'How can we explain what we can't see': An Interpretive Description study on key stakeholders' perceptions of newly qualified nurses entering General Practice as a first post destination

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Abstract

Introduction - There is a widespread nursing shortage in the United Kingdom, and trends suggest that vacancies will continue to rise. The challenge is particularly acute in primary care, where unclear recruitment, career pathways and inconsistent employment conditions mean that only a small proportion of nurses enter General Practice within five years of qualifying. Published research has established that General Practice Nursing is subject to myths and misperceptions, which may impact newly qualified nurses' entry into the profession.

Methodology and Methods - A qualitative interpretive descriptive study was undertaken to explore key stakeholders' perceptions of newly qualified nurses entering General Practice as their first post-destination. The research comprised of three separate but interlinked studies. Purposive sampling was conducted by recruiting student nurses within their final year of study, newly qualified nurses whose first post-destination was General Practice, and General Practice Nurse senior stakeholders. Data was collected using semi-structured interviews, which were explored through a thematic analysis framework.

Findings - Two main themes were identified in all three connected studies: 'General Practice Workforce Inconsistencies' and 'General Practice Nurses' Professional Identity. ' The research showed that various inconsistencies in a General Practice Nurse's professional journey affected their recruitment and retention. Additionally, the study found that General Practice Nurses face challenges related to their professional identity, which impacts how they are perceived and interacted with by aspiring General Practice Nurses, current healthcare professionals, and senior stakeholders.

Conclusion - Improving the inconsistencies that General Practice Nurses are subjected to may help support their professional identity and make this role more visible and attractive to newly qualified nurses.

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Preface

I started this research to address a practical question I had about the General Practice nurse (GPN) workforce. What began as a professional inquiry soon turned into a desire to explore and comprehend how we can expand and maintain a GPN workforce for the future.

Many years ago, I transitioned into General Practice from a National Health Service (NHS) based hospital where I worked at a senior level in accident and emergency (A&E). When I was ready to explore a career shift and transition from acute hospital nursing, I was interested in shifting from reactionary care into preventative, long-term care. I felt that being a GPN provided that ideal professional shift. Over twenty years ago, when I applied for my first GPN post, I was under the impression that I had to have secondary care nursing experience and that it was an ideal post for anyone with caring responsibilities. However, when I was in the post, the tenure, knowledge, and experience I had garnered within A&E, which were undoubtedly useful, did not equip me for a seamless transition. I quickly appreciated that I had to undertake additional study and professional growth to be a safe and effective GPN.

As my knowledge and experience grew, so did my responsibility and professional standing within General Practice. Throughout my tenure, I have worked for different health authorities in small, single practices, and large multi-site organisations. By 2013, my professional development had led me to become an MSc-qualified Advanced Nurse Practitioner (ANP), and by 2016, I was the Chief Nurse for a large nine-site General Practice partnership. In these roles, I led and supported a diverse team of registered nurses, clinical support staff, and allied health professionals, innovating and supporting service development and delivery. I also played a crucial role in supporting our then local Clinical Commissioning Group (CCG) with GPN professional development, General Practice regulatory support, and business-led initiatives.

I have enjoyed working with medical colleagues who valued and listened to the GPN's input, acknowledging their characteristic knowledge, professionalism, and care. I have also worked for and with medics who were keen to ensure that GPNs remembered they

were there to support their medical colleagues, only providing care under the guidance of the GPs and employers. An example of this is when an employing General Practice was recruiting a further practice partner. I enquired about this position to increase my professional portfolio and was told I wasn't suitable as '*I was only a nurse'.*

As a hiring employer for GPNs, I noted that our current workforce was predominantly over 50 years old and wanted family-friendly working hours. As a training practice, we supported medical and nursing students, which provided visibility of the inequity in time, finances, treatment and resources available for both groups. When supporting student nurses, it was noted how surprised they were by the wide range of knowledge and skills that GPNs hold and their lack of knowledge about how General Practice operates. I was keen to explore the information and support provided for student nurses interested in General Practice. When recruiting, I was aware of the current local recruitment practices, the policies and funding available to support GPN recruitment and retention, and the challenges we were facing locally. However, I noted and wished to explore why we had challenges attracting Newly Qualified Nurses (NQNs) and younger Registered Nurses (RNs) into the General Practice workforce.

My initial interest in conducting desk-based research quickly transformed into doctoral research. This decision was driven by my desire to delve deeper into the field and develop a more comprehensive understanding of the challenges and opportunities in recruiting into General Practice nursing while affording myself academic and professional growth. Therefore this research was focused on exploring the perceptions of key stakeholders on NQNs joining General Practice as a first post destination.

Acknowledgement

Whilst this thesis has been a solo body of work it's taken a team to make it possible. I would like to acknowledge and give my sincere thanks to the following:

Firstly, I would like to thank my husband and children for their patience, understanding and ability to nod and smile at the most appropriate times. To them, I appreciate that for the last seven years, I haven't been fully present as I've been thinking, writing, refining or reading instead of being present in the moments. My greatest thanks go to them, as without their flexibility and support, I wouldn't have been able to self-fund and complete this research while still maintaining a semblance of my professional and personal life.

My academic supervisors, Professor Paul Galdas and Dr Beth Hardy have been undeniably supportive, patient and understanding. Without them, I wouldn't have been able to grow and develop my academic understanding. Their faith and guidance were invaluable, as was their belief in my research. The support and guidance on not only the process but also their focused, pragmatic and kind feedback on my work have been greatly appreciated and fully warranted.

I would like to express my heartfelt gratitude to all the participants and the supportive recruiting Higher Education Institutes (HEIs) and Advanced Training Practices (ATPs) in this research. Their willingness to share their time, stories, and perceptions of Newly Qualified Nurses entering General Practice as a first post destination has been invaluable to my research. I am forever grateful for their generosity in time, spirit, and interest.

Finally, I would like to extend my thanks to the University of York. Each departmental contact has been helpful in my research journey, providing their time, knowledge, and support. Without their assistance, I would have faced even greater challenges. The research ethics department, academic librarians, student support teams, and post-graduate administrators have all played a positive role in making York a great place to study. I am deeply grateful for their contributions.

Declaration

I declare that this thesis is a presentation of original work, and I am the sole author. This work has not previously been presented for a degree or other qualification at this University or elsewhere. All sources are acknowledged as references.

A research article, *'Pre-registrant nurses' perceptions of General Practice as a first post destination'* representing Study One, which forms part of this research, was published in 2022 (Lythgoe, Galdas and Hardy, 2022) (Appendix 21).

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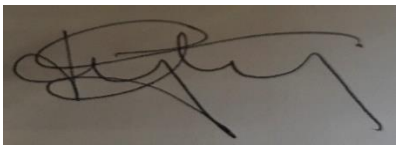
Signature 

Cheryl Lythgoe

Thesis abbreviations

ACP	Advanced Clinical Practitioner
A&E	Accident and Emergency
AfC	Agenda for Change
AHP	Allied Health Professionals
ANP	Advanced Nurse Practitioner
ARRS	Additional Roles Reimbursement Scheme
APMS	Alternative Provider Medical Services
ATP	Advanced Training Practice
CCG	Clinical Commissioning Group
CPD	Continuing Professional Development
GMS	General Medical Services
GP/GPs	General Practitioner(s)
GPN	General Practice Nurse
HCA	Health Care Assistant
HEI	Higher Education Institutes
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
ID	Interpretive Description

JBI	Joanna Briggs Institute
NIHR	National Institute for Health and Care Research
NHS	National Health Service
NMC	Nursing and Midwifery Council
NQN	Newly Qualified Nurses
PCN	Primary Care Networks
PMS	Personal Medical Services
QoF	Quality Outcome Framework
QNI	Queens Nursing Institute
QR	Qualitative Research
RCN	Royal College of Nursing
RN	Registered Nurse
SSI	Semi-structured Interviews
SSP	Statutory Sick Pay
UK	United Kingdom
VTS	Vocational Training Schemes

Chapter One - Introduction

1.0. Introduction

This research explored the perceptions of key stakeholders on newly qualified nurses (NQNs) undertaking their first post destination in General Practice. General Practice is an independent business that contracts work from the National Health Service (NHS) to provide holistic care delivered by a team of generalist health professionals to people within their local communities (National Health Service, 2016b). General Practice Nurses (GPNs) are part of this diverse professional team. Within the United Kingdom (UK), healthcare is evolving and increasingly being delivered in the community and away from the traditional secondary care settings (National Health Service, 2016b; National Health Service and British Medical Association, 2019; National Health Service, 2019). GPN's knowledge, skills, and experience are more valuable than ever when viewed in the context of the transfer in locations of care, and in relation to current General Practice workforce challenges. Research has demonstrated that the GPN workforce also faces recruitment, retention and attrition challenges (Clifford *et al.*, 2021). Therefore, this research aimed to understand the perception of key stakeholders on Newly Qualified Nurses (NQNs) undertaking their first post destination in General Practice.

Chapter One, Introduction, presents a comprehensive overview of the historical and contemporary perspectives of General Practice, with a particular emphasis on the impact and funding mechanisms of GPNs. Chapter One also explores the recruitment and retention of the nursing workforce in the UK, offering a broad understanding of the current state of the nursing profession. Special attention will be given to the development of the GPN role, including an exploration of the recruitment, retention, and attrition challenges faced by the current GPN workforce.

Chapter One concludes with a high-level overview of the research and a summary of the content of the remaining chapters of this thesis.

1.1. General Practice

Primary care services in the UK consist of a group of healthcare providers based within the local community. These include General Practices, pharmacists, NHS dentists, and optical

services. General Practices support acute and chronic healthcare needs and provide the first point of contact for most healthcare users. Section 1.3 will provide the context of where GPNs fit within General Practice.

1.1.1. Role of General Practice (in the context of wider health care provision)

As people are living longer, many with multiple and complex health conditions, there is an increasing requirement for health care. To support the growing demand, many countries are moving health care into the primary care arena (Royal College of Nursing, 2013). Within the UK, the Department of Health (2006) published a white paper that provided a clear directive to improve community services, recommending that six speciality areas would be appropriate to manage in primary care, thereby moving services historically located in secondary care into primary care settings. The shift of care continued to be supported by the publication of the Five-Year Forward View (Department of Health and DoH, 2014) and the Long-Term Plan (National Health Service, 2019), which acknowledged community-based care's economic benefits, and the health benefits patients receive through being treated by their known primary care providers. However, this shift in health care provision hasn't always been cohesive or well communicated (Mitchell *et al.*, 2023) with challenges noted in workforce engagement, IT infrastructure and fundings allocation that matches the political support.

General Practice, part of primary care health care provision, delivers over a million appointments daily (National Health Service England and Department of Health and Social Care, 2023). This vital role in the local and wider health economy provides accessible, thorough and patient-centred care to its patients (National Health Service England, 2016; National Health Service, 2019). General Practice supports its local communities with health promotion, screening, vaccinations, and supporting both acute and chronic health management. The work provided by General Practice is also crucial in providing early disease detection and prevention, positively impacting our patients and the wider healthcare economy (National Health Service England and Department of Health and Social Care, 2023).

The General Practice workforce holds specialised knowledge of their local healthcare community and systems, supporting their patients in accessing other services, often acting as a coordinator or gatekeeper should other services be required (Beech and Baird, 2020b). Today, the General Practice workforce has moved away from the single-handed General Practitioners (GPs) and GPNs of yesteryear and consists of numerous clinicians within which health support and advice can be given (National Health Service England and Department of Health and Social Care, 2023) . As their primary care providers, they will often support patients with ongoing or multiple health conditions, by coordinating and providing complex care through multiple clinical and tertiary agency sources. Through this multi-focal management, patients can achieve continuity of care, with their General Practice clinicians acting as advocates, advisors, and allies in their healthcare journeys (National Health Service England and Department of Health and Social Care, 2023).

In the UK, most General Practices are independent businesses primarily run by GP partnerships, which contract work from the NHS. Funding within General Practice is provided through various means with the global sum payment, which provides a preset amount of money per patient based upon various demographics (British Medical Association, 2024), being provided for each patient registered within the practice. There are also three different contract types that are used. These are the General Medical Services contract, commonly known as the GMS contract with around 70% of English General Practices operating under a General Medical Services contracting stream (Beech and Baird, 2020b), the Personal Medical Services (PMS) contract which supports a more tailored healthcare provision and is currently being phased out and the Alternative Provider Medical Services contract which supports more flexibility and can allow the procurement of services that go beyond the PMS contract such as supporting the homeless (Beech and Baird, 2020a). As business owners, the General Practice partnership is responsible for meeting these contractual obligations, maintaining their premises, and being fair and equitable employers. In addition, the partnership is responsible for exploring additional funding streams to build and sustain a profitable business.

1.1.2. Structure and funding of General Practice

General Practice funding streams have evolved over recent years when, in 2022, the formation of the Integrated Care Systems (ICS) was legally established (National Health Service England, 2024b) following the publication of the 2022 Health and Care Act (The Kings Fund, 2022), taking over from the previous Clinical Commissioning Groups (CCGs) responsibilities. CCGs were primarily dissolved to streamline and improve the efficiency and delivery of primary care healthcare services, aiming to enhance the strategic commissioning, accountability and integration of services. The 42 ICSs are local partnerships (Beech and Baird, 2020a) with statutory powers and responsibilities that provide strategic commissioning of services delivered through shared care planning. ICSs contain two key elements: Integrated Care Boards (ICBs) and Integrated Care Partnerships (ICPs) (National Health Service Confederation, 2023). The ICBs are statutory bodies responsible for funding and planning NHS services, working closely with General Practice to plan and provide the services that support their local communities, taking over care provision and planning from the previous CCGs. The ICPs are committees bringing together system partners such as General Practice, local councils, and other key stakeholders to support their community healthcare needs (National Health Service Confederation, 2023). The NHS Confederation (2023) reports that some ICSs are working at pace and have developed collaborative ways of working for their local communities. However, some ICS leaders have reported that barriers, such as staff shortages, social care workforce challenges, financial challenges, and ICB funding issues, hinder their progress. General Practices receive funding from their ICSs, and as small independent businesses, they must provide all their contracted services whilst remaining solvent and providing their GP business partners with a working income. The current monetary flow and amounts for 2023-2024 are demonstrated in Figure 1 (National Health Service England, 2023b).

Figure 1 National Health Service monetary flow

1.1.3. General Practice workforce

The workforce in General Practice is multidisciplinary. NHS Digital (2024) reported that General Practice in UK consists of 37,208 full-time equivalent GPs, 16,997 nurses and 17,003 direct patient care staff, including phlebotomists and health care assistants. However, in the UK the local General Practice workforce does not follow a nationally standardised model but is based on their community's healthcare needs, the availability of clinicians, and the business's finances, which is thought to be secondary to their primarily private business status and funding streams. Therefore, there will be a variety of healthcare professionals working within different GP businesses. The mix of clinicians provides a diverse range of expertise and skill with an aim to improve access, efficiency and improve patients' outcomes whilst addressing the current workforce challenges (Fisher, 2024; Shembavnekar *et al.*, 2022)

There has been an expansion in the multidisciplinary roles to meet the increasing demands on General Practice services and workforce shortages. Secondary to recruitment and attrition challenges GPs and GPNs have been recognised as a workforce pinch point within General Practice, which has increased the strain and burnout of the remaining professionals (Clifford *et al.*, 2021; National Health Service England and Department of Health and Social Care, 2023). The General Practice workforce has had to diversify to meet the needs of the ageing population, the shift of care from secondary to primary care, and the complexity of health needs. Diversification aims to relieve pressures in General Practice by using allied health professionals (AHP) such as physiotherapists, mental health workers, and paramedics, who will consult with patients within their scope

of practice, competence and knowledge. Advanced Clinical Practitioners (ACPs) are healthcare professional from multiple professional backgrounds, who have undergone additional training (Timmons *et al.*, 2023) and are also providing care within General Practice. ACPs have been found to provide an important contribution to patient care (Evans *et al.*, 2020) through their autonomous practice. The upskilling of nurses and their AHPs to an ACP role provides benefits to both the individual, employer and patients (Timmons *et al.*, 2023). To further support the gaps within the General Practice workforce new roles have been added to the suite of available professionals, including physician associates and nursing associates.

Many of these roles are funded through the Additional Roles Reimbursement Scheme (ARRS) (Leary and Punshon, 2024), which provides financial support to the employing practices, supporting patients to be seen by a suitably qualified and knowledgeable clinician. The ARRS scheme pledged to support General Practice in employing 26,000 staff in primary care by 2024 (National Health Service England, 2020). Whilst this scheme is aimed at supporting a more resilient, cost-effective, and flexible workforce, it has created de-valuation concerns amongst General Practice GPs and GPNs (Ford, 2024; Lind, 2023; MacConnachie, 2024). Currently, GPNs and GPs are expected to create induction programmes, provide supervision and support for this new General Practice workforce with no recognition, additional time or remuneration (Lind, 2023).

1.2. Nursing recruitment and retention

Within the UK, to become a Registered Nurse (RN), a person must undertake a degree-based programme, which can be accomplished through multiple pathways (National Health Service, 2024a) and may be eligible for financial support. However, as a result of increased academic costs and, for the majority or nursing students, the removal of the nursing bursary, which has been replaced by the 'Annual Nursing Payments' (National Health Service England, 2024a) it is currently estimated that NQNs are leaving university with up to £50,000 in debt (Royal College of Nursing, 2023b). Nursing degree courses in the UK are seeing a year-on-year decrease in applications, with a 10% decrease from last year

(Church, 2024) and an overall 32.5% decrease since 2021, with notably fewer mature student applications (Farrar, 2023). The Royal College of Nursing (RCN) (2023) cites many reasons for this including, the cost-of-living challenges, the public's perception of nursing as a career, the impact of the pandemic and applicants wish for careers which are perceived to offer better financial stability and career prospects. These figures are adverse to the aspirations of the NHS Long-Term Workforce Plan (National Health Service England, 2023a), which aimed to increase the number of nurse training places by 80% by 2031, providing 53,858 nurses per year.

Like many other countries, the UK has a shortage of RNs (Royal College of Nursing, 2023a), resulting in a high vacancy rate (Farrar, 2023). The high number of UK nursing vacancies is thought to be secondary to poor recruitment and high levels of early attrition, which affects our current RN colleagues, healthcare employers, and the ability to safely deliver healthcare. To support the shortage of RNs, the UK supports the recruitment of international nurses, which some consider expensive, unsustainable, and damaging to the international nursing workforce (McKeown *et al.*, 2023). However, the UK is not alone in its RN shortage and, therefore, has to compete with other countries for international nurse recruitment (Buchan, Shembavnekar and Bazeer, 2023). Recruiting international nurses may support our domestic healthcare needs, but it will deplete the RN resources in other countries and is not an ethical or globally sustainable plan (Buchan, Shembavnekar and Bazeer, 2023).

The nursing recruitment challenge is thought to be multifactorial and affects all clinical areas (Royal College of Nursing, 2023a). The current RN workforce is subject to high workload levels, increased patient expectations, and increased challenges in service availability (Royal College of Nursing, 2023b). When these metrics are combined, nurses are often left working long hours within a challenging clinical context, which increases burnout and stress and affects job satisfaction and retention. The Nursing and Midwifery Council (NMC) reported (2023a) over 27,000 registrants left the nursing register in 2022-2023, with more than half of those leaving it earlier than their retirement age, implying RN retention challenges. Retention is especially important as our current workforce is ageing,

with 44.6% of nurses over 45 (Royal College of Nursing, 2023a). Improving nursing retention is thought to be achieved through fair remuneration, a work-life balance and professional support (Gregory and Cunliffe, 2021; Clifford *et al.*, 2021).

1.2.1. Newly qualified nurse recruitment

Once NQNs enter the NMC register, they have many different first post destination options. Following discussion with a number of Higher Educational Institute (HEI) key personnel, academic supervisors, a senior nurse within a national nursing organisation and online searching it was evident that no UK statistics were available on the NQNs' first post-destination choice. This may indicate a useful area for future research. However, The Health Foundation (2023) explored the retention and movement of nurses within the UK, and 2021/2022 statistics provided high-level data, reporting that most NQNs work within the NHS, with 38% of NQNs working in non-NHS areas, which may include private hospitals, charities, community, or adult social care.

NHS secondary care nursing is often viewed as diverse, providing team support and offers a structured remuneration package through Agenda for Change (AfC) (Wareing *et al.*, 2017a). AfC is a pay scale system that is used to determine the pay for NHS staff through the use of various pay bands and points with salary increases based on experience and role (Public Accounts Committee, 2009). Community nursing could be viewed as providing a similar professional and emotional support structure to that offered within secondary care, with the advantage of remaining within AfC (Royal College of Nursing, 2025). The healthcare landscape in the UK is changing with private providers increasing the scope and scale of care offered; these roles often don't come with the structured AfC pay scales but do offer the structure, team support and diversity that NHS secondary care provides (Care Staff 24, 2023).

Wareing et al.'s (2017a) and Anyango et al.'s (2024) work reported on the increasing importance of placements in career choice, with third-year placements holding the most influential sway. These placements help student nurses create, refine, and reaffirm their career choices. Advanced Training Practices (ATPs), known as 'local training hubs', hold

the allocated funding to support placement activity within General Practice. This localised support can provide visibility and awareness of the GPN role, which aids in promoting General Practice nursing as a career.

A scoping review (Chapter Two) was undertaken in 2017 to understand the factors influencing career choice for student nurses and NQNs. The review showed that career choice was determined by what participants felt would work well for their professional and personal lives, mentorship availability, and perceived career support.

1.3. General Practice nursing

GPNs work alongside doctors and the multidisciplinary team within General Practice. The GPN's role has evolved enormously over the past 100 years from being described as 'doctors' handmaidens' (Summers and Summers, 2010) to the highly skilled autonomous professionals working nationally and internationally today (Clifford *et al.*, 2021).

1.3.1. Historical development of the General Practice nurse role

For hundreds of years, medical services have been undertaken in the patient's home or community setting, with most GPs, who were predominantly male (Royal College of General Practitioners, 2024) working from their own homes with their wives or housekeepers undertaking supportive duties (Kmietowicz, 2006). Kmietowicz (2006) discussed how the initial framework for health care provision for the working man was the 1911 National Insurance Act, which Lloyd George delivered. This act provided limited health cover for working men only, with those not meeting the scheme cover having to pay the GP for any medical care received (Kmietowicz, 2006). The inequity of this model of care provision meant that those with limited financial resources would go without medical care or only access care when their health was no longer manageable. The 1911 scheme contracted GPs under a 'Terms of Service' agreement, which was later transferred into the NHS contracts. In 1948, Labours Minister for Health, Aneurin Bevan, spearheaded the formation of the NHS, where GPs were contracted under an independent status to provide NHS services (Barton, 2016). For GPs, the new NHS contract meant they were contracted to provide medical care to the whole population and act as gatekeepers for secondary care, echoing our current service provision. In keeping with today's healthcare

system, the GPs of the 1950s were subject to enormous pressures (Kmietowicz, 2006), highlighted in the Collings report (Collings, 1950). Collings noted that many of the challenges pre-existed the launch of the NHS and, in summary, felt that General Practice was subject to high demand, financial challenges, working in isolation from their secondary care and specialist colleagues, and had organisational decisions made by hospital and service development staff.

The 1966 funding for additional staff influenced the emergence and growth of the GPN role in the United Kingdom (Fanning and Berry, 2017; Duncan and Hayes, 2017). Early GPNs were employed to perform primarily task-based patient-facing duties assigned by their GP employers (i.e. pulse, temperature, blood pressure and wound checks) and administrative support (Duncan and Hayes, 2017). However, the 1980s marked a turning point for GPNs as they began engaging in health screening, health promotion, and holistic patient care. Subsequent iterations of the GP contract in 1990 and 2004 further expanded the GPN role, with GPNs starting to support and manage patients with long-term conditions (Queens Nursing Institute, 2017). Recognising the need for specialised training and support, the GPN forum of the RCN advocated for officially recognising the GPN role as a specialist practitioner; however, the nursing regulators never adopted the specialist practitioner role (Queens Nursing Institute, 2017).

The GPN role continued to evolve beyond task-based care, with GPNs pursuing additional training to enhance their ability to diagnose those presenting with minor illnesses, manage and treat their patients. As Butler (2022) discussed, today's contemporary GPNs collaborate and coordinate multi-disciplinary teams, providing autonomous professional care to patients with various presenting conditions. Although they still do not hold a recognised specialist practitioner title, their role remains crucial in supporting the healthcare needs of their communities.

1.3.2. What does the current UK General Practice nurse role look like?

The evolution and diversification of the primary care workforce provide challenges and benefits for the modern-day GPN (Clifford *et al.*, 2021). GPNs are considered a versatile and integral part of the wider primary care team, taking on clinical work that a doctor

would have historically undertaken. As discussed, General Practice in the UK primarily operates as small independent businesses that contract work from the NHS (British Medical Association, 2019) and GPNs are primarily directly employed by the General Practice where they work. Therefore, as small business employees, GPNs deliver the services required by the individual business at their employer allotted or negotiated contracted rate and conditions provided (Clifford *et al.*, 2021). Clifford et al. (2021) discussed that GPNs are subject to a huge variation in their role titles, working conditions, salaries, terms and conditions, educational/professional support and working practices. The GPN role, therefore, can be individualised and nationally inconsistent. However, it can also be liberating as this private contractual arrangement may enable GPNs to negotiate pay, terms and conditions at source.

The GPN role currently has no national standardised role profile or career structure. Health Education England developed a Career and Core Capabilities Framework (2021b) to support both employers and employees in defining GPN roles. This followed a competence framework published by the Royal College of General Practitioners (Royal College of General Practitioners, 2012 revised 2015), providing details of six nursing care levels, linking these with suggested role titles, high-level role descriptors and indicative recommended qualifications. The framework provided guidance, recommendations, and support for General Practice employers; however, as this was a recommendation, there is no requirement or incentive for employers to use the framework (Health Education England, 2021b). Therefore, many GPN roles are not benchmarked, recognised, or supported through a professional development pathway. The GPN role is often shaped and defined by their employers and the communities they serve. As there is no mandatory training, standardised educational pathways or statutory requirements for the GPN role, this has resulted in the GPN workforce having varying levels of academic study and role knowledge, with a Queens Nursing Institute (QNI) (2015) report stating that 43% of practices felt their GPN workforce did not have a suitable amount of appropriately qualified or trained staff to meet their community's needs.

Today's GPNs are at the forefront of care, providing front-line first-contact care, health prevention, and complex multi-morbidity disease management (Health Education England, 2017). However, Clifford et al.'s (2021) report, which NHS England commissioned, explored the value and role of GPNs and highlighted the GPN role as relatively invisible but highly valuable to employers, patients, communities, and the wider NHS system. The 'invisible' nature of the role is thought to impact people's role awareness, with many health care and education professionals basing their assumptions about what GPNs do on myths, misperceptions and personal GPN contact (Clifford *et al.*, 2021).

1.3.3. General Practice nurse recruitment

The UK and international GPN workforce have a notable older demographic (Butler, 2022; Buchan et al., 2015; Heywood and Laurence, 2018), which may indicate a domestic and international GPN workforce crisis. The NHS Long-Term Workforce Plan (2023) aimed to increase clinical staff in mental health, primary care, and community care by 73% by 2036-37, with nursing accounting for 65% of the training places required (The Health Foundation, 2023). Within General Practice, these aspirational figures may provide some challenges secondary to available GPN mentors, qualified trainers, assessors and HEI course availability (Hunter, 2023).

GPN recruitment will be required to support the UK's current healthcare model of moving various clinical modalities into the community, the diversification of General Practice workflow and the decrease of GPs. As is highlighted in Chapter Two's scoping review, there is evidence that student nurse placements are a good recruitment option for employers and potential employees, providing General Practice visibility and clinical area knowledge. However, the availability of GPN placements is currently lower than desired (Williamson *et al.*, 2023). The incumbent GPNs are under increasing workloads and stress, with fewer having the time, experience or training to mentor or support those students and NQNs entering General Practice (Panda *et al.*, 2021). When considering these factors, the academic and experiential learning quality could hinder student nurses and NQNs' GPN experience. To support a future GPN workforce and ensure it is fit for practice,

consideration will need to be made on the measures used to maintain both the quality and safety of their placements whilst increasing placement capacity within General Practice (Hunter, 2023).

Various bodies have undertaken work to support General Practice recruitment, including NHS England (08/2020), Health Education England (2021), the British Medical Association (2019), and the Royal College of General Practitioners (2012 revised 2015). Butler (2022) discussed how many General Practices currently recruit experienced GPNs from neighbouring practices, using the lure of improved pay, terms, or conditions. However, this recruitment method can create instability within the GPN workforce and affect care provision within local communities. Nonetheless, this can also create a competitive General Practice arena, sometimes increasing GPN local pay and favourable working conditions to recruit and retain staff. Another GPN recruitment pathway is to facilitate and support health care assistants, nursing apprenticeships or nursing associates' transition into RNs; this 'grow your own' mentality retains staff and provides aspirant GPNs with a working knowledge of the environment and culture that being a GPN offers (Clifford *et al.*, 2021). Recruiting NQNs into General Practice would enable GPN workforce growth without depleting other areas of experienced RNs, provide a tangible career for the NQN and support the movement of healthcare into the community.

The GPN Ready Scheme (Health Education England, 2016a), which was a nationally-funded training scheme delivered by locality ATPs, supported NQNs into General Practice by providing financial and training support. However, secondary to a shift in funding responsibilities (Lane and Peake, 2015; Aston, 2018) this funding has now been withdrawn, and locality training initiatives are decided by the ICBs and subject to their funding decisions. The General Practice Fellowship Scheme (NHS England, 2020) was developed to support and advise ICBs in increasing General Practice recruitment and onboarding of new staff. At the time of writing, a decision is awaited on whether this scheme will continue to be funded (Devereux, 2024). Several locality groups have generated Vocational Training Schemes (VTS) to support new-to-practice GPNs; these quality-

assured transitional support programs have been found to benefit both the employee and employer (Lewis, 2022).

Recruitment pathways into General Practice often differ from those of NHS employers. NHS employers tend to advertise their available roles through a national website providing a central site of employment opportunities for interested potential applicants. General Practice employers choose whether to use this website; therefore, not all GPN roles are available on this central online site. Therefore, jobs can be advertised through various platforms without uniformity in where or how roles are displayed. To support GPN recruitment, the NHS has developed a national website (National Health Service, 2024b) to aid with the advertising of roles and provide information on what a GPN's role may look like. However, at the time of writing, minimal jobs were advertised on this website.

1.3.4. General Practice nurse workforce crisis

Research (Anderson, 2024; Ford, 2023; Clifford *et al.*, 2021) suggested that the current availability of qualified and experienced GPNs is not keeping pace with the increasing demand for primary care services. Several factors influence GPN shortages: decreased recruitment rates (both within nursing and GPN roles), retention difficulties, an ageing workforce, and inadequate workforce support planning and management. The Health Foundation (Shembavnekar *et al.*, 2022) reported that the NHS faces a 25% shortfall of GPs and GPNs by 2030, raising concerns for the remaining workforce and patient safety.

Dunkley (2023) described the current UK nursing workforce crisis as the '*worst*' in healthcare history. In 2015, the QNI (2015) stated that by 2020, 33% of GPNs would be due to retire, with NHS Digital (2015) reporting that in England, 11,801 full-time equivalent (FTE) nurses were declared as working within General Practice. When reviewing these figures in 2020, 16,774 (FTE) GPNs were working in England, with the current 2024 figures standing at 16,997 (FTE) GPNs (National Health Service Digital, 2024). However, whilst these figures appear stable, Clifford et al. (2021) and Ashwood (2018) have highlighted the increasing GPN age demographic, with Anderson (2024) reporting that 33% of GPNs are

aged 55 years or older, with a growing number in the above 65-year age group. Only 5% are under the age of 30 years.

Therefore, the need to attract younger colleagues into General Practice is paramount. Clifford et al. (2021) reported that student nurses aren't always aware of or have the opportunity to experience a GPN role. Recruiting younger people into General Practice was reported to be challenging secondary to imbalanced pay, terms and working conditions (Ford, 2023), with General Practice not being able to compete with NHS employers.

The result is that the current GPN workforce is under additional strain with fewer resources and support, risking further professional attrition. The NHS workforce plan (2023) acknowledged the high levels of illness within nursing and noted the primary causes were mental health issues, citing stress, anxiety, and burnout as the major causes. The increased pressures that GPNs face alongside their General Practice colleagues provide additional mental and physical stress to the already stretched workforce.

1.4. The research

As Chapter One has identified, the GPN workforce faces several recruitment, retention, and attrition challenges. The GPN age profile and the fragmented recruitment and employment conditions of General Practice are all cited as contributors to the current GPN workforce crisis. To support the NHS's Long Term Plan (National Health Service, 2019; National Health Service England and British Medical Association, 2019) improving GPN recruitment will need to be considered to move care into the community and enable General Practice services to continue to be provided. There has been evidence of various funded access schemes, national policies and frameworks to support the GPN workforce. However, the literature (Clifford *et al.*, 2021; Queens Nursing Institute, 2020a; Lewis, 2023) continues to report that there has not been any positive increase in GPN awareness or discernible increase in the GPN workforce. As discussed, GPNs are a vital component of General Practice, making up about a third of the workforce. To futureproof this workforce, discernible action needs to be taken to improve recruitment and retention strategies and consider limiting GPN attrition.

This interpretive descriptive study explored key stakeholders' perceptions of NQNs entering General Practice as a first-post destination to understand factors surrounding NQNs' first-post decision-making. Dependent upon the study findings, these may support HEIs, employers, commissioners, and policymakers in encouraging NQNs to consider General Practice as a first-post destination.

1.4.1. Research question

The research question evolved from the scoping review (Chapter Two) findings, which provided context and understanding within the published research. The thesis research question was generated after identifying the gaps within the literature.

The research question is "*What are key stakeholders' perceptions of newly qualified nurses entering General Practice as a first post destination?"*

1.4.2. Thesis structure

This thesis has eight chapters. The first chapter provided a picture of the current General Practice landscape and how GPNs fit into it. Chapter One also provided information on why this research is considered important and discussed the research question.

Chapter Two offers a critical scoping review and discusses any knowledge gaps. The scoping review question was *"What does the current research tell us about which factors influence the career choice of pre-registration and newly qualified nurses?"* and was undertaken from an international perspective. The findings of the scoping review informed the generation of the research question.

Chapter Three discusses the methods used to undertake the three separate but interlinked studies. This chapter provided the details and rationale for the research methods, procedures, ethical conduct, and rigour. The research methodology, Interpretive Description (ID), enabled an understanding of descriptive and interpretive data. Through exploring and understanding the personal perceptions of the participants, the research aimed to capture the nuances of their beliefs and motivations. ID methodology acknowledged that perceptions, beliefs, and motivations are not singular events but are driven by multiple interactions, providing a valuable lens to explore and

understand this phenomenon. Chapter Three also provides context and detail of the methods used to undertake this research, covering the sampling, recruitment, data collection, data analysis, study rigour and ethical consent. The methods were chosen both for their applicability with ID but also for their practical applications within research. The interlinked studies provided a triangulated view of the question, enabling the findings to be developed and acknowledging the differing perspectives.

Chapters Four, Five and Six detail the three separate but interconnected studies used to answer the research question. Three participant groups have been used to explore the research question: student nurses, NQNs who have entered General Practice as a first post destination, and senior General Practice stakeholders. The sampling, data collection, and findings relevant to each study are detailed within each respective chapter.

Chapter Seven, the discussion and recommendations chapter, demonstrates the three interlinked study's triangulated findings. The discussion explored this research's findings and placed these in the context of current published research and relevant national and local policies. The research's strengths and limitations are discussed with the chapter concluding with the research recommendations.

1.5 Conclusion

Chapter One has provided an overview of this thesis and demonstrated the need and value of undertaking this research. GPNs are pivotal and vital in providing healthcare within General Practice. The current published research demonstrated that this vital workforce has a recruitment and retention crisis, which, if not addressed, would have a detrimental effect on patient access and care. This research seeks to understand *"What are key stakeholders' perceptions of newly qualified nurses entering General Practice as a first post destination?"*. Through exploring this question, it is hoped the findings will provide information which could support discussion and policy making.

Chapter Two - Scoping Review

2.0. Introduction

In Chapter One, it was established that the GPN workforce faces challenges with recruitment, retention, and attrition. Chapter Two will concentrate on exploring what is currently known within this field, establish any gaps within the current literature and support the development of the research question. A scoping review was chosen as the most appropriate method to examine the existing literature. The review will follow the Joanna Briggs Institute (JBI) methodology, ensuring a clear and reproducible body of work. While the review uncovered several research articles, there is limited UK-based research on this topic.

2.1. Scoping review

Before conducting the research, it was decided that a scoping review would be the best approach to understanding the existing body of evidence on the chosen topic. Scoping reviews provide a flexible and broad exploration of the evidence, supporting and clarifying the identification of any gaps within this evidence. Unlike a systematic review, a scoping review allowed for the exploration and mapping of a wide range of literature without the need for critical appraisal (Munn *et al.*, 2018), which can be advantageous as the goal was to provide an overview rather than an assessment of the quality of the evidence. Within scoping reviews critical appraisal is not always required, however, dependent upon the reviews objectives critical appraisal may be beneficial (Tricco *et al.*, 2018). The objective within this scoping review was to establish the breadth of articles that met the scoping review criteria and identify if there were any gaps in the literature.

The Joanna Briggs Institute (JBI) methodology was used to undertake the scoping review due to its clear systematic style, available resources, and association of academia with a clinical focus (Peters. Micah *et al.*, 2015).

2.1.1. Identifying the scoping review question

The process of creating the scoping review protocol began with refining the title. JBI (Peters. Micah *et al.*, 2015) recommended that the title should be informative and specific to the topic. Since scoping reviews cover a wide range of articles, it was important for the

title to be broad yet focused enough to meet the defined parameters. Crafting a suitable title helped guide the direction and development of the scoping review, allowing the reader to grasp the review's premise and objectives. The title needed to be sufficiently descriptive to provide clear guidelines without restricting the comprehensive nature of the scoping review.

