme based at Leeds Metropolitan University and the University of Huddersfield

QUESTIONNAIRE FOR NURSE PRACTITIONERS (Primary Care)

Introduction

The development programme is underpinned by a view of the Nurse Practitioner (NP) role as one who – because of a high level of competencies including diagnostics, therapeutics, decision making and clinical management – is capable of managing a whole range of clinical situations and of working interdependently with others in the primary care health team.

1a. What year were you awarded the NP PostGraduate Diploma? _____

1b. In what context have you had most experience as a Nurse Practitioner?
(Please tick, or specify another context)

GP Practice PCT Other (please specify): _____

2. On a scale of 1 (low) to 10 (high), how do you rate the main parts of the programme in terms of effectiveness in preparing you for the Nurse Practitioner role as you have actually experienced it so far?

	Rating from 1 (low) to 10 (high)
The university-based taught modules	
Weekly supervised clinical practice with the GP	
Project work, portfolio development, and suchlike	
Mentoring, individually or in groups	

3. In what ways (if any), is the role as you have experienced it more demanding or less demanding in terms of skills and competencies than the development programme prepared you for?

Ways in which the role is more demanding (if any):-

Ways in which the role is less demanding (if any):-

4. How often as a Nurse Practitioner do you play a lead role in the following clinical situations?
 (Please tick the relevant frequency, and use the spare boxes to add any other clinical work that you regard as significant and to indicate its frequency.)

	Routinely	Fairly often	Occasionally	Seldom	Never
Taking medical histories					
Dealing with undifferentiated illnesses					
Making diagnoses					
Undertaking full medical examinations					
Initiating investigations					
Initiating treatments					
Referring patients to other professionals					
Prescribing medicines					
Prescribing non-medicinal therapies					
Managing on-going care					

5. In your experience, to what extent is the Nurse Practitioner role accepted by patients, carers, and other healthcare workers? (Please tick the relevant box in each case, and make additions of you wish.)

	Fully	Largely	Somewhat	Not much	Don't know
Patients					
Carers					
PCT Managers					
General Practitioners					
Practice Managers					
Practice Nurses					
Reception staff					
District Nurses					
Health Visitors					
Allied Health Professionals					
Hospital Consultants					
X-ray personnel					
Laboratory personnel					

6. Overall, how satisfied are you with the Nurse Practitioner role? (Please tick)

Very satisfied		Fairly satisfied	
Quite dissatisfied		Very dissatisfied	

7. What is the main cause of satisfaction or of dissatisfaction with the role?

Main cause of satisfaction:

Main cause of dissatisfaction:

8. In what concrete ways (if any) has the Nurse Practitioner role affected your professional career so far, and your future prospects?

Effects on career so far:

Likely effects on future prospects:

9. If you have a Masters degree, to what extent does it affect you vis-à-vis the factors listed? (Please tick the relevant box in each case, or skip the question if you don't have a Masters.)

	A little	A lot	Hard to say
Your confidence in your role as NP			
Others' acceptance of the role			
Your actual competence			

10. How in the foreseeable future do you intend to develop your role as Nurse Practitioner?

11. In view of how the Nurse Practitioner role is developing in general, what changes would you make to the development programme for it?

12. Is there anything else you would like to add in relation to the questions we have asked or the Nurse Practitioner role?

Your co-operation in completing this is much appreciated.

A stamped/addressed envelope is supplied.

FOLLOW-UP INTERVIEWS: if you are willing to take part in a short follow-up interview, please refer to the enclosed information and consent form.

APPENDIX B:

SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS WITH NPs who have completed the survey questionnaire and agreed to be interviewed

INTRO

- Thanks again for completing the survey questionnaire, and for agreeing to be interviewed
- Re-cap purpose of interview, scope and duration (will have been discussed when arranging the interview)
- Note-taking and confidentiality

Note: Qs 1-3 are covered by the questionnaire, but since it doesn't identify individuals, it will help analysis of the interviews to know:-

1. What year were you awarded the NP PostGraduate Diploma? _____

2. Do you have a Masters as well as the Diploma? Yes: _____ No: _____

3. In what context have you had most experience as a Nurse Practitioner?

GP Practice ___ PCT ___ Other _____

4. Based on your experience, what is it that particularly distinguishes the role of Nurse Practitioner in primary care from other clinical roles?

5A. In general, how well does the role as you have experienced it fit in with how you think it should be?

5B. *Possible follow-up Q:* What needs to happen to bring the role more into line with how you think it should be?

6. Which aspects of the role - as it is – do you feel most confident in performing?

7A. Are there any aspects of the role that you don't yet feel comfortable doing?

7B. If yes, clarify which and the limiting factor(s).

8A. Are there any aspects of your role that other people seem keen for you to develop?

8B: If yes, which aspects, and why?

9A. Are there any aspects of your role that other people seem reluctant to let you develop?

9B. If yes, which aspects, and what makes them reluctant?

9C. What do you think would relieve such concerns?