The iterative title was set as *"What does the current research tell us about which factors influence the career choice of pre-registration and newly qualified nurses? A Scoping Review."* As meets the JBI criteria, the population is the pre-registration and NQNs; the concept is their career choice, and the context is the influential factors that will alert the reader of the information being mapped.

The defined parameters clarified the information being mapped, and the terms were adjusted and expanded during the process. "Career choice" was defined as any educational, clinical, or attrition from the nursing profession. "Pre-registrant" and "NQN" referred to nursing students who had completed a healthcare qualification leading to nursing registration or registered nurses who had worked in healthcare for up to two years. Pilot searches were conducted to test the terms and refine the terminology. The aim was to retrieve articles that met the search criteria for consideration and ensure each article met the required sensitivity and specificity for comprehensive mapping of internationally available research in this field.

2.2. Scoping review methodology and methods

The search strategy aimed to comprehensively locate the relevant published primary research that met the scoping review research question and was identified to meet the pre-selected eligibility criterion. The aims and objectives section will explore the methodological framework used and provide the rationale for its choice.

2.2.1. Methodological framework

A scoping review is a methodology used to map and summarise the evidence within a specific field. It involves collecting, evaluating, and presenting researched data to explore the scope and scale of the information available, as well as identify any areas with missing data or requiring further research (Arksey and O'Malley, 2005). The methodology

supported an informed assessment of the existing literature without aiming to answer a specific hypothesis or clinical question but rather to determine the breadth of information on the chosen topic. The main goal was not to conclusively define all relevant themes within a topic but to provide an overview of available subject matter (Mak and Thomas, 2022). A thorough assessment of each article's quality was not undertaken as it was beyond the scope of the scoping review.

If a systematic review had been undertaken, it would have been advisable to use a reporting guideline which supports with rigour, transparency and reasoning of why the systematic review was undertaken (Liberati *et al.*, 2009; Hutton *et al.*, 2015). However, as this body of work used a scoping review methodology then a reporting guideline was not used. Following the completion of this scoping review in 2017, the Prisma ScR checklist was published, which was developed to enhance reporting within scoping reviews. If this was available at the time of this scoping review, it may have improved its methodological and reporting quality (Tricco *et al.*, 2018).

The JBI methodology was used within this scoping review to provide clear guidelines and a systematic process to ensure a replicable body of work was produced. The protocol aimed to illustrate the process transparently, present the search strategy, mention any search limiters, highlight the relevant databases used and show how the resulting data was extracted and mapped.

Before conducting the scoping review, Prospero, an international database for the registration of systematic review protocols in health and social care (York, 2018), was searched to ensure no previous work had been undertaken. An a-priori scoping review protocol was developed (Appendix 1) to transparently illustrate the process, demonstrate the search strategy, and highlight how the data was extracted and mapped.

The scoping review was not repeated, as it was used to develop the research question by identifying any gaps within the literature. To ensure contemporary and relevant knowledge was maintained, various key strategies were used. Alerts were set up on academic repositories for any new research, local and national policy databases were regularly searched and regular attendance at local and national primary care meetings.

2.3. Identification of relevant studies

2.3.1. Database sources

Following discussions with the academic librarian and academic supervisors and additional learning in database searching, the databases were chosen to represent the body of research within this scoping review. Databases were the only information source used, with the following databases searched: Medline, Cinahl, British Nursing Index, Health Management Information Consortium (HMIC), and PsycINFO. These databases were chosen for their coverage, relevance to the search criteria and the quality of articles, and includes journals, conference proceedings and empirical research. These databases provided a thorough and reliable review into General Practice nursing.

2.3.2. Exclusion and inclusion criterion

The scoping review aimed to identify the influences and factors surrounding career decisions, enabling the mapping of any recurrent themes. The search approach was designed to retrieve the maximum number of pertinent studies that met the scoping review criteria. Very few limiters were applied to this scoping review, which aimed to be as inclusive as possible. Citation and reference list tracking were not employed within the data gathering phase as this review was aimed purely to understand and map the current level of knowledge within the subject.

Exclusion criteria

Type of evidence - For this Scoping Review, secondary research, grey literature, opinion papers, journal articles, reference lists and letters were deliberately excluded as these sources may not have provided a directly relevant, reliable or valid findings (Higgins *et al.*, 2024). This decision ensured the mapped results were based on measurable and evidence-based primary research. This strategy did represent a risk through the non-identification of current or new research areas; however, as a sole researcher, the decision was carefully considered to maintain the depth and breadth of the retrieved information within a practical and pragmatic timeframe.

Language— Due to the lack of linguistic support for this scoping review, only research published in English was included. This decision ensured that all included research could be fully understood and analysed, addressing potential language barriers that could have affected the review's comprehensiveness.

Inclusion criteria

Date – As the purpose of the scoping review was to obtain a broad understanding of the current literature in this field no date limiters were applied.

Geographical limiters - All geographical areas were included, as literature from different countries could provide a comprehensive cultural overview of the factors that impact nurses' first-choice posts. These cultural perspectives could add depth to the societal viewpoint of nursing, which in turn could influence career decisions and planning.

Research type - Primary research studies that involved individuals enrolled in a pre-registration nursing course and qualified nurses up to two years post-registration was included. The two-year timescale was used to provide insight into the factors influencing the cohort's first post destination decisions.

Nursing career stage - Student nurses were considered at any stage within their training; this provided an overview of any preconceived career choices and considered if their training or student nursing experiences altered these career choices. NQNs can undergo a sharp learning process in both professional socialisation and their clinical arena (Miller, Blackman and Caballero, 2005). This workforce cohort is classed as ‘newly qualified’; therefore, their decisions and choice factors are considered important. Sampling this cohort allowed exploration of whether their clinical or educational experiences changed their career trajectories.

Career choices - The concept under consideration focused on the career choices for this cohort. All career choices were considered, including those who went into clinical roles, those who continued into education, and those student nurses/registrants who did not enter nursing.

2.3.3. Keyword terms and search strings

Following the JBI (Peters. Micah *et al.*, 2015) methodology, the search terms were clustered under the parameter's 'participant', 'concept' and 'context'. Boolean operators and parenthesis were applied to the search terms to provide logical relationships between the terms used. Due to the differences between the databases, the keywords and search strings were adjusted to match the alternative Medical Subject Headings (MeSH) and exploded terms available within each database.

Initial search terms were used to assess the search strategy. The publication titles were quickly reviewed with a subsequent adjustment of the terms to make sure all relevant search terms were included. The terms were led by the inclusion criterion and further defined using the database index lists and a thesaurus. Variants were applied to the terms, i.e., alternative spellings, MeSH and Boolean operators, 'AND' or 'OR', while undertaking the search.

2.3.4. Electronic database search strategy.

The initial search was run in the designated databases using the key terms detailed within APPENDIX 2. Employing the defined search strings (APPENDIX 3), producing 8,451 results. These results were transferred to Endnote, a reference/citation software package used throughout this process. All the duplicates were discarded, which left 8,256 results. The articles retrieved underwent an initial review where the titles were scanned for relevance to the scoping review question. When the article title was unclear, a high-level review of the abstract was undertaken. 7,991 articles remained. The next review stage was based on a high-level review of the abstract, resulting in 178 remaining articles. A thorough assessment of the abstracts resulted in 87 articles. Articles were excluded if they did not meet the scoping review criteria, examples of this were research that included experienced post-graduate nurses, studies that did not include student or NQN nurses or non-empirical research papers. The remaining 87 articles underwent a secondary screening for relevance.

2.3.5. Study identification

As discussed, all primary research studies were included to explore the scoping review question *"What does the current research tell us about which factors influence the career choice of pre-registration and newly qualified nurses? A Scoping Review."* The review aimed to map the current evidence and identify gaps.

The full articles for the remaining 87 studies were obtained. These were reviewed and assessed for eligibility against the scoping review's inclusion and exclusion criteria (Section 2.3.2.). An example of an excluded study may be if the participants were in long term established post-registrant positions. As a single researcher it was acknowledged that there may have been the potential for selection bias within this stage.

Following review, 17 studies were considered to have met the scoping review criteria.

2.3.6. Charting the data

The evolution of the search strategy was planned to obtain the maximum number of studies that met the inclusion and exclusion criterion. Consideration was made concerning the sensitivity and specificity of the studies obtained. The iterative process of developing the search strings aimed to provide a broad spectrum of relevant studies for consideration and screening.

The studies were reviewed using thematic analysis (Nowell *et al.*, 2017; Braun and Clarke, 2006) which looks at recurring patterns in the data and aims to identify any recurrent phenomenon. Immersion in the data highlighted relevant concepts within the research articles. The manual assessment of the articles generated a list of 15 initial codes. These codes were then analysed and linked into three overriding themes; this was an iterative process involving amending and refining the codes and themes (Braun and Clarke, 2006). The results were charted within an Excel spreadsheet (Appendix 4).

The initial codes identified were familiar/not with the role, altruism, realisation of own values, autonomy, geographical location, job values/satisfaction, perceived qualifications, placement experience, personality/gender, educational opportunity, career planning, teamwork, preceptorship programmes, diversity of role and staffing ratios. These were

iteratively reviewed, refined and grouped into three key themes: mentorship and clinical experience, personal attributes, and career support/progression. These are shown in Table 1.

Table 1 Scoping review key themes

Mentorship and the practice placement experience	Personal attributes	Career support/progression
Familiar/Not with the role Perceived qualification Placement experience Teamwork Diversity of role	Altruism The realisation of one's values Geographical locality Job values and satisfaction Personality and gender	Autonomy Education opportunities Career planning Preceptorship/peer support programme Staffing ratios

2.3.7. Presentation of results

Consistent with the scoping review methodology (Peters. Micah *et al.*, 2015) no secondary screening or scrutiny of the research's quality was undertaken. The study details, characteristics, main findings, and thought processes were collated and charted. The information was presented in a table (Appendix 5), demonstrating the key findings generated through the thematic analysis approach.

2.4. Scoping review findings

The results demonstrated a variety of study characteristics. Three studies were undertaken in Norway (Abrahamsen, 2015; Kloster, Hoie and Skar, 2007; Rognstad, Aasland and Granum, 2004a). Six studies in Australia (Bloomfield *et al.*, 2015b; Boyd-Turner, Bell and Russell, 2016b; Courtney *et al.*, 2002; Happell, 1998; McKenna, McCall and

Wray, 2010; Stevens, 2011b). Four studies were conducted in the UK (Cronin and Cronin, 2006; Marsland and Hickey, 2003; Muldoon and Reilly, 2003; Wareing *et al.*, 2017a). The Netherlands has one study (Hoekstra, van Meijel and van der Hooft-Leemans, 2010), Peru one (Huicho *et al.*, 2015a), Taiwan one (Lai, 2006) and Jordan one (Shoqirat and Abu-Qamar, 2015).

All studies were qualitative, using a variety of methodologies and methods. Six studies used interviews (Boyd-Turner, Bell and Russell, 2016b; Hoekstra, van Meijel and van der Hooft-Leemans, 2010; Huicho *et al.*, 2015a; McKenna, McCall and Wray, 2010; Rognstad, Aasland and Granum, 2004b; Shoqirat and Abu-Qamar, 2015). Four employed focus groups (Cronin and Cronin, 2006; Huicho *et al.*, 2015a; McKenna, McCall and Wray, 2010; Shoqirat and Abu-Qamar, 2015). Three studies used focus groups and interviews (Shoqirat and Abu-Qamar, 2015; Huicho *et al.*, 2012; McKenna, McCall and Wray, 2010). Nine studies used participant questionnaires (Abrahamsen, 2015; Courtney *et al.*, 2002; Happell, 1998; Kloster, Hoie and Skar, 2007; Marsland and Hickey, 2003; Muldoon and Reilly, 2003; Rognstad, Aasland and Granum, 2004b; Stevens, 2011a; Wareing *et al.*, 2017a). One study used an online questionnaire (Survey Monkey) (Bloomfield *et al.*, 2015b).

The demographic age range of the results was a predominantly young cohort with a mean age of 25 years, and the respondents were primarily female across all the studies. Fourteen studies demonstrated data collection from student nurses and three studies provided data from NQNs.

The 17 studies sampled between 6 and 2,109 participants (Boyd-Turner, Bell and Russell, 2016b; Marsland and Hickey, 2003).

Table 2 represents the key findings from these papers, and further narrative discussion provides a thematic analysis of the findings. Theme One, mentorship and clinical experience was generated from those papers that explored how placements and the mentorship delivered may impact career choice. Theme Two provided research on the personal drivers and attributes that may influence career choice. Theme Three was developed based on articles demonstrating how teamwork and professional support networks influenced perceived career support, progression, and career choices.

Table 2 Scoping review findings

Themes	Papers	Key Findings
Mentorship and clinical experience	(Abrahamsen, 2015; Bloomfield *et al.*, 2015b; Boyd-Turner, Bell and Russell, 2016b; Courtney *et al.*, 2002; Cronin and Cronin, 2006; Happell, 1998; Hoekstra, van Meijel and van der Hooft-Leemans, 2010; Huicho *et al.*, 2015a; Kloster, Hoie and Skar, 2007; Lai, Peng and Chang, 2006; McKenna, McCall and Wray, 2010; Marsland and Hickey, 2003; Stevens, 2011b; Wareing *et al.*, 2017a).	*Clinical placements can increase or decrease the desire to work in an area. *Mentorship influences the career decisions of the student. *HEIs can influence the decision process through how the area is delivered in training. *Pre-nursing experience can alter the desire to seek employment within that speciality.
Personal requirements and attributes	(Abrahamsen, 2015; Boyd-Turner, Bell and Russell, 2016b; Courtney *et al.*, 2002; Cronin and Cronin, 2006; Happell, 1998; Hoekstra, van Meijel and van der Hooft-Leemans, 2010; Huicho *et al.*, 2015a; Kloster, Hoie and Skar, 2007; Lai, Peng and Chang, 2006; McKenna, McCall and Wray, 2010; Marsland and Hickey, 2003; Muldoon and Reilly, 2003; Rognstad, Aasland and Granum, 2004a; Shoqirat and Abu-Qamar, 2015; Stevens, 2011b; Wareing *et al.*, 2017a)	*Personal perception of the role and its inherent values. *The individual's perception of the required care and altruistic stance. *Gender, culture, society and family were found to be impacting factors. *Job security.

Perceived career support and progression	(Abrahamsen, 2015; Bloomfield *et al.*, 2015b; Boyd-Turner, Bell and Russell, 2016b; Courtney *et al.*, 2002; Cronin and Cronin, 2006; Huicho *et al.*, 2015a; Kloster, Hoie and Skar, 2007; Lai, Peng and Chang, 2006; McKenna, McCall and Wray, 2010; Marsland and Hickey, 2003; Rognstad, Aasland and Granum, 2004a; Shoqirat and Abu-Qamar, 2015; Stevens, 2011a; Wareing *et al.*, 2017a)	*Teamwork is considered essential *Professional socialisation aligning with the area's ethos of working. *Training offers further educational possibilities, not necessarily within clinical roles. *High desire for high-tech nursing as opposed to hands-on nursing.

The themes were analysed and discussed in the next section. Before evaluating the literature within each thematic area, a brief discussion of the premise behind the themes is conducted.

2.4.1. Mentorship and clinical experience

The first theme identified related to the influence of clinical placements and mentorship that student nurses undertake during training.

Danbjorg and Birkelund (2011) stated that many student nurses felt that practical training better equipped them for the nursing role (Danbjørg and Birkelund, 2011). Bloomfield et al. (2015) research discussed clinical placements as essential for recruiting NQNs, raising awareness, increasing knowledge within that area, and providing the ability to showcase varied clinical professional roles. These research articles suggest that clinical placements are important in both supporting student nurses' professional socialisation and raising the profile of the hosting clinical area. A positive placement experience can be multifactorial, with the area, staffing, and environment all playing an important role. Boyd-Turner's (2016a) research showed that the clinical speciality might not affect career preference. Still, if the clinical placement showed a supportive and welcoming environment, this would change the students' career perceptions.

This scoping review viewed mentorship as the person facilitating learning for the student within the clinical arena, providing clinical knowledge, learning, support and role modelling. Positive or negative role modelling can affect a student nurse's perception of the clinical area (Bloomfield *et al.*, 2015b; Boyd-Turner, Bell and Russell, 2016b). Mentorship was considered critical in forming the student's perception of the placement area and had a great potential to influence the recruitment and retention of the workforce. Boyd-Turner et al.'s (2016) research showed that approachability and having the time and resources to help were rated highly among student nurses; this encouraging and supportive stance allowed students to feel respected, supported, and validated within their learning. This was corroborated by Courtney et al's (2002) questionnaire-based research, which, within its findings, identified the impact that positive and negative mentorship experiences had on career choice; with positive mentorship directly correlating with the appeal of future career decisions (Hartigan-Rogers *et al.*, 2007).

Various studies noted (Bloomfield *et al.*, 2015a; Happell, 1998; Marsland and Hickey, 2003; Wareing *et al.*, 2017a) the importance of Higher Education Institutes (HEIs) in career planning. Happell's (1998) study reported on whether and how presenting a clinical area in the student nurse curriculum can impact student nurses' interest in that area. With Marsland and Hickeys (2003) findings corroborating this, providing the hypothesis that HEI course exposure to a clinical area was more likely to encourage career choice. This UK-based longitudinal study found a strong association between HEI course influence and the long-term career plans of its participants. Wareing et al (2017a) postulated that HEIs can alter career preferences.

Stevens (2011a), Australian-based research explored student nurses' career preferences for working with older people. Around 20% of the participants had undertaken prior Health Care Assistant (HCA) work in older people's care, and this was found to negatively impact their wish to continue in this clinical area. Therefore, prior clinical experience within an area can positively or negatively affect career preferences.

Theme One provided the hypothesis that nursing placements and the quality of mentorship received can influence career choice.

2.4.2. Personal requirements and attributes

Theme Two examined the personal motivators and influences that shaped career choice. These can be multifactorial, including the individual's inherent perceived or desired characteristics, geographical location, and professional requirements.

Career choice was impacted by personal perceptions of the role with various studies (Courtney *et al.*, 2002; Happell, 1998; Huicho *et al.*, 2015b) acknowledging this. Courtney et al's (2002) Australian-based research explored the career intent of working in rural clinical placements, which, when exploring the paper, appeared to hold similar characteristics to our primary care settings. More than half of the participants chose hospital settings as a career destination, citing family issues as the reason for not wanting a rural position. A further, older, Australian-based study (Happell, 1998) corroborated these findings, noting that over half of its participants wished to undertake their first career posts within hospital high-tech areas. Huicho 's (2015a) identified that these decisions may be secondary to personal perceptions of the value the roles play within both the profession and wider society.

Happell (1998), Hoekstra (2010) Huicho (2015b) research found that the perceptions of the care required and the altruistic stance it offered affected career choice. Hoekstra's (2010) mixed-methods qualitative study found that all the respondents were motivated by altruistic reasons; it wasn't clear within the study if these were secondary to personal, societal, or professional motivators. Happell's historic (1998) Australian-based research explored student nurses' perceptions of a career in community nursing. The participants perceived the clinical area as low-skilled, and their personal perceptions of community nursing may have influenced their career decisions.

The second theme held various factors which may affect career choice, including gender, culture, society and family. Abrahamsen's (2015), Muldoon and Reilly's (2003) and Shoqirat and Abu-Qamar's (2015) research all discussed the impact that culture and society have on student nurses' career choices. Muldoon and Reilly's (2003) UK-based study and Shoqirat and Abu-Qamar's (2015) study based in Jordan further explored the cultural influence from a gender perspective. Shoqirat and Abu-Qamar's (2015) study

stated that 58% of the study participants cited religion and culture as the reasons that critical care was their preferred career choice. Within this study, the male participants felt that the nursing profession was a female-gendered environment and had undertaken their training as a stepping stone to further education. Muldoon and Reilly (2003) reported similar findings with the perception of gender-typing clinical environments affected career choice with male nurses wishing to enter 'gender neutral' areas, such as management or acute clinical settings. Family influences were also found to affect career choice (Courtney *et al.*, 2002; Huicho *et al.*, 2015b) at different points in their careers. These studies found that some participants did not wish to enter 'rural' nursing secondary to family issues; however, participants would consider this possibility as a later career option.

Huicho et al's (2012) Peruvian-based research and Shoqirat et al's (2015) Jordan-based research acknowledged job security as a high motivating factor when considering career choice. These studies acknowledged that the labour market was saturated with nurses at the time of the research, and therefore, job availability may have been scarce.

Theme Two developed the premise that career choice can be multifactorial and is impacted by sociocultural influences.

2.4.3. Perceived career support and progression

Many inherent factors supported and nurtured the transition of socialisation of student nurses to NQNs. The lure of a professional working environment appeared to be associated with the perceived support and career opportunities presented within that area.

Various studies (Courtney *et al.*, 2002; Cronin and Cronin, 2006; Kloster, Høie and Skår, 2007; Wareing *et al.*, 2017a) discussed how 'teamwork' is often a requirement when considering early career choices. Courtney et al's (2002) findings stated that 20% of participants considered this a positive influencer, Kloster et al (2007) viewed it as providing experienced support, and Cronin et al's (2006) UK A&E-based study identified how specific clinical environments consider teamwork essential which was considered a desirable NQN post.

Teamwork is considered to support professional socialisation. Several studies (Bloomfield *et al.*, 2015a; Boyd-Turner, Bell and Russell, 2016a; Courtney *et al.*, 2002; Cronin and Cronin, 2006; Lai, Peng and Chang, 2006; Wareing *et al.*, 2017a) identified the need for professional socialisation when commencing a nursing career. The findings discussed a high need for support (Boyd-Turner, Bell and Russell, 2016a; Courtney *et al.*, 2002) which was discussed through a preceptorship lens, supporting professional socialisation. Lai et al (Lai, Peng and Chang, 2006) acknowledged this finding within their research, arguing that increased socialisation within clinical placements decreased fear and anxiety. However, Wareing et al's (2017a) study did acknowledge that placement with poor staffing numbers and a lack of support affected career choices; this may have been secondary to the perception that a decreased level of professional socialisation would be achieved.

Further training and educational possibilities were an identified theme within six studies (Courtney *et al.*, 2002; Cronin and Cronin, 2006; Kloster, Høie and Skår, 2007; Lai, Peng and Chang, 2006; Rognstad, Aasland and Granum, 2004b; Wareing *et al.*, 2017a). The perception around what and how much training was available was found to negatively affect clinical areas with Courtney et al's (2002) research demonstrating that its participants didn't feel that training was available within rural employment areas. A few studies highlighted how nurse training was being used as a stepping stone to facilitate further education and professional development (Lai, Peng and Chang, 2006; Rognstad, Aasland and Granum, 2004b). As these studies are international and demonstrate a wide date range, the attraction for further training was not isolated to the movement within the UK to an all-degree nursing profession. Those more acute or higher-tech areas were associated with providing increased learning and educational possibilities (Wareing *et al.*, 2017a).

A number of the studies identified that the participant's first post preferences were often in areas that could be considered high-tech (Cronin and Cronin, 2006; Happell, 1998; Rognstad, Aasland and Granum, 2004b; Stevens, 2011a; Wareing *et al.*, 2017a). Happell's (1998) retrospective Australian research stated that acute high-tech areas account for half

of all first-choice posts, with participants perceiving community care as boring and not 'hands-on'. Moving into high-tech clinical areas as a first-choice post was echoed by Rongstad (2004b) and Stevens (2011a) with the participants (Rognstad, Aasland and Granum, 2004b) discussing how they didn't want to undertake ward nursing for more than 1-2 years feeling that high-tech areas supported skill development (Stevens, 2011a).

Theme Three explored career support and the participants' thoughts on career progression. The participants' perceptions, placement experiences, and future career plans all contributed to this theme.

2.4.4. Scoping review conclusion

The scoping review findings provided various factors that could impact the career choice of pre-registration and NQNs. The factors identified were linked to their experiences in clinical settings, their perceptions of a clinical area, or were influenced by their sociocultural environments. Section 2.6, the summary, will discuss these findings in detail and highlight any gaps in the literature as per the scoping review aims.

2.5. Strengths and limitations

Bandolier (Bandolier, 15.2.2018) discussed selection bias concerning the systematic way research articles are chosen for inclusion within this work. Arksey and O'Malley (2005) acknowledged that a scoping review requires researchers to access research according to pre-determined criteria. Any selection bias within this body of work would be secondary to the single researcher status. To address this, the study selection process was supported with pre-defined transparent boundaries that met the scoping reviews premise.

2.6. Summary

The scoping review generated seventeen articles through which three key themes were developed: mentorship and clinical experience, personal requirements and attributes, and perceived career support and progression. Within the literature, several articles discussed the value of positive clinical placements in a student nurse's educational journey. Wareing's (2017a) questionnaire-based research suggested that clinical placements have the highest impact on final-year students, with the importance of placements being corroborated by Marsland (2003), McKenna (2010) and Muldoon (2003).

However, secondary care was highlighted as being a preferable first post destination in four studies (Bloomfield *et al.*, 2015a; Courtney *et al.*, 2002; Happell, 1998; Kloster, Høie and Skår, 2007) with the predominant reason being NQN's wished for professional support and skill consolidation.

The research articles have included several Australian studies, with those undertaken in the UK (n.4) primarily being historic. There was only one Australian-based study (Bloomfield *et al.*, 2015a) that explored student nurses' intentions to enter primary care. Primary care within Australia at that time contained General Practice, community mental health teams and community nursing. As my area of interest is the GPN workforce, very few studies focused on General Practice/Primary Care recruitment, with no studies in the UK focusing on GPN recruitment. This represents a gap in the current literature.

In addition, within the scoping review findings, there was no focused research to explore or provide insight into participants' views on a first post within General Practice. A few studies did provide insight into participants' thoughts on entering other clinical areas – however, these did not provide transferrable data to the UK General Practice provision.

The scoping review did highlight the importance of placements, the international perceptions surrounding non-hospital-based roles, and the value students and NQNS place on post-registration professional support.

Therefore, based on the scoping review, it was considered interesting to explore student and NQNS perceptions of a UK-based GPN role. The research was strengthened through exploring these perceptions from multiple stakeholders who may impact that journey.

2.7. Conclusion

Chapter Two provided details, discussion and the findings from the 2017 scoping review. The scoping review was undertaken following the JBI methodology (Peters. Micah *et al.*, 2015), however. Following a thematic review of the findings, a gap within the current evidence base was identified, which supported the generation of the research question.

Chapter Three will discuss the methodology and methods used in this research.

Chapter Three – Methodology and methods

3.0. Introduction

Chapter Three introduces Interpretative Description (ID) as the research methodology. It explores and rationalises the research methods, including sampling, recruitment, data collection, and analysis. Finally, Chapter Three reviews the ethical considerations undertaken within the research.

3.1. Research question

The scoping review findings have demonstrated limited evidence surrounding the perceptions of students and NQNs undertaking a first-post destination in General Practice. Therefore, to address this gap in the evidence, the research focused on exploring the perceptions of key stakeholders on NQNS entering General Practice as a first-post destination.

Following the initial refinement process, the research question was: "*What are key stakeholders' perceptions of newly qualified nurses entering General Practice as a first post destination?"*

To answer this question and enable a detailed exploration, three separate but interlinked studies were undertaken: Study One focused on student nurses' perceptions, Study Two explored NQNs perceptions, and Study Three explored senior stakeholders' perceptions. The research was undertaken using a qualitative exploratory research design.

3.1.1. Research aims and objectives

The research was constructed through three separate but interlinked studies, with Table 3 providing a synopsis of the three studies with the methods used. Each separate (but related) study was intended to inform and drive the subsequent study stage relevant to the study aims. The focus was on generating robust data within each study which would support theme development. The themes developed within each study were considered individually and in collaboration to address the research question. The research question was defined as follows.

- *What are key stakeholders' perceptions of newly qualified nurses entering General Practice as a first post destination?*

Study One sub-question.

1. *What are student nurses' perceptions on choosing General Practice as a first post destination?*

Study Two sub-question.

2. *What are the experiences of newly qualified nurses choosing General Practice as a first post destination?*

Study Three sub-question.

3. *What are the perceptions and experiences of senior stakeholders on newly qualified nurses entering General Practice as a first post destination?*

3.2. Methodology

3.2.1. Qualitative research

Qualitative research (QR) involves examining the significance and actions that people attribute to their experiences, allowing the researcher to interpret a phenomenon or event based on the meanings that individuals associate with them (Pope, 2000). The theoretical perspective for QR was approached from a social science research standpoint. Conducting QR enabled the exploration of participants' stories within their social and cultural context, making this form of exploratory research suitable for addressing the research question. In QR, researchers delve into participants' perceptions, experiences and subjective interpretations to understand their experiences. By immersing themselves in the participants' stories (Reeves *et al.*, 2008) and analysing the participants' interactions and responses, researchers can gain a comprehensive view of their experiences and how they are shaped. In the context of this study, QR facilitated an exploration of the experiences and perceptions of key stakeholders in relation to the initial employment decisions of NQNs to enter General Practice.

A framework of QR methods was used to interpret situations and provide detailed descriptions to address the study question. Within QR participants' stories are acknowledged and retold (Ploeg, 1999) to develop hypotheses within the study's context.

Creswell (2007) discussed social constructivism as individuals making multiple subjective socially situated meanings which are constructed through their interactions; this theoretical perspective was used to guide the QR process, which ensured that the participant's perspectives and decisions were considered in the research. Social constructivism was considered appropriate for this study as it acknowledges that knowledge is a synthesis of multiple cultural activities which builds a person's perceptions and experiences (Abderrahim and Gutierrez-Colon Plana, 2021). Using social constructivism supported the subjective and context dependent data, focusing on a participant centred approach and recognised the importance of reflexivity. This study's findings may be relevant to senior stakeholders, aspirant and current members of the General Practice workforce and may have broader applicability to other health professionals beyond the study's initial aims.

3.2.2. Methodology - Interpretive escription

The QR methodology used to facilitate concept development was Interpretive Description (ID). ID methodology was created to tackle clinical issues and generate knowledge that is relevant in a healthcare setting (Thorne, 2016). ID is a non-categorical framework that extracts embedded themes from the data being developed borrowing from ethnographic and phenomenological research traditions. This aimed to explore nursing field questions and generate healthcare-focused knowledge to address practical issues (Thorne, 2016; Bertero, 2015). Some key aspects of IDs conception relate to IDs pragmatic, iterative approach, leaning heavily into participant engagement and encourages the understanding of the context within which data is collected and analysed (Thorne, 2016).

As a qualitative approach ID is deeply rooted within the nursing discipline and is designed to be practically applied in the discipline of health sciences as opposed to those disciplines that work to theorise such as the social sciences. A nurse's epistemological stance, our disciplinary hardwiring, drives us to view events as both parts and the whole of

an interaction which echoes ID. ID acknowledges that as nurses and researchers we individualise and aim to understand the commonalities and differences within our professional interactions, recognising that we don't presume to have reached a theory or answer but that we accept a tentative truth claim that may be open to change.

This methodology is suitable for investigating the research question by examining the intricate interactions resulting from the participants' biological and psychosocial experiences. It acknowledges that elements of subjective reality may be shared among individuals with similar experiences. Using ID allowed for the gathering of the key stakeholder's stories and, through the analysis and interpretation of these knowledge sources supported the generation of a 'tentative truth claim' (Thorne, 2016). As with many forms of QR, in ID there is less need to generate a formal hypothesis (Ploeg, 1999) but rather ID aims to generate a deeper understanding of the phenomenon being studied and generate a 'tentative truth claims' (Thorne, 2016) from the detailed analysis of the participants stories and experiences. Additionally, ID recognises that the researcher conducting the study commonly possesses both a relevant clinical background and practical knowledge, which contributes to the researcher holding pre-existing theoretical knowledge (Thorne, 2016). Thorne et al (2004) suggested that the preexisting knowledge supports the basis for the study methods and early data analytical decisions.

Whilst ID, as a methodology, provides many strengths, it's practical relevance, placing participants at the forefront of engagement and discussion, the valuing of their perspectives and the iterative flexible process the limitations also have to be considered. ID places an emphasis on the participants perspectives and context which may affect the subjectivity of the data, there may be a degree of researcher bias, and the time-consuming iterative data collection and analysis process may make it challenging, especially when considering consistency and rigour through the research (Okoko, Tunison and Walker, 2023). Throughout this research the use of academic supervisors, research journals and reflexivity have aimed to manage some of the limitations within ID.

Thematic analysis (Ritchie *et al.*, 2014) which explores and analyses the data to provide patterns and themes, and Interpretive Phenomenological Analysis, which explores how

individuals make sense of their social and personal experiences (Ritchie *et al.*, 2014) may also have been suitable methodologies for this research. However, none of these have the aim of providing practical insights supporting a nursing focus, therefore these methodologies were discounted.

The research context was appropriately determined and defined using Thorne's (2016) methodological approach. Using ID allowed for a systematic research approach that informed the design, framed the study, and led to data transformation and knowledge generation. The methods utilised within ID are adapted from other methodologies with the aim of exploring potential clinical inquiry. It's important to use methods within ID that provide a coherent and logical research process; these methods are further discussed in this chapter.

3.2.3 Ontology and epistemology of interpretive description

Within ID the ontological stance is constructivist where reality is seen as constructed through the participants social interactions and experiences. It is acknowledged that there are multiple realities which are shaped by the individuals' experiences and can hold a contextual understanding (Scotland, 2012). Therefore, the participants will all have their own individual perceptions of a phenomenon based upon their personal setting and situation and the influences they have been subject to.

Epistemology is concerned with the nature and scope of the participants knowledge and how it is acquired, therefore within ID this is interpretivist. Knowledge is viewed as constructed and interpreted through the interactions between the researcher and the participant and therefore it is not objective but rather co-created (Scotland, 2012). Through using this co-created knowledge, the goal was to generate practical insight that can inform actionable practice which aligns with the applied nature of ID. This was acknowledged that any findings were developed through the iterative process of data collection and analysis and was subject to continuous refinement enabling multiple views on the subject and providing a deeper understanding of the research question.

3.3. Methods

The core methods discussed within section 3.3 were applied throughout each interlinked study.

3.3.1 Population

Thorne (2016) discussed the need to ensure that the research population provided relevant data to enable concept generation. Student nurses, NQNs, and senior stakeholders were cohorts with specific knowledge and experience to answer the study question. Therefore, they were defined as 'key informants'(Thorne, 2016).

Study One, student nurses in their last year of study were chosen as this population will be considering or planning their post-qualification options. Study Two, NQNs who have entered General Practice as their first post destination were considered as having relevant lived experience within which to explore the study question. Study Three's population were senior stakeholders who may or would impact GPN's recruitment or working practices.

3.3.2 Sampling

There are no prescriptive design methods within ID (Thorne, 2016); therefore, sampling may be undertaken through different methods. The required data volume, sample selection, and recruitment method determined the research sampling within this study (Braun and Clarke, 2013). Within this research, purposive and snowball sampling was used throughout the three interlinked studies.

Purposive sampling is where participants are chosen based on their relevant characteristics to explore the study question (Ritchie *et al.*, 2014). Within the three interlinked studies, the relevant characteristics relate to their experiences, behaviours and professional roles. Purposive sampling is a non-probability sampling method that relies on the researcher's judgment (Dudovskiy, 2019) to meet the sampling requirements of each study, allowing the participation of key informants (Russell, 2003) to answer the study questions. Thorne (2016) (*p. 99)* discussed the use of 'key informants' and considered that some participants may be better placed to answer the research question. She discussed that those participants who are reflective and theorise the questions are

the target sample population. The aim of the three studies was to purposively sample these participants and, when undertaking data collection, support an open narrative that encourages reflective theorisation. Sampling these participants supported theme development.

To support recruitment, snowball sampling from the already recruited participants was used. Braun & Clarke (2013) discussed snowball sampling as increasing the participant pool through utilising the researcher and participants' networks. Snowball sampling is a non-probability sampling method aimed at populations that are difficult to reach; this was considered a suitable strategy as the participants recommended contacts who had shared educational or professional traits (Kirchherr and Charles, 2018). Cresswell (2007) and Kirchherr (2018) recognised that the diversity of the sample allowed for an in-depth exploration of the study questions, which meets ID requirements.

In ID, the sample size is constructed to meet the research question's needs and satisfy the purpose of the study (Thorne, 2016). Malterud et al. (2016) discussed the concept of utilising information power, which is concerned with matching your sample size to address the study's aims, the specificity of the sample, the quality of the data obtained and the analysis strategy. Therefore, within this research, the sample size was not pre-determined, and sampling continued whilst new concepts arose. Sampling, recruitment, data collection, and analysis proceeded circuitously until a stable pattern of emergent and repeated codes was established. The flexible and cyclical nature of the sampling process facilitated the development of rich data aiding in code development (Braun 2013). Therefore, the sample size was generated from the circuitous data collection and analysis process. Participant sampling was discontinued once no new codes were identified.

In the event recruitment was oversubscribed, the participants would have been selected to demonstrate diversity in age, gender, and ethnicity. However, this process was not required.

3.3.3 Recruitment

Recruitment for each study was undertaken once ethical agreement had been received. The recruitment strategies used within each of the three studies was particular to the

study and are discussed within the study's relevant chapter. Recruitment bias was acknowledged (Pannucci and Wilkins, 2010) and it was mitigated using balanced judgment based on robust, clear inclusion/exclusion criteria and a defined (ID) theoretical framework.

Recruitment was circuitously continued alongside data collection and data analysis for all three studies, this was to ensure meaning saturation was achieved. Following a review of Thorne's (2016) and Hennink's (2017) literature, it was decided not to apply the traditional concept of theoretical saturation (Glaser and Strauss, 2000; Braun and Clarke, 2013; Charmaz, 2006). Thorne (2016) suggested that theoretical saturation may indicate that the data obtained would hold no further variations. Whereas within ID, the emphasis is on acknowledging the nuances that the data may provide and being open and authentic. Saunders et al (2018) discussed how saturation should be operationalised to consider the research question, framework analysis and theoretical position. To provide a structure within this research, the concept of meaning saturation was used; Hennink et al. (2017) discussed this as continuing data collection until all aspects of the code have been explored. Through using this approach it is aimed to ensure that the findings acknowledge that not only has everything been 'heard' but it has also been 'understood' (Hennink, Kaiser and Marconi, 2017).

3.3.4. Data collection

Glaser and Strauss (1967) discussed the importance of using rigorous data collection methods within QR. Miles & Gilbert (2005) felt this was achieved by utilising a non-restrictive open-ended strategy to encourage participants and researchers to explore their thoughts.

The methods used for data collection in ID should align with the study aims and resonate with the intended audience without any specific constraints on the types of methods (Thorne, 2016). The data collection tools in this research were semi-structured interviews (SSI) and reflexive journals. The SSIs were conducted both in person and via video conferencing platforms, with the details provided in each study. Whilst the data collections settings are discussed in more detail within each study these were primarily

held over video conferencing platforms which was secondary to the challenges of participant availability, the Covid-19 pandemic and researcher availability. Each interview was undertaken following the United Kingdom GDPR rules which considered areas such as confidentiality and data storage, all elements were clearly laid out in the Participant Information Sheet (Appendix 9).

Interviews are a well-established method for collecting data in QR and are popular within nursing research due to their relevance and ability to capture rich data. Denscombe (2010) discussed interviews as offering the ability to explore and understand opinions and experiences on multiple issues, enabling a detailed understanding of the interrelationships with multifaceted concepts. Alternative data sources could be utilised within the data collection phase, i.e. policy documents and observations; whilst these provide essential context and insight, they were not considered effective in meeting the aims of this research. The study wished to explore the perceptions and experiences of key stakeholders and therefore interviews were considered the most effective method.

Within social constructivism, a person's understanding is formed secondary to their social, cultural and temporal standpoint, which acknowledges the multiple realities that create their interpretation of events. Knowledge is constructed because of the participant's reality and aligns with a recognised form of social constructivism. Galbin (2014) discussed how multiple social and genetic influences form people's opinions and actions; therefore, this research acknowledged the social influences that formed participants' views.

3.3.4.1. Semi-structured interviews

The data collection phase allowed meaning to be constructed through actively studying participant interactions and generating an evolving group of concepts. Thorne (2016) *(p.138)* advocated interviews as an appropriate ID data collection method for exploring subjective knowledge. Structured interviews were deemed to limit the expression of personal opinions by participants, while unstructured interviews risked veering off-topic. Semi-structured interviews (SSIs) allowed the participants to provide their interpretations and feelings in response to predetermined open-ended questions, enabling a more in-depth understanding of the participants' personal opinions. As the researcher had

perceived knowledge within the area, study participants may identify them as an 'insider' (Cresswell, 2007); this is related to experience, career position, and shared knowledge. Therefore, the researcher requirement within SSIs is to be an information gatherer supporting the mutual understanding of examining a subject from multiple perspectives. Reflecting on the nursing culture and participants' perspectives were considered familiar to both parties (Schluter, Seaton and Chaboyer, 2008).

To support data gathering, and address what may have been perceived as a power imbalance, the aim was to be flexible and responsive to the interviewees conversational cues and maintain neutrality (Ritchie *et al.*, 2014), validating and valuing the interviewee's responses (Edwards and Holland, 2013). Avoidance of terms such as 'I agree' or 'that's good' were applied as these may have been viewed as value-laden prompts that may have directed the participant's interactions (Thorne, 2008).

As the sole data collection instrument, the interviews were conducted using an interactive relational approach to interviewing (Chirban, 1996); this considered both the interviewer and interviewee sharing their experiences, encouraging and supporting reciprocal involvement. The fostering of collaborative engagement allowed the building of knowledge and understanding of the participants, which aimed to build trust and share information (Chirban, 1996; Schluter, Seaton and Chaboyer, 2011). The aim was to ascertain participants' authentic, open, and transparent insights while acknowledging any researcher's perceptions and experiences.

Throughout the research, each interview was audio-recorded to aid with transcription and understanding. An interview guide, as demonstrated in Appendix 6, 15, and 19, that contained participant demographic details, broad interview questions, and interview annotation space were also used (Jamshed, 2014). The SSI guide was used to increase the breadth, depth and meaning of the data (Hennink, Kaiser and Marconi, 2017) and supported an enquiring conversation, allowing the participant to drive the flow and content. As the interviews progressed, the broad interview questions were adjusted in response to the previous participant replies – this ensured the SSIs were responsive to the emergent data and representative of the exploratory research design. The questions were

assumption-free, contextually relevant, and based on the study's aims and objectives. The resulting free flow of conversation was aimed to aid rather than stifle participant-rich inductive data collection (Crabtree, 1999). Active, collaborative communication allowed for deeper immersion and understanding of the data (Charmaz, 2006). To support data gathering and address the study question, the interviewee was guided to actively share information which acknowledged the generation of multiple realities within the data (Denscombe, 2010; Crabtree, 1999).

The interview guide held open-ended questions and provided space for annotating non-verbal communication and researcher prompts (Creswell, 2007). The SSI evolved during each study and was relevant to the research stage.

Each SSI guide was developed following a three-stage approach (Charmaz, 2006)

1) curtain-raising questions,

2) exploratory questions, and

3) closing questions.

The initial curtain-raising questions (open introductory questions) endeavoured to establish rapport and explore the participant's thoughts. Exploratory questions were aimed to increase rich narrative data and were guided by the answers received from the initial questions (Crabtree, 1999). The closing questions allowed a 'clean up' of any unanswered areas not previously discussed (Braun, 2013). The questions were amended depending on the previous participant's replies and the resulting nature of data collection.

3.3.5. Data analysis

Data analysis was undertaken through a thematic analysis approach (Braun and Clarke, 2013), which involved the discovery and interpretation of patterns within the data to provide meaningful findings (Ritchie et al., 2014). Each data source was explored and integrated, applying codes to topics which were continually tested, amalgamated, and integrated into larger key themes. To support this the constant comparative method

(Glaser and Strauss, 2000), which is used in Grounded Theory, supported the sorting and organising of the raw data and supported theme structuring to formulate the key themes. Using this eclectic data analytical mix, where various methods have been used is supported within ID (Thorne, 2016), with Thorne (2016) acknowledging that this flexible and responsive approach enables the researcher to better address the needs of practice-based research.

Thorne (2016) advised that there is no defined data analysis method within ID. Instead, it should be driven by an inductive approach, helping to give structure and meaning to the data and uncover new insights and understanding. Ranney et al. (2015) also supported the use of inductive reasoning to create a framework for organising raw data and establishing connections between the study question and the data. Thus, the analysis was guided by the research objective, with participants' responses shaping the direction and framework of the data analysis. In ID, data collection and analysis happen alongside each other, leading to refined and revised questions based on the initial analytical findings. The data was continuously reflected on, questioned, and repositioned to consider emergent codes, using background knowledge to analyse the data from various perspectives. This multifaceted approach aligned with the pragmatic aspects of ID, recognising the researcher within the data, and ID's practical application within applied disciplines.

Thorne (2016) recommended active immersion in the interview transcripts by manually working within them to allow depth of understanding and appropriate challenges to existing and new concepts. This process improved the building of codes and themes, supported through the reflection and further data collection phases. Immersion into the taped interview data and transcripts ensured that the complex nuances of the interviews provided continued intimacy and understanding.

Throughout the research, manual and automated data analysis were undertaken to ensure the principles of ID methodology were recognised, annotating memos alongside the transcripts as familiarity with the data increased. To store, maintain, logistically manage, and digitally support the generation and amalgamation of codes (Creswell, 2007), the data was entered into Nvivo 12, a qualitative data management software.

Preparatory training in its use and application was undertaken. Nvivo 12 was combined with the manual reflexive journal, enabling efficient and effective data management.

To enhance the research's rigour, discussion with academic supervisors and additional learning in data analysis supported transparency in the coding and data analysis (Ranney *et al.*, 2015).

3.3.5.1. Coding the data

Charmaz (2006) discussed coding as 'generating the bones of your analysis' *(p.45)*, providing a structure and frame to the data analysis. Coding begins with breaking the interview transcriptions into small units; with the smallest being known as a code. A code infers an event, happening or phenomenon and a short label, termed a knowledge object (Thorne, 2016), is attributed to this code. Coding allows parts of the data to be labelled, categorised, and summarised, providing concept development and interpretation (Ranney *et al.*, 2015). Information derived from the SSIs, written notes (memos) and reflexive journals contributed to forming codes, sub-themes, and themes to analyse and generate theory. Ranney et al. (2015) recognised that coding is one of the most challenging parts of qualitative research. An example of a short transcript extract is provided in Appendix 11; this represents a page of Study One Participant One, 'Anne's' interview with some initial coding and annotated thoughts. The initial first coding pass demonstrated within this short extract underwent various review stages which resulted in the refining of various codes.

The data in Nvivo 12 was organised and coded using thematic analysis, a flexible research method that enables qualitative data to be shaped into patterns or themes (Braun and Clarke, 2013). Braun and Clarke (2013) acknowledged that the six-step approach is not viewed as a procedural continuum but rather a flexible, structured approach. Each study will demonstrate within the appendices an example of how the various codes were refined into a key theme.

Stage One

Braun & Clarke (2013) discussed stage one as familiarising yourself with the data. Undertaking the interviews represented the first level of engagement with the data,

providing active participation in understanding and exploring topics. Transcription of all the interviews ensured immersion within the data, supporting the full analytical process.

Stage Two

Stage two explored code generation, which began with the interview guides for this research. Concrete codes contain specific data with a tangible meaning. For example, 'nursing field' is a pre-set category that was not subject to change throughout the data collection phase. These codes were deductive in origin and were therefore classed as ‘researcher-driven’ through the content within the interview guide.

Codes generated through topics within the transcripts and codebook were classed as inductive content-driven and primarily developed conceptual codes. Conceptual codes are naturally participant-driven throughout the interviews and hold abstract issues like perception, feelings, and personal understanding. Examples of conceptual codes were 'learning opportunities' and 'teamwork'.

Braun and Clarke (2013) recommend that data collection and analysis be done through a cyclical process which echoes Thorne’s (2016) ID methodology. Thorne (2004) discussed the importance of using a flexible and iterative process when undertaking data collection and analysis as this allows the researcher to adapt their methods to the emerging insights. As immersion in the data continued, codes were added to address new topics of interest. Some codes were merged if they represented duplicate or similar topics; some were expanded and relabelled.

Stage three

Braun and Clarke (2013) define stage three as potential themes. Codes with similar values or concepts were clustered together, forming potential core themes; this formation provided the initial themes. The development of these themes and patterns was then explored again concerning their singular inherent value and, in combination with the other potential themes (Thorne, 2016; Thorne, Reimer-Kirkham and O'Flynn-Magee, 2004). Thorne's practical application use of ID asks the researcher to review the data, asking holistically, 'What is happening here?’ (Thorne, Reimer-Kirkham and O'Flynn-Magee, 2004); this allows the development of coherent themes specific to the study's

target audience. Braun and Clarke (2013) discussed this by examining the initial themes and providing a meaningful pattern in the data and the study question.

Stage four

Stage four explores reviewing those initial potential themes (Braun and Clarke, 2013). The themes must be coherent, organised, and distinct, creating an overall study picture. Therefore, the themes were reviewed, reworked, and developed throughout stage four. This process was viewed as the quality control part of the thematic analysis process, ensuring the themes were useful representations of the data.

Stage five

Stage five provides the final refinement of the themes and can be classed as defining them. Consideration was made to naming the theme and framing what each theme meant and how this helped to frame and understand the data.

Stage six

This thesis represents stage six within this research, as it represents the endpoint of the research by writing up the research findings.

To conclude the methods section, Table 3 provides a synopsis of the three studies, demonstrating the methods used within each study to achieve the research objective.

Table 3 Research overview linking study stages to objectives and design plan

	Objective	Sampling & Recruitment	Data Collection Methods	Data Analysis Methods
Study One	• Explore perceptions of student nurses on their first post destinations	• Student nurses (within the last year of study) • Purposive and snowball sampling	• Semi-structured interviews • Interview guide	• Constant comparative method • Thematic analysis

	• Identify emergent concepts • Generate questions for Study Two	• Sample size (10 per site initially considered) determined by concept development • Three diverse Universities in Yorkshire	• Researcher reflexive journal	
Study Two	• Explore NQN's perceptions on their first post destination in General Practice • Question and reassess emergent concepts • Generate questions for Study Three	• NQN (within two years of entering the NMC register) • Purposive & snowball sampling • Sample size is not pre-set (approximately 10 participants)	• Semi-structured interviews • Interview guide • Researcher reflexive journal	• Constant comparative method • Thematic analysis
Study Three	• Explore senior stakeholders' perceptions of NQNs entering General Practice as a	• Senior stakeholders (employers, educators, policymakers and clinical commissioners)	• Semi-structured interviews • Interview guide	• Constant comparative method • Thematic analysis

	first post-destination • Critical reflection /analysis on concept development • Linking concepts • Review findings in combination with research questions and existing evidence.	• Purposive and snowball sampling	• Researcher reflexive journal	

3.4. Research rigour

Within QR, there are no universally agreed quality criteria. Johnson et al (2020) discussed QR rigour as providing a clear and focused research question that is supported by a robust conceptual framework and the use of researcher reflexivity. Lincoln & Guba (1989) discussed establishing and enhancing the trustworthiness of QR and suggested four criteria, credibility, triangulation, external checking and peer debriefing. Braun & Clarke (2013) further reviewed and developed Lincoln & Guba's (1989) work and discussed their key strategies for ensuring quality in QR, including member checking and triangulation.

Credibility was demonstrated through prolonged exposure and engagement both in the field and within the data, which included undertaking transcribing of all the interviews, enabling an in-depth understanding of the participants perceptions. Thorne (2016) discussed this as prolonged engagement providing scope and persistent observation

providing depth of data. Triangulation of sources was actioned using academic supervisors, which could be termed investigator and theory triangulation and reflexivity. Triangulation was achieved through transparent data collection methods, narrative notes, and reflexive journals throughout the research process. The use of constant data comparison aided in developing the concepts. Whilst this study didn't echo triangulation in its purest sense the research did explore different key stakeholders to provide credible data. External checking and peer debriefing were undertaken to review and explore various aspects of the data, test theme generation or explore new avenues. Using multiple types of stakeholders supported the enquiry into disconfirming evidence and conflicting viewpoints; this was undertaken through using the study participants to explore some of the emergent themes thereby member checking study one with study two and study three with the previous studies.

Consideration was made regarding the researcher's stance within the study, ensuring that data collection focused on the participants' responses, not pre-perceived 'experience' within the study area (Braun and Clarke, 2013). The researcher ensured they were a passive collaborator within the data collection process, instead of the clinician/manager directing and leading the clinical interview; this was achieved through undertaking additional training, active reflection and using a reflective journal. Passive collaboration refers to supporting rather than leading the discussion, allowing the participants to provide and drive their responses based around their perceptions and experiences. Reflexive practice (Chapter Seven) was also employed to address any clinical similarities with the participant's knowledge and profiles within primary care. Reflexive practice within QR is considered as examining your own judgments, thereby applying your mental, emotional and value stance to question where you are situated within the research (Olmos-Vega *et al.*, 2022). A reflexive journal was maintained throughout the research, which helped with tracking reflections and peer review (Thorne, 2016) and was particularly helpful when interpreting and authenticating the participant's narrative. Through journaling critical self-reflection of the methods, application and researcher actions could be raised, discussed with academic supervisors and explored or addressed. The journals enabled a review of where personal assumptions may sit, identifying and

clarifying where individual belief systems may not be the same as the participants. Through undertaking this process, an audit trail of personal feelings and assumptions was identified to support researcher subjectivity.

3.5. Ethical considerations and approvals

Each study within this research project required ethical approval prior to data collection. Study One, involving students recruited through their HEIs, required a submission to the Research Governance Committee at the University of York for ethical approval. Study One approval was granted in July 2019 HSRGC/2019/351/A (Appendix7). Study Two, involved NQNs working in General Practice required HRA ethical approval, obtained through the Integrated Research Application System (IRAS) in November 2021, REC reference 21/PR/1355 (Appendix14). Study Three, which involved senior stakeholders working in General Practice, Universities and national bodies, required ethical approval as an amendment to Study Two's HRA-acknowledged ethical approval; this was approved in March 2022. REC reference 21/PR/1355, IRAS reference 304245 (Appendix17).

Ethical considerations such as confidentiality, risk, privacy, and the subjective context of the findings were undertaken throughout this research. Confidentiality and data security ensured that participants identities were protected which built trust and an open and honest data collection process, ensuring the data was collected and held in a secure and robust manner. Privacy and consent were undertaken ensuring that no data collection was commenced until informed consent had been obtained. Data collection was subject to, and followed, General Data Protection Regulation (UK Research and Innovation, 2020) which ensured that only data necessary for the study was collected, informed consent was received, data was anonymised and held securely to protect against data breaches. The main risks and limits identified within this research were around the use of video conferencing platforms and ensuring that the methods used were consistent and secure.

3.6. Conclusion

Chapter Three detailed the methodological framework and methods used in this research. The three interlinked studies that form this research used the same methodology (ID) and methods (purposive sampling, SSI, and thematic analysis).

Chapters Four, Five and Six will discuss the separate but interlinked studies, providing specific details on the study's methods and findings.

Chapter Four – Study One

4.0 Introduction

Chapter Four presents the methods and findings from the first of three interconnected qualitative studies that addressed the research question, *'What are student nurses' perceptions on choosing General Practice as a first post destination?'*

Chapter Four provides an overview of the research methodology and methods, as discussed in detail in Chapter Three, that were used in Study One. Further Study One specific details on participant recruitment, data collection, and data analysis will be discussed. The discussion will focus on the successes and challenges of these methods and a rationale for how the challenges were addressed.

Participant recruitment, data collection, and analysis were undertaken simultaneously from November 2019 to February 2021. Sixteen participants who met the sampling criteria were recruited and interviewed. Data collection and data management were inductively conducted, with participant content driving the development of both. Data analysis was undertaken, and verbatim comments were used to acknowledge their significance and presence within theme generation.

Braun & Clarke's (2013) six-step approach enabled theme generation, using constant comparison of codes to develop key areas. The descriptive and analytical discussion undertaken within the findings section identified three key themes. The key themes present interconnected and isolated factors and highlight the complexity of choosing General Practice as a first post destination. The discussion section provides a contextual analysis of the key themes.

The developed key themes are used to form Study Two's initial data collection questions, discussed in Chapter Five.

4.1 Study One methodology and methods

4.1.1. Research question

Study One explored *'What are student nurses' perceptions on choosing General Practice as a first post destination?'* The question was explored using qualitative methodology and,

methods appropriate to the phenomenon being studied (Braun and Clarke, 2013) and discussed in detail in Chapter Three.

4.1.2. Study design

The study design was aimed to determine the participants' perceptions of entering General Practice as a first post destination and their experiences and understanding of General Practice nursing. ID methodology, (as described in Chapter Three) was used to explore these perceptions and experiences (Thorne, 2016).

4.1.3. Sampling and recruitment

Sampling

As discussed in Nyimbili & Nymbili's (2024) journal article within purposive sampling relevant participants were sampled when considering how best to answer the research question. The sampling criterion was student nurses, within any nursing field, based at one of three identified universities within their final year of study. These participants were classed as the key informants and were considered important and valuable for exploring the research question with Teodoro et al. (2018) acknowledging the importance of exploring the phenomenon within its context.

The sampling criteria was aimed to enhance the study's descriptive capabilities through sampling relevant stakeholders who could provide relevant perceptions and experiences (Nyimbili and Nyimbili, 2024; Ritchie *et al.*, 2014). In Study One, the required characteristics for the purposive sampling set were student nurses in their final year, any nursing pathway, and no gender or age limiters.

As meets with ID methodology and discussed within Chapter Three, a pre-set sample size was not identified. Thorne (2016) suggested that the breadth and depth of the research question and data collection led to the sample size. Therefore, the sample size was determined by the quality of the collected data and subsequent analysis. Data collection was discontinued once data reached stability in its breadth and depth of meaning (Hennink, Kaiser and Marconi, 2017), as discussed in 3.3.4 data collection. Meaning saturation aimed to provide a depth and breadth of data which supported the scope and

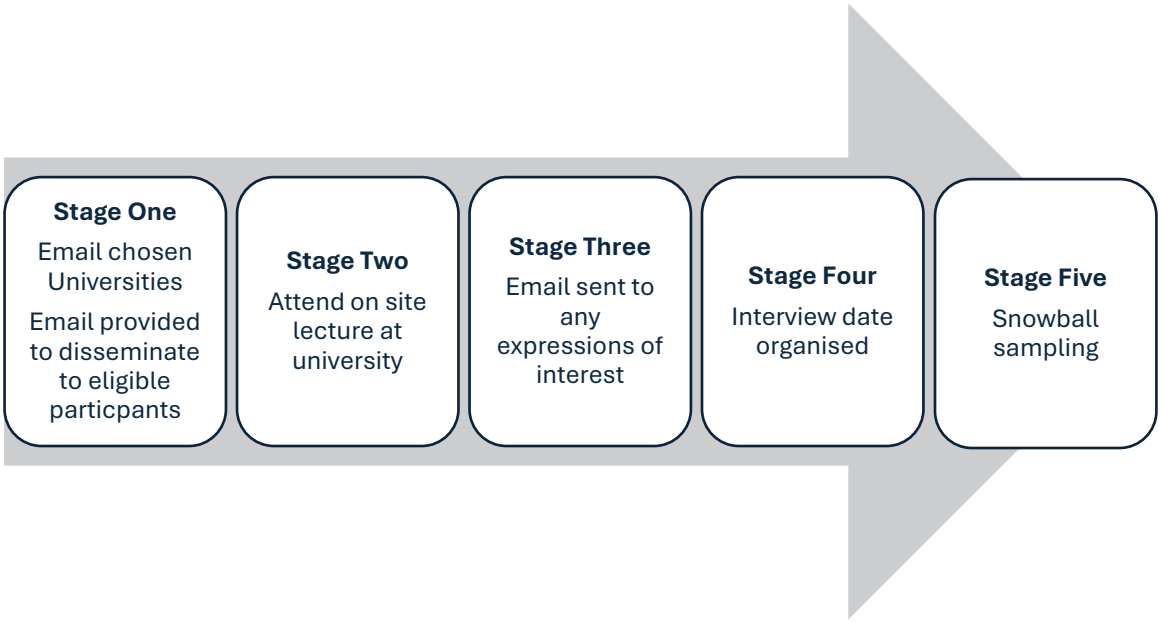
richness of the findings. When exploring depth this aimed to provide detail, complexity and nuanced insights, breadth was concerned with collecting a wide scope of data from the participants. As this process was iterative, recruitment, data collection, and analysis continued simultaneously; whilst the sampling criterion remained static.

Recruitment

Student nurses, from any nursing pathway, were recruited from three UK Universities (in local regions known to the researcher). The University settings were chosen secondary to locality and known professional network contacts; the geographical area represented rural and urban topography and the availability of a mixed demographic of students.

The following flow chart demonstrates the high-level process undertaken for participant recruitment (Figure 2)

Figure 2 Study One participant recruitment



Stage One. Following ethical approval (Appendix 7), the university nursing department heads were emailed (Appendix 10) to obtain their support for participant recruitment. The email contained information on the study (Appendix 9), the ethically agreed-upon participant pool, and a copy of the Research Governance Approval (Appendix 7). All three universities were happy to support the study and agreed to disseminate the recruitment

email to the specified cohort, defined as student nurses within the last year of their training, studying at one of the eligible university settings.

An email was provided to the universities for dissemination to the eligible participants (Appendix 10); it contained the study details, criteria, and academic contact information. The initial email was sent at the beginning of the academic year when eligible participants began their final year of education. By recruiting at this time, it was hoped that the cohort would not be on clinical placement and would be available to participate. Three rounds of university emails were sent throughout the academic year. Step one was repeated at the beginning of the next academic year, secondary to a researcher leave of absence due to the national COVID-19 pandemic. The COVID-19 pandemic was a global outbreak of a severe acute, primarily respiratory, infection which began in December 2019. The World Health Organisation (2024) categorised this as an international pandemic in March 2020 which led to widespread health, social and economic disruption with immense pressures on healthcare, national lockdowns and restrictive measures to help reduce the spread and severity of the disease. Within the nursing profession the COVID-19 pandemic affected both pre and post registration nurses (Henshall *et al.*, 2023); affecting both how and where training was delivered in addition to how post registration nursing was undertaken.

Stage Two. To boost participant recruitment, a university-based lecture was attended to promote and create awareness of the study among the students present. At the start of the lecture, a brief study overview was provided alongside flyers containing information and academic contact details. Secondary to the COVID-19 pandemic, all face-to-face teaching had been suspended, therefore attendance was achieved at two of the three university settings.

Stage Three. As per the ethical approval, following participant expressions of interest, participants were emailed an information sheet (Appendix 9) and a consent form (Appendix 8). A total of three emails were sent to interested participants to encourage participation. Contact was ceased if an interview was not achieved following the third chaser email. Five students who initially expressed interest in the research were lost secondary to this.

Stage Four and Five – Written informed consent was obtained before the interview took place. The written consent form was combined with their interview guide and was stored following United Kingdom data protection law. Participants were then considered available for interview. It was acknowledged that participants were providing their time; therefore, to limit any associated participant costs and competing commitments, the participants were provided with as much control over the timing and place of the interview as possible (Braun and Clarke, 2013). An interview date was booked, and once the interview had been concluded, interviewees were encouraged to tell their university year group about the study and to share academic details. This method represented snowball sampling (Braun and Clarke, 2013) and generated seven further expressions of interest. No payment was provided to participants, although refreshments were offered.

4.1.4. Participant details

Sixteen participants were interviewed, with fourteen participants entering their nurse education straight from undertaking their A levels or an access course. Two participants were postgraduates who had a previous degree, one in a health sciences field and one within languages. Seven participants had prior care work experience. During their training, all sixteen participants had experienced a community placement, with thirteen participants undertaking time with the community nurses and three working with GPNs in General Practice. Three participants disclosed they had ongoing personal caring responsibilities and therefore, within their social lives, were in close contact with their General Practice surgeries.

A summary of the recruited participant demographic data is demonstrated in Table 4.

Table 4 Study One participant profile

Participant Profile	Number
Total Participants	16
Gender Female	14
Male	2
Age 20-24 years	11
25-29 years	3
30-35 years	1
I preferred not to say	1
Ethnicity White British	14
Asian British	1
Black African	1
Placement experience	
Secondary care	16
Primary care	3
Community care	13
Pre-training highest qualification status	
Bachelors degree	2
A levels	11
Access course	3
Prior caring experience	

Secondary care Primary care Community/Nursing home care	2 1 4
Ongoing personal caring responsibility	3

As demonstrated in Table 5, each participant was allocated a pseudonym to ensure a confidential, clear, and consistent textual flow. Pseudonyms were used to maintain and protect participant anonymity which respects the participants privacy, encourages honest and open conversations and adheres to ethical guidelines (Heaton, 2021). The allocated pseudonyms were researcher generated in an alphabetical order.

Table 5 Study One participant anonymisation

Participant Number	Pseudonym
Participant 1	Anne
Participant 2	Belle
Participant 3	Charlie
Participant 4	Debbie
Participant 5	Fiona
Participant 6	George
Participant 7	Helen
Participant 8	Irene
Participant 9	Jane
Participant 10	Kim

Participant 11	Lynne
Participant 12	Mary
Participant 13	Nancy
Participant 14	Orla
Participant 15	Penny
Participant 16	Rita

4.1.5. Data collection

Data collection was undertaken through semi-structured interviews (SSIs). The SSIs were used to produce raw data that could be transformed into an interpretive account of the participant's responses (Thorne, Reimer-Kirkham and O'Flynn-Magee, 2004); this enabled the generation of 'constructed truths' to answer the research question. Chapter Three includes a more in-depth discussion of SSIs. Between November 2019 and February 2021, sixteen SSIs were conducted, supported by the use of an interview guide (Appendix 6).

Ten face-to-face interviews were undertaken within a private room in the participant's University library, which Galletta (2013) acknowledged aids with confidentiality and audio recording. An additional six interviews were conducted using video conferencing platforms (Microsoft Teams). All participants were offered a copy of their interview transcripts to ensure they felt the transcripts represented a valid and reasonable account of their experiences (Mays and Pope, 1995). The timing for each SSI was initially set at approximately one hour, with an extra 30 minutes for pre and post-discussion, with the interviews ranging from eighteen to forty-six minutes. Field notes/journaling were completed post-interview, which supported reflection upon the interview responses and the context of answers. Modification of future questions was implemented after the interview with reflection and action taken to improve the interview technique (Ritchie *et al.*, 2014; Cresswell, 2007).

The decision to collect data using video conferencing platforms followed the COVID-19 pandemic and its national restrictions. This pragmatic approach to data collection enabled the research to continue despite national restrictions and provided greater interview time and place flexibility (Greenspan *et al.*, 2021). Unfortunately, it proved more challenging to read non-verbal cues and occasionally, connectivity affected the narrative flow, with online digital interviews feeling more tiring secondary to the increased focus required. Keen et al (2022) acknowledged the challenges that video conferencing platforms can bring; however, contrary to the Study One interviews, Keen et al (2022) and Lobe et al (2020) reported that facial and vocal cues are retained in video calls, and therefore, rapport can be maintained. As discussed by Carter et al (2021) the accessibility and functionality of video conferencing platforms provides a positive additional tool to the researcher's collection, provided the ethical, technical, research design, and social challenges are considered. To support the data collection process and the challenges of video conferencing platforms, each interview was manually transcribed rather than using a paid or electronic platform. The first two transcripts underwent academic supervisor review, which provided feedback and direction on interview style and guidance to direct and support data collection.

4.1.6. Data Analysis

The anonymised transcripts were uploaded into Nvivo 12. Code generation provided the data analytic bones (Charmaz, 2006) to build and develop a body, structure, and frame. The initial codes were intuitive, demonstrated short descriptive labels, and evolved following reflection and development of the data i.e., ‘positive placement experience’ or ‘GPN role perceptions’. Newly generated codes, such as 'primary care career advice not available', developed from SSI four, were tested in subsequent SSIs to determine whether this was a developing topic or an individual variance.

The transcripts were systematically reviewed to ensure the data's meaning was identified within the codes, with existing and new codes organically driven from the data. Charmaz (2006) discussed how the aim was that the codes were understandable both within and outside of the context of the broader data set.

Within the first six interviews, 60 of the 68 codes were generated; therefore, 88% of codes were identified and established. These codes represented both concrete and conceptual codes. Conceptual code stability was achieved by interview eight. Data collection was continued to ensure confidence that the nuance of each code had been explored, which met the values of meaning saturation (Hennink, Kaiser and Marconi, 2017) and the principles of ID methodology. Meaning saturation was determined to be achieved by interview eleven, where no new concrete or conceptual codes had emerged in the last three SSIs, however, a further five interviews were undertaken to ensure that all topics were explored deeply and broadly.

Throughout various cycles of examining the codes, themes and sub-themes were generated, fragmented, and amalgamated to test their content. The sub-themes and themes also underwent subtle title changes to ensure that they appropriately reflected the codes. A few initial themes were 'older workforce', 'experience required', and 'employment pathways'. Appendix 12 demonstrates a worked example of how the theme GPN Career Support evolved through the amalgamation of various interconnected codes.

The initial theme of 'older workforce' was prevalent from the first interview and was amalgamated into the overall theme of perceptions of the GPN role. The 'experience required' theme was fragmented into various sub-themes that examined what experience was perceived as required, who recommended this, and which facility should provide the experience; the final theme became 'the requirement for secondary care experience'. When exploring employment pathways, the short-label descriptors underwent various changes. The terminology used by the participants primarily centred around careers as opposed to employment pathways; therefore, there was a short-label descriptor change. A subsequent amalgamation of codes provided the final key theme of career advice.

Each potential theme was reviewed, checking that the data contained was rich in content and focused on the theme title. Any data embedded within those possible themes that felt too diverse were re-coded, reviewed, and reassigned if it did not add value to the theme. The remaining data within the themes was examined concerning the original transcript and the whole data set. Through this continual nonlinear process, an in-depth

awareness was gained of the building themes which increased their quality. The number of themes generated was driven by the data available to provide robust, well-supported themes.

The three themes presented have discernible boundaries and contain data that supports the study question. The three key themes, 'perception of the General Practice Nurse role', 'secondary care experience is presumed to be a required first post destination', and 'limited availability of career advice to enter General Practice', are felt to present a meaningful overview of the participant's responses to the study question.

Theme one – perceptions of the GPN role were generated through amalgamating various codes. The codes included - deskilled, GPN role awareness, first post in primary care, community nursing, workload pressures, work-life balance, workforce age, and workforce terms and conditions. The codes were further refined to represent the sub-themes for theme one. The sub-theme areas were aligned with a low-skilled, older workforce, family-friendly working hours, slow pace, and terms and conditions.

Theme two – secondary care is presumed to be a required first post destination was generated by combining several codes: secondary care experience, who's requested secondary care experience, length of advised experience, and secondary care experience not required. These codes have been refined to represent the sub-themes of who advised secondary care experience, why this advice is given around first post destination, what timescales are advised and preceptorship availability.

Theme three is the availability of career advice to enter General Practice. This key theme has been developed by merging career advice available, career advice being investigated, career advice not available, career decision factors, and career pathways. The codes were aligned to two sub-themes: available career support and career support is not available.

4.2. Findings

The findings section represents Braun and Clarke's phase five within the thematic analysis process, providing a concise, logical, and coherent account of the data (Braun and Clarke, 2013).

Only three participants (Fiona, Lynne, and Orla) had experienced an allotted General Practice placement. In addition, Jane had organised a two-day General Practice spoke placement, and Debbie had been employed as a health care assistant in General Practice before her nurse training. The remaining eleven participants had no clinical experience in General Practice.

A weight of evidence centred around the overarching theme of the perceptions and apparent myths of working within General Practice. These perceptions were aligned to three key themes: a perception of the GPN role, secondary care is presumed to be a required first post destination, and finally, the availability of career advice to enter General Practice.

An overview of the key themes is demonstrated in Table 6.

Table 6 Study One key themes

Key Themes	Sub-Themes	Participants
Participants perception of the General Practice Nurse role. *"I just wouldn't associate that with nursing"*	Low skilled Older Workforce Family-friendly working hours Slow working pace Terms and conditions	Anne, Belle, Charlie, Fiona, George, Helen, Irene, Jane, Lyne, Mary, Nancy, Orla and Rita.

It was believed that secondary care is presumed to be a required first post-destination. "*people think I should work in the hospital first because that's where you learn to be a nurse".*	Who advised secondary care experience as a first post destination? What advice is given around the first post-destination? What timescales are advised Preceptorship availability	Anne, Belle, Charlie, Debbie, Fiona, George, Helen, Irene, Jane, Kim, Lynne, Nancy, Penny and Rita.
There is limited availability of career advice to enter General Practice "*I think you have to look a little bit harder to get that guidance".*	Available career support Career support is not available	Anne, Charlie, Debbie, Fiona, George, Helen, Irene, Jane, Kim, Lynne, Mary, Nancy, Orla, Penny and Rita.

4.2.1 Theme One - Perception of the General Practice nurse role. "*I just wouldn't associate that with nursing"*

The need for more understanding of the GPN role was a common thread throughout the interviews. Participants' perceptions of working within General Practice were that the GPN role was mostly suitable for older nurses who wished for a family-friendly work-life balance and that the role didn't require the same nursing skill level seen within secondary care. The perception was predominantly demonstrated in those without prior knowledge of the GPN role. These perceptions appeared to be represented through peer discussion, secondary care placements and family motivators.

Participants highlighted a significant gap in their educational experience, noting that the General Practice Nurse (GPN) role was scarcely discussed within their HEIs. Those who

had undertaken a General Practice placement within their community rotation, or had prior General Practice knowledge were able to discuss the differences. However, the distinction between community nursing and the GPN role remained unclear for some (Anne, Belle, and Charlie). This confusion persisted upon further questioning, with uncertainty about whether the GPN role was facility-based community role.

Conversely, participants with direct exposure to both community and GPN roles (Debbie, Jane, Orla) demonstrated a clearer understanding of the role's nuances. Those with prior knowledge or experience in General Practice placements (Fiona, Lynne, Orla, Jane, and Debbie) viewed the GPN role more positively and did not share the negative perceptions of the GPN role as being associated with a deskilled, older workforce or poor work-life balance.

This disparity underscores the need for clearer discussion about the GPN role within HEI nurse education programs to ensure all students have an accurate and informed understanding.

'I would consider it as a first career place. I was working with GPs, HCA, GPNs and ACPs'. (Fiona)

'the GP placement always stood out to me. I can't put my finger on what it was about that, but I really enjoyed the placement' (Lynne)

4.2.1.1 Low skilled

When asked about the GPN role, five participants (Anne, Belle, Charlie, George, and Kim) wanted more knowledge of roles, responsibilities, capabilities, and skills. When asked about her thoughts on starting her first position in General Practice, along with her views on peers considering the same, Anne commented.

‘I just wouldn't associate that with nursing, but I've never had a placement there’ (Anne)

‘Well, I don't know that would be for me; I'm more of, hmm, a nurse’ (Anne)

'She would be an ace ward nurse, and I think it's such a waste' (Anne)

Anne's broad statements reveal a critical perception that GPNs are less important and skilled compared to nurses in other clinical settings. She struggled to articulate what the GPN role entailed and consistently viewed nursing as primarily represented in secondary care. Despite her community placement within a community nursing team, which she enjoyed for the '*respect*' community nurses received, Anne did not equate GPNs or community nurses with the professional status of secondary care nurses. The combining of community nursing and GPN roles, which may have been influenced by her university's placement structure, could signify an educational gap. Anne's inability to distinguish between these roles highlights the need for clearer, more distinct educational content regarding the GPN role to ensure student nurses students can accurately understand and appreciate the unique contributions of GPNs.

Anne's perception of the nursing role appeared to be secondary to managing acute events only, '*you know, your cardiac arrests and things like that'*. Anne was not alone in this perception, as other participants could not distinguish between the roles of a community nurse and a GPN. Aligning both community and GPN roles was a common concept with participants.