10. Apart from formal recognition at national level, what steps could be taken at PCT or SHA level to help improve recognition of the role by other clinicians?

11A. Do you see your role changing significantly within the foreseeable future, or just continuing to develop on current lines?

11B: (*Possible follow-up Q*) Clarify any significant change, or uncertainty, foreseen.

12. In regard to CPD, what is your next priority?

13. Is there anything else you'd like to say about the Nurse Practitioner's role, or professional development for it?

THANKS AGAIN FOR YOUR CO-OPERATION.

APPENDIX C:

SCHEDULE FOR SEMI-STRUCTURED INTERVIEWS WITH DOCTORS

When arranging the interview remind respondent about the evaluation of the NP development programme, and that he/she kindly agreed to be interviewed. Consists of a few general Q's about the Advanced Nurse Practitioner role, and about their own role as tutor, so should take only 10-15 minutes.

At time of interview:

- Thanks again for agreeing to be interviewed
 - Re-cap purpose of interview and duration
 - Note-taking and confidentiality
 - Evaluation report or digest of it will be on SHA website, and you will be notified about that.
-

PART 1: YOUR OWN ROLE AS IN-HOUSE TUTOR and CLINICAL ASSESSOR FOR THE NP DEVELOPMENT PROGRAMME ...

1. How many NPs have you formally tutored so far (i.e. as part of the programme, including currently)?

2. Apart from contributing to their professional development, do you see any benefits for yourself in acting as tutor and clinical assessor for the Nurse Practitioner role? (*Follow up as necessary to clarify positive or negative replies*)

3. On the other side of the coin, are there any disadvantages in acting as tutor & assessor for the role? (*Again, follow up if necessary*)

4. Do you foresee any circumstances that would make you less willing to act in that kind of role? With the NP/NPs that have since qualified, in what ways has the relationship between you altered since they got the advanced qualification?

5. With the NP/NPs that have since qualified, in what ways has the relationship between you altered since they got the advanced qualification?

TURNING TO THE ADVANCED NURSE PRACTITIONER'S ROLE IN PRIMARY CARE

6. Apart from your role as tutor, how much experience have you of working directly with a qualified Nurse Practitioner?

7. What is it that particularly distinguishes the Nurse Practitioner role from other clinical roles?

8. How does the NP's role affect the level and quality of patient care?

9. What is your view on how the ANP's role is accepted by patients and recognised by other clinicians?

10. Is there anything you'd like to see happening to consolidate or improve recognition of the role?

11 How would you hope to see the Nurse Practitioner role developing over the next few years?

12. Do you have any concerns about how the role might develop?

13. Finally, is there anything else you'd like to say about the Nurse Practitioner's role, or professional development for it?

THANKS AGAIN FOR YOUR CO-OPERATION.

11 How would you hope to see the Nurse Practitioner role developing over the next few years?

12. Do you have any concerns about how the role might develop?

13. Finally, is there anything else you'd like to say about the Nurse Practitioner's role, or professional development for it?

THANKS AGAIN FOR YOUR CO-OPERATION.

APPENDIX D:

COMBINING THE BEST OF NURSING AND MEDICAL CARE

**Executive Summary of the report on the
Evaluation of the West Yorkshire Nurse Practitioner (Primary Care) Development
Programme from 2001 to 2005
for Yorkshire and the Humber Strategic Health Authority, the University of
Huddersfield and Leeds Metropolitan University**

1. THE WEST YORKSHIRE PROGRAMME

The West Yorkshire development programme for Nurse Practitioners (NPs) in primary care was designed to address an impending shortage of General Practitioners (GPs) at the turn of the decade and government policy to encourage the development of advanced practitioner roles in nursing and other non-medical professions.

In the absence of national guidelines on NP development, in 2001 the West Yorkshire NHS Workforce Development Confederation (WYWDC) took the initiative to establish a group representing primary care, educational and commissioning interests. This led to the production of an agreed framework for developing the role of NP in primary care and for commissioning courses and support infrastructures for aspiring NPs – a framework that gained the support of all PCTs in West Yorkshire and enabled the WYWDC to secure funding for the programme by establishing it as a priority for primary care organizations.

The development approach combined a two-year taught course at Masters level with practice-based clinical development one day per week for two years, with about 50% of the in-practice learning being facilitated a specific clinical tutor/educator. The programme leads to a PostGraduate Diploma, with the further option of completing a Masters. Two courses are provided, at the University of Huddersfield and at Leeds Metropolitan University.

So far, approximately 200 Nurse Practitioners have completed the programme. The report presents an evaluation of it vis-à-vis the first three cohorts: 2001-3, 2002-4 and 2003-5. The evaluation is based on data drawn from several different perspectives, ranging from a review of the thinking that underpinned the programme to a survey of graduates and interviews with some NPs and with some doctors who have tutored NPs.

The main purposes of the report are:

- to evaluate the commissioning strategy;
- to assess the effectiveness of the programme in preparing NPs who are fit for purpose and practice; and
- to examine the impact of the course on the students' career opportunities

2. MAIN CONCLUSIONS

The weight of evidence from all the perspectives considered leads to five main conclusions.