Other participants corroborated the concern over becoming deskilled within General Practice. George, Helen, Irene, and Rita felt that skills established within a secondary care environment would not be used within a community/General Practice environment; therefore, they expressed concerns that community and General Practice were perceived as lesser-skilled areas. When asked about undertaking a first post in General Practice, Helen also reported concerns about not achieving adequate skill consolidation. Again, these participants had not experienced a GPN placement and were basing their perceptions on peer group discussion, secondary care, and university feedback.

'I felt from my training I was being deskilled [this perception was based upon a community placement]*, and I wasn't able to flex the muscles that I had been developing up to that point' (George)*

'I will be a bit deskilled in primary care; they seem to think I won't be doing everything a nurse will be on a ward' (Helen)

'it's not a lot of my clinical skills' [this perception was based upon a community placement] *(Rita)*

The terminology used, '*deskilled*', '*not a nurse*', and '*not a lot of my clinical skills'*, indicated negative perceptions of the GPN's skill level. These negative perceptions were particularly prevalent amongst those without professional experience in the GPN role. In contrast, those with clinical experience offered a more positive perception of the role. For example, Lynne, who had undertaken a GPN placement, discussed the skill mix of a GPN within a positive context, noting her increased confidence and knowledge of wound care, long-term conditions and communication. When discussing her placement, she used terms such as '*enjoyed*', '*well supported*', '*tight-knit*' and '*well organised*', with comparative terms used by other participants who had undertaken a GPN placement.

'the practice nurse who was doing all the appointments, which were really good, she was really knowledgeable' (Jane)

'I don't feel there would be any deskilling no – have that time to have a conversation is a good skill as well' (Lynne)

'I just think it's a different set of skills, and they are all needed' (Orla)

Role visibility was also explored from the perception of a service user with participants discussing the GPN role in a positive manner. 'S*potting lots of different conditions'* (Charlie), and '*when I go to a GP, I will see a nurse, not a doctor'* (Mary), which may infer that GPNs are perceived differently with service users to the perceptions of their professional peers.

When participants discussed the GPN role, they used phrases such as '*autonomous', 'decision making', 'responsibility'*, and '*prescribing*'. These phrases align with a complex role requiring knowledge, contrasting with the participants' perceptions of becoming deskilled. Kim summarised this as '*I can't quite imagine what the day-to-day role is'.*

When questioned about the visibility of the GPN role, participants reported that more targeted knowledge would only be obtained through placement activity (Anne, Charlie, Kim, Lynne, and Rita) and theoretical discussion supported through their university (Jane, Lynne and Penny). This supports the perception that HEI facilitated education and discussion would be beneficial in understanding the GPN role.

Several participants expressed an interest in undertaking Advanced Clinical Practice (ACP) roles within General Practice (Belle, Helen, Irene and Lynne). However, George aspired to train in an ACP role but in a secondary care environment and attributed this to the perceived lower-skilled General Practice ACP role. Even within the realms of undertaking an ACP role, General Practice again seemed to be deemed a lower-skilled area to work in

I loved my A&E placement and would like to be an ACP there, however I think it would be easier to do my ACP training in General Practice, as well, it's easier there (George)

'I think eventually if I'm confident enough and I feel brave enough, I will go out into A&E and walk-in centres, but I might start in a GP practice' (Belle)

Several factors influenced student nurses' perceptions of the GPN role, such as clinical experience, peers, families and educators. Debbie discussed how she felt secondary care colleagues drove the GPN's incorrect role perception but did balance this comment with the knowledge that they may not have direct experience within which to advise. Charlie's mum was a community nurse, and following the completion of the interview, and picked up from the SSI guide annotations, he commented that he did not want to '*nurse like his mum*'. The non-verbal communication signs during this statement were negativity and sadness; therefore, community nursing appeared to have also formed negative role perceptions for him.

These findings suggest that educational, secondary care environments, family members, and friends influence GPN role perceptions.

4.2.1.2 Older workforce & family-friendly working hours

The data on the workforce demographic profile of GPNs revealed a perceptions of GPNs as an '*older workforce*' (Anne, Belle, Charlie, George, Jane, Nancy and Rita). Participants

linked the perceived working patterns more appropriately to those older or wished for a better work-life balance (Anne, George, Helen, Irene, Jane, Mary, Nancy and Orla). A commonly held perception was that the GPN role was linked to nurses with caring responsibilities (children) or those who did not want to undertake the shift patterns commonly seen within secondary care. This perception was further supported by comments from participants like Rita, who viewed the GPN role as suitable for those with children and extra responsibility. She further alluded to this in her comment, '*they want to be in hospital whilst they are young and don't have that extra responsibility'.* The desire for a perceived 9-5pm schedule without weekend or night shifts was echoed by several participants, including Anne and Charlie who saw the role as more compatible with a work life balance.

'It seems to be that it's more for those that have a home life and want the 9-5 and the set working patterns with no weekend or night work' (Anne)

'As I grow older, I will probably be going to a GP surgery' (Charlie)

'She wants to go straight into the community because she wants to start having children immediately' (George)

'It just felt like it was more for women that didn't want the lifestyle of a ward – I will be honest with you, it tended to be a lot of older nurses' (Jane)

Those participants who expressed these opinions did so primarily from a positive stance, perceiving that these were desirable attributes of the role.

'I think a lot of us, because I'm talking from like a mature student perspective, that have to balance the fact that we are all also mothers, well because a lot of us look at areas that we want to do, but also that can fit around our lifestyle and childcare' (Jane)

'I don't want to feel like I've got no work-life balance, and I don't want to be doing 12-hour shifts in my 50s' (Nancy).

Several participants acknowledged that working within secondary care is perceived as shift-based working patterns (Anne), not providing a work-life balance (Nancy) and may

not fit with caring responsibilities (Jane). Participants, therefore, provided the perception that the GPN role could overcome the work challenges that secondary care offered. Jane was the only participant over 30, and Jane and Debbie had children. The positive perceptions of an improved work-life balance appealed to these participants, and both were basing their first post destinations decisions on this.

Critically these perceptions highlighted a significant aspect of the GPN role and it's appeal to those seeking a balance between professional and personal responsibilities. The data suggested that the perceptions of how GPN work is undertaken is a key preference when considering first post destination.

4.2.1.3 Slow working pace

The work within General Practice was sometimes perceived as slower-paced, with no acute care required (Belle, George, Helen and Irene). The perceived lack of stress for the GPN role was another perceived positive role attribute. Belle, George and Helen had not undertaken any General Practice clinical placements; therefore, perceptions have been informed by peer groups and anecdotal conversations rather than experiential learning.

'It's not like ward nursing where you are standing and running around, but you are sat behind your desk' (Belle)

'The rate of working in a GP practice wouldn't really appeal to me' (George)

'Seem to think that I won't be doing everything that a nurse would be on a ward; it's not as fast-paced' (Helen)

When discussing the GPN role, the above comments were not isolated findings alluding to the perception of a slower working pace. Several participants linked the perception of the slow working pace with the presumed age profile and family-friendly hours of GPN roles.

Nancy commented that she felt she wouldn't be interested in a GPN role as it '*isn't as intense and fast-paced'* but did go on to say that she felt this would benefit patient care as she felt the slow pace meant you could '*spend more time with the patients'.* Whereas Belle acknowledged that whilst the shifts may represent the same duration as secondary care,

the work pace was more manageable, '*it's not like ward nursing where you are standing and running around, but you are sat behind your desk'.* When discussing the pace of work within General Practice, terms such as '*easier', 'relaxed' ', and 'less stressful'* were given, which denotes the perception of a slower work pace. This is in contrast to the perceptions of working in secondary care which was discussed in terms of '*busy', 'stressful', 'understaffed'* and *'burnout'.*

For those participants who had experienced a General Practice placement, the terminology utilised was positive and measured. Jane acknowledged that the work pace was transient: '*busy days and you're not so busy days'*. In contrast, Debbie discussed the work pace needing '*time management'*, which denotes work-related pressures.

4.2.1.4. Terms and conditions

Discussions around terms and conditions were limited, with Helen (interview 7) raising the topic. As this is a topic that receives a high level of social media and press discussion, it was felt worthy of further investigation; therefore, subsequent participants were asked about their knowledge of pay, terms and conditions. Helen, Lynne, and Penny were the only participants who felt confident enough to discuss their knowledge of the difference in General Practice terms and conditions (salary, perceived lack of structured career pathway) to that of NHS secondary care employers; with Helen expressing concern that there would not be comparative salary increases to those of her peer group. Many participants did not know that General Practices were not routinely aligned with the NHS pay structure – Agenda for Change (AfC). Even those participants who had experienced a General Practice placement were unaware of the differing terms and conditions.

'the pay banding because it's not matched to the NHS you will be stuck on the same pay for a few years whereas fellow students in my cohort will go on to wards and they will go up the pay band quicker' (Helen)

'I'm assuming they will be similar, but I don't know '(Penny)

'it's got its differences, I think. Obviously, the environment is different, but I'm not really sure of the other differences' (Lynne)

4.2.2. Theme Two - Secondary care is presumed to be a required first post destination

"people think I should work in the hospital first because that's where you learn to be a nurse"

The data was densely populated with the perception that secondary care experience is required before entering General Practice. Twelve of the sixteen participants were directly told that secondary care experience was advisable. Irene and Penny commented,

'in my placement, they did say it was better that you had it [hospital experience]*. It was also emphasised at university as well' (Irene)*

'*a few nurses have said it's probably best to work on a ward for a year or two' (Penny).*

Two participants, Jane and Orla, were told, during their General Practice spoke or placement experience, that direct new registrant entry into General Practice was possible.

Many participants expressed concern over their roles as new graduate nurses, with Debbie likening this to passing your driving test and then learning to drive. The concerns centred around becoming competent and confident in the role. Therefore, they sought advice and support in their peer groups, university settings, and placements. Belle expressed this as

'they all kind of gave their opinions and views of nurses and newly qualified nurses, which is something you take on as they have been in the field a longer than you have' (Belle)

The plethora of advice provided by the participants' registered peers was accepted as the 'experts' opinion, suggesting that student nurses may be more receptive to their peers' opinions and recommendations.

When participants described the GPN's role, they used terms such as *'autonomous', 'alone'* and *'responsibility'.* The GPN role holds elements of these terms; therefore, the participants may be demonstrating role awareness; however, terms such as '*autonomous'* and '*responsibility* can also be applied to any nursing role. When considering this in the context of NQN role consolidation, the terms may negatively assume a perceived lack of support or isolation.

When discussing secondary care work environments, the terminology appeared favourable with terms such as '*learn', 'team', 'comfort'* and *'experience',* providing the

perception of a more supportive environment. Participants' terminology corresponded to the advice that secondary care may be considered a more suitable first-post destination.

Charlie discussed his concern over autonomous working practices and associated this with professional development. He inferred that a secondary care environment is better placed to provide skill consolidation; therefore, he didn't feel this was offered for new GPNs.

'It's good to go on a ward and get the fundamentals of nursing because you never know if you go into the community, it's a lot of your own independent thinking, which might not have developed as you graduate.' (Charlie)

When exploring skill consolidation and where is the best place to acquire it, Study One did not delve into the deeper meanings of the fundamentals of nursing for participants. Instead, it focused on why secondary care was recommended for consolidating these skills. Skill consolidation was found to be connected to the provision of preceptorship and support.

The primary theme that emerged was the assumption that experience in secondary care is necessary before entering General Practice. This assumption was derived from various codes and was further explored through three sub-themes: who recommends secondary care as the first post destination, the reasons for recommending secondary care experience, suggested timelines, and the preceptorship role.

4.2.2.1 Who advised secondary care as a first post destination?

The participants were asked who they had spoken to about their first post-destination wishes, which resulted in various responses. From the responses, participants stated that the primary responses were from secondary care nurses, '*they've been nurses in the hospital,'* and '*a lot of the colleagues at the hospital'*. Other sources were also cited as offering advice: community teams (Kim), university lecturers (Irene), and peer groups (Lynne).

Secondary care nurses suggested that working in hospital settings should be the first choice for employment after completing their training. The responses also indicated that

secondary care nurses may lack knowledge about the role, workflow, and availability of professional support for GPNs. Lynne acknowledged and commented.

'when I say this is what has been advised to do, let's bear in mind that all of these nurses we're on a general ward, which is probably why they gave that advice' (Lynne).

In contrast, those participants who had undertaken a General Practice placement or had prior knowledge challenged the perception that secondary care experience was required. Before training, Debbie worked within General Practice as a health care assistant and was confident that secondary care experience was not required; however, she did not feel confident in challenging her more experienced registered colleagues' opinions.

'I have had some negative feedback because people think that I should work in the hospital first because that's where you learn to be a nurse' (Debbie).

Orla, who had completed a General Practice placement, felt confident discussing and challenging the perception of requiring secondary care experience. She acknowledged that this had been discussed whilst she was on her placement and was advised that this was no longer required; *'you don't need the secondary care experience anymore'.* She further discussed '*possibly before the placement I wouldn't have known really'.* At Orla's General Practice placement, she felt empowered with information to challenge perceptions and navigate the negative interactions with her qualified peers. Fiona was also able to challenge this perception. Whilst she was on her General Practice placement, a new GPN (not newly qualified) highlighted to Fiona that skills learned are specific to the area instead of generic core skills.

'It was completely different to what she had done before, so I kinda understand why people would go into GP practice straight away because it's completely different, it's a different type of nursing anyway – it's not like you could transfer all your skills' (Fiona)

4.2.2.2. What advice is given around the first post-destination?

It was considered relevant to understand why participants felt secondary care experience was required. Participants stated that the advice they had received was primarily based on a consolidation of skills and the availability of peer support.

'I've had that conversation with a lot of qualified nurses, and they all tend to say similar stuff: you've got many years to work your way to where you want to be, but along that path, you need to gain as much experience at the same time' (Belle)

'Um, I have had some negative feedback because people think that I should work in the hospital first because that's where you learn to be a nurse' (Debbie)

'it will get me the opportunity to develop my clinical skills and have a supportive environment with other nurses and sisters and matrons' (Fiona)

'So I guess, well, I think it's just the way they teach it, especially the teachers at XXX Uni have said, you know, you should go into hospital for a year to do your preceptorship and then do your community afterwards' (Irene)

'the advice I was given was to think about going into a general ward for maybe a year just to build up a base, you know, a general acute medical where you can build up a kind of range of skills' (Kim)

'it's being able to continue that learning sort of through your preceptorships' (Mary)

The data suggested that skill consolidation was a concern among the participants. Participants expressed a desire to '*build up my skills', 'develop a range of skills',* and *'develop my nursing judgement'.* Secondary care acute areas were linked with developing and consolidating skills and were viewed as desirable first-post destinations. Anne, Charlie, Fiona, Jane, Mary, and Nancy expressed a desire to work as NQNs in acute areas (A&E, ICU, HDU) as these were perceived to provide a wide range of skills and support. The link with acute clinical areas appeared to form the perception of where you '*learn to be a nurse*', with most participants actively seeking acute settings as their first post destination. Theme one discussed the perception of the GPN role being deskilled and slow-paced; therefore, the requirement for acute placements provided further correlative perceptions around the GPN role not being a suitable first-post destination.

Helen wished to pursue a GPN role as her first post destination but was undergoing peer-group negativity around this. She reported the negativity was focused on the perceived

lack of skill consolidation in primary care and concern over the lack of career progression. Neither of these factors was a concern to Helen.

Kim reported that registered nurses in other secondary care areas also expressed the sentiment of increasing their skill base before entering what they perceived as a specialist area. Irene, who wanted her first post to be either in General Practice or the community, provided feedback from a community nurse who also recommended secondary care experience.

'they kinda said I wish I'd done a little bit longer on a general ward, and I just think that might have given me a wider skill base' (Kim)

'In my placement, but they did say it was better that you had it. It was also emphasised at the university as well' (Irene).

4.2.2.3. What timescales are advised?

Secondary care experiences were often perceived to be required before becoming a GPN, with between twelve and twenty-four months of experience being discussed. The required longevity of experience appeared to correlate not only to the anecdotal discussions with their peers and registered colleagues but also to GPN recruitment advertisements. Irene, Mary and Nancy discussed the commentary used within job advertisements that might influence a person's career choices.

'I looked in the application, and that said you can't apply unless you have two years postgraduate experience' (Mary)

'I've not been able to apply for a few jobs because it's been listed in the specification must have 12 months experience' (Nancy)

Some participants were unclear whether the requested timescales were a role or a recruitment preference. Irene felt this was a recruitment preference, as different geographical areas specified different timescales. Irene commented on her frustrations with this.

'it's weird that in [area] you have to have a years' experience in hospital before they'll let you work, and in [area], they will take you straight from Uni'. (Irene).

Therefore, the inequity of information available appears to come from many different sources and is further confused by that provided through professional portals.

4.2.2.4. Preceptorship availability

Preceptorship programmes are a model of providing professional support, guidance, and clinical education to NQNs and are recognised by nursing regulators and unions. These programmes were considered to be only available within secondary care and provided NQNs with skill consolidation and professional socialisation. Only two participants, Lynne and Orla, who had both undertaken a General Practice placement, knew that preceptorship programmes were established within General Practice. Of note, Lynne's General Practice placement was within the localities' ATP, where there was an expectation for a high-quality General Practice placement to be provided. Other participants weren't aware if General Practice offered a preceptorship programme.

'I didn't even know they did preceptorships - I'm not going to lie to you.' (Nancy)

4.2.3. Theme Three - Availability of career advice to enter General Practice "*I think you have to look a little bit harder to get that guidance*"

When the participants were asked about generalised career planning, many already had formed ideas and preferences for their first post-destination as NQNs, with some already securing employment offers. Table 7 demonstrates the initial career fields of choice.

Table 7 Study One preferred career fields

Academia	Unsure	Secondary Care	General Practice	Community Care
1 (Belle)	2 (Jane & Kim)	9 (Anne, Charlie*, Fiona*, George*, Mary*, Nancy*, Orla*, Penny and Rita). *= employment secured	3 (Debbie, Helen and Lynne)	1 (Irene)

Six participants (Charlie, Fiona, George, Mary, Nancy, and Orla) had already secured a job offer within a secondary care settings. Irene was actively pursuing a first-post destination within a community setting; she did express a desire to enter General Practice but felt working within the community was more attainable. Participants actively used career fairs throughout their university and trust settings, or NHS web portals designed for job hunting.

The key theme of career advice availability to enter General Practice was derived from two main codes, which were developed as sub-themes: available career support and career support not available. Participants felt that career guidance and support were a general requirement for final-year student nurses. Participants acknowledged that many secondary care employers provide this guidance through placements or career fairs held at the academic institution or within the hospital setting.

4.2.3.1 Available career support

Participants thought the university was responsible for providing career advice, support and information. Participants from alternative university settings used different terms when discussing what career support is offered; terminology includes *'career workshops', 'career support',* and *'recruitment support'.* These alternative terms may indicate personal colloquialisms, understanding or an adaptation of the terms used within local policy/process.

When discussing career fairs, all participants knew or had attended these within the university or secondary care setting, with the majority reporting that the available career fairs did not include information on accessing General Practice employment. Jane did feel that her academic environment had provided a broad range of career options and felt this was a supportive and productive way to consider all nursing fields. Jane's comment is dissonant with her peer group within the same university setting, who were unaware of any GPN visibility at career fairs.

'We had a day where different trusts came into the university, and there were a few nurses there and also a trainee practice nurse who had just qualified' (Jane).

Career advice was available from personal tutors, peer groups, career fairs and placements. When participants were asked about the availability of career advice, responses were;

'No, not really, we've had a couple of emails sent out around careers fairs' (Lynne)

'I think you have to look a little bit harder to get that guidance, but there is a general page on the University website…..information is not just easily available, I think' (Mary)

Secondary care employers were predominantly present at career fairs within universities and secondary care facilities. Therefore, their presence allowed student nurses to gain insight and information on first-post destination roles. Charlie, Fiona, and Nancy all commented on the availability of career fairs.

'there was a trust fair that we had to attend, and we had to email a lady, and she would book us onto the fair where we would attend and have an interview. From there, we would either get a post or not get a post' (Charlie).

'they did have [NHS provider]to come in and [NHS provider]hospital. So, they had stands in like the foyer' (Fiona)

'now and then we will get an email through, you know XXX has got a job fair, XXX got a job fair…' (Nancy)

Career advice and recruitment also appeared to be available when participants were on placement, with final-year student nurses on placement being an accessible source to offer career advice and support, resulting in recruitment. Placement opportunities reassure the student nurse, potential employer, and clinical area, providing visibility of the expected registered nurse position.

'If you get a good picture of the placement, you do get a good feel for what you want to do later' (Nancy).

'getting your face in the door type of thing. Then when you do apply for a job, they may think, ah yes, we've already seen them; they seem really keen. So, well, you would be more likely to get through to interview' (Orla)

4.2.3.2 Career support not available

Some participants (Fiona, George, Irene, Jane, Kim and Nancy) wanted further support and guidance on career planning basics. The participants discussed the need to understand how to search for roles appropriately, generate a CV, timing of applications, interview technique, and plan a first post destination. These participants discussed career support as *'unsure', 'don't know', and 'not discussed',* this was similar across all three university sites. However, a few participants had discordant views on this and acknowledged that career advice was available but caveated this with the requirement that you had to search for the information.

'There was no initial lectures or anything about how you should construct a CV or anything. Interview techniques and stuff like that which could be quite beneficial' (Fiona)

'We've not really had anything to do with employment; it's kind of just been what the ward has said' (Irene)

'For me, I've not got a lot of interview experience because I've only had two major interviews all my life' (Jane)

'We've had no help on what we are going to be asked in interviews, what should you prepare, you know, just a basic understanding of what they are gonna say' (Nancy)

The timing of the SSIs may have been conducted before the university's rollout of planned career support tools.

Obtaining career support to enter secondary care appeared easier to access than those wishing to enter General Practice. Participants reported a lack of knowledge in searching and applying for non-secondary care environments. Six participants (George, Helen, Irene, Jane, Kim and Lynne) were unaware of where or how to obtain General Practice recruitment information, with other participants assuming that these posts would be advertised within NHS web-based job sites.

Debbie, who wished to enter General Practice as an NQN, established a recruitment contact during her pre-training General Practice health care assistant work (HCA). She acknowledged that had she not been employed as an HCA before her training she may also have been unsure how to access GPN posts.

'I think it would be better if there were more information about it because it is very hard to find information on what you need to do and how to apply and how to get into it' (Debbie).

Helen stated she would like to enter General Practice as a first post destination; however, she was unaware of who and how she would achieve this despite undertaking self-motivated research into accessing primary care as an NQN. Other participants echo the challenge of accessing GPN recruitment information.

'I don't really think there is a lot of information on primary care - there is no support as to how you get into primary care' (Helen)

'There is not enough information out there to support us in our future careers – you think to yourself, who do I know, who can I ask?' (Jane)

'I just don't feel that either in the university or with the nurses I've met anybody has really spoken to me about that or been able to tell me anything about it really' (Kim)

'No, not at all. No, we've not been given any information about that; it's just all about going to work on a ward, going to work in secondary care, you know, the hospital and things like that' (Lynne).

'You kinda think they would showcase different areas so that you could experience it and see what or where you want to be' (Anne).

Jane stated that GPN posts are discussed extensively within their student nurse peer group, and many have expressed interest in this area. She links this with the ability to provide holistic care whilst having access to multidisciplinary team support.

'It's a topic that's talked about quite a lot at uni with all the student nurses. I think what they like about it is the whole General Practice side; it's kind of like the patients that you get to see, also how you get to know them, and it's all about the relationship that you can develop with them – work within the multidisciplinary team' (Jane)

Some participants wished to enter General Practice at some point in their careers. Still, the distinct lack of GPN post visibility and career guidance may impact future recruitment.

The career support described appeared to be secondary care-centric. Many participants felt it would be advantageous for different nursing areas to be identified and promoted within the university setting. Only secondary care was represented within the available career fairs across the University and placement settings. Therefore, there was a lack of access and information visibility for those wishing to enter primary, tertiary or private care areas. As only a few participants had undertaken a General Practice placement; therefore, the lack of access and visibility may extend from an unequal placement allocation to these areas.

4.3. Conclusion

Chapter Four discussed the first of the three interlinked studies within this research. The findings identified three key themes, indicating that there could be challenges with the myths and misperceptions surrounding the GPN role. These may be secondary to a lack of GPN role awareness and visibility.

Study One offered valuable insights into student nurses' perceptions of taking on a GPN role as their first registered post. These insights were instrumental in shaping the interview proforma for Study Two, using the key themes generated from the participants responses to drive the initial Study Two questions. This provided the opportunity to

explore some of Study One's themes with their peer group, some examples of this were General Practice placements and skill consolidation.

Study One has undergone peer review and has been published (Lythgoe, Galdas and Hardy, 2022), and is shown in Appendix 21.

Chapter Five will discuss the second of the three interlinked studies, Study Two, which sampled NQNs whose first post destination was General Practice.

Chapter Five – Study Two

5.0. Introduction

Chapter Five will discuss the second of the three interconnected qualitative studies. Study Two explored the study question, '*What are the experiences of newly qualified nurses choosing General Practice as their first post destination?*' The objective of Study Two was to explore the experiences, influences, and perceptions of NQNs who had chosen General Practice as their first registered post. The research methodology and methods discussed in Chapter Three have been continued within Study Two. The application of these methods will be discussed regarding the successes and challenges of these, before focusing on the findings from Study Two. These will be explored in isolation and within the context of Study One.

5.1. Study Two Methods

5.1.1. Research question

The research question for Study Two was '*What are the experiences of newly qualified nurses choosing General Practice as their first post destination?*'

5.1.2. Study design

The methodological framework continued using I.D. (Thorne, 2016); discussed in Chapter Three, Section 3.2.

Ethical approval was HRA acknowledged through the Integrated Research Application System (IRAS) in November 2021, REC reference 21/PR/1355 (Appendix14).

5.1.3. Sampling and recruitment

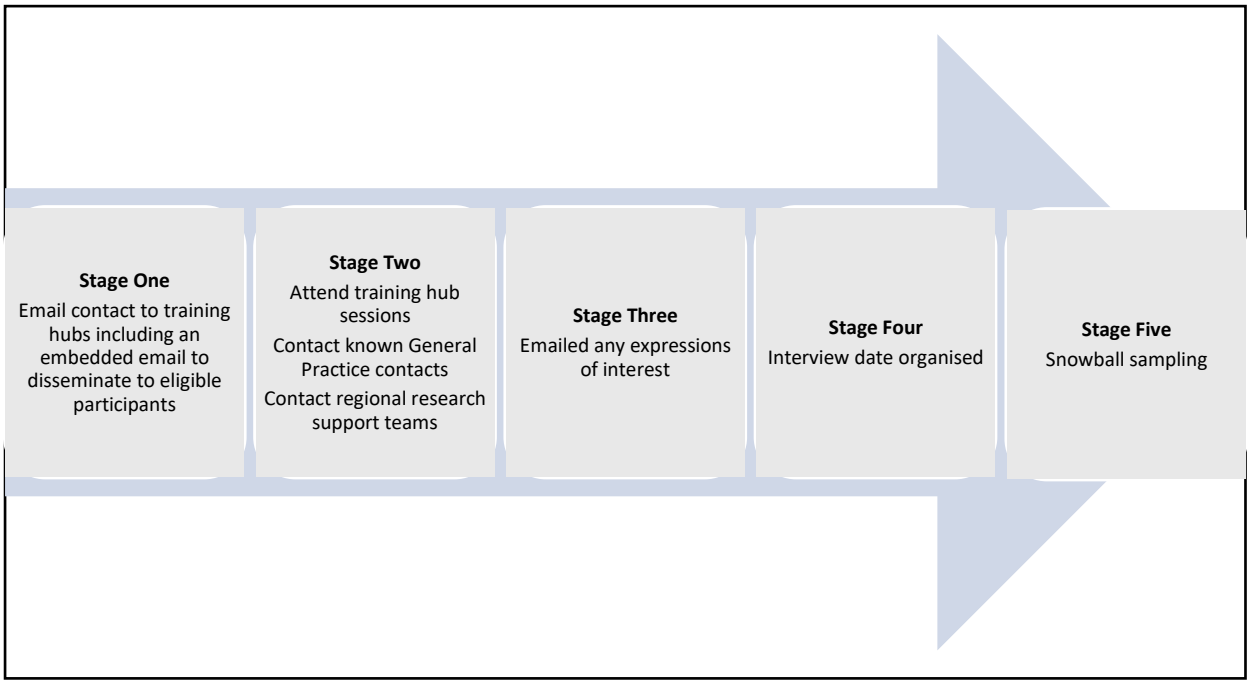
Purposive sampling was used to recruit relevant participants (Chapter Three Section 3.3.2.). Study Two's inclusion criteria were NQNs within two years of qualifying who, had chosen General Practice as their first registered nursing post. As these NQNs had chosen their first post destination, exploring the drivers behind their decision process was relevant to answering the study's question. During the data collection period, a two-year time frame was chosen because many newly qualified General Practice nurses were employed through funded courses designed to support both the NQNs and their

employers. These funded courses typically lasted for two years. The primary funded courses available for NQNs in General Practice are the GPN Ready Scheme (Health Education England, 2016a), which has subsequently had its funding withdrawn, or the VTS training scheme (Haxby Training Group, 2020) funded by NHSE (NHS England, 2018) and provided by the local training hubs (ATPs).

General Practice environments are primarily independent businesses (Lewis, 2023); therefore, there isn't a local or national centralised staff database to aid recruitment. Once NQNs are employed under a funded scheme within General Practice, their employers will utilise the local ATPs to access training, funding and support. Therefore, when considering recruitment, the training hubs would have knowledge and access to most of the NQNs' within that locality's General Practices.

The recruitment process was undertaken in five stages and is represented in the below flow chart - Figure 3.

Figure 3 Study Two participant recruitment



Stage One

In November 2021, ATPs in the same geographical locations used in Study One were emailed (Appendix 13) with the study's details (Appendix 9) and evidence of ethical approval (Appendix 14). The email requested that all nurses who met the study's eligibility criteria were contacted with a provided email that detailed Study Two's premise, the ethical approval details, and the academic contact information. Once the email had undergone ATP approval, the ATP's shared the email with all eligible participants and posted it on their locality's intranet page.

Stage Two

In addition to using the ATPs, known General Practice contacts were emailed with the same pre-prepared email (January 2022), and regional General Practice protected learning sessions (February 2022) were also attended. To raise study awareness and support recruitment, regional research support teams funded through National Institute for Health and Care Research (NIHR) were contacted (February 2022) to provide and support further recruitment opportunities.

Stage Three

Any participants who expressed an interest in the study were emailed a participant information sheet (Appendix 9) and a consent form (Appendix 8). If and when these were returned, the participants were contacted to arrange a time to participate in an SSI (Chapter Three, Section 3.3.4.1.). Meeting ethical approval, all interested parties were contacted by email three times; if prospective participants had not responded by this point, they were considered lost to follow-up.

Stage Four

A mutually convenient date and location was organised for the SSI.

Stage Five

During each SSI, participants were encouraged to share information about the study with their peer groups, representing stage five, snowball sampling (Ritchie *et al.*, 2014) (Chapter Three Section 3.3.2.). Snowball sampling provided two more expressions of interest, resulting in one further SSI.

Participant recruitment, data collection, and analysis for Study Two were circuitously undertaken between December 2021 and September 2022. Participant recruitment was challenging, so to effectively manage timelines, Study Two and Three ran concurrently from April 2022.

5.1.3.1. Participant characteristics

All participants were female, although there were three expressions of interest from male GPNs. It would have been interesting to interview the male GPNs to explore their perceptions and experiences and determine whether there were any gendered differences from those of their female peer group. However, they did not respond to anything other than the original email and did not progress to the interview stage. The study has provided minimal diversity from both a gender and an ethnicity stance but does provide a variance in age.

Twenty-two participants expressed interest in the study, with sixteen progressing to interviews. Three participants expressed an interest but did not complete consent, and three participants returned consent forms but did not engage when attempting to book an interview. The recruited participant profiles are detailed in Table 8**.**

Table 8 Study Two participants' profile

Total Participants	16
Gender Female	16
Male	0
Age 20-24 years	3
25-29 years	4
30-35 years	4
35 years +	3
Did not respond	2
Ethnicity White British	14
Asian British	2
Pre-nursing General Practice experience	
Yes	2
No	14
Student nurse General Practice placement	
Yes	11
No	5

Table 9 provides an overview of the participants with an allocated pseudonym to maintain confidentiality (Adarmouch *et al.*, 2020) and support the narrative flow. It also identifies participants who were employed under a funded training scheme, which recruitment route they had undertaken, and those who desired to progress to an Advanced Clinical Practice pathway.

Table 9 Study Two participant details

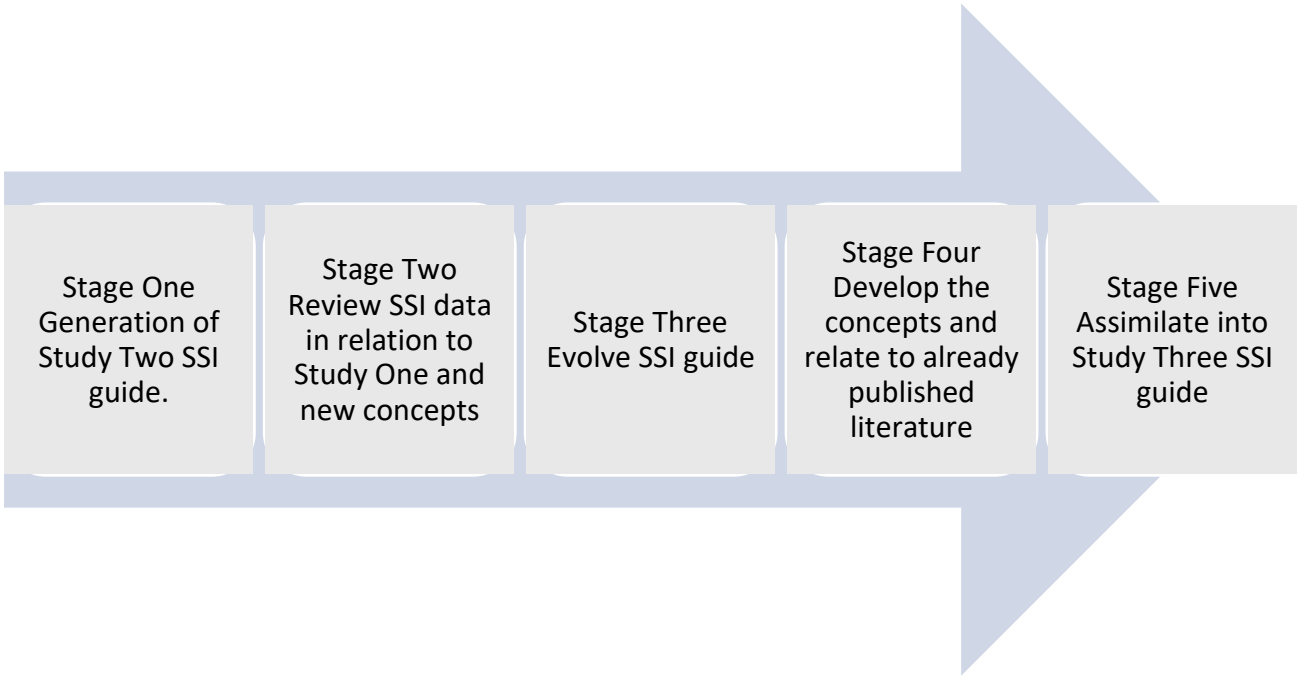
Interview number	Pseudonym	Funded training scheme	Recruitment route	Advanced Clinical Practice career planning
1	Abbie	X	Word of mouth	
2	Becky	X	Word of mouth	X
3	Charlie	X	Placement	X
4	Dawn	X	University careers fair	
5	Ellie	X	Seconded	
6	Frankie	X	NHS jobs	X
7	Georgie	X	Indeed	X
8	Holly	X	NHS jobs	
9	Iris		NHS jobs	X
10	Jo	X	Opportunistic CV	
11	Kelly	X	Word of mouth	X
12	Leah	X	Word of mouth	X
13	Molly	X	Word of mouth	X
14	Niamh		Opportunistic CV	
15	Olive	X	Word of mouth	
16	Poppy	X	Placement	X

5.1.4. Data collection

As discussed in detail in Chapter Three, this researchs data collection tools were SSIs, an interview guide, and a reflexive journal; these remained consistent in Study Two. An interview guide, which was developed from the findings of Study One, was used to support all the SSIs, with the interview guide for Study Two provided in Appendix 15. The themes from Study One were involved in developing the interview guide for Study Two. The interview guide evolved following the inductive data collection and analysis process, which was conducted circuitously to ensure participants' perceptions supported future interviews and the findings.

Figure 4 shows a flow chart demonstrating the generation and evolution of the Study Two interview guide, which was used to support the SSIs. This format was repeated within Study Three.

Figure 4 Study Two interview guide generation and evolution



During stage one, the interview guide for Study Two was developed from the study question and the resultant findings from Study One. Progression to stage two allowed the initial interview findings to be explored and cross-referenced to Study One's findings,

identifying any interrelationships or newly developed concepts. The concepts were reviewed in isolation and in relation to each other.

Stage three allowed for any established and newly developed concepts that required further exploration to be integrated into the evolving SSI guide. Developing the SSI guide provided an aide memoire which supported both the conversation and data collection, enabling the opportunity to explore and develop the concepts more thoroughly. The developing concepts were explored within previously published literature (Stage Four), allowing for an understanding of emerging themes in comparison to the existing literature. Exploring the data collection phase through this lens allowed the evolution of the SSI guide, supporting Study Two's data analysis, with the iterations being used to support Study Three (Stage Five).

The initial SSI interview guide (Appendix 15) explored the participants' employment decisions, recruitment journeys, how they had found their GPN posts from a support, skill, and preceptorship stance, and peer feedback.

All the SSIs were conducted using a video conferencing platform, primarily Microsoft Teams which allowed greater flexibility for the participants' working patterns and met the COVID-19 recommended working practices of the time. The majority of the participants in Study Two conducted the interviews in their own time, utilising days off, lunch times, evenings, and weekends to complete them. The interviews lasted between twenty-three and forty-two minutes.

5.1.5. Data analysis

Braun and Clarke's (2013) six-step thematic analysis approach, described in Chapter Three, guided the data analysis process. Consistent with all three of the interlinked studies within this research, the codes were subject to constant comparison (Glaser, 1965) comparing each code within the codebook to the existing findings; this assisted in developing the themes and sub-themes. Consistently exploring and challenging the data through critical appraisal helped clarify ideas and expand concepts. The development of the themes and sub-themes arose from the codes that were generated.

Within the codebook, fifty-six codes were developed from the data. These codes were initially refined into ten themes with forty-six sub-themes. Forty-eight of the codes were developed by the tenth interview. Interview twelve achieved stability within the codebook in both concrete and conceptual codes. Four further SSIs were conducted to ensure meaning saturation (Hennink, Kaiser and Marconi, 2017). Some of the initially developed themes explored the participants' student nurse placement, terms and conditions and training. Interview guides, reflexive journals and self-reflection enabled the generation of the theme definitions, and the codes were tested against these definitions. If the codes did not meet the theme definition, these codes were disconnected and considered in relation to other themes, the possibility of new theme generation or as remote codes. Appendix 16 demonstrates the codes which were used to evolve and generate the theme GPN Salary Terms and Conditions.

As discussed by Braun and Clarke (2013) theme development, review, and refinement were an ongoing process with amendment and movement, which continued through to the writing-up stage. The final developed themes were *Awareness and understanding of the General Practice nurse's role;'How can we explain what we can't see?'* and *General Practices' independent business status;'It's about practice nursing being the Cinderella service of the NHS.'*

Elements within each theme demonstrated a relationship with some of Study One's student nurse findings. Within theme one, *Awareness and understanding of the General Practice nurse's role* echoed some of Study One's findings, especially those concerning the myths and perceptions of the GPN workforce (low-skilled and older workforce) and the impact and importance that student nurse placements exerted.

Theme two also generated some correlation with Study One's findings. *General Practice's independent business status* correlated with Study One's participants who discussed the lack of career advice or support to enter General Practice, which was echoed by some of Study Two's participants.

5.2. Findings

Study Two's findings are organised into two overarching themes. Theme one explored awareness and understanding of the GPN's role. This theme provided the participant's perceptions of GPNs' visibility and explored some myths and misperceptions perpetrated around the GPN role. Within this theme are three sub-themes: participants' previous student nurse placements and exposure to primary care; myths, perceptions, challenges, and perceived role benefits of the GPN role; and training and preceptorship support received.

Theme two was generated from discussions on General Practices' independent business status. Study Two participants provided insight on how this affected the routes to becoming a GPN and working practices. The theme was explored through three sub-themes: General Practice infrastructure, pay, terms and conditions, and routes to becoming a GPN.

Table 10 provides an overview of the key themes, sub-themes, and the participants who populated these themes.

Table 10 Study Two key themes

Theme	Sub-themes	Participants
Theme One *A*wareness and understanding of the General Practice nurse's role. '*How can we explain what we can't see?*'	• Student nurse's previous placements and primary care exposure • Myths, perceptions, challenges and perceived role benefits • Funded training and preceptorship	Abbie, Becky, Charlie, Dawn, Ellie, Frankie, Georgie, Holly, Iris, Jo, Kelly, Leah, Molly, Niamh, Olive, Poppy

Theme Two General Practice's independent business status. '*it's about practice nursing being the Cinderella service of the NHS'*	• Infrastructure • Pay, terms and conditions • Routes to becoming a GPN	Becky, Charlie, Dawn, Ellie, Frankie, Georgie, Holly, Iris, Jo, Kelly, Leah, Molly, Niamh, Poppy

5.2.1 Theme one – -Awareness and understanding of the General Practice nurse role - '*How can we explain what we can't see'*

The first theme relates to the participant's experience and understanding of the GPN role before commencing their post and is supported by three sub-themes. Sub-theme one explored those participants who had previous exposure to the GPN role through pre-nursing employment or student nurse placements, having different experiences and perceptions from those who didn't. General Practice placements were scarce within the participants' university settings, with limited to no theoretical General Practice discussion which echoes Study One's findings. GPN role exposure appeared to support NQNs' expectations and knowledge of working within General Practice. The participants' NQN GPN role also provided some context to the myths, perceptions, benefits, challenges and training available within the role. The participants discussed how access to training and preceptorship/support was viewed as beneficial for both employees and employers. Therefore, theme one encapsulates GPN role awareness and understanding.

5.2.1.1. Student nurse's previous placement & primary care exposure

Fifteen participants undertook their nursing education through campus-based settings, and one participant was supported through distance learning. Those educated through campus-based universities were subject to their universities' allocation of placements, with one participant (Ellie) having more control over their placement decisions. Six (Abbie, Charlie, Holly, Kelly, Leah, and Olive) said that within their university setting, they

had received no theoretical education or discussion about working within primary care. The participants defined primary care as the services provided in the community, i.e., General Practice, community pharmacy and community nursing. General Practice was discussed in the context of the work undertaken by a multidisciplinary team within a primary care facility.

Eleven participants had undertaken a General Practice placement, and two had prior General Practice experience. Charlie felt there was a distinct lack of awareness when discussing whether primary care was an option for NQNs, which may highlight a gap within the pre-registrant education journey. Frankie mentioned that although her university didn't actively encourage undertaking a GPN role as a first post, there was an isolated discussion around an initiative to recruit NQNs into General Practice; this is in contrast to Frankie's experience, however the limited HEI discussion and exposure may reduce the effectiveness of these discussions. Iris felt that her university '*wasn't keen'* to allocate GPN placements; however, many of her cohort were interested in the GPN role but didn't know if this was possible due to not having a placement.

'They wanted to go into [General] *practice; they just didn't know if they had the skills for it'. (Iris)*

'I'd requested a placement, I think, like 15 times throughout my degree, you know, a ridiculous amount. Please let me go into General Practice nursing or primary care for a placement, and it was just really on the decision by the university '(Jo)

'I tell you what I did find with the [online pre-registration nursing programme] in comparison to a brick uni that they like you to have a big say in your placements and try to meet these. I tried to focus my placements on areas that would support me being a General Practice nurse'. (Ellie)

It was recognised (Becky, Georgie, Iris, and Molly) that COVID-19 had impacted placement allocation during their training, with General Practice being absent from both an availability and accessibility stance.

'we had very little exposure to anything else out of the ward because of COVID' (Georgie).

I think they've kind of pulled students away from GP practices and clinics to spend more time on the wards' (Iris).

General Practice placements were also discussed from the participant's NQN perspective, with practices struggling to support their new registrants and the expectation to continue taking student nurses. These struggles were highlighted by Dawn, Georgie, and Molly who acknowledged that their employing General Practices were not currently supporting student nurses secondary to staffing issues. When considering this challenge it may allude to more systemic issues within General Practice and could provide some context to the barriers that hinder the effective integration of NQNs into General Practice. Ellie felt that to improve placement access, locality-based placements, where groups of General Practices combine placement activity, may support placement availability and exposure.

'I think if all practices got together, then we could do something. We could develop training sessions and shadow many different nurses' (Ellie).

When exploring student nurses' General Practice placement experience, participants often discussed the placement timing within the training programme, with Becky discussing how short placements provided experience and increased student nurse exposure to the GPN role. Opinions differed on which part of the course student nurses would derive the most value from undertaking a General Practice placement. The predominant opinion was that final-year placement allocation was thought to benefit the student nurse and the General Practice most. Some of the perceived challenges were around the specialist nature of the role (Abbie, Charlie, Ellie, Frankie, and Jo), the requirement for each task needing additional learning, working in isolation and uncertainty on what duties were appropriate for a student nurse. Abbie expressed a similar sentiment, describing General Practice placements as '*the worst'.* Having previously worked as a General Practice HCA before starting her nursing degree, she discussed that she felt these placements often fail to accurately reflect the complexity and diversity of a GPN's workload, frequently leaving student nurses in observational roles rather than actively supporting patient care.

The student nurses' skills portfolios (Becky and Charlie) were also discussed as providing additional challenges. A student nurses skills portfolio provides a valuable tool for professional development, however, if these skills don't echo the General Practice environment, then this may lead to decreased engagement and increased stress for both the practice assessor and student. The skills portfolio books were considered secondary care-centric, with students allocating placement value to skill completion.

'When they are looking at their placements and competency books, it gives a lot of pride and achievement to be able to complete them – if you can't complete them, was the placement worthwhile' (Becky)

'I feel like it was very much secondary care based; I don't think there was really that much, well, from what I can remember, adapted to primary care' (Charlie).

For those participants who had experienced a General Practice placement, they provided positive comments and acknowledged that their experience had allowed a true representation of the role, which would provide positive professional identification and role awareness. Leah describes the '*nurse-led care*' she witnessed and the '*passion'* the GPN team displayed. Charlie, Frankie, Iris and Leah commented that the GPN team worked collaboratively and supported their peers and the patient. Participants felt this represented a different team culture and way of nursing to that previously seen during their secondary care placements, with participants positively noting team size and increased support and training available during their General Practice placements. This was discussed as enabling increased visibility and role awareness (Becky, Frankie, Iris, Molly, Niamh); which was felt important due to the role not being theoretically acknowledged or discussed within their educational settings.

'I didn't; well, I, obviously I, never really knew anything about practice nursing until I had my placement in the 3rd year, and that was when I realised it was what I wanted'. (Leah)

'Then, it was just by chance that my General Practice placements happened, and I absolutely loved it. I knew literally from the first few days that's what I wanted to do'. (Charlie)

'Before I saw the role for myself when I was a student, I didn't know what they did' (Niamh)

Exposure to General Practice allowed the participants to understand and interact with the primary care environment. Molly's description encompassed the essence of the sub-theme '*How can we explain what we can't see?'*

'There are so many opportunities I never realised how much a practice nurse does. I got to spend time with lots of people, and it opened my eyes' (Molly).

Charlie, Kelly, Molly, and Holly felt they had little to no exposure to General Practice through a theoretical or placement stance while at University. This was echoed by many participants who found that their pre-registration education was secondary care focused. Participants in Study Two, who had exposure to primary care during their nursing education, chose a primary care setting as their first job. Olive's University did have General Practice representation at an HEI-held careers fair, which provided information and access to GPN role availability. However, whilst Olive found this informative and useful, her GPN contracted role was accessed through a family friend. Participants felt that careers fairs provided valuable information and access to a GPN role availability and would help to bridge the awareness gap and support the NQNs first post destination journey.

Niamh's university setting offered a scheme to explore alternative placements, which widened the scope of her learning environment. She took most of her placements in the community, with outreach nurses and charity settings. These experiences demonstrated to her that nursing wasn't secondary care-centric; however, when interacting with her peer group and secondary care colleagues, Niamh felt they appeared quite dismissive of her student nurse experience.

'It was pushed a lot by secondary care that secondary care is the only way forward; this is the only way you will become a nurse. The only way you'll pick up experience and knowledge like as if there was no other pathway' (Niamh)

Ellie, who undertook a distance-learning nursing degree, noted that exploring the primary care environment can positively support the student nursing journey.

'It was a really rounded experience in General Practice as I was able to come back to my base [GP SURGERY], connect with my other colleagues and learn from their experience, still have that secondary care experience and support, and still have a good university online learning experience' (Ellie).

Abbie's university had provided a virtual career fair where primary care was included; however, she reported that her university peer group felt that the GPN role was undesirable, describing it as '*the worst thing ever'.* When Abbie expanded on this, she reported that the presenter encapsulated every negative GPN stereotype, which further enforced the group's GPN perceptions. Abbie's statement highlighted the powerful impact of negative perceptions and stereotypes. If the virtual career fair presenter reinforced these stereotypes it may significantly deter NQNs from considering GPN roles, further acknowledging the myths and preceonceptions of GPNs. Frankie's university offered a General Practice lecture, but the lecturer lacked practical General Practice experience, so shared knowledge, which was felt to have no credibility or practical expertise in the field.

'None of our nursing lecturers had been in practice nursing…. we had speakers come in, and none of them had been practice nurses either' (Frankie).

When exploring the exposure to primary care within the wider environment Dawn and Kelly provided feedback when viewing how primary care is represented within the media. Both discussed how when General Practice was discussed, it was felt to misrepresent the nursing team's vital and professional role. Both discussed how, particularly in the COVID-19 and vaccination seasons, patients were directed to see their '*local doctor'* when the nursing team were often at the forefront of organising and delivering these campaigns. Misrepresentation in the media could lead to an undervaluation of GPNs contribution which can affect professional identity, poor public and professional understanding and a lack of respect and recognition for the profession. Without appropriate media exposure and discussion NQNs may overlook the GPN role as a viable career option.

Participants felt that the GPN role was not readily understood by anyone who had not worked within primary care, articulating that this was attributed to role visibility and perceived value.

5.2.1.2. Myths, perceptions, challenges, and perceived role benefits

Participants noted many myths, perceptions, and challenges surrounding the GPN role, feeling that these were often given from ignorance rather than an experienced knowledge base, echoing Study One's findings. The ability to challenge these myths was often provided through directly working with or having experience in the GPN role. When exploring these myths, perceptions and challenges, participants did feel that the GPN role provided more benefits than obstacles to their professional roles.

Myths, perceptions and challenges

When discussing the myths, perceptions, and challenges of the GPN role, it was felt that these were demonstrated by their peers and registered secondary care colleagues. Some of the phrases used were that they would be '*deskilled*', '*need ward experience first*', and GPN work being more commonly associated with a '*slow working pace*' and '*retirement*' (Becky, Ellie, Frankie, Iris, Jo, Molly). These comments did not deter them from their chosen first registrant posts, which they attributed to having undergone direct pre-registrant knowledge of General Practice. Frankie felt her placement empowered her to counter many of these myths.

'It was always "you need ward experience first". I think my peers were the same as me because I know a couple of my friends wanted to do practice nursing, and they were the same as me; where they just assumed we couldn't really get into it straight away'. (Frankie)

When challenging the 'ward experience first' observations, Leah commented that in her experience, she had worked alongside colleagues who had entered General Practice from secondary care who had found that the skills learnt weren't always transferrable. This appears to question the value and necessity of this career path, with Leah also feeling that undertaking a secondary care role first would have been a waste of her time, as she stated.

'I don't think I would have learnt as much or progressed like I have'. (Leah).

When exploring working pace General Practice was discussed as different as opposed to faster or slower than their secondary care peers. Molly described working in General Practice as '*fast, varied and changing',* which suggests a dynamic and engaging workpace. Ellie, Frankie, and Charlie emphasised General Practice as providing a supportive and collaborative environment using words like '*kind'* (Frankie)*, 'love the team'* (Ellie) and *'supportive'* (Charlie). . In contrast, the stressful, pressurised, and hierarchical nature of secondary care, as noted by Frankie, Dawn, Georgie, Holly, Jo, and Niamh, along with Holly's concerns about potential toxicity, painted a less appealing picture. The negative perceptions associated with secondary care, combined with the positive experiences in General Practice, can make the latter a more attractive option for NQNs seeking a fulfilling and supportive work environment.

'Then, when I went into a hospital, it felt a lot more pressure' (Frankie).

'Wards are physically demanding' (Dawn)

'A lot of pressure, well I'm not very, well I don't work incredibly well under real critical stress' (Jo).

The age demographic is well documented and discussed in Chapter One. Within Study Two, it was noted that some GPN demographic stereotypes still existed, and some could be challenged.

'It used to be understood as a retirement job, you know, it's kind of either practice nursing or out-patients are kind of the pre-retirement jobs' (Frankie).

'People think we are doing bloods and dressings all day, every day, and a lot of people said, I think you'll get very bored' (Georgie).

'I think professionally, I think it's quite a, well, I think there's still this real perception that it's something that you will go into when you're ending your nursing career' (Jo).

' I guess it's some older nurses' viewpoint that they still think of it as a retirement role, whereas, you know, I feel like the bulk of younger nurses see the progression and understands the role of the GPN' (Leah).

‘ When you think of your practice nurse, I think people always assume that you're going to be a lady in your early 60s. When you look at posters of practice nurses, its always what nurses used to look like, not what we should be representing’ (Dawn)

The participants' perceptions of their NQN GPN roles provided insight into the myth that GPN roles are unsuitable for NQNs because they are lone workers and lack peer support. Working within secondary care was associated with being surrounded by a large, visible team with an assumption of available support. Becky, Charlie, Ellie, and Frankie discussed their experiences of GPN ‘lone working’. Charlie felt that within her General Practice, support was provided through the availability of internal and external colleagues she could access anytime. Participants acknowledged that working alone might deter new applicants from entering General Practice. However, these were tempered by the reality of the role.

‘I know that the support is there; I am so supported even though I am alone in a room at times. I work with an amazing team, and I could go to whoever, whenever, and I feel really supported in my job’. (Charlie)

‘We then have to think about lone working - even though we know you are not alone. It’s that perception of I'm going to be on my own. I'm not gonna be supported by a big team’ (Becky)

‘it’s quite nice to work on your own sometimes, to have your clinic and go through at your own pace’ (Frankie)

Role benefits

When exploring some benefits of working within General Practice, the participants were keen to extol its virtues. These perceived role benefits were discussed through verbal and non-verbal feedback, demonstrating their love and passion for the GPN role. Non-verbal feedback was documented within the intra-interview annotations noted within the interview guide and represented leaning forward in their seats, a lighter tone of voice and occasional smiles mid discussion. General Practice was viewed as providing patient-centred care, which wasn’t always felt to be provided within secondary care. General

Practice was considered to allow time to develop a relationship with your patients. Leah discussed this as the ability to provide true holistic patient care and felt that hospital nurses are task-orientated rather than patient-centred.

'We are doing so much more for patient care' (Leah)

Ellie's characterisation of hospital nursing as "*repetitive*" and '*unable to truly understand your patient'* may indicate an issue within secondary care settings with the potential for fragmented patient interactions due to high patient turnover and specialised roles. Molly's appreciation for the variety of patients in General Practice highlights the holistic and continuous nature of primary care, where nurses can support patients throughout their life cycle. Abbie's observation about pre-hospital care and education in General Practice emphasised a proactive and preventive approach, which could reduce hospital admissions and improve patient outcomes. Frankie's perceptions of the power dynamics in hospital nursing suggested that General Practice offers a more democratic and patient-centred environment, fostering holistic care and enhancing job satisfaction for nurses. These perceptions collectively challenged the notion that hospital experience is superior, presenting General Practice as a viable and rewarding option for NQNs.

'I like the fact that it is pre-care, you know, it's education and the like. The motivational interviewing thing I love. I love that' (Abbie).

*'I feel like patients are kind of much more in a vulnerable state [*secondary care*], and you kind of, you've got this kind of complex second superiority dynamic, where you are in this position of power, and they're in this really vulnerable position' (Frankie)*

'Most of the time, true patient care wasn't your main focus on the wards. So, you were sort of there; I always felt it was very much like you were there to give the medication to treat a primary reason and then get them somewhere else in the hospital' (Leah)

Olive enjoyed the ability to '*build a relationship'.* Kelly described the role as '*autonomous*' and '*independent*'. Molly felt the role was '*fast and changing'* and liked the '*variety'.*

Some participants expressed the work-life balance benefits of working within General Practice, such as having a fixed rota, flat professional hierarchy, sustainable routine, and social hours. Participants stated the GPN role has provided them with '*routine'* (Iris), '*passion'* (Leah), '*patient-led care'* (Kelly) and '*education'* for both the patients and employees (Abbie, Dawn). Dawn, Ellie, Poppy, and Becky discussed being highly motivated by their family's needs and felt that General Practice provided their career aspirations whilst supporting their personal responsibilities.

'I think it is better for family life; there's no doubt about it'. (Dawn)

'The benefits of working, well, for me, it works with my family. I know my days, and I'm not on a rota or shift system. I know the extra hours are there if I want them' (Ellie)

'I think the work-life balance is another great benefit, well it's really the main benefit. It is, but well, you know your shifts as well. In the hospital, you're on a rota, aren't you, and you only get so many weeks in advance'. (Molly).

'I'm very highly led by family life; my family is very important to me. So, my future career choice was to drive around my family'. (Becky).

'It's the hours and not having to be on a rota and doing night shifts. I just couldn't wind down because I'd come home, and the girls were going to school. I was having like 3 hours sleep after a night shift'. (Poppy).

5.2.1.3. Funded training and preceptorship

Government-funded training schemes have supported General Practices in recruiting additional staff, helping to manage workforce challenges. Fourteen participants felt these training schemes had positively affected their recruitment and discussed these as supporting confidence, training, and career opportunities. Within this subtheme, findings are discussed in relation to the following areas: funding for training, training support, GPNs' personal confidence and competence, and career progression.

Funding for training

Fourteen participants had been employed under a funded training scheme. Funded training schemes have monetary and training value for employers, providing financial support and preparing NQNs for their General Practice positions (National Health Service England and British Medical Association, 2019; Walker and Norris, 2020; Health Education England, 2016a). These schemes have also been developed to provide value for the novice GPN by providing knowledge, allyship, and awareness of their new registrant position. The nature of the GPN role will require additional training and support, of which the funded training schemes, commonly known as the Fundamentals of Practice Nursing, or VTS (Vocational Training Scheme), are generated to provide education with preceptorships providing the support (Queens Nursing Institute, 2020b). Abbie, Leah and Dawn provided various insights into this area.

'As practice nurses, every skill that they do is because they've completed some higher learning' (Abbie)

I think that practices don't necessarily wanna put the money into training because now that they've got things like the funded GPN courses, it's definitely easier to get someone trained up' (Leah)

'The funding was a big part to play. So, I thought I would try and apply the day before the deadline, and I managed to get in' (Dawn)

Training support

For NQNs to enter General Practice as a first post destination they will require training and preceptorship. Training support was positively viewed, with participants reporting that the training received to undertake their role had been readily available; Dawn stated that General Practice provided a great opportunity to improve knowledge, skill, and career potential, which she felt her secondary care peer group didn't have the same access to. Georgie echoed this and felt that the supportive environment eased the transition from a student to a qualified nurse. Niamh shared how she had completed an intensive first month of training by completing '*10 courses'* within this time. The participants discussed the in-house practice teams' support interchangeably with preceptorships; however, very

little was shared on formalised preceptorship programs. Molly, Holly, Iris, Olive, and Poppy confirmed that the training providers and the practice teams supported the training. The ongoing learning cycle was discussed as *'progressive'* and *'constantly learning'* Becky, Molly discussed the '*role's opportunities'*, with Poppy recognising the intensity of the provided training.

'I can't believe how much I've learned really in seven weeks' (Poppy)'It's a very good opportunity in General Practice. If you're keen to learn and to keep up with education, then I think you can progress quite quickly, whereas perhaps some of my friends that have gone on to a ward you have to wait for those positions to become available' (Dawn)

'So, it's a nice structure. I'm not being forced to, you know, learn a skill too quick or, you know, if it's in the module you learn something, you go with your mentor, you watch them do it, then you're off on your own sort of thing' (Molly)

'It's such a small team, but so much support, so much training was provided' (Iris)

'I've had lots of time and space to grow here, and they've mentored me and, you know, really supported me' (Olive)

*'She [*manager] *was really excited when she got a newly qualified nurse at the practice, and she was kind of very forward-thinking about training…whole induction package for six months' (Niamh)*

Kelly felt that the training derived from the funded scheme was good, however she felt that her General Practice support could have been better. While preceptorship support was felt to be available, it wasn't highly promoted or consistent (Abbie, Frankie, Kelly). Frankie noted that her reality of receiving support felt inconsistent with her peers.

'So, there's no preceptorship program. I've got a named mentor, but it took a few months to get a named mentor, and then once she was named as my mentor, we had some time blocked out. It then got cancelled because somebody went off sick, and then we both had to cover the clinics' (Frankie).

'So literally, I went on the VTS scheme and then a week later, I started at the medical practice centre, and then I did one week of shadowing and then got straight into my own clinics. I felt I could have, well, I wished, I'd had more shadowing because I did my own clinics more or less straight away. I feel as though I weren't that aware, so it was quite frightening' (Kelly).

Becky and Dawn highlighted that the availability of funded courses for GPNs demonstrated its recognition as a viable NQNs career path. This availability reassured them that General Practice is a supported and legitimate option for new nurse registrants. Becky, Molly, and Kelly further discussed that these funded courses provide assurance and tangible evidence that NQNs can confidently choose General Practice as their first destination post, reinforcing the accessibility and attractiveness of this career path.

'So online, it clearly says you can, and the whole programme is about newly qualified nurses entering general practice as a first destination career' (Becky).

'I think with the GPN ready scheme I think it sort of manages that comment' [GP NOT SUITABLE FOR NQN] (Dawn)

Frankie also stated that her funded training scheme (VTS Scheme) supported preceptorship and provided context and support on the independent business side of General Practice. She explained that the course providers felt it was important for GPNs to understand the business dynamics of General Practice. Therefore, the education and training provided within these funded training schemes support patient care, workforce sustainability, and a more General Practice health economy-educated nurse.

'I think there's things that you just don't understand when you're coming into general practice, things like QoF and, you know, the kind of business dynamics of general practice' (Frankie).

For some NQNs, the training journey wasn't as seamless as it was for others. Even though Ellie and Georgie were employed through a funded training scheme, they had to explore and generate their training schedules, with Olive recognising the non-standardised nature of the training. Jo also expressed concerns that the training isn't accredited and,

therefore, GPNs often aren't able to demonstrate any post-certification evidence. These factors appeared to suggest a level of provider, facilitator and geographical inconsistency within the funded training schemes, which may further confuse and deter NQNs.

' XXXX have just put me on the courses so that I can do my job' (Ellie)

'With training, I've been told to find what I want on eLearning, do it, and then they will give me the time back'. (Georgie)

'So, there is no standardisation at all. I have absolutely had the cream of the crop training, where some of my colleagues haven't' (Olive)

Most participants spoke positively about their CPD opportunities, though some highlighted negative aspects. Georgie appreciated the support from her General Practice employers post-training, which ensured she felt competent and confident in her role, which she believed would have been lacking in secondary care. Conversely, Dawn felt that COVID-19 had significantly disrupted her training and preceptorship experience, leaving her feeling professionally and emotionally vulnerable. This contrast underscored the importance of robust support systems for NQNs in General Practice, particularly during challenging times, and highlighted the perceived potential gaps in primary to secondary care environments.

Career progression

Career progression was felt to be available; however, some participants voiced concerns about the visibility and clarity of it in General Practice. Becky and Poppy noted that career advancement seemed less apparent in General Practice compared to secondary care, potentially due to the long tenure many GPNs have. She went on to explain how she felt that the absence of visible hierarchies, title changes, uniforms, or status markers further obscured career progression opportunities. Kelly's concerns about the diversification of the General Practice workforce affecting her role added to the uncertainty. This perceived lack of clear advancement pathways may deter NQNs from entering General Practice, as they may fear limited professional growth and recognition in their careers.

'I don't think that progression is as visible as it is in the hospital, where you see the nurse's progress to sisters' (Becky).

'You know you only get a promotion, or you only get a top-up to the next salary, or you can only progress if somebody dies or leaves or retires' (Abbie).

'Well, they've got a lot of P.A.s, you know, physicians' associates, so all I basically do is bloods and wounds. So, I feel as though I've kind of lost my confidence from all of the VTS training days' (Kelly).

Participants discussed that undertaking training in Advanced Clinical Practice (ACP) roles may provide career progression. Nine of the sixteen participants desired to advance their career into an ACP role. ACP roles are MSc-educated clinical roles that bridge the elements of medical and nursing roles (Health Education England, 2021b; National Health Service, 2017). General Practice commonly uses these roles to support the medical team by providing diagnosis and condition management. As workforce challenges are also recognised for General Practices medical teams, funding has been allocated to support the training and development of ACP posts. Whilst many participants spoke of their desire to progress into an ACP role, not all perceived these as a positive GPN career option. Leah felt GPNs were being '*pushed'* into ACP roles and wondered if the additional prescribing training received during the student nursing journey drove this. Kelly, Molly, and Iris felt that the ACP training was a great option as it would not limit their roles but provide career progression. Becky stated that the ACP training will enable her to *'constantly learn'.* Therefore, for nine participants, General Practice was viewed as providing educational, professional and career progression opportunities, which may be deemed attractive for NQNs.

5.2.2. Theme Two - General Practices independent business status. *'It's about practice nursing being the Cinderella service of the NHS'*

Theme two explored participants' perceptions of General Practice, a small independent business, compared to the large NHS secondary care providers and the implications of this on their NQN experience. Two participants (Abbie and Ellie) had worked in General

Practice before training; however, the other fourteen participants had limited General Practice experience. No comparisons were made to other organisations or nursing roles.

As with many small businesses, General Practice may not have the same infrastructure as larger organisations, may have different organisational processes, and would usually hold a keen interest on their financial liquidity. The non-standardisation of these small businesses was thought to affect employees' pay, terms, and working conditions (Clifford *et al.*, 2021; QNI., 2020). Participants discussed General Practices infrastructure and its impact on their experiences as an NQN GPN. This is explored in the first sub-theme, 'Infrastructure'.

Every participant contributed to the second sub-theme of Pay, Terms and Conditions, sharing their experiences and thoughts on the perceived 'inequity' when benchmarking GPNs' pay terms and conditions with their peers and secondary care colleagues.

Recruitment into General Practice is considered in sub-theme Three. Participants discussed GPN role recruitment pathways through how, where and when GPN roles were advertised. Table 9 'Study Two participant details' demonstrated each participant's employment route, showing the wide variety of routes used to access their GPN posts, balancing this with secondary care settings.

The recruitment routes into General Practice demonstrated a range of journeys, with different platforms used to search out and access GPN role availability. Six participants used known and new contacts to gain access to job availability. Through networking with these contacts, the participants were able to apply for GPN roles as opposed to using job platforms or websites. The ability to maximise placement opportunities had a beneficial effect on two participants: supporting both the participant and General Practice employer on the GPN role, culture and requirement. Four participants used commonly known digital job platforms and websites when searching for their first post-destination positions.

5.2.2.1. Infrastructure

Participants discussed the challenges of working within a small independent business environment, including working alongside their employers, not having the availability of specialist human resource and payroll departments, and not having locality-standardised processes and procedures. Participants balanced these views against their secondary care placements, feeling these offered visible layers of clinical management, a supportive infrastructure of multiple dedicated departments for training, payroll, and large-scale standardisation from pay to processes. The challenges caused by General Practices variability and inconsistency within its infrastructure were keenly felt by many of the study participants. Niamh described General Practice and the GPN's role as the '*Cinderella service of the NHS',* inferring that it is often forgotten or not accredited with the attention and recognition she felt it deserved. Iris's journey highlighted the negative impact this could have on a NQN entering General Practice as a first post destination, with poor communication, little paperwork and no support.

'I feel like it's a bit all over the place, like there's not well, every single GP practice works in a different way' (Kelly)

'I'm sure you're aware sometimes General Practice management just isn't quite as wonderful as other places. It can make it a real challenge as it can impact the whole practice because you've got one person managing everyone. Whereas on a ward, you've got layers and layers of management and support teams'. (Jo)

'It's been very poor communication on their behalf; they said it would take about four weeks to send the paperwork out……so it's been about three or four months, and I've not heard back' (Iris)

General Practice funding streams

Participants noted that no information or discussion on how health care is funded or structured was received during their student nurse training. General Practice currently derives a large proportion of its income through delivering on the Quality Outcomes Framework (QoF) (Hackett *et al.*, 2014) which offers financial incentive for providing direct

patient care in certain disease areas, undertaking screening services, and providing public health (immunisation) procedures (Beech and Baird, 2020a). Participants felt that providing this knowledge may enable students and NQNs to understand General Practices business infrastructure and altered employment conditions. Frankie, Leah, Molly, and Kelly discussed how their GPN training schemes covered this within the curriculum.

'I did the GPN course, and they actually said there's like a workbook for that' (Leah).

'So, I think it [VTS] could be beneficial with things like the kind of business side of things, how G.P.s differ from secondary care'. (Frankie).

'I kind of knew a bit about it, but that's only because of the placement I went on. The nurse who was my mentor explained pay rates and also told me about QoF, but if it wasn't for her, I wouldn't have known' (Kelly).

The lack of student nurse knowledge around this area was predominantly seen in participants without prior General Practice experience; those who had undertaken prior General Practice employment or who had undertaken a placement could demonstrate a clearer understanding. However, Leah shared that even within the primary care environment, there might be limited understanding of General Practices private business status. Practices are keen to demonstrate they are meeting the QoFrequirements to receive the allocated remuneration; with participants acknowledging this through the structuring of appointments, the use of the diverse workforce and the digital capabilities within the practice.

'I know for a fact that some nurses in primary care don't understand the business side because I'm working with one currently who is an ANP, and she has no idea with QoF is'. (Leah)

'I think because it is so directly run as a business, you see it more than you would in secondary care' (Jo)

General Practice inconsistencies

Inconsistencies in the GPN role could create uncertainty about what the job entails, which NQNs my find a challenge to understand the scope of practice, responsibilities and expectations of the GPN role. Jo felt the business decisions were being directly weighed against patient care, with the business and society's need to drive increased appointments directly affecting GPN's workload. The data suggested workload was far more than that managed through appointment systems, with participants undertaking administrative roles in addition to their clinical roles, Abbie '*audits',* Ellie *'stock control',* and Poppy '*patient recall lists'*. The SSI's demonstrated there wasn't an equitable standardised timing structure for appointment lists, which created further non-standardisation. The lack of standardisation was felt to further feed into the inconsistency of role requirements.

'So, I feel like that is, yeah, the inequalities are ridiculous from surgery to surgery; it's definitely unfair. I think I got the 20 minutes because I'm new, but my other colleague got 15 minutes'. (Leah)

'I had some time blocked out, but then it got cancelled, so I had to cover both clinics' (Frankie)

It was felt that secondary to the isolated General Practice working environment GPNs used national social media sites to explore working practices. Dawn discussed how many GPNs use social media to acquire generalised knowledge of their work environments. These media platforms provide a source of community, sharing both positive and negative knowledge with the nation's GPNs.

'I see discussions on these Facebook groups of nurses asking, 'I do these skills, how much time do you think I should get''. (Dawn).

The '*financial pressures'* and '*alternative management structure'* (Jo), the '*inconsistency'* of business models (Kelly), and '*poor communication'* (Iris) all provided GPN challenges that participants felt wouldn't have been as evident in secondary care. Participants discussed how the lack of role clarity may be a deterrent for NQNs exploring GPN roles as they may prefer more defined and predictable first post destinations (Jo, Dawn). Frankie provided

tangible evidence of how the decreased infrastructure support is directly affecting her; she has continued to work in a face-to-face environment throughout the COVID-19 pandemic and felt that she has a work-acquired illness. However, secondary to a lack of support, she didn't feel her voice was heard, as there was no occupational health department or nursing representation within the management structure.

'It does feel a lot more stressful, and it does make you feel less supported' (Frankie).

5.2.2.2. Pay, terms and conditions.

Due to many General Practices holding independent business status, there are no standardised employment terms and conditions (Clifford *et al.*, 2021). Becky (SSI two) was the first participant to discuss the non-standardised pay scales within General Practice and how these don't echo the NHS secondary care Agenda for Change (AfC) pay scales. The difference affects salary, holidays, sickness, maternity, and pensions; these will be classed as employment terms and conditions to aid narrative flow. There was limited knowledge and findings within Study One on this sub-theme, however, this is a densely populated topic within Study Two and the current published literature.

Pay

When exploring the participants' pre-registrant knowledge of General Practice employment terms and conditions, nine participants stated they had presumed the role would be paid using AfC. Five participants directly referenced being unaware of their employment terms and conditions until they were contracted into their GPN roles. Three participants were made aware during their GPN interview that their roles were not paid under AfC, but they were happy to proceed.

'I'm very lucky in that my partner's got a very good job so I knew if it were a bit less, it would be fine and he'd rather me be happier in my job than earning more money. It would have impacted the decision if our personal circumstances were different' (Georgie).

'I think I was a bit naïve, to be honest, and I think I was going to get the same as the NHS banding system' (Niamh)

There was evidence of misunderstanding and misrepresentation when discussing employment terms and conditions. Becky was unsure why GPNs are providing NHS services but not paid according to NHS terms and conditions. Participants thought the diverse and covert employment terms and conditions were considered inequitable.

'I think it's a massive issue. I don't understand how we can be providing an NHS service, and we're not, well, we're not the same as the hospital' (Becky)

'Every General Practice works differently, so you never really know what's normal' (Kelly)

'I don't know how the pay scale works or how it works to get into higher positions' (Georgie)

To explore the national norm within GPNs pay, terms and conditions some participants have noted questions and debates within the wider media and social media channels, using these as one source of gathering knowledge.

'I also see discussions on these Facebook groups of nurses asking, 'I've got this; what do you think I should be paid?'. It's all a huge challenge, and I do feel sorry for lots of practice nurses as I don't think they are paid appropriately' (Dawn).

'They say look in your area at job descriptions and see how much they pay. Print them off, you know, tick along each one that you can do and then go and ask for your pay' (Molly).

When exploring employment terms and conditions, it was evident that these directly impacted the GPN's value, recruitment and retention. Leah discussed how, within her GPN training programme, they held a frank discussion about their current hourly rates. Abbie shared how she could increase her salary by moving to a neighbouring practice but did acknowledge the wider implications of workforce stability; she felt this strategy was widely used to increase pay, terms or perceived promotion.

'I think our pay scale went from something like £12.50 to £20.00 an hour, all in one room' (Leah)

'If I'm not getting that kind of well, for example, what Agenda for Change provides, if I'm not getting that, I don't know if I want to continue staying here for multiple years' (Iris)

Within General Practice, role titles and responsibilities are often termed differently to the standardised NHS secondary care roles, leading some participants to speculate that this contributed to locality inconsistency and variation. Several participants perceived the misrepresentation and misinterpretation of pay, terms, and conditions as being linked to the way GPNs are titled. Notably, many General Practice employers use the title "sister," which typically signifies a role requiring higher levels of experience and education and is therefore associated with a higher AfC pay grade.

'She's desperate to be a practice nurse, and then she said it's a band six, isn't it? So, when I said we hadn't got Agenda for Change, and she was so disappointed as she didn't realise that she would be taking a massive pay step down' (Becky).