First, the whole approach to commissioning for this initiative was underpinned by the framework agreed in 2001. It was the product of an unusually cohesive process of purposeful co-operation and partnership that is greatly to the credit of everyone involved. The approach has already been transferred to other contexts in modified form, so its value in that regard has been thoroughly proven.

Secondly, the effectiveness of the courses has been probed from several different angles. All the indications are that graduates are indeed fit for purpose and practice, and that the content of the courses is well aligned with what most NPs from these cohorts actually do.

Thirdly, the impact of the course on career opportunities is generally positive, but also quite variable. Most of the NPs surveyed or interviewed view the course as a step-change in their development, one which many find deeply fulfilling – despite objections to the extent of pay differentials between doctors and themselves. On the other hand, a minority of the graduates have had to revert to their former nursing roles, apparently because their employers do not want to develop the potential of NPs. In contrast, quite a few of our respondents are confidently aiming at practice partnerships or nurse-led practices.

Fourth, while some graduates in these cohorts have been stymied in regard to using their advanced skills and knowledge, most of the NPs have been able to do so successfully, with commensurate gains in self-confidence and the respect of colleagues. Indeed, the NPs who have found a way to ***make their own of the role*** are gaining recognition as clinicians of a high calibre. With both patients and practice colleagues, the hallmark of success for NPs is their ability to combine the best of nursing and medical care.

That said, the one area where there appears to have been a significant gap in clinical development for the NPs in these cohorts is in relation to mental health.

Fifth, overall therefore, the initiative and commissioning strategy has been a considerable success. Furthermore, while it has required substantial investment – mainly because of 'backfill' payments to practices – the cost per student for NP development is much the same as for other primary care nurse training at a less advanced level.

3. COMMENTS ON OTHER ISSUES

The Nursing & Midwifery Council have produced a statement of what patients, carers and other health professionals can expect an advanced nurse practitioner to be capable

of doing. While the formal status of NPs remains to be resolved, using the term Advanced Nurse Practitioner might reduce some of the uncertainty about their level of capability, particularly if it were tied to a specific standard of professional development.

However, government policy is pushing for the development of practitioners with advanced skills, regardless of what they are called, and the courses at Huddersfield and Leeds Met are becoming more multidisciplinary in response to pressures in that direction, and also because concerns about the shortage of GPs have subsided. This broadening of the qualification worries some of the NPs surveyed or interviewed, who fear that they may have got the benefit of the programme at its best but that the value of the qualification is now being diluted, and is further endangered by the emergence of Physician's Assistants trained to lower skill levels. Such fears might be alleviated if the recently-created SHA can let people know more about its strategy for advanced practitioner development.

Furthermore, aligning CPD for NPs more closely with CPD for GPs might also help to sustain the momentum of development for NPs, while also making a valid distinction between advanced nurse practitioners as the NMC describe them and other types of clinician.

Finally, it is clearly the case that – in combining the best of nursing and medical care – advanced nurse practitioners are in effect practicing preventative medicine and integrated healthcare more comprehensively than GPs have generally sought to do. Some NPs have begun auditing their own practice and producing evidence of the concrete benefits of their interventions. Given the whole thrust of government policy from *The NHS Plan* (DoH, 2000) through to last year's White Paper, *Our Health, Our Care, Our Say* (DH, 2006), and the scale of resources invested in public health campaigns, it is remarkable how little research has been done in this country on the cost-effectiveness of preventative medicine.

4. RECOMMENDATIONS

Since the evaluation began, Workforce Development Confederations have been amalgamated into the new Strategic Health Authorities – the new SHA for Yorkshire and the Humber being created as a result.

In a parallel restructuring, PCTs have been merged to form more powerful new ones that are charged specifically with: (a) following through on the policy of practice-based commissioning; (b) making primary care provision more patient-responsive and more cost-effective; (c) integrating health and social care and putting more resources into preventative healthcare; and (d) moving treatment of long-term conditions away from acute hospitals and into intermediate and community-based facilities (DH, 2005, 2006). The combined effect of these radical changes in primary and community care will create a new culture of provision in which advanced nurse practitioners can flourish, because their combining of the best of nursing and medical care is particularly suited to it.

In the light of these developments, three recommendations are appropriate, all addressed to Yorkshire and Humber SHA.

- That the SHA should build on the success of the West Yorkshire Nurse Practitioner initiative to promote recognition across Yorkshire and Humber of the

role and potential of advanced nurse practitioners, taking account of the main findings of this research and the conclusions and comments above.

- That the SHA should consider developing a course for experienced advanced nurse practitioners to learn the business side of practice development – so that lack of business know-how is not a barrier to full development of the role.
- That the SHA should also set about developing a robust approach for evaluating the cost-effectiveness and social benefits of integrated primary care as practiced by advanced nurse practitioners. The success of the West Yorkshire NP initiative would provide unusually favourable conditions for research of such real significance for the future of health and social care.