'I don't know if I'm a band five or band six because I got a name badge the other day that says XXX Practice Nurse Sister, and I thought, oh, am I a sister'? (Georgie)

'A lot of people assume that practice nurses get paid at band 6, and I have no idea where that comes from' (Frankie).

However, some participants (Dawn, Leah, and Molly) said that the non-rigid pay scale enabled increased opportunities to renegotiate their pay following any training and skill improvements which was not felt possible within secondary care; with Kelly feeling that within her experience, the training provided offset the perceived lower pay. They had found that their ATP schemes gave them the confidence and opportunity to renegotiate an increase in their pay.

'I always found when I went to ask for a pay rise, I could financially make a case. I could discuss that I know actually half of what you need to get your money in we can do as nurses' (Leah).

'It was interesting because, on our first course of the fundamentals, the first lecture was about negotiating your pay' (Molly)

Terms and conditions

The terms and conditions discussion covered not only salary but also maternity and sickness benefits. Becky was happy with her sickness cover; however, she only received standard maternity cover, which, secondary to being pregnant, she viewed as challenging. When signing her GPN contract, she did not review this section and presumed sickness, holiday, and maternity would echo that of her NHS AfC peers. When exploring maternity cover, Ellie also discussed the terms and conditions and how these affect General Practice recruitment.

'If there is no maternity benefit, then they will stay at the hospital' (Ellie)

Sick pay was also discussed as '*inconsistent'*, '*inequitable'* and '*challenging'*. Frankie stated she only received statutory sick pay (SSP) for the first six months; she is currently off with what she perceives to be a work-acquired COVID-19 illness and is receiving SSP. Niamh was undergoing cancer treatment but only received her full salary for four weeks and then went on SSP; however, she felt that had she been in a secondary care role, she would have received improved financial support during this time. Becky also shared how some of her secondary care peer groups are interested in the GPN role but are financially unable to transition.

'It would have put me off definitely, in comparison to what they get at the hospital in relation to sick pay and maternity pay. I think they only get about four weeks of sick pay, which is really terrible; it's really poor. No one expects to be off ill for any time' (Ellie).

'I've got a friend who would love to be in primary care, but her and her colleagues say there's no way they could afford to do it, you know, 'I couldn't lose that money, I couldn't afford to come across'……No childcare schemes; they have those in the hospitals, but we don't in primary care, and colleagues have said there's no way they could afford to lose those' (Becky).'It wasn't a kind of a question that I'd ever really thought about, and because I, just because I'm in my first six months, I don't get any sickness pay' (Frankie).

'Sick pay is tough, especially when you didn't realise you wouldn't get the hospital equivalent' (Niamh)

Ellie understood how these inconsistencies and inequities can dissuade new applicants from joining General Practice. Ellie's GPN lead had recommended the team purchase illness insurance to protect their incomes.. The extra costs would not be funded by the General Practice as a benefit but rather by the employee. Ellie felt this penalised GPNs creating a further decrease in their salary.

5.2.2.3. Routes to becoming a General Practice nurse

GPN role advertisement and recruitment demonstrated further evidence of a non-standardised process. In comparison, secondary care recruitment tends to follow a standardised pathway and journey for both student and registered nurses. General Practices' non-standardised role advertisement and recruitment processes may impact the NQN's journey into General Practice.

As echoing the findings from Study One several participants (Abbie, Becky, Frankie, and Leah) commented that their perception before qualifying, and that of their peer group, was that General Practice was '*hard*' to get into. During nurse training, participant's university settings held careers fairs predominantly perceived as secondary care-centric (Becky, Charlie, Ellie, Frankie, Holly and Kelly). Many local secondary care providers would be represented in the careers fairs and occasionally hold immediate interviews to support direct recruitment into their trusts (Abbie, Becky, Charlie, Holly, and Kelly). Kelly felt this was secondary to the university and student nurse journey being secondary care-centric.

'I suppose part of this might be the fact that universities are very secondary care orientated and not interested in primary care' (Kelly)

'We did do careers fairs, and no, there wasn't any General Practice representation, so it's as if they weren't accepting NQNs into General Practice, but again, it just is a further barrier, isn't it into highlighting what we can and can't do in General Practice' (Becky).

'The trust just came in for the day, and then they, you know, they recruited from all of my year for the hospital. They just said, what department, you know, what are you interested in? Where would you want to work'? (Frankie)

When exploring university-held career fairs, any employer has a captive audience within which to increase speciality and organisational awareness. When considering this from a General Practice standpoint Abbie was confident that General Practice had been represented at her university-held careers fair. Whereas Kelly felt that she 'thought' an email had been distributed about the VTS scheme and the recruitment of NQNs into General Practices, but she wasn't sure. However, the data showed a lack of direction or support for NQNs to enter General Practice nursing. The terms used were.

'it's quite hard to get into' (Becky),

'there was no guidance as to how to get into General Practice' (Frankie,

Poppy did discuss how her local training hub had run a campaign through their local ICB to raise awareness of NQNs entering General Practice; this supported Poppy and another student nurse in her training cohort to undertake NQN GPN posts.

Many participants reported the challenges of not knowing where GPN jobs would be advertised, which would indicate that this is a more widespread challenge for NQNs who wish to enter General practice as a first post destination. Therefore, several search tactics were employed when looking for GPN posts, using both NHS job search portals and more commercially based job boards.

'I was completely blind, so I messaged; well, I went onto Google, and I searched newly qualified practice nurse jobs, and there was literally none' (Kelly).

'I just literally started looking for jobs on NHS jobs when everyone was going for them. There wasn't any for General Practice' (Leah).G

'Otherwise, I wouldn't have known about it because it was on Indeed, as General Practices are private, so like don't always use NHS jobs' (Georgie).

For those participants who had seen GPN roles advertised, a further challenge was how the roles were articulated. No participants reported seeing role advertisements for NQNs or 'new to' General Practice. Participants reported that GPN advertisements requested experienced nurses and often provided a list of required elements.

'Every time you look, it's like must be experienced, must have so many years, must have long-term condition knowledge. You do sometimes get the odd one, which says we will be willing to train the right candidate, but that's always just the odd one'. (Kelly)

'We need you trained in', and then they give you a full list of needs that match a fully-fledged practice nurse and even some practice nurses don't have that'. (Leah)

'But I don't see many jobs advertised for newly qualified. I do look, and the job profiles don't say they will develop your skills. You just don't see it around here'. (Molly).

Participants who had undertaken a placement in General Practice or had prior experience did appear to have easier journeys. The professional connections they had established provided support and knowledge in navigating and exploring the job search and recruitment process. Leah had expressed her job intentions whilst on placement and commented on the practice's support, with Abbie using her already-known GPN connections. This may infer the importance of General Practice placements can improve NQNs recruitment journey.

'They pointed me in the right direction; they probably really helped me to navigate the way' (Leah).

'I've already built connections like throughout different places, so I got offered a couple of jobs' (Abbie)

Participants provided information on their alternative job-seeking methods. Jo discussed how she contacted all the General Practice surgeries in a chosen area to ascertain if they had any posts available; she also used a known contact within the ATP to provide knowledge and feedback on any available positions. Abbie also used her local commissioning group to explore relevant contacts and employers who could support her GPN journey. Niamh wrote and visited General Practices and primary care events in person using networking as a job search tool. Kelly used family friends to support her portfolio generation before applying for roles; Becky discussed using free General Practice specific training and webinars to network and improve her portfolio.

5.3. Conclusion

Chapter Five presented the findings generated from Study Two, which explored the participants' perceptions of undertaking a first post-destination in General Practice. Two themes were developed, each containing three sub-themes.

Role awareness and visibility appeared to be a continued theme for the research participants; these have been developed themes in both Studies One and Two. The findings from Study One highlighted a frequently held perception that the GPN role is primarily a slow-paced, deskilled job that was the premise of retirement-age colleagues, have been challenged with Study Two's findings. Study Two explored the experiences of NQNs working as GPNs and highlighted that the role is perceived as dynamic and rewarding, often offering training packages that enable its GPNs to be highly skilled members of the nursing workforce. Study One and Two's findings highlight the importance of role visibility through both theoretical and practical experiences; this was thought to have a positive impact on GPN recruitment. Study Two's participants, however, have discussed that the GPN role can be difficult to enter and is subject to contractual inconsistencies.

The findings of Study One and Study Two were used to develop the initial data collection questions of Study Three, which are discussed in Chapter Six.

Chapter Six – Study Three

6.0 Introduction

Chapter Six will introduce and discuss the third of the interconnected ID studies presented in this research. Study Three explored the views of senior stakeholders on NQNs entering General Practice as a first post destination.

Senior stakeholders (e.g., GPN lead nurses, General Practice employers, policymakers, and training providers) have considerable influence over the recruitment, training, and retention of GPNs. Therefore, Study Three provides an alternative cohort's perspective to enhance this research's breadth and depth of understanding.

Consideration was given to the themes generated within Studies One and Two, using these as a foundation to explore the phenomenon within Study Three. Study Three continued with the methodology and methods detailed in Chapter Three, with any study-specific findings discussed here. Study Three's findings are demonstrated within this chapter.

6.1 Study Three Methods

6.1.1 Research question

The research question for Study Three was '*What are the perceptions and experiences of senior stakeholders on newly qualified nurses entering General Practice as a first post destination?*'

6.1.2 Study design

The methodological framework continued using ID (Thorne, 2016), as discussed in Chapter Three.

Study Three was developed to provide Thorne's (2016) 'thoughtful practitioner test'. The thoughtful practitioner test allowed critical reflection within the emergent data, corroborating or highlighting concepts that had not previously been considered. A discriminant data set within Study Three aimed to confirm, deny or consider new concepts (Cresswell, 2007). Therefore, a corresponding but non-comparative data set was chosen to achieve this.

An ethical amendment to Study Two was submitted to undertake Study Three. The HRA acknowledged ethical approval through the Integrated Research Application System (IRAS), which was approved in March 2022. REC reference 21/PR/1355, IRAS reference 304245 (Appendix 17).

6.1.3 Sampling and recruitment

Purposive and snowball sampling was undertaken (Chapter Three). Participant recruitment, data collection and analysis were undertaken simultaneously, with participant recruitment and data collection occurring between April 2022 and September 2022.

Study Three's inclusion criteria are presented in Table 11. Senior stakeholders were defined as those individuals who could influence or impact GPN recruitment, NQN or GPN policy, and/or nursing education. Participants must have held a senior stakeholder decision-making post for five years to meet the inclusion criteria, as these participants were felt to hold experience relevant to the research question. Five years was felt to provide confidence that these individuals had gained a competent level of General Practice knowledge, mapping with Huitt (2006), who stated that, on average, two to five years of on-the-job experience are required to be considered to be at a decision-making level. No geographical limiters were used as the aim was to explore the impact of local and national decision-making on the GPN role.

Table 11 Study Three inclusion and exclusion criteria

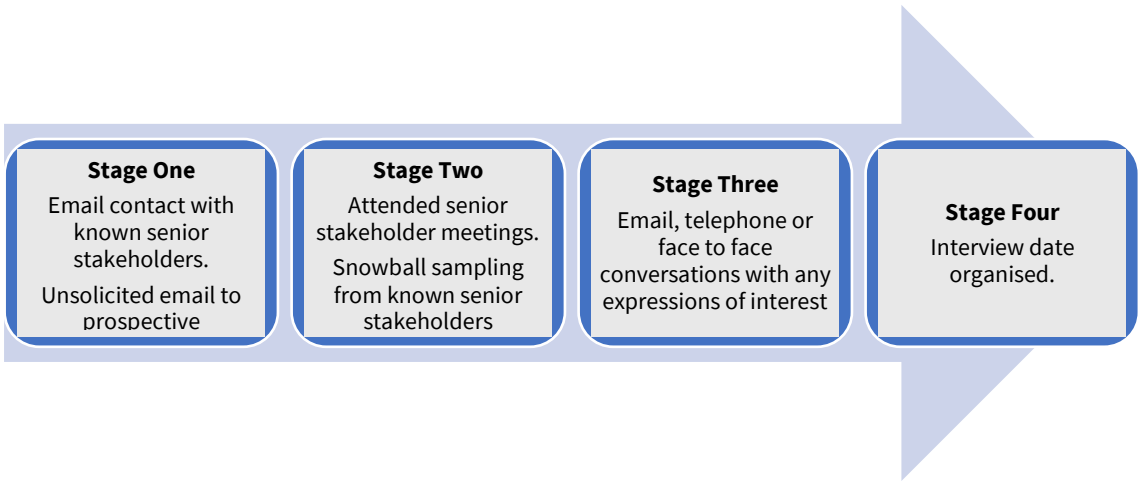
Inclusion criteria	Exclusion criteria
Senior stakeholders (Defined as GPN nurse managers, General Practitioners, Clinical Commissioning Group/Integrated Care Board/Integrated Care System staff, Higher Education Institutes (university) lecturers, senior hospital staff and health-related national organisation decision-makers)	Not connected with GPN nursing or nursing recruitment

Tenure of the post must be ≥ five years within a General Practice senior decision-making or HEI role.	≤ 5 years in post
Consent to research participation	

Purposive and snowball sampling was undertaken with any stakeholders employed within roles that could influence or impact GPN recruitment and retention. Recruitment was facilitated through telephone, email and written contact with the relevant bodies. A study information sheet (Appendix 9) was provided with evidence of the ethical approval (Appendix 17) and academic contact details.

Study Three's recruitment process was undertaken in four stages and is represented in Figure 5.

Figure 5 Study Three participant recruitment



Stage One

Due to the availability of an already established network of experienced senior stakeholders in this area, an introductory email to those known contacts (Appendix 18) was sent. The email contained a study information sheet (Appendix 9) providing details of

the research premise, Study Three's specific premise, and academic contact details. However, it was also recognised that sampling and recruiting from known contacts may not provide depth and breadth of opinion. Therefore, snowball sampling supported a wider iterative approach.

Within the established network, stakeholders provided recommendations of other personnel within the field, and a further unsolicited email was sent to those raising study awareness. This represented snowball sampling and supported potential interest and appetite for participant recruitment. It was acknowledged that this method of recruiting would provide individuals who are experienced in this arena and meets the study criteria.

Stage Two

Stakeholder meetings were regularly attended at both local and national level. Study Three was promoted within those meetings, with a clear recruitment request. Academic contact details were shared to garner any expressions of interest. When interest was established, the study information sheet was provided.

Senior stakeholders within the meetings also discussed colleagues who they felt would offer valuable insight into GPN NQN recruitment. Through this method, three interviews resulted from professional introductions.

Stage Three

Once an expression of interest was made, a Participant Consent Form (Appendix 8) was supplied, which, when signed, enabled the booking of a mutually agreed SSI date.

Ethical approval (Appendix 17) allowed three email contacts; however, sixteen participants responded following the first or second reminder email. One participant originally expressed an interest but did not respond to further email contact and was lost to follow-up.

Stage Four

Fourteen SSIs were held over video conferencing platforms, namely Microsoft Teams, with two held in person. Using video conferencing platforms helped support a mutually convenient time for the interviews. All interviews were held within core working hours (8 am—6 pm), Monday to Friday. The interviews lasted between twenty-eight and fifty-two minutes. At the end of each interview all participants were asked if they could recommend any colleagues who would meet the study criteria (snowball sampling).

6.1.4. Participant characteristics

Seventeen participants requested study details, sixteen of whom expressed interest and progressed to interview. Table 12 provides a profile of Study Three's participants.

Table 12 Study Three participant profile

Total Participants		**16**
Gender	Female	14
	Male	2
Work area	Primary Care training hub (ATPs)	2
	Clinical Commissioning Group (CCG)/Primary Care Network (PCN)	1
	Health Education England (HEE)	2
	NHS England/Improvement	3
	Higher Education Institute (HEI) lecturer	3
	General Practice Nurse Manager	2
	General Practitioner/Integrated Care Board (ICB) lead	1
	Hospital workforce senior stakeholder	2
Ethnicity	White British	16

Current or previous clinical experience in primary care	Yes No	10 6

All participants were assigned a pseudonym to support the narrative flow, as demonstrated in Table 13.

Table 13 Study Three participant anonymisation

Interview number	Pseudonym	Area of work	Current or previous clinical/managerial experience in primary care
1	Andrea	Training hub workforce lead	Yes
2	Beth	GP Federation workforce manager	No
3	Claire	Locality chief nurse	No
4	Dani	National leader nursing and midwifery workforce	Yes
5	Emma	HEI university lecturer	Yes
6	Flora	GPN head of nursing	Yes
7	George	National senior stakeholder in primary care	No
8	Hetty	National senior nurse	Yes

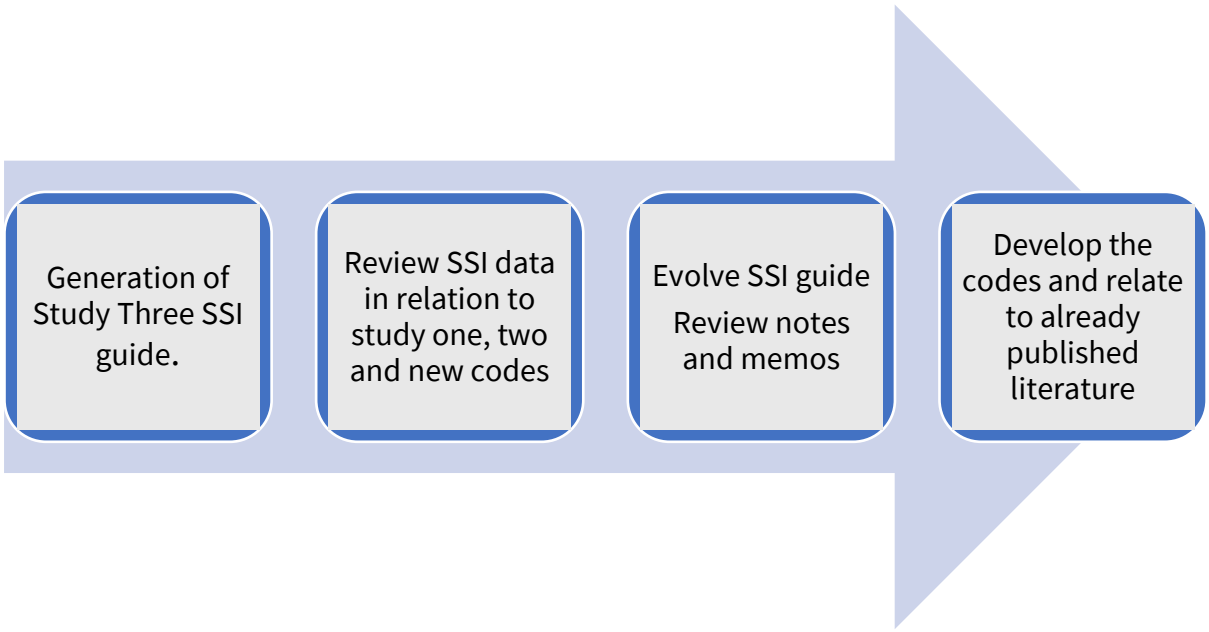
9	Ivy	GPN head of nursing & PCN lead nurse	Yes
10	Julia	HEI university lecturer	Yes
11	Kels	HEI university lecturer	Yes
12	Louise	Acute hospital chief nurse	No
13	Mona	National senior stakeholder in primary care	Yes
14	Nick	GP & senior primary care lead	Yes
15	Pippa	Hospital Director	No
16	Ruth	National organisation – programme director	No

6.1.5. Data collection

Data collection, as discussed in Chapter Three, was supported through SSI's, with the initial interview guide (Appendix 19) generated from Studies One and Two's themes. These themes helped provide some initial questions to guide the interview process. Throughout Study Three, the interviews, data collection and data analysis were undertaken simultaneously, facilitating the amendment of the interview study guide and developing potential sub-themes and themes.

As the data collection stages used in Study Three echoed those used previously, a pictorial flow chart (Figure 6) has been provided. However, further data collection discussion will not be provided within Chapter Six.

Figure 6 Study Three data collection stages



6.1.6. Data analysis

Chapter Three provides an in-depth discussion of the data analysis process.

As with Studies One and Two, Study Three's data underwent a coding process. Collapsing the codes and code definitions allowed for redefining and refining the data. A composite picture was presented once the concepts were generalised and analysis had been undertaken. The elements and concepts were assessed and cross-referenced with their interrelationships within the research data. Critical appraisal of the interview data from Studies One and Two in conjunction with Study Three interview data aided in clarifying ideas, further expanded concepts, and allowed the new data to be sighted in context to the already published data.

Within the initial data analysis, 45 codes were developed; these underwent a first review process, resulting in five key themes with 20 sub-themes. Interview twelve was the last to provide any new codes; however, further interviews were undertaken to ensure meaning saturation (Hennink, Kaiser and Marconi, 2017) had been reached. No new codes were generated within the final four interviews, which provided confidence in meaning saturation (Hennink, Kaiser, and Marconi, 2017).

The first generated themes were developed by aligning similar codes and exploring these for related or individual features (Braun and Clarke, 2013). These themes represented the participants' career journeys, the GPN workforce, pay terms and conditions, local or national initiatives, and the participants 'wish lists', with an example provided in Appendix 20.

The final themes, established at the writing-up stage, were generated following an ongoing reflection, review, and refinement process. Various codes were moved and considered for their individual and collective value during this process. The final themes are demonstrated and discussed in 6.2 Findings.

6.2. Findings

The sixteen interviews showed ten participants had previous or current experience working in General Practice. Fourteen of the sixteen participants had direct involvement with local or national decision-making that may directly affect GPN recruitment, with two participants offering a wider range of knowledge on the NQN recruitment journey. All the SSIs had been undertaken within the participant's core working hours, which is contrary to Studies One and Two, whose interviews were primarily undertaken within the participant's own time.

The findings were developed into three key themes which could or would impact an NQN undertaking their first post destination in General Practice. The first theme, '*The journey from student nurse to established GPN'*, provided content and context on the participants' perceptions of student nurses' experiences moving into the GPN role, with all participants contributing to this key theme. The theme was split into three sub-themes, which explored *student nurses' placements and recruitment journey*, *GPN role visibility, awareness and value,* and *available GPN training schemes and career progression*. All participants recognised the importance of student nurse placements supporting role visibility, awareness, and the recruitment journey.

Theme two, '*Lack of a coherent strategy for the GPN workforce,'* explored the perceived lack of a clear and consistent local or national strategy for the GPN workforce. It was underpinned by two sub-themes exploring *pay terms and conditions and communication,*

and perceived data challenges within a disconnected group. As with Study Two, pay terms and conditions was a densely populated theme, demonstrating a diverse and inequitable structure under which GPNs work. To enable a cohesive strategy, General Practice was considered to need effective communication channels, which whilst considered a requirement were felt to be subject to challenges.

The third theme, '*The impact of decisions and decision-makers, '* considered the impact decisions and decision-makers had on the GPN's value and role. Two sub-themes were developed and explored the *impact of policy, initiatives*, and *nursing leadership*. The rollout of local and national policies and initiatives was thought to directly impact GPN's roles. According to the finding's, nursing leadership was not always positively viewed.

The key themes are demonstrated in Table 14, detailing which participants contributed to each theme.

Table 14 Study Three overview of key themes

Key Themes	**Sub-Themes**	**Participants**
The journey from student nurse to established GPN '*is a bit piecemeal and not quite as coordinated as it perhaps could be'.*	Student nurse placements and recruitment journey GPN role visibility, awareness, and value GPN Training schemes and career progression	Andrea, Beth, Claire, Dani, Emma, Flora, George, Hetty, Ivy, Julia, Kels, Louise, Mona, Nick, Pippa, and Ruth
Lack of coherent strategy for the GPN workforce – '*The problem is we don't have a really good grip on things like vacancy factor*	Pay terms and conditions. Communication and data challenges within a disconnected group.	Andrea, Beth, Claire, Dani, Emma, Flora, George, Hetty, Ivy, Julia, Kels, Louise,

structures, job descriptions, who was about to, you know, retire, what's the impact of an ageing workforce, and what the plans are.'		Mona, Nick, Pippa, and Ruth
The impact of decisions and decision-makers *'If you look at the exec leadership teams in the system, how many have worked in primary care, how many have operationally managed teams in primary care?'*	Impact of policy and initiatives Nursing leadership	Andrea, Beth, Claire, Dani, Emma, Flora, George, Hetty, Ivy, Julia, Kels, Louise, Mona, Nick, Pippa, and Ruth

6.2.1 Theme 1 The journey from student nurse to established general practice nurse '*is a bit piecemeal and not quite as coordinated as it perhaps could be'.*

Participants suggested that if student nurses undertook a primary care placement, it would provide role knowledge and awareness, improving GPN role visibility and value, which may lead to it being considered a career option. As identified in Studies One and Two, it was acknowledged that not all students would experience a GPN placement due to challenges in providing education opportunities in the rapidly evolving primary care sector and workforce. The participants recognised that the perceived challenges with placement availability were multifactorial, including equitable funding, availability of practice mentors and assessors, and lack of visibility. The participants noted Study Two's findings that various training schemes were available for the GPN role, but the non-accredited nature of many of these courses may devalue the GPN role.

6.2.1.1. Student nurse placements and recruitment

Placements

Participants provided their perceptions on challenges with General Practice student nurse placements and student nurses' recruitment journey.

General Practice placement availability was discussed by several participants as supporting role awareness and visibility, in addition to aiding the transition from student nurse to GPN. However, providing General Practice placements was felt to be a challenge. For instance, Andrea actively generates and supports General Practice and HEIs to provide placements and enhance the student nurse placement experience. She believed that the workforce challenges in General Practice have impacted placement availability, reporting that a decrease in nursing staff within General Practice, secondary to retirement or attrition, directly affected the number of available mentors and assessors (now known as practice supervisors and assessors). Some participants cited COVID-19 as having a direct negative impact on both placement and mentor and assessors' availability.

You've got that lag getting those trained up again and getting the confidence before they can start teaching others. It's that vicious cycle and we've literally lost two years with COVID' (Andrea – Training hub workforce lead)

'I think what happened with COVID obviously is a lot of placements totally shut down' (Beth GP federation workforce manager)

Andrea and Dani reported the time-consuming nature of training new mentors and providing time to '*increase their confidence'* (Dani); Flora agreed with this and felt the lack of trained mentors within her practice directly decreased placement availability. Pre-COVID-19, there were slight improvements in mentor and assessor numbers and building placement capacity. However, COVID-19 was felt to have slowed down this traction.

'The way we offer healthcare has also changed, which causes challenges for mentoring. Yeah. I mean, the supervisors now need to look at more innovative ways of getting students involved. If we're doing telephone consultations and, you know, consultations like this rather than face-to-face'. (Andrea – Training hub workforce lead)

Nick and Flora felt the training tariff, which refers to the budget for undertaking medical and nursing placements and training, needed to be more equitable. Medical doctor training tariffs were noted to be more lucrative, which was felt to provide further challenges to nursing placement availability. Nick, a GP and senior primary care lead, felt this was unbalanced, considering nurses' increasing numbers, and complex GPN roles, with Flora feeling the inequitable funding directly impacted the recruitment of mentors and practice assessors.

'We have 150 clinicians of all types, and 37% of them are doctors, and roughly a similar number, around 40%, are nurses' (Nick – GP and senior primary care lead)

Ruth acknowledged the training tariffs but felt that how General Practice appointments are now facilitated, with several conducted over the telephone, had a larger impact on placement availability. However, as highlighted in Study Two, with the advent of the ICBs and Primary Care Networks (PCN), which should be able to offer multiple student nurse placements, Andrea, Nick, and Ruth feel this may improve availability, with Nick attributing this to work undertaken in the training hubs.

'Instead of being single practices, there might be two or three practices merged together, and their perception, then, is that they will still only have to take one student. Really, they could take more as they are now larger practices. So, we have to say, well, no, you need to take at least two. You know you, if it's three practices, three students would be great' (Andrea – Training hub workforce lead)

'So rather than the students going in isolation, one in one out into a practice, could we look at how the students go into the primary care network instead as a bundle of students that maybe have some sort of rotation in and out of different environments? So, we're reducing assessor burden' (Ruth – National organisation programme director)

Some participants discussed the changing primary care infrastructure with the introduction of the ICBs and PCNs, as well as additional funding and support programs which may be to grow and train the primary care workforce, which was seen to positively impact placement availability(Humber and North Yorkshire Health and Care Partnership,

2021). To support this programme, Andrea and Flora discussed their work of nurturing and supporting professional HEI contacts and learning communities.

Due to a lack of regulation, Dani felt additional support for student nurses and NQN GPNs wasn't provided. She expanded on this, corroborated by Andrea and Julia, who explained that non-regulation allowed some employers and commissioners to prioritise service delivery at the cost of placement and educational support. She discussed how this decreased visibility and educational growth, increasing the risk of '*poor patient outcomes'.*

'Because they are their own businesses, they want to have numbers on the ground to see patients. Every time you release the member of staff, you are taking away appointment times' (Julia – HEI university lecturer)

'I think one thing that it did highlight to me is the inequity in different practices; there was one [GPN] *mentor who I realised had had no official training in anything' (Dani – National leader in nursing and midwifery workforce)*

The inconsistent infrastructure of General Practice compared to that of secondary care was reviewed as impacting placement access and availability. Dani and Kels compared the General Practice's business infrastructure with their secondary care colleagues, stating how the lack of organisational infrastructure impacted placements and support, causing challenges for the student nurse experience. Some of the challenges cited were a need for access to learning and development departments, clinical educators, and more robust links to HEIs. Claire discussed how her local acute sector has worked with an HEI to design nurse education to meet its workforce needs and balance the secondary care challenges; this is lacking in General Practice.

'I mean, we have recently recruited some more practice nurses to work as lecturers within the preregistration team, but my instinct is that the emphasis is on secondary care, not primary care' (Kels – HEI university lecturer)

'What the acute trust locally has done in [geographical area] is they've got into bed with [named HEI] University, who's got a campus up in [geographical area] and designed nurse

training to suit their future arrangements. That's the sort of thing that locally has been done to support the design and development of the workforce' (Claire – Locality Chief nurse)

Andrea felt that the lack of an integrated or collaborative multi-departmental team increased the challenges of creating relevant learning modules, recruiting and supporting mentors, and providing robust support programmes. Nick and Emma discussed this as being further compounded by a lack of local clinical education leads or practice education facilitators.

Flora and Ruth discussed how student nurses interested in General Practice often struggled to find placements through their HEIs. Flora shared a story about a student who had trouble securing a General Practice placement through their HEI with Flora acting as a conduit between the student nurse and HEI to arrange the placement. Ruth acknowledged the challenges, stating that if placements are not available for those interested, the potential workforce may '*lose interest'.* Within Study Three, there were three HEI participants; however, they did not offer a different view on this finding.

Recruitment

Participants compared GPN recruitment approaches with those established in secondary care, which involved more effective multi-departmental working and established links with HEIs. Louise and Pippa discussed that collaborative working within their institutions and HEIs enabling regular '*careers fairs', 'fast track applications', 'supportive recruitment journeys'* and '*greater options'* to *'upskill and growing our own'.* Louise and Pippa felt they could '*tap into*' the NQN market through these processes. Pippa felt that to provide equity and stability for all sectors, '*primary, secondary and community care*', you would need an agreed equitable training budget and a robust national health and social care recruitment strategy.

Participants had a range of views on General Practice recruitment. However, it was perceived to be less organised or streamlined than their secondary care peers. Hetty and Dani related some of the GPN workforce instability to the current recruitment methods where practices '*cherry-pick'* and '*poach*' established GPNs from neighbouring General

Practices to meet their patient needs. It was felt that this consistent job hopping, as discussed in Study Two, caused workforce instability (Dani), and the GPN recruitment pool was getting smaller.

'You quite often tend to find that when it comes to the workforce, you've got the same workforce groups who move around because of things like, well, because they're not agenda for change, and the practice down the road might offer them an extra £2.00 an hour'. (Hetty – national senior nurse)

GPN role availability isn't always widely advertised or discussed, with participants (Ruth and Hetty) referring to how they directly had to signpost or support individuals in finding GPN roles. Ruth, alongside some of Study Two's participants, acknowledged the use of social media as a source of information, placement, and role availability.

'I was on a Twitter feed recently and a young lady was reaching out as a newly qualified nurse saying she wanted to work in primary care ……. that's so sad that she's ended up going out to Twitter to find out where she can get employment, it shouldn't be that difficult' (Ruth – national organisation programme director)

Several participants felt that funded training schemes were beneficial; with roles that offered an agreed training budget and programme being desirable for both employee and employer. Julie noted that when she was working as a GPN, her practice only employed NQNs, which she attributed to being based on available funding; she does acknowledge that this impacts the tenure, experienced knowledge and support within the team.

'We took the decision, and I'm not sure I agree with it, but we only looked at employing newly qualified nurses. It was a funding decision because, obviously, it makes a difference on pay scales to taking on an experienced nurse. I do think that we should have advertised across the board for all inexperienced and experienced practice nurses' (Julie – HEI university lecturer).

Various opinions were expressed regarding the recruitment of NQNs into General Practice. Ivy and Pippa held different views compared to other participants. They believed that GPNs should have prior experience in secondary care. Ivy's reasoning was that NQNs

might struggle to identify acutely unwell patients. However, she also discussed that she worked with an experienced nurse who was a new GPN who still couldn't work safely. These conflicting opinions highlighted the disparity among the participants. However, most participants agreed that General Practice was a suitable first post destination for NQNs, and they felt that the available training and support would ensure safe working practices.

6.2.1.2. General practice nurse role visibility, awareness and value

Reflections on GPNs' role visibility, awareness, and value were consistent across many participants' narratives. Many participants acknowledged their perception of the GPN workforce as not feeling '*visible*' or '*valued*'. Participants felt that the lack of visibility and role awareness would create challenges for student nurses considering their first posts.

Echoing Study One and Two's findings, several participants discussed the role as invisible and not recognised or discussed for its true value and offering within the wider health economy. Many factors were offered to support their perceptions of the *'invisible workforce'* (Hetty), which was felt within the broader healthcare community and the public. The *'invisible'* nature of the GPN role was felt to increase the risk of it not being considered a career option for those students, NQNs or established RNs. Ruth also wondered if senior decision makers' lack of GPN visibility affected funding for the GPN role and the wider healthcare community.

'It's [GPN role] *not promoted as, you know, a career, or it's not seen as a career that perhaps, you know, a high achieving school leaver would want to go to' (Kels – HEI university lecturer)*

'It's very much focused on the number of doctors per patient population, and I'm not sure that there is much of a voice to General Practice nursing' (Ruth – National organisation – programme director)

When considering role awareness, participants felt there needed to be more GPN visibility within HEIs, secondary care, policymakers, and budget holders. Louise, a Chief Nurse at an NHS Trust, agreed with this and acknowledged that she does not have a *'good grasp on*

what the role looks and feels like'. Louise felt that offering *'rotational posts'* between primary and secondary care may increase awareness, knowledge, and continuity of care, benefitting the employer, employee and patient care. Flora felt the visibility and understanding of the GPN role were supported through placement access.

'The feedback we get every time is that they didn't wanna come, but they loved being here. They saw a different side to nursing that they didn't realise before and without giving them the opportunity to see what the role is like' (Flora – GPN head of nursing)

Participants suggested a range of benefits in increasing GPN role exposure, including enabling student nurses, other healthcare providers, and the public to understand and appreciate the required diverse skill set. For students and NQNs, this exposure and visibility would enable true representation of the role, which Flora felt would benefit workforce stability and increase understanding and value. Kels commented that she had seen a rise in questions around GPN roles from HEI settings and secondary care, which felt like a positive advance; however, she acknowledged that RN movement could cause workforce challenges in other sectors. Participants felt that GP and stakeholder allyship were considered essential to support GPN role visibility and value.

'There's a lot of, well, because it's General Practice, you know, Dr. led, they're the ones that get the recognition. I think that sometimes even GPs are guilty of it because they don't always acknowledge the role that the practice nurses do' (Flora – GPN head of nursing)

'there's no voice, there's nobody able to then explain to the exec how the role works' (Ruth – national organisation programme director)

Participants acknowledged that GPNs feel they need to be more valued and viewed as a professional, intelligent workforce in their own right. Ruth suggested that non-medical elements aren't considered valuable within primary care teams and, therefore, aren't allocated equitable funding or considered when decision-making. However, Ruth, Pippa and George felt that feeling undervalued would require changing how GPNs, individually and as a workforce, discuss their professions, roles, and themselves.

'I don't think they (GPNs) *have a voice at the table, I think we have our national nursing officers who are conspicuous by their lack, and again this is a personal view, of their lack of leadership during the last couple of years' (Pippa – hospital director)*

Nevertheless, they did say there were challenges in getting GPNs engaged, involved, and committed to changing their narratives.

6.2.1.3. Training schemes and career progression

The third sub-theme was developed based on the effect and availability of GPN training schemes. Training schemes were used to provide competency and confidence within the role in addition to supporting career progression. NQN GPNs are degree-educated professionals, which fits with several participants' GPN role descriptors as complex and professional. To underpin this complex and professional role, access to training was discussed alongside the merits of accreditation and opinions on GPN career progression.

To support NQN's, General Practice surgeries can access various funding streams to aid recruitment, education, and career progression to meet primary healthcare needs; however, these were felt to present some challenges. Nick wondered if some challenges were secondary to the inconsistent funded training schemes and funding streams available.

'So, it's a bit piecemeal and not quite as coordinated as it could be. We have to fight for that funding every year. What that means is you can't plan, and you can't evolve it in the way that you'd like to evolve it' (Nick – GP & senior primary care lead)

Participants (Nick, Dani, and Flora) shared how the allocated funding for training doesn't always meet the workforce's, locality's, and patients' requirements. Flora provided a direct example of this with established GPNs not being able to receive long-term condition updates that would enable them to continue working safely, explaining this as a patient safety issue.

'your statutory and mandatory are just covered, but what about our specialist area updates? You know we should be sending them; we need to do these things to do our job correctly – it's a clinical safety issue' (Flora – GPN head of nursing)

'there isn't really any, you know, specific training available any more, and a lot of the universities have stood things down' (Hetty national senior nurse)

A range of different views were provided when considering the NQN training available. Nick felt that new-to-practice GPNs appreciated the rapid increase of their skill sets; George countered this by stating that some of the initial unpublished local workforce data showed that NQNs in a GPN role realise that General Practice isn't easy and are starting to leave. However, whilst there was widespread support from the participants for the funded training schemes, many discussed the importance of accreditation. Accreditation, as identified by Study Two participants, isn't often available in GPN training courses but was felt to provide '*academic, role and professional'* value (Dani) with similar areas of care, district, and school nursing, offering accredited specialist practitioner qualifications. Accredited training was discussed to '*recognise and professionalise* (Julia) the role and '*maintain clinical standards* (Dani)*'*. Standardising and accrediting an educational framework were felt to support role value and provide career progression for NQNs (Dani, George and Hetty); however, Emma felt there was a lack of HEI educators with General Practice experience to facilitate these.

The lack of accredited training appeared to link with the perception of the GPN workforce feeling undervalued. Hetty discussed this through the perception of funded, available training courses being decommissioned and the message this provided on the value of the GPN role to potential NQN GPNs. Currently, most training is not accredited or a role requirement, with Dani and Mona identifying the standard of care challenges this may provide.

'At that point, I didn't have diplomas in respiratory, asthma or diabetes. It was very much where you sit with the GP, you learn how to consult, and this is how you do it' (Mona – National senior stakeholder in primary care)

GPN role development funding and investment were considered when discussing the professional and business needs. Kels discussed that GPs and General Practice managers, as business owners, weren't felt to appreciate or demonstrate value in the GPN role with more of a focus on driving business needs. Other participants acknowledged the business

requirement within which training is viewed, with training only being allowed if it's '*free*' (Dani) and can be done *'in your own time'* (Andrea and Flora).

A range of workforce development discussions were undertaken. Participants had a shared view that workforce development was managed at a General Practice level, with very little local or national overview and limited evidence of sharing good practices; Nick commented that this may change with the advent of the PCNs. When undertaking workforce analysis, Andrea and Ruth acknowledged that many smaller practices need help with workforce knowledge, vision, or finance, which she felt further impacted workforce stability.

'Wider impact of all of that work is it links to talent management: succession planning in individual organisations and student recruitment is inextricably linked to the workforce plans of the organisation. Many practices don't see or do this' (Ruth – National organisation programme lead)

Beth discussed the invisibility of workforce planning, comparing this to the visible secondary care '*career corridor',* which was very structured and tiered. In contrast, participants felt this was not visible in primary care, potentially affecting career interest in the GPN role or progression for NQN GPNs. Andrea and Julia felt that the ACP role, a recognised and accredited role, offered the only visible career progression for GPNs. However, that was not felt to provide support and acknowledgement of the value of those colleagues who wanted to remain within the GPN role (Hetty).

'You could do a workforce skills analysis, and you can see your gaps and then ask people what they want to do, but if you don't have the money, you can't do that' (Flora GPN head of nursing)

Julia and Nick felt that many use the GPN role as a '*stepping stone'* (Julia) for further training; this was felt to be encouraged by General Practice employers secondary to the available funding and current workforce diversification. Kels noted that those nurses who wished to progress often wait for course or practice availability, which can lead to individuals moving practices to meet their career goals.

'There's a lot of different roles, but the message that we hear loud and clear is from those people who have come into general practice nursing who want to remain a general practice nurse. Who don't, you know, who really enjoy doing that core general practice nursing work, and they're the people who feel that they don't get the support and recognition that they need' (Hetty – National senior nurse)

'When you think about it, you know, the course is six months or longer, and I worked out I'd be, you know, 35 or 40 by the time I got to do it. So, I moved practices, and you know that's what we sometimes need to do' (Kels – HEI university lecturer)

As established in Study Two, the GPN workforce is at high risk of being transient. Study Three participants corroborated this by discussing how GPNs move employers for access to training or improve contractual pay, terms or working conditions, destabilising the GPN workforce and affecting NQN's GPN role availability. Participants offered diverse opinions, with Emma and Flora feeling this was secondary to sporadic and inconsistent training, Dani linked it to improved terms and conditions, with Hetty and Ruth attributing the job hopping to the perceived lack of GPN role value.

6.2.2 Theme 2 – Lack of a coherent strategy for the general practice nurse workforce '*The problem is we don't have a really good grip on things like vacancy factor structures, job descriptions, who was about to, you know, retire, what's the impact of an ageing workforce, and what the plans are.'*

Theme 2 was developed, encapsulating the participants' views on the lack of a coherent strategy for the GPN workforce. Participants discussed how inconsistent and ineffective nursing leadership caused challenges with raising the GPN's voice and visibility. Inconsistent working practices were discussed through the lens of both local and national policies and the different and often veiled GPNs' pay terms and conditions. Participants shared their perspectives on the level of support provided to GPNs by their employers and local and national networks. The conversations primarily focused on the challenges that GPNs and the primary care system face due to the nature of their employment contracts, echoing some of Study Two's findings. As established in Chapter One, General Practices are predominantly independent businesses; therefore, a nationally standardised GPN

employment contract isn't used. Participants discussed the need for increased awareness around not using the NHS standardised AfC contacts. The lack of consistency in employment terms and conditions was viewed as a potential obstacle to workforce recruitment and stability. A coherent national strategy for the GPN workforce, which included training, employment contracts, and career pathways, was considered to alleviate many of the challenges experienced by GPNs.

Study Three discussed the lack of centralised understanding regarding the entire GPN workforce, which hampers effective planning and support. Participants discussed the operational challenges stemming from the absence of a national GPN database. The fragmented GPN workforce encounters difficulties due to the lack of a shared infrastructure for storing and sharing GPN employment data. As a result, there are communication challenges between local and national decision-makers, the front-line GPNs, and their employers.

As a result, participants felt it essential to improve knowledge and confidence in GPN workforce data to facilitate effective stakeholder communications. These communication challenges extend beyond workforce data; they impact organisational, local, and national communications across the GPN workforce. Notably, communication challenges were also identified to exist within national decision-making organisations, not just among GPNs.

6.2.2.1. Pay terms and conditions.

Pay, terms and conditions were identified as a densely populated theme in both Studies Two and Three. Study Three participants felt that the current system of providing GPNs with alternative pay terms and conditions to their NHS-employed counterparts provided for an unstable workforce and unfair practices. Hetty discussed the inconsistencies as a '*real concern';* Dani stated there's no '*equity'* with Kels, calling them '*very alien'.* Beth, Claire, and Mona believed there needed to be more awareness among the public and healthcare professionals around General Practices independent business status and the impact this has on pay. Beth stated that it wasn't until she worked within General Practice that she became aware of the different pay structures, echoing some of the findings from

Studies One and Two. Claire felt that the public and many colleagues '*think everybody works for the NHS',* and if generalised terms and conditions were offered, it would benefit all staff.

'Probably for the first twelve months, I had no idea about terms and conditions, and luckily, I wasn't off sick or anything; but after that, I started to think about increments, and I started to think about what I've taken on at the practice. Then it made me realise that, you know, there wasn't any obviously NHS terms and conditions' (Mona – National senior stakeholder in primary care)

Whilst many participants acknowledged that before working within General Practice, they were unaware of the differing pay terms and conditions; some felt that new to practice or NQN recruitment was affected due to a lack of assurance of a sustainable pay structure. As discussed in Study Two and Study Three Theme One, Hetty, Pippa and Julia noted that the inconsistencies also encouraged movement within the workforce, where colleagues would move between employers to improve their contracts or training opportunities. This suggests that the inconsistent employment terms and conditions contribute to GPN workforce instability.

'the same workforce groups who move around because of things like, well, because they're not agenda for change, and the practice down the road might offer them an extra £2.00 an hour' (Hetty – National senior nurse)

'because I think you would not necessarily get the staffing movement that appears to be happening across the sectors' (Pippa – Hospital director).

'We lost a couple of our nurses back into secondary care because of the benefits that you can get within the NHS Trust compared to what you can get in General Practice (Julia – HEI university lecturer)

The independent business model of General Practice directly impacted pay, terms, and conditions (Nick). Beth discussed that until a national unified operating model was available, changing the current General Practice independent business status, then the challenges around GPN pay would continue. However, the independent business model is

not the only GPN contracting challenge. Mona highlighted the inequity within the GPN and GP contracts and felt that until these were addressed, we were '*not going to get stability in primary care'*; she commented that this was a national issue currently being explored.

Hetty and Emma discussed the common practice of 'veiling of pay', which was thought to confuse General Practice employees, locality, and the wider workforce. Under this practice, only the business owners and the individual know the contract package; this means you will have colleagues within the same practice doing the same job but holding differing pay, terms, and conditions.

'As long as GPs and practice managers are in charge of pay, you know, and benefits and career progression in most practices, that's the factor that holds them back. It's so alien to us in the NHS because you just got your automatic, you know, increments, pay banding, and everything. Your standard benefits are all the same' (Kels – HEI university lecturer).

Hetty and Dani discussed how the '*uncertainty*' and '*lack of consistency'* led to people feeling *undervalued* and '*unsupported'*. George echoed these sentiments, linking the premise of '*feeling valued'* with standardised pay and conditions. He provided an anecdote of a GPN being placed on SSP within six weeks of a cancer diagnosis. Hetty provided details of a long-standing GPN who would only receive statutory maternity pay. Julia and Hetty felt that to lower the GPN age, effective contracting of GPNs' pay terms and conditions would support workforce transformation, with Nick suggesting a national body of work on standardisation would support this.

'I had one colleague who had an unexpected pregnancy in her late 30s, and we both sat and cried together when we found out that she was going to get six weeks maternity pay' (Hetty – National senior nurse)

'They're probably facing a bigger crisis than GPs themselves, I think nationally, well, the average age is quite high, and there's a lot, there's a significant percentage of them approaching retirement' (Nick – GP & senior primary care lead)

'One of the problems with only taking on newly qualified nurses was they were all very early 20s to mid-20s. So, they're all looking at starting families at some point in the near future, and they then can't be able to fund it at the minute. When you work in General Practice, things like maternity pay and benefits are a real issue for those newly qualified' (Julia – HEI university lecturer).

Most participants provided similar data on the benefits of providing a standardised pay terms and conditions structure. Julia and Hetty felt it was more profitable for many nurses to work within settings that provide AfC pay scales, with Hetty commenting that she '*skipped through the door'* when she got her current national role as she wouldn't have to '*battle'* for pay terms and conditions. Several participants felt that to provide visibility and standardisation, linking GPNs' pay, terms, and conditions with a skills and career framework would provide '*equity'* (Pippa and Mona), '*visibility'* (Dani), '*structure*, *stability* and *support'* (Hetty)*, 'increased value'* (George) in the GPN role, '*stop job hopping'* (Beth, Dani and Emma), and link a '*quality assured educational programme with comparative pay scales'* (Dani). George discussed how The Career and Capabilities Framework (Health Education England, 2021b) aimed to map GPNs' skills and competencies, stating that '*providing the data collected is accurate'* would provide a clear accurate picture of the current GPN's workforce capability. However, Claire did discuss that she felt this body of work wouldn't be explored due to the NHS undergoing a massive recovery and reorganisation programme following COVID-19.

'As you can imagine the biggest reorganisation the NHS has seen for quite some time, is the COVID recovery, it's what's on everybody's mind, so terms and conditions wouldn't be seen as a priority' (Claire – Locality chief nurse)

Some participants acknowledged that the GPN role currently offered family-friendly hours. However, they did comment that these may be subject to change as the current primary care workstreams expand. However, Emma felt that this benefit alone wouldn't attract a younger workforce as she felt they would '*go where the money is'* with Ivy acknowledging that there are no incentives to work within General Practice. Andrea, Flora,

and Nick did offer a different perspective, stating that some General Practices will '*pay your registration'*, '*pay expenses'* and provide '*better training'*.

'They [GPNs} don't always see that side of it, the training that they can access and things, but that doesn't pay the mortgage' (Andrea – Training hub workforce lead)

6.2.2.2. Communication and data challenges

Participants often discussed ineffective and disconnected communication at practice, local, regional, and national levels. Communication challenges were discussed as 'disconnected', with poor communication between the decisions made at the senior stakeholder level and if, or what, was communicated to front-line GPNs. Hetty emphasised this by suggesting that communication channels could have been more effective.

'When you think about access and communication within primary care and actually being able to make sure that information gets through to the General Practice nurses, I think there's still a lot of concern that the right people aren't getting the message from a primary care network level'. (Hetty – National senior nurse)

Hetty and Ivy felt the reasons behind the challenges are that GPNs don't operate under *'team-based working'*, tending to work within isolated working environments. The isolation impacts communication, with information not being effectively shared throughout the practice, local primary care teams or escalated to the regional and national senior stakeholders. This suggests communication challenges are experienced from the front line up and the decision maker down. Hetty felt that local communication is often held at the General Practice level with no escalation process; therefore, she wondered if this increased the feeling of isolation and the lack of national awareness. Communication barriers were thought to increase recruitment challenges, role awareness, and sharing good practice. Ivy provided a direct example of this, noting the difference in the level of communication she received in her new PCN role as opposed to her GPN Manager role.

'In my PCN role, I get lots more emails from lots more different people that I ever got before. And I'm like, oh, I didn't know there was a, well, they ran that course'. (Ivy – GPN head of nursing and PCN lead nurse)

Flora echoed this but felt the communication channels could be more effective even within practice environments. As a GPN Nurse Manager, she stated she had to spend time '*chasing providers'* and additional '*background research*' work when exploring recruitment, support, training, or services. Her impression was that the communications are provided to those higher in the organisation but not disseminated to those who would benefit. Hetty corroborated this and felt it was secondary to the information being *'sat in someone's inbox'* instead of directed to those who could act and benefit. Perceived inept communication channels meant some stakeholders weren't aware of available funding to support recruitment or training. Kels and Ivy discussed how the independent business status encouraged silo working and hindered GPN's recruitment, financial and professional progression. As identified in Study Two, the lack of robust back-office departments, such as wages and human resources, provided further communication concerns for several participants, with the lack of an aligned HR department creating workforce challenges (Emma) from both a recruitment and retention stance. George, as a key national stakeholder, was aware of these issues.

'I recently met a practice nurse who was leaving, and she sat, and ironically, she cried again when I went to do a practice visit. She loved it, she loved the patients, but she had no contract; she'd worked there for a year, and she had no contract' (Ivy - GPN head of nursing and PCN lead nurse)

'One of the challenges that we have is how do you get your communication through. How do you communicate with the GPN workforce? They are so dispersed in that you have so many practices. You've got 1225 PCNS. You know, I've forgotten the last count; it's something like 21,000 practices out there as independent employers? There's no easy way to communicate' (George – National senior stakeholder in primary care)

Recognising this challenge, George collaborated with the Royal College of Nursing (RCN), using social media, video conferencing platforms, and websites to facilitate national

multi-agency communications. George, Ivy, and Flora felt a '*dedicated comms channel'* for GPNs would help, as they know front-line GPN managers are experiencing communication challenges.

Participants felt that the lack of consistent and quality data provided a range of challenges for the GPN workforce (George, Claire). Three participants discussed how high-level data is available; however, it felt unreliable or relatable to allow decision-makers to act confidently. Claire felt that you cannot adequately understand or forward-plan without understanding what sits behind the high-level metrics.

'The problem is we don't have a really good grip on things like vacancy factor structures, job descriptions, who was about to, you know, retire, what's the impact of an ageing workforce, and what the plans are' (Claire – CCG chief nurse)

Participants discussed the data challenges in relation to local initiatives, with Ruth acknowledging there was a lack of information collated and stored around General Practice data. Emma, however, had undertaken a pre-COVID-19, eighteen-month secondment exploring her locality's GPN workforce and the value that this provided. Unfortunately, she recognised the value of this piece of work has quickly become outdated and felt this workforce analysis now sat with the ICBs, therefore, she feels any workforce data needs to be contemporary and maintained to be effective. Nevertheless, Ruth and Emma discussed how knowledge of the local data provided the ability to generate locally run initiatives that provide tangible information to support local workforce issues.

'Now, ICS clinical directors are responsible for looking at the skill mix and the workforce plans, but I'm not sure they have the skills to do that' (Ruth – National organisation programme director).

When exploring the challenges within the workforce data, Hetty estimated that her employers receive an approximate 20% return on workforce data from primary care. In contrast, she has easy access to electronic staff records within secondary care. Therefore, she felt the data needed to be more reliable for collaborative workforce planning. When

George and Mona discussed workforce planning, they felt the workforce data could support change in workforce transformation. However, Mona did caveat that the GPN workforce metrics didn't provide enough detail to understand the current workforce challenges.

'Another area in primary care that's not really looked at is turnover. So, we might nationally get data on nursing attrition rates, but again, we don't know the details behind those figures' (Mona- National senior stakeholder in primary care).

Mona described how the slow reporting and lack of placement data impacted the student nursing experience. Not being able to explore which geographic areas are performing well and the ability to share good practices is limited, measures could be taken if a geographic area needed additional student placement support.

'We want to understand how many students go through General Practice per month. Then, if placements are going through the roof in one area, why isn't [geographic area] doing the same? For example, we need that reporting quarterly, and we need to understand what good looks like' (Mona- National senior stakeholder in primary care).

Participants (George, Claire, and Hetty) shared their perceptions that GPNs are primarily discussed and viewed through a community nursing lens when considering national communications, creating some fundamental issues that need addressing. When Hetty asked why GPNs weren't mentioned, it was felt they were the same as community nurses. Community nurses are contracted under AfC and provided with established regional-wide support mechanisms and, therefore, are not under the same GPN employment conditions.

Dani felt the GPNs '*lack of voice and visibility'* increased the challenge of effective communication. Many senior decision-makers devolved policies and workstreams for the GPN workforce without understanding their role within health care delivery, with GPNs feeling they did not have the power to question or redirect inappropriate decisions or workstreams. Hetty acknowledged the impact this would have on student nurses and NQN recruitment.

6.2.3 Theme 3 Impact of decisions and decision-makers '*If you look at the exec leadership teams in the system, how many have worked in primary care, how many have operationally managed teams in primary care?'*

Study Three's final key theme was the impact of local and national policies and initiatives on the future and current GPN workforce. As discussed, communication channels were perceived to be poor, with a lack of confidence in the workforce data; therefore, these initiatives and policies weren't always known to the targeted cohorts (student nurses, NQNs and GPNs). Several participants felt that the decisions had impacted the quality and quantity of the nursing workforce, impacting both students' and registrants' professional journeys, with the value of some previously made decisions and policies being explored and questioned. The participant data highlighted that only a limited number of senior decision-makers who commissioned courses and policies had lived experience of the GPN role or had worked within General Practice and, therefore, may know but not understand some of the issues experienced. Dani, a national workforce lead with lived GPN experience, discussed how a GPN Careers Framework was generated and released from her organisation without input from those with General Practice experience.

'If you look at the exec leadership teams in the system how many of them have worked in primary care? How many really operationally managed teams in primary care? I can pretty much guarantee that hardly any of them have, and don't get me started on commissioners'! (Ruth – National organisation programme director)

'Things like the 10-point and the five-year plan and things like that, they're all very well and good at saying what they want to do, but we just haven't noticed anything in fruition. --- I feel like we have a lot of things written but not necessarily actually doing anything'. (Julie HEI lecturer)

'A career framework document [for GPNs] *has just been released, which, ironically, I didn't know anything about' (Dani – National Organisation Nursing and Midwifery workforce lead)*

Participants felt a mismatch between decision makers' understanding of the student nurse, NQN, GPN role, and workforce requirements. They discussed how current training

policies affected student nurse training costs (Nick) and the potential debt incurred. Nick considered this in relation to removing the nursing training bursary, leaving many NQNs with substantial debt; he felt that a GPN post might not be desirable as they may perceive this as poorly valued, remunerated and with limited career progress. He also provided his thoughts on the diverse student nurse journeys available. He felt that the nursing associate and nursing apprenticeship pathways again were high costs for often low-income applicants.

'So, you're taking the people who are the least affluent in society, have had the hardest upbringings from the most deprived areas. Make them study for longer and rack up more debt to go into a profession that's undervalued because it doesn't get paid enough' (Nick. GP & senior primary care lead)

Pippa, Ruth, and Nick discussed the challenges of recruiting '*the right people'* into student nursing courses. Participants discussed how a '*lack of a bursary*' or any '*subsidy support*' for most student nurses means many potential nurses cannot undertake their training.

'I think that was potentially a mistake in government policy, and I think the difficulty would be trying to change that now; I'm not sure that it could be reversed. Whether or not there's an option to do some sort of subsidy for people on student training, given that there is an increasing gap between the workforce we have and the workforce, we need that there is a need to do something proactive' (Pippa – Hospital director)

'They used to obviously provide the bursary for the training for registered professionals, but with the education reforms that ended now what they do is they have delegated responsibility from the government to actually put in place all the interventions and the activities to do that piece around workforce succession planning numbers' (Ruth – National organisation programme director)

Nick wondered if one of the challenges of an all-degree profession had further impacted the workforce. He felt those candidates who wouldn't normally consider a university pathway, either through financial or education challenges, were being encouraged into

HEI-educated Nursing Associate roles. Whilst acknowledging Nursing Associates' value within the workforce, he did feel this current system further penalised this cohort.

NQNs were perceived as driven and career-focused with clear ideals of what they wanted from their nursing careers; however, GPN nurse managers and workforce leads felt they sometimes needed to gain the knowledge, experience, or role tenure before rapidly advancing within their GPN career pathways. Ivy verbalised this as '*needing to walk before they can run'.* Participants felt that whilst nursing leadership courses increased confidence and competence in future leaders and supported postgraduate career-driven GPNs, tenure is often overlooked. Dani described a locality '*Careers Start programme'*, which supported GPNs to become leaders and build a GPN career, which was a desirable career opportunity for many NQNs in General Practice. However, these courses may not support legacy GPNs, who report needing more hands-on support to complete their daily role (Beth and Dani).

6.2.3.1. Impact of Initiatives and Policy

The impact of local and national initiatives and policies, such as the GPN Ready Scheme (Health Education England, 2016a), the GPN 10 Point Plan (NHS England, 2018) and the locality Vocational Training Schemes (Haxby Training Group, 2020), can be far-reaching for any profession. George and Dani discussed how national schemes are being utilised to support GPNs throughout their career journeys, from the Next Generation Nurse programme (Talent Foundry, 2024), where school leavers are made aware of careers in nursing focusing on General Practice nursing, through to funded ACP roles. Additional leadership courses, such as The Care Programme, are now commissioned to help support GPNs into leadership roles and make them feel comfortable undertaking '*those political discussions'* (Dani). However, some participants feel these courses are often undersubscribed and inappropriately used. Employers don't see the value within them (Dani) as they offer no apparent business or revenue opportunity. Mona felt that support was available for those at the beginning or wishing to progress within their GPN roles; however, she felt there wasn't the training or funding available for those '*in the middle'*, which she termed the '*core General Practice team'*.

'They have no leadership and management experience, and practices are resistant to release people for that because actually they really need them to go on a diabetic course or a cytology course which brings money in' (Dani – National leader nursing and midwifery workforce)

When exploring how funding and policy decisions may be generated or directed, Claire discussed how the volume of health interactions occurs within a community setting and claimed that 96% of the activity is undertaken outside hospitals. She felt that '*funding services is hugely disproportionate'*, with most funding allocated to secondary care and out-of-hospital care being seen as the '*second cousin'* to the '*rock stars'* that are the acute hospitals. However, she did acknowledge that the funding challenges also impacted education, recruitment, and role visibility. She felt this was secondary to the data being predominantly collected at acute secondary care level, leaving the GPN role and its impact predominantly invisible.

Kels and George discussed various nationally commissioned documents that support career pathways into and within General Practice. However, whilst these policies and frameworks have been commissioned, it was acknowledged that they haven't been adopted. The 2015 HEE Career Framework (National Health Service and Health Education England, 2015) aimed to provide an overview of the General Practice careers available, with the Career and Core Capabilities document (Health Education England, 2021) supporting a robust career framework within General Practice. George felt these were commissioned and generated through a joint approach to produce accessible and visible documents. However, Dani, a previous GPN and now a key national nursing lead, disagreed. As discussed in the communication findings, she had not been consulted for her inherent GPN knowledge when her employers produced the Careers Framework.

'We're working really closely with HEE, the primary care team and the nursing directors. I insisted that it was done with the leads from HEE and the primary care team, so they were the co-chairs of the overarching group, so we were taking a joint approach'. (George – National senior stakeholder in primary care)

'I didn't know anything about it [career framework document] --- *I was a bit miffed with that to be fair' (Dani National Organisation Nursing and midwifery workforce lead)*

As a locality Chief Nurse, Claire's job description stipulated that she is to provide professional support for GPNs; however, she remarked that she doesn't have the budget, experiential knowledge or policy support to undertake this. George, who also had no lived General practice experience, held a different opinion on this and felt the support was essential as the GPN workforce could potentially deliver on local and national policy.

'The CCG Chief Nurses have always had the role written into their job descriptions, which is about professional support to primary care nursing. It's never described what it is, how to deliver it or fund it' (Claire, Locality chief nurse)

'Suppose you think about the long-term plan, any kind of thinking about the future. In that case, there's one group that can really deliver, and it would be GPNs around those issues' (George – National senior stakeholder in primary care).

Local and national policies can impact student and NQN GPN's recruitment and retention. The NHS's People Promise (NHS, 2020) didn't originally include primary care (George). However, he felt that primary care and GPNs are now considered within this national policy and attributed this to a positive policy shift development. Hetty's opinion was slightly different in that she felt there was no national priority or identified national workstream; therefore, GPNs don't have a voice or visibility, resulting in no financial input. Claire and Ruth discussed the local initiatives, ranging from bespoke out-of-hospital nursing education programmes to NQN General Practice support programmes. Due to the constant pressures and instability with funding (Nick), neither Claire nor Ruth felt these programmes would have tenure or undergo a robust review and refinement process.

Six participants discussed the nationally released GPN 10 Point Plan (GPN10PP) (NHS England, 2018), which specifically aimed at recruiting NQNs into the GPN role, addressing the ageing GPN workforce with allocated priorities and target areas (Hetty). George was alone in his thought that the plan had increased placement opportunities by *'800%'*, adding it supported the recruitment of a younger workforce of '*over 675 people under the*

age of 30 into General Practice nursing'. However, both were pre-COVID19, with several participants acknowledging that any positive workforce movement had been lost in the post-COVID19 General Practice environment. The GPN10PP (2018) has concluded and is no longer being funded or explored.

'Everything that's happened over the last few years makes that even harder to do because we're very much firefighting' (Ruth – National organisation programme director)

'We've lost that traction, and it's gonna take us quite a long time to catch up with that' (Andrea – Training hub workforce lead).

'The things that we've all seen in the news that we could have predicted were going to happen once you did the maths around the workforce have actually been accelerated because of COVID' (Pippa – Hospital director)

Ruth felt that *'small pockets'* of evidence provided a positive structure for supporting NQN GPNs. Dani challenged this perception as she felt it wasn't currently on anyone's '*agenda or workstream'*. Ruth felt the generation of PCNs and ICBs could use the principles of the GPN10PP, providing the possibility to work at scale and have a higher impact. Several participants discussed how they had expected a phase two initiative to be released.

'We had a GPN board where we had, fortunately, a group of like-minded people who would then link in with their local areas to make sure that what we were trying to achieve was important and that it really was the voice of the GPN. To be honest, I think we all expected that as it finished, because it was a five-year plan, as it finished something new would come in…….. We were asked to do a legacy piece and to summarise areas that had worked well because it was a really positive piece of work, and it really felt like we were starting to make progress. But I think the decision had already been made by the time we submitted that piece of work'. (Hetty – National senior nurse)

'Even things like the 10-point plan and the five-year plans and things like that, they're all very well and good at saying what they want to do, but we just haven't noticed anything in fruition. It just doesn't. Well, I know that the QNI write quite a lot about GPNs as well, and I

just feel like we have a lot of things written but are not necessarily actually doing anything' (Julia – HEI university lecturer).

'It's like the 10-point plan great thought behind it, but then nothing evolves from it once the funding and interest has waned. It just kind of ended, didn't it, and then nothing more is said' (Kels – HEI university lecturer)

6.2.3.2. Nursing leadership

'Learn quickly' (Hetty), '*prioritisation and professionalism'* (Ivy), and '*complex interplay between health and the patient's social situation'* (Flora) were terms used when the GPN role was discussed. Julia provided similar responses, further discussing the impact of GPNs as *'the heart of nursing',* where GPNs can put the patient first and build a rapport, providing *'continuity'* and *'cradle to grave'* care (Kels) through the perception of being part of a small community. To enable and support the GPN's professional role and requirement, strong nursing leadership is thought to be required (George).

Senior decision-makers within nursing impact the student nurse journey, the NQN and the established GPN workforce. Positive nurse leadership was thought to provide the profession visibility, value, and voice. Therefore, GPNs require strong nurse leaders, which would raise the profile and could make a GPN career more accessible and attractive. Several participants discussed this from a practice, regional, and national perspective. Nurse leaders are in a key position to generate and sustain strategies enabling students, NQNs, and established GPNs to flourish within their roles. Many participants felt that GPN and PCN nursing leaders were there to '*tick the box*' (Dani) and aren't '*empowered to be effective leaders' (*Dani), '*aren't in decision-making positions'* (Claire) with General Practice business owners and PCNs not '*take nursing more seriously'* and left feeling like '*it's me against them'* (Ruth).

GPN Nurse Managers Flora and Ivy discussed the challenges of generating interest among GPNs in leadership roles. They felt that this was further impeded by their employers, who discouraged them because there was no financial incentive attached; Beth considered this was due to a loss of appointments and revenue due to a lack of allocated backfill funding. These feelings were felt to feed into GPNs feeling *'disempowered' (Claire)* and GPN leads

being confined by *'culture processes' (Beth)* and *'operational challenges'* (Flora) with very little local or national representation where decisions are made from a medical or business stance. Participants shared the perceptions that having a knowledgeable GPN lead for each PCN would support '*workforce*' (Dani) and *'staff development'* (Ruth). Some participants noted a sporadic national picture of effective PCN-lead nurses demonstrating their knowledge and commitment to building the workforce. These PCNs were felt to be more mature in their evolution of the GPN workforce with committed additional funding to ensure this happens (Hetty). Mona felt this provided isolated evidence of PCN lead nurses supporting the workforce, which aids GPNs awareness and visibility. Dani was unsure if this was a natural progression or secondary to the national Chief Nursing Officers' communication extolling primary care support, encouraging more GPN leads to be visible and have decision-making capability within PCNs.

'It does vary so much from system to system, doesn't it, and how much involvement, and this is going back to the visibility and the seat at the table, how much involvement are those clinical nurse directors or those PCN nurse leaders having at regional level' (Mona – National senior stakeholder in primary care).

'I think there is a realisation and, especially now that Ruth May [Chief Nursing Officer for England] *has sort of really put our ring in the hat and said, you know, we need to concentrate on primary care; there's no reason why each PCN can't have a GPN lead, and she's absolutely right' (Dani – National leader in nursing and midwifery workforce)*.

The lack of consistency in nurse leadership across the primary care infrastructure was thought to increase the challenges in elevating discussions at a national level. Hetty discussed how she was requested to submit a list of all the PCN nurse leads within her region to support national workstreams. However, she was met with surprise when explaining that this wasn't a required role or was facilitated in many PCNs, resulting in a disconnect in communication and expectations of national decision-makers. A lack of regional leadership was thought to impact the full GPN journey. However, Dani did feel that many current GPN leaders are there through the tenure of service rather than understanding leadership requirements.

'If a person is put in that situation as being the most experienced, that doesn't mean you're a leader. There's a difference being a leader and a manager, but we can put people in a situation of being the most experienced in a practice within a very short space of time' (Dani – National leader in nursing and midwifery workforce).

Participants discussed how to enable nurse leaders to be more '*strategic'* (Claire) and '*empowered'* (Dani) to engender a change in the workforce; additional leadership training and knowledge may be required. Ruth felt this would allow new and experienced GPNs to stand alongside their medical counterparts when discussing strategic nursing workforce and provide a valued '*voice at the table* (Pippa)*'*.

When exploring the roles of regional and national decision-makers within General Practice and nursing workforce, most participants felt that many of those involved needed more direct General Practice or GPN experience.

'A lot of the lead people in the national team have not actually worked within primary care'(Hetty – National senior nurse)

'They are looking at some national work, which I'm trying to get into because I'm probably one of the only practice nurses within [national organisation] who's worked in General Practice' (Dani—National leader in nursing and midwifery workforce).

Pippa and George felt that the national representation of nursing as a workforce isn't as positive, visible, or effective as it could be. Nursing's regulatory and union representation was felt ineffective compared to their medical counterparts, describing these as '*incredibly powerful*' and demonstrating a *'superb job'* when advocating for the medical workforce. Pippa felt that she had been '*let down'* by nursing leaders. However, George attributed GPNs' feelings of being '*undervalued, not seen, not recognised*' as secondary to GPNs being predominantly female and viewed in terms of care, with GPNs needing to become more assertive. Changing the GPNs narrative to a more positive professional one, may make the role more attractive as a career option for student nurses (Hetty).

'The one thing I want to say, there's something around nurses themselves having to change their narrative. You know, they see themselves pretty much as the victims in the whole thing,

and they don't take ownership, they don't lead' (George- National senior stakeholder in primary care).

As a nurse and national decision-maker, George's comments demonstrate the perception that the issues are with the GPN nursing workforce instead of the infrastructure within which they work. Of note, six participants, including George, have never worked in primary care. They may have GPN knowledge; however, they don't possess lived experience. This may infer a respect and value stance of the role and could impact their perceptions when reviewing recruitment, retention, and attrition within the GPN workforce.

6.3. Conclusion

Chapter Six provided details on Study Three's methodology, methods and findings, which explored senior stakeholders' perceptions of NQNs entering General Practice as a first post destination. A wide range of participants who impact the GPN workforce were recruited and provided stakeholder perceptions on NQN's journey into General Practice.

Three themes were identified and discussed; senior stakeholders' perceptions of the journey from pre-registrant to established GPN, which the data suggested are challenged by inconsistency and lack of visibility. The lack of a coherent strategy was felt to impact established GPNs through the lack, use and variety of communication channels and the discordant pay terms and conditions; these were felt to impact GPN recruitment and GPNs' perceived value. Finally, the impact of decisions and decision-makers was explored through the lens of policies, initiatives and nurse leaders. Short-term policy and funding decisions, alongside locality variance and a perceived weak and invisible nursing leadership, were considered impactful to both aspirant and established GPNs.

Chapter Seven will explore and discuss the three interlinked studies within this research and consider the findings in relation to published research. The chapter will define the research strengths and limitations and discuss how reflexivity has shaped and driven the research, concluding with the research recommendations based around education, practice, health policy and further research.

Chapter Seven- Discussion and recommendations

The findings, detailed in Chapter Seven, represent an ID study on what are key stakeholders' perceptions of NQNs choosing General Practice as a first-post destination. The research was conducted to gain a deep understanding of the perceptions of NQNs entering General Practice as a first post-destination. The research involved in-depth SSIs with three distinct study populations: student nurses, NQNs who chose General Practice as their first post destination, and General Practice senior stakeholders. In response to the research question, the three interlined studies' findings provided a well-rounded review which sheds new light on the complexity of the issues surrounding NQNs entering the General Practice workforce.

Chapter Seven will discuss the findings of the three interlinked studies and their connection to the research question, existing literature, and newly emerging evidence. Discussion will provide detail on the research's strengths and limitations and will demonstrate the ongoing process of reflexivity examining the academic, professional, and personal growth and challenges experienced during this research.

Based on a thorough analysis of the data, the research findings and recommendations will be discussed, covering education, practice, health policy, and further research.

7.1. Introduction

Through three separate but interlinked studies, the research explored, "*What are key stakeholders' perceptions of newly qualified nurses entering General Practice as a first post destination?"* The three interlinked studies recruited student nurses, GPNs and senior stakeholders to explore and understand their perceptions of NQNs entering General Practice as a first post destination. Study One was generated from the scoping review findings with the data collection evolving and progressing following each interview enabling the testing of each new area. Study One's findings helped to establish the initial questions for Study Two, which again evolved during this studies interviews. Study Three

represented an amalgamation of Studies One and Two key findings, aiming to test, confirm, challenge or add new perceptions to Studies One and Two's findings.

Chapter Seven presents an analysis of the findings from all three studies, highlighting three key areas of commonality that represent the primary contributions of this research. Following Thorne's (2016) concept of 'research Integration' in meta-synthesis, themes, concepts, and quotes from each study were extracted to identify these commonalities. Using meta synthesis within ID allowed the three study's findings to be integrated to provide a deeper and more comprehensive understanding of the research question with the aim to generate practical insights and nuanced interpretations (Thorne, 2016).

The codes from each study were exported into Nvivo, where the process of engaging with and developing overarching themes was undertaken. This was a flexible process, with themes being constructed from the codes, then deconstructed and redefined as necessary (Braun and Clarke, 2013). Through undertaking this process the aim was to explore if any overarching concepts were evident enriching the interpretive nature of this research. These themes represent the interpretive meaning derived from the three studies, with an example of theme construction provided in the Appendix 22.

The key themes of each study were carefully reviewed and re-read to identify significant data. The overarching themes were then validated by checking the consistency of the findings and through peer review. Finally, the three overarching themes were refined into sub-sections, with each area discussed in relation to the research question, existing literature, and relevant national policies.

Table 15 presents a high-level representation of the commonly identified areas, demonstrating which themes from each study have fed into the final research key themes and with the identified sub-sections. Section 7.2 will detail the studies strengths and limitations, with Section 7.3 demonstrating the reflexivity undertaken throughout the research process.

Table 15 Research key commonalities

Research key themes	Research Sub-section	Study and sub-theme
The professional identity of GPNs (section 7.4.1.)	Entering General Practice without secondary care experience. General Practice nurse training and development.	Study One Preceptorship availability Study Two Myths, perceptions and challenges Funded training and preceptorship Routes to becoming a GPN Study Three Student nurse placement and recruitment GPN role visibility, awareness and value Training schemes and career progression
Awareness and visibility of the GPN role (section 7.4.2.)	Placement availability Not all nurses work in hospitals – GPNs value and leadership GPN professional career pathways.	Study One What advice is given around the first post-destination What timescales are advised Preceptorship availability Available career support Study Two Student nurses' previous placements and primary care exposure

		Myths perceptions and challenges Funded training and preceptorship Routes to becoming a GPN Study Three Student nurse placements and recruitment GPN role visibility, awareness and value Training schemes and career progression
General Practice business infrastructure (section 7.4.3.).	How do I become a GPN? Pay terms and conditions.	Study One Terms and conditions What advice is given around the first post destination Career support Study Two Infrastructure Pay terms and conditions Routes to becoming a GPN Study Three Student nurse placements and recruitment Pay terms and conditions Communication and data challenges within a disconnected group

		Impact of policy and initiatives Nurse leadership.

7.2. Strengths and limitations

Using ID supported an understanding of the complex social, personal, and professional lives each participant brought to the table. Exploring, accepting, and documenting these perceptions and journeys, enabled an understanding of the commonalities between the participant's responses. ID methodology enabled acknowledgement of the researcher's presence within the research, accepting the professional and personal self. This research represented a purely qualitative body of work which enabled a detailed exploration of the participant's perceptions on the subject.

In her analysis, Thorne (2016) emphasised that when using interpretation, ID does not develop established facts but rather constructs subjective truths. The effectiveness and defensibility of these constructions are intended to provide an extended or alternative understanding of the practice disciplines. This can depend on the researcher's ability to present the subjective truths in a way that transforms raw data into a framework that offers new and valuable perspectives on the phenomenon. Within this research, the raw data was discussed with both academic supervisors and participants, which contributed to the finding's strength. Consideration was given to the multiple perspectives the participants shared, strengthening the encompassing nature of the research.

Purposive and snowball sampling were used to recruit forty-eight participants throughout the three interlinked studies. A limitation of these sampling methods may mean the recruitment of 'like-minded' individuals may be higher (Palinkas *et al.*, 2015). Therefore, their views may not represent all the existing views; this was balanced by recruiting from different geographical locations and participants at different stages of the GPN journey to provide multiple perspectives. The participants provided limitations in their demographics, particularly in their gender (Studies One and Two) and ethnicity (Study Three).

ID recommends and often uses, multiple data collection tools (Thorne, 2016; Thorne, Reimer-Kirkham and O'Flynn-Magee, 2004). However, Thorne does acknowledge that ID is not a *'cookbook'* (Thorne, 2016) *(p.41)* and has very few explicit guidelines. This research used SSIs as the only data collection method. It was acknowledged that only undertaking SSIs may have limited any sharing of sensitive information, participants may have felt less control over the data, and it was time-consuming (Braun and Clarke, 2013). SSIs were chosen because they are ideally suited to exploring subjective data on experience type research (Ritchie *et al.*, 2014). To support me as the interviewer, allowing myself to be a '*curious learner'* (Thorne, 2016) *(p.140)* an interview guide was used as an open supportive tool to encourage participants to take the lead and share their rich and detailed stories (Ritchie *et al.*, 2014; Braun and Clarke, 2013).

The lack of national sampling adds further caution regarding the transferability of these findings. The research was undertaken within a small geographic location of the United Kingdom, therefore, due to the diverse working patterns of General Practice, the findings may not be nationally transferrable.

The COVID-19 pandemic created challenges, with intra- and post-pandemic access to General Practice being particularly difficult. During COVID-19, General Practice offered fewer student nurse placement opportunities, and there was a decrease in the number of nursing mentors/assessors available. Additionally, the perceived value placed on GPNs during the pandemic (Anderson *et al.*, 2023) may have affected the participants' interview responses. The post-pandemic effect for GPNs is yet to be fully understood. However, this research has touched upon the increased risk of GPN attrition, poor professional identity, increased workload and unheard voice. Further research would be required to explore and understand COVID-19's longer-term impact on GPN recruitment and workforce.

7.3. Reflexivity

Reflexivity in qualitative research is standard practice; both Thorne (2016) and Hunt (2009) recognise and actively encourage reflexivity, which explicitly engages self-awareness and self-evaluation. I have maintained thorough process and reflective records of each stage

within this research, supporting and providing rigour with a reliable and transparent process (Mays and Pope, 1995).

Efforts have been made to avoid conscious bias, and I am aware of my knowledge and position, which may have influenced the research process, individuals, and outcomes. Ritchie et al. (2014) acknowledge that qualitative research is never completely neutral but is influenced by the researcher. The reflexivity section aimed to demonstrate where potential areas of conscious and subconscious bias were reflected on and how these were managed.

I was the primary researcher throughout this research, which was undertaken for my PhD award, and any individuals involved in the research or throughout my learning journey were made aware of this. As a previous GPN, GPN Nurse Lead, ANP and locality advisor, I believe my research thoughts, ideas, and direction have evolved from my experiences and knowledge. Secondary to my tenure, knowledge, and experience, I was involved in and led numerous discussions around workforce planning. I was interested in and frustrated with the workforce planning initiatives and wished to understand how, why, and if student nurses wanted to become GPNs. My professional experience and tenure supported me to explore the multi-faceted reasons that may impact a recruitment journey. Thorne (2016) acknowledged that a researcher's enthusiasm for an area develops from an initial interest in that area. Using these personal insights and supervisory support, I developed and grew my knowledge and skills as a qualitative researcher and within my research subject.

The first step in my reflexivity journey, which helped me identify my assumptions, was maintaining a reflective journal. Journaling has allowed me to explore my actions and reactions, enabling me to raise awareness and situate my professional and personal self within the study context. The increased reflection has supported the research (Schluter, Seaton and Chaboyer, 2008) and acknowledged my stance, experience, and integrity in the findings (Thorne, Reimer-Kirkham and O'Flynn-Magee, 2004). During the research process, my preconceptions and assumptions could have influenced the findings (Tong, Sainsbury and Craig, 2007). However, through discussions with my academic supervisors, I achieved academic support, researcher growth, constructive challenges, and a valuable

resource for promoting transparency and managing my beliefs. However, the research process has created a steep learning curve and has felt equally painful and enlightening.

Undertaking the Scoping Review supported and challenged my perceptions of the GPN workforce. I undertook additional academic learning to ensure I was efficiently and effectively undertaking a literature search. Academic learning continued in areas such as qualitative research, systematic reviews, and health research in practice, which provided a grounding on how to undertake a qualitative study, additionally supported by supervisory discussion.

Recruitment for Studies One and Two was very slow. As a novice researcher, my perception and expectation of participant recruitment did not match reality. Recruitment in these studies was impacted by COVID-19, which also necessitated a leave of absence. I reviewed my reflective journal and noted that I had unconsciously written a high-level reflection utilising a reflective model that echoed Gibbs's Reflective Cycle (Johns, 2017). I have used this six-stage reflective cycle within my professional life, and therefore, it felt like a natural way of 'making sense' of a situation and providing an action plan. The reflection enabled me to identify that my recruitment expectations didn't match the reality of the current healthcare climate and differing levels of participant interest. The action planning stage supported several supervisory conversations, resulting in proactive strategies to aid recruitment.

COVID-19 impacted my research journey in several ways. The COVID-19 pandemic commenced in March 2020 and the UK underwent various periods of lockdown where individuals were not allowed to leave their homes. The COVID-19 virus increased healthcare demand and decreased accessibility for all healthcare services (Institute for Government Analysis, 2022). COVID-19 resulted in professional, academic, and personal challenges for me. Professionally and personally, I felt great empathy for the GPN teams and frustration as they appeared to be expected to work at increased risk to their GP colleagues. I had to endeavour to keep my personal assumptions and thoughts out of any academic work and, therefore, worked to remain neutral when the value of GPNs, especially around COVID-19, were discussed. Academically, the COVID-19 pandemic

created a hiatus within the research as I could not gain access to participants for recruitment or data collection.

Data collection was undertaken through SSIs, and I found this the most enjoyable part of my research. Exploring, examining, and understanding a person's perceptions of GPNs whilst being cognisant of my impact within this process was fascinating. I noted a growing improvement in my interviewing style and technique when collecting data. Through reflection, growth was aided by using the interview guide, undertaking the SSI's transcription, supervisory discussion, and engaging in further reading. An engaged participant who expressed an opinion on the questions was considered a good interview. Unfortunately, not all interviews felt like that, with no notable difference between those held over digital platforms versus face-to-face interviews. When beginning the SSI, I noted that I had to manage my presumption of what I perceived would be a good interview; this was apparent in the early stages of Study One, where a participant expressed a keen interest in General Practice in the pre-interview consenting process. However, the interview felt stilted with multiple monosyllabic answers. I altered my interview style to increase the free flow of conversation and used open questions, long pauses, and non-verbal cues. The face-to-face interview concluded, leaving me feeling bewildered. Following the interview transcription, I re-listened to the recording, re-read my initial post-interview journaling, and reflected on the interview process. I reflected that the interview provided interesting data and valuable insight; the frustration was primarily secondary to my pre-conceived expectations. This reflective development increased my awareness of 'self' within the study process.

During the interviews, I noted the challenges of those participants who engaged with brief answers, took more comfort in asking the questions, and presented challenges in remaining 'on the topic'. My post-interview reflections enabled me to identify a few interviews where this had happened. Therefore, I underwent further skill training and development on how to become a researcher rather than a conversationalist in an interview, which provided steer and guidance. This highlighted the need to be authentic and open whilst maintaining a clear researcher stance. I acknowledged that holding the

silence contributed to data collection, (Kvale, 2006) but my personality made the silence feel uncomfortable. With this in mind, I evolved the interview guide to provide minimal prompts and practised being comfortable with the silence. Engaging with these areas of researcher growth supported me in leaving personal presumptions out of the interview, driving towards a mutually understood perception (Schluter, Seaton and Chaboyer, 2008; Chirban, 1996), which assisted in generating data as opposed to directed conversation. The running of interviews over digital platforms did provide a slight hesitation in the conversational flow, which was attributed to internet connectivity and the absence of reading body language and non-verbal cues. Lobe et al.'s (2020) paper discussed the need to feel comfortable using video conferencing platforms in an ethical and managed manner when supporting data collection. Additional reading on virtual data collection provided insight and personal development.

The cyclical data collection and analysis process supported the ongoing immersion into the data while providing new topics for exploration in subsequent interviews. Reflexivity provided the basis for challenging my perceptions of the data and acknowledging the professional and personal 'me'. To avoid premature interpretation of the findings (McNair, Taft and Hegarty, 2008) I discussed the data with my academic supervisors. When exploring data analysis, I would often undertake multiple reviews of the SSIs; the first was transcribing the spoken content, then reviewing the interview guide for annotated nonverbal body language and unspoken pauses. This further immersion in the data enabled me to reflect and consider body language, tone of voice and facial expressions, which supported data analysis. The clear process of data collection, analysis and interpretation provided a logical flow; this was supported through memoing, accurate recording and reflexivity to support the translation of the data into an ID output of ‘so what’ (Thorne, 2016).

I continued to work reflexively, recognising that the process and actions weren’t merely retrospective activities but provided an opportunity to predict and use proactive behaviours supporting ongoing researcher growth. Reflexivity was an inherent part of this

study, strengthening my personal and professional development whilst supporting its findings.

7.4. Findings summary

The first theme consistently identified across the three studies related to GPNs' professional identity. Professional identity in nursing refers to the self-concept and sense of oneself as a nurse which is shaped by the values, characteristics and expected roles of the nursing profession (Owens *et al.*, 2024). The risk of not having a strong professional identity for any nurse is a reduced level of job satisfaction, high staff turnover and compromised patient care (Hill, 2023). Within the GPN role all of these risks have a direct negative impact on an already compromised workforce, with both internal (other nursing and medical colleagues' perceptions) and external (senior decision makers) perceptions and discussions risking a disconnect and disengagement for this vital workforce. Participants perceptions of GPNs prerequisite skills and experience contribute to their professional identity; how GPNs' professional identity is perceived may affect NQNs' intentions and aspirations to enter General Practice as a first post destination.

The second common theme explored the awareness and visibility of the GPN role, which was perceived to be obtained through General Practice placement activity and theoretical discussion. Visibility and understanding were thought to achieve insight into the GPN's role, value, and career potential, which may increase future GPN recruitment.

The third commonality explored how the private business status of General Practice impacted the recruitment, remuneration, and working practices for GPNs, affecting both NQNs and incumbent GPNs.

7.4.1. The professional identity of General Practice nurses

Key points

- There was a broad agreement that the GPN role is suitable for NQNs.
- Findings suggested that accurate GPN role representation is missing.

The first theme in the research findings centred on the professional identity of GPNs in the healthcare sector, a topic discussed by many participants across all three studies. This theme was explored through the lenses of whether secondary care experience is necessary and GPNs training and development.

The perceived necessity for secondary care experience was deemed essential for bolstering the confidence and competence of NQNs, with many seeking high-tech secondary care environments feeling these would consolidate and grow their skill sets. This finding aligned with the scoping review, which also highlighted the perception that high-tech areas were required for skill development, with concerns about deskilling being well-documented in existing literature (Bloomfield et al., 2015a; Courtney et al., 2002; McKenna, McCall, and Wray, 2010; Wareing et al., 2017a; Oxtoby, 2024; Health Education England, 2021b). This research suggests that despite numerous interventions, policies, and campaigns, negative and incorrect perceptions persist.

Many NQNs considering General Practice as their first post destination received a plethora of advice from registered peers, HEIs, and student colleagues. This advice often stemmed not from lived experience, theoretical learning, or evidence-based practice, but from myths and misconceptions about the GPN role.

The findings suggest that the GPN role remains largely invisible or misunderstood, with minimal professional recognition. Participants with lived experience could articulate the available skill development opportunities for GPNs, which could enhance recognition and awareness of the role. Participants in Studies Two and Three acknowledged the role's potential for significant growth and professional opportunities. However, they felt these aspects were not always recognised through discussions, appropriate remuneration, or professional accreditation. This lack of acknowledgment could potentially affect recruitment, job satisfaction, and morale.

These perceptions, either positively or negatively, can significantly shape the professional identity of GPNs and impact interprofessional relationships and allyship within the healthcare community. If GPNs are perceived to have an invisible or poor professional

identity, it may influence an NQN’s decision to enter General Practice, potentially deterring them from considering it a valuable career choice.

7.4.1.1. Entering General Practice without secondary care experience

A recurring theme across all three studies was the perceived necessity of secondary care experience before undertaking a GPN post, this advice often implied that General Practice was unsuitable as a first post destination. However, participants from Studies Two and Three noted that not all secondary care skills are transferrable or required in General Practice, and most GPNs undergo an induction programme upon entry. These induction programmes, intended to acclimatise and support new GPNs, were frequently described as inconsistent, fragmented, and poorly funded.

The Queen's Nursing Institute's (QNI) Standards of Education for new-to-practice GPNs (2020) emphasised that while other nursing experience may be beneficial, it is not mandated. Published research (Butler 2022, Ipsos Mori 2016, Lewis 2023, Cunliffe 2019), dispels the myth on the requirement for secondary care experience. Butler (2022), a HEI Programme Director, highlighted the challenges around GPN workforce numbers, noting that many NQNs and RNs are unaware they can directly enter General Practice. Some of the participants in this research discussed how the reluctance to enter General Practice without prior secondary care experience perpetuates the misconception that such experience is necessary.

Participants across all three studies identified a significant gap in knowledge and information that could support NQNs in considering General Practice as their first post destination. Gilroy (2020) suggested this gap might be due to nurse training being hospital-focused, with placements and modules oriented towards secondary care. This perception was evident throughout the three studies, with participants acknowledging that General Practice was not an integral part of student nurse education. The lack of visibility of General Practice within the educational journey may support the implication that it is not a suitable first post destination.

While participants recognised the additional training required to become competent in a GPN role, some from Study One were uncertain if this training would be necessary if you had secondary care experience. The GPN Core Capabilities Framework (2021) lists recommended training, but the exact requirements and availability depend on General Practice finances, population needs, and localities ICS commissioned training.

The studies also discussed how the labelling, recruiting, and promotion of GPN roles as 'Sister' might contribute to misconceptions about their suitability for NQNs. Launder's (2022) survey revealed that GPN roles are often poorly understood, leading to GPNs feeling undervalued and misunderstood, with their nursing peers frequently unclear about the scope and depth of these roles. However, participants in Studies Two and Three recognised that with appropriate support and training, NQNs could successfully transition into these roles. This challenges the notion that the role is only suitable for those with secondary care experience, suggesting that NQNs can thrive in General Practice settings.

7.4.1.2. General practice nurse training and development

In Study One, many student nurses expressed concerns that starting their careers in General Practice might lead to skill loss or an inability to consolidate their training. Most participants wanted their first post to support their development in being confident and competent practitioners, which did not align with their perceptions of the GPN role. However, Study One also revealed a dichotomy of opinions, with some viewing the GPN role as deskilling while others discussed it as complex. Most Study Two participants, having completed a GPN student placement, were aware of the role's requirements and complexities. As NQNs, they discussed the rapid skill acquisition facilitated by training schemes and locality funding. Participants in Studies Two and Three felt these schemes enabled NQNs to enter General Practice with supported professional growth. The disconnect between role understanding and awareness across the studies indicated a lack of comprehension of the GPN role's requirements and its impact on the healthcare system. Calma et al. (2021) echoed this in their Australian research, noting that perceptions of the GPN role were often shaped by shared beliefs rather than direct experience. These findings align with the results of this research, which revealed that

many perceptions and myths about the GPN role were formed through conversations with colleagues rather than experiential learning.

The QNI (Leary and Punshon, 2024) ARRS Workforce Impact Survey echoed participants' perceptions, reporting on the role's complexity, skill, and autonomy alongside available training and support. NHS England's (2018) Ten-point Plan and the GPN Student Nurse Network (2018) aimed to challenge common GPN perceptions; none of the participants from Studies One or Two discussed these initiatives.

Perceptions of GPN training provisions, requirements, and expectations were evident throughout the data. Study One participants were mostly unaware of CPD opportunities for GPNs, while those in Studies Two and Three acknowledged the high volume of training but expressed concerns about its non-accredited nature. CPD education was seen as essential for developing GPNs beyond a foundational role, but it was viewed as inconsistent, sporadic, and inequitable. This was attributed to the poor adoption of a GPN skill and competency framework.

Data collection in Studies One and Two was conducted in participants' own time, while Study Three's data collection occurred during working hours. This reflects the acknowledgment in Studies Two and Three that training is often undertaken in personal time to avoid impacting appointment availability. Employers' willingness to utilise non-business critical training programs was reported to be low. Participants in Studies Two and Three felt that training availability could be a challenge in localities without visible and vocal nurse leadership or GPN allyship at the senior level. However, senior stakeholders (Study Three) did highlight concerns over decreased funding for GPN training, echoing wider health sector issues (Launder, 2023). GPN training was described as disjointed and ad hoc, secondary to unstable and localised funding. Using a nationalised competency framework would support consistent training, but despite several frameworks, there is no nationally adopted GPN framework (Practitioners, 2012 revised 2015; Institute, 2020; Health Education England, 2021b).

Participants expressed concerns that available training does not address challenges related to non-accreditation, module time, and lack of educational mentorship support. NQN GPN training is often provided without accredited qualifications, regardless of module time or academic commitment. For participants in Studies Two and Three, this undermined the professionalism and value of the GPN role. Many NQNs and senior stakeholders felt that non-accredited training implied a lower degree of knowledge or quality assurance, impacting the GPN's professional identity. The RCN (2024) noted that accredited training assures both employer and employee of a quality-assessed, current best practice program, demonstrating that a national standard has been met. The General Practice Fellowship Scheme (NHS England, 2020), part of the NHS Long-Term Plan (NHS, 2019), provides a two-year support and training program for new-to-practice GPs and GPNs. However, the service and funding are inequitable, with GPs having access to an additional mentor scheme. At the time of writing, this scheme awaits a current budgeting decision before recommissioning.

The Queen's Nursing Institute (2019) identified that GPN induction programmes are often inconsistent and lack structure. However, these programmes were recognised for enhancing GPN role awareness and fostering professional development, contributing to the development of GPNs' professional identity. NHS England's (2018) ten-point plan aimed to facilitate NQNs' induction into General Practice, but due to funding redistribution, this policy is no longer supported resulting in inconsistent local provision. This inconsistency aligns with the primary findings of the studies discussed in this thesis. Induction programmes with preceptorship support were seen as aiding skill consolidation and professional development, eliminating the need for secondary care experience. Study One participants were mostly unaware of these supportive programmes in General Practice. While Study Three participants were comfortable with their availability, some NQNs in Study Two felt that staffing and workflow challenges did not always allow for preceptorship support, however, those who experienced positive preceptorships aligned with senior stakeholder opinions. This infers that preceptorship is presumed available by

those who commission services, but GPNs do not always have employer support, access or time allotted; further enforcing the premise of an inconsistent, non-nationalised programme.

The NMC (2017) and Moorley (2020) emphasised the importance of preceptorship, aligning it with the need for students and NQNs to feel supported in a clinical environment. Clifford et al. (2021) highlighted that education and training for new GPNs enhances role value and quality care, thereby supporting a GPN's professional identity within both their specific and broader clinical areas. The NHS Long-Term Plan (NHS, 2019) and the GP Contract confirmed the provision of GPN induction and education, supported by various policies (Department of Health, 2014; Department of Health, 2018). This policy acceptance suggests that General Practice is a suitable first-post destination. However, NHS England's recent withdrawal of national funding for GPN retention and education schemes (Devereux, 2024) places the responsibility for induction and education on local ICBs, potentially exacerbating national inconsistencies. Study Three's data collection, conducted before this announcement, revealed that many students, NQNs, and established GPNs were unaware of the policies, support, and training available to them. This indicated a significant disconnect between what is available, what is offered, and what is openly discussed and accessible.

This research has demonstrated that the lack of awareness and communication about available support and training undermines efforts to establish General Practice as a viable first-post destination. The inconsistency in funding and support further complicates the professional development of GPNs, potentially impacting their professional identity and the quality and consistency of care they provide.

7.4.2. Awareness and visibility of the General Practice nurse role

Key Points

- Participants consistently affirmed that General Practice placements in pre-registrant education programmes improved visibility and awareness of the GPN role.
- The benefits of a nationally adopted GPN career pathway to support potential and current GPN workforce, employers, and stakeholders was a common thread in the data.

Participants across the research acknowledged that there was limited accurate knowledge of the GPN role unless there had been direct professional contact. This finding echoed the scoping review (Bloomfield et al., 2015a; Boyd-Turner, Bell, and Russell, 2016a; Courtney et al., 2002; Kloster, Høie, and Skår, 2007; McKenna, McCall, and Wray, 2010; Marsland and Hickey, 2003; Shoqirat and Abu-Qamar, 2015; Stevens, 2011a; Wareing et al., 2017a), which established placements as essential for both role awareness and career planning. Study One provided rich data showing that if participants couldn't visualise or experience the GPN role, it was harder to consider General Practice as a first post destination. Those without GPN role experience or knowledge often relied on information from peers who may also have had limited GPN exposure. Participants in Studies Two and Three acknowledged the value of lived experience or increased theoretical discussion to understand the GPN role, which they believed provided a tangible understanding and supported role representation.

Study Three discussed the current funding streams and healthcare provisions between primary and secondary care, indicating that most patients are cared for outside hospital systems. However, all three studies highlighted that pre-registrant education, placements, and recruitment were secondary care-centric. The lack of General Practice representation may create the perception that the GPN role is unsuitable for NQNs and obscure the GPN's value within healthcare provision.

Participants in Studies Two and Three discussed how the absence of a national career pathway for GPNs created a barrier to understanding the complexity of the GPN role. This lack of a clear career pathway may hinder GPNs from seeking career progression. Discussions in Studies Two and Three also addressed the impact of the diversified General

Practice workforce on the visibility and impact of the GPN role and career pathway. It was suggested that a nationally recognised career pathway would benefit the GPN workforce by outlining skill requirements and a salary structure, ultimately facilitating GPN recruitment and retention efforts.

7.4.2.1. Placement availability

Many participants in Study One reported a lack of knowledge about General Practice if they had not received a primary care placement, underscoring the connection between awareness of the GPN role and primary care placements. Participants in Studies One and Two perceived that placement allocations were predominantly focused on secondary care. Many felt that primary care placements would have enabled them to explore, understand, and challenge peer comments about the GPN role. Those in Study One who had experienced a GPN placement had an increased GPN role awareness and were better informed, supporting more informed employment decisions. Similarly, many NQNs in Study Two had undertaken General Practice placements, using these experiences to facilitate their recruitment journeys into GPN roles. However, senior stakeholders acknowledged the value of placements but discussed challenges with access, availability, and funding.

The disconnect between the three studies emphasised the value of placements in exploring employment options, especially during the final academic year. However, there appeared to be a restricted ability to provide General Practice placement opportunities. Williamson et al.'s (2023) study, through a collaborative learning in practice lens, echoed these findings, discussing how placements support role visibility, value, and employment opportunities. However, Williamson's study did not explore the availability, funding, and lack of mentorship support identified by Study Three participants.

The GPN-ready scheme (Health Education England, 2016a) and the Ten-Point Plan (NHS England, 2018) were developed to raise GPN role awareness and recruitment by supporting General Practice placement availability. As previously discussed, funding for these schemes has ended, with Study Three participants acknowledging the detrimental

effect this may have on the positive momentum gained during its tenure, corroborated by Aston's (2018) and the National Association of Primary Care's (2022) work.

Participants across the three studies felt there was easy access to NHS secondary care placements. For Study One and Two participants, placement allocation was facilitated primarily through their HEIs with additional access to spoke placements. Some Study Two participants used their community placements to undertake spoke placements within General Practice. Studies Two and Three participants discussed the challenges in supporting placements, citing reasons such as pandemic pressures, financial challenges, staff attrition, and staff resilience. The QNI (2020) and a survey-based study by Ford (2022) demonstrated the placement challenges articulated by participants from Studies Two and Three, which were felt nationally. Ford (2022) and Trivedi (2022) recognised the challenges of providing nurse mentorships and commented on how clinical simulation could support clinical education. However, while the use of simulation may meet regulatory needs (Nursing and Midwifery Council, 2023b; Garrow et al., 2022), unless the simulations replicated GPN scenarios, they would not support increased role visibility or awareness.

Within Studies Two and Three, the placement challenges associated with staff attrition were related to the lack of available GPN mentors (practice assessors and supervisors), vitally impacting student nurses' learning journeys within General Practice. Participants, (studies Two and Three), felt that mentor attrition was due to retirement, general workforce erosion, increased workload, and limited funding. Wood et al. (2023) corroborated these findings, with Thorne (2023) stating that nursing was being devalued and poorly funded, and the absence of nurse mentors was a direct result of this. Nationally, several primary care areas have recognised these challenges, and there is isolated evidence of localised schemes to support GPN mentorship (Hall and Harris, 2022). Legacy Mentoring (NHS England, 2023), a GPN initiative, uses the skills and experiences of nurses, usually in the latter stages of their careers, to support those at the start of their GPN careers. This premise fits well with the GPN workforce age profile and supports the preceptorship (Cummins, 2009) requirement. The low availability of legacy nurses has been identified in a recent preceptorship survey (Mitchell, 2024), and it's acknowledged

that this scheme has not been instigated at a national level but at an ad hoc local and system level with limited funding, further adding to the inconsistent nature of the GPN role.

7.4.2.2. Not all nurses work in hospitals – General Practice nurses value and leadership

Participants in Study One who had not experienced the GPN role demonstrated a poorer understanding of its value, often responding dismissively, making it difficult for them to appreciate how GPNs fit within healthcare provision and the value of their knowledge, skills, and experience. As discussed within the research findings GPN role perceptions were largely driven by anecdotal evidence, peer discussions, and family influences. These perceptions echoed Lewis et al.'s (2019) survey, which found that 80% of student nurses needed a better understanding of the GPN role. Secondary care nurse visibility was facilitated through placements, HEIs, media, and family. Studies Two and Three participants, and Innes (2019) study, discussed the underrepresentation of GPNs, with the media focusing on General Practice medical roles, further eroding the GPN's professional identity and visibility. The General Practice Forward View (NHS, 2016) and Health Education England (2023) initiatives aimed to raise the GPN profile, but national translation may not be chieved through localised training.

Participants with direct knowledge or experience of the GPN role expressed confidence in the roles significance and value. Studies Two and Three explored perceptions of GPNs' value and their impact on the broader health economy. While Study Two participants felt valued by fellow GPNs, they discussed the perceived devaluation of their role by other sectors, reflected in decisions made by employers, health sectors, and the public. Some Study Three participants articulated the value of the GPN role both locally and within the broader health economy. However, those senior stakeholders without experience in General Practice often presented a different narrative, with some framing the GPN workforce negatively, suggesting that many of the challenges faced by GPNs could be better managed through the GPN workforce being more proactive and assertive rather than the perceived passivity currently thought to be exhibited. Additionally, some senior stakeholders conveyed, through their tone of voice and both verbal and non-verbal

language, a sense of distancing themselves from GPNs. This suggested a lack of allyship with the workforce they are employed to support and represent. This othering, which is the process of treating or perceiving a person or group as fundamentally different, (Akbulut and Razum, 2022) of the GPN workforce may indicate a lack of professional identification and association, which is not aligned with the basis of their senior stakeholder roles. Those stakeholders with General Practice lived experience spoke through a GPN lens and provided a collaborative understanding of the multifactorial workforce challenges.

Study Three participants discussed that GPN leaders often acquire their roles through tenure rather than skill or leadership knowledge, echoing Allan et al.'s (2016a) findings. This lack of development and support for GPN leaders could further devalue the workforce, affecting role interest, recruitment, attrition and role professionalisation. The need for GPNs to be vocal, professional leaders aligns with feedback from the Sonnet Report (Clifford et al., 2021) and the GPN Ready scheme report (Health Education England, 2016a), which encouraged GPNs to be catalysts for change. However, this empowerment does not consider the multifactorial and systemic challenges GPNs face.

7.4.2.3. General Practice nurse professional career pathways

Participants recognised that poorly articulated, inconsistent, and often invisible career pathways may deter NQNs from entering the workforce. Those aware of the GPN role perceived that nursing teams in General Practice operated within a flat hierarchical structure. When comparing this to secondary care the NQNs in Study Two felt this environment provided a supportive team dynamic but lacked a visible career trajectory. Many participants believed that the clear clinical hierarchy in secondary care offered assurance on professional development and provided clear direction for reporting and responsibility. Subtle indicators such as uniform colours, working hours, and responsibilities were thought to serve as non-titled markers of seniority within the NHS, which are not commonly observed in General Practice. Some Study Three participants suggested that the lack of a visible career pathway in General Practice could deter degree-educated nurses from entering the GPN workforce.

Echoing feedback from Study Two, the Queens Nursing Institute's (2015) report established that GPN role titles are inconsistent and have little connection to tenure, knowledge, or skill. Health Education England (2021b) developed a Career Framework document for GPN role requirements, but it has not been nationally adopted and was minimally discussed in this research.

Studies Two and Three highlighted the role of funding in the recruitment, training, and retention of GPNs. Many Study Two participants acknowledged they were recruited due to GPN-funded schemes (NHS England 2016), which provided access to GPN roles that might not have been available to NQNs. The GPN Ready Scheme (Health Education England, 2016) provided educational and socialisation support for NQNs in GPN roles, aligning with Nursing and Midwifery Council (2020) guidance. Following the withdrawal of national funding, these programs have been devolved to locality provided schemes, which suggest these are at risk of fragmented delivery. However fragmented and inequitable training support is echoed even within the General Practice environment with studies Two and Three discussing the inequitable funding and support compared to their GP colleagues. Doctors have a robustly funded training program (Health Education England, 2021a) facilitated through a central website, which supports recruitment and training. However, this website did not demonstrate comparable GPN support which highlighted further inequity within the General Practice workforce.

While this research focused on key stakeholders' perceptions of NQNs' employment choices within General Practice, many participants (Studies One and Two) viewed the GPN role as a stepping stone to ACP training. Currently, within the UK, the ACP role title is not protected (Timmons et al., 2023), allowing its use without regulatory oversight. Unlike most GPN training, ACP training is accredited and perceived to provide assurance and value for the trainee, employer, and patient, offering GPNs an accredited and visible career pathway. Some Study Two participants acknowledged they would start as GPNs and develop into General Practice ACPs. While the visible career development into an ACP made the GPN role more attractive for some participants, Study One participants

perceived General Practice ACP posts as less complex than secondary care ACP roles. This suggests a lack of understanding and shared perception of the GPN and ACP roles and the General Practice environment. This was balanced by those with visibility or knowledge of General Practice and the GPN role. Published literature presents a dichotomy of opinions. Evans (2022) distinguished between primary and secondary care ACP roles, noting minimal definition and detail of the ACP role in General Practice, suggesting a visibility challenge. Lewis's (2023) qualitative study provided a more positive stance, stating that the GPN role would evolve to be more autonomous and highly skilled, with the ACP role seen as a desirable career option. However, Lewis's participants disparaged the GPN role, whereas NQNs in this research found it complex and interesting. Various reports (Ipsos Mori, 2016; Department of Health 2018) discussed how increased visibility of ACP roles in General Practice can promote sustainable career pathways, echoing findings from Studies Two and Three. The visibility of a career pathway may ultimately increase the desirability of the GPN role to NQNs.

7.4.3. General Practice business infrastructure

Key findings

- The research noted that how GPN roles are advertised may affect student nurses' decisions to enter General Practice as their first post destination.
- The research demonstrated that non-standardised pay, terms, and conditions directly impacted GPN recruitment and retention.

The final key theme explored the participants' perceptions of how the independent business model of General Practice affected GPN's recruitment, retention, and workforce stability (Studies Two and Three). Study One participants were primarily unaware that most General Practices within the UK are independently owned businesses. Those without knowledge or experience of the role discussed their perceptions of General Practice as akin to the NHS and therefore offered the same employment package. Recruitment advertisements and entry pathways were discussed as not visible or unclear which was thought to be further impeded by a lack of organisational departmental support. Participants who had experienced the GPN role through placement or

employment could understand and identify the recruitment and contractual differences from their secondary care colleagues.

7.4.3.1. How do I become a General Practice nurse?

When exploring first post destinations, many participants (Studies One and Two) relied on career fairs or placements within the HEI setting. The research participants noted the dominance of secondary care employers at these events, with minimal primary care visibility. It was unclear whether this was due to a lack of engagement by facilitators (HEIs or placement settings) or providers (CCGs, ATPs, ICBs, General Practice employers). The research demonstrated that secondary care providers actively optimise career fairs and placements for recruitment, while the lack of primary care visibility may subconsciously reinforce the notion that GPN roles are unsuitable for NQNs. Study Two and Three participants felt that many GPN posts are recruited through word of mouth or headhunting, creating further recruitment barriers for NQNs. Aston (2018) reported similar themes, suggesting this recruitment model lacks long-term sustainability for the GPN workforce.

Participants discussed the inconsistent advertising of GPN roles, noting confusion about role titles and descriptions. As discussed in 7.4.1.1. many GPNs are called 'Sisters,' indicating a tenured nurse with higher banding and pay (Public Accounts Committee, 2009; Health Education England, 2021b), which may deter NQNs from considering General Practice as a first-post destination. Inconsistent role titles may cause role ambiguity, affect professional identity, hinder interprofessional communication, and impact patient safety. Barrett et al. (2021) found that inconsistent role titles are a global issue. The Queens Nursing Institute and General Practice Nurse Education Network (2023) provided a flowchart to support new registrants, however, its practical use was not discussed by participants. Throughout this research the findings have indicated a need for further research on the promotion and use of published guidelines.

GPN recruitment advertisements were often seen as misleading and difficult to find (Studies One and Two), with many employers recruiting through non-NHS websites or

locality communications. This was echoed in Grimmer's (2023) study of nurses who found that recruiting into General Practice highlighted the non-standard recruitment journey and its challenges. Study Three participants acknowledged this, noting that General Practice is difficult to recruit to, with inconsistencies in job function, requirements, role titles and remuneration packages.

Participants identified that General Practice's working patterns could be favourable for GPN employment and used in recruitment campaigns. However, Study Three recognised that increased opening times may require contractual terms matching those in NHS settings. The link between fixed working patterns and work-life balance, reported by Clendon and Walker (2013) and Grimmer (2023), could support the aging GPN workforce or attract those seeking a different work-life balance.

7.4.3.2. Pay terms and conditions

Within this research, pay terms and conditions emerged as a significant issue in Studies Two and Three, with both groups recognising the disparity and challenges of GPNs non-standardised pay structure. Aligning with Study One's findings prior to their GPN tenure, most Study Two participants were unaware of the inconsistent pay terms and conditions in General Practice. Study Three participants without a General Practice background only became aware of pay differences upon entering the sector. For contracted GPNs, their employing practice dictated their salary, terms, and conditions, which were perceived as inferior to those offered by NHS providers under the AfC pay scales. AfC supports a banded salary structure alongside standardised maternity and sickness pay (Public Accounts Committee, 2009) which was thought not echoed within General Practice employment contracts.

The research findings indicated that current GPN contracts do not support younger GPNs or those with families due to the lack of childcare schemes, family-friendly policies, robust maternity, or sickness allowances. This was seen as a barrier to NQNs entering or remaining in General Practice. Participants from Studies Two and Three provided direct evidence of how inequitable sickness and maternity benefits impacted GPN recruitment

and caused personal concern amongst the workforce. Although the GPN role is often discussed as a family-friendly career option, participants felt that many RNs could not afford to transition into a GPN role due to the inequitable contracted terms compared to AfC. Gregory and Cunliffe's (2021) questionnaire of 1200 GPN respondents reported similar themes, with 92.4% of GPNs not on AfC and 41% only receiving statutory sick pay. The NHS provider sector (2021) published a report advising General Practice employers on a pay, terms, and conditions scale for GPNs. However, Study Three participants noted that, as independent businesses, General Practices must ensure financial liquidity to continue operating. Training, development, and salaries currently depend on the decisions of General Practice partners and NHS England's General Practice's allocated funding (Beech and Baird, 2020b). Senior stakeholders expressed caution about how practice cash flow would be balanced if all GPNs were placed on AfC, suggesting that nationally allotted funding would be required.

Senior stakeholders recognised the challenge of integrating a standardised pay scale due to the vast array of non-recognised and non-regulated roles combined with General Practices' independent business status. NQN participants expressed concerns about their confidence and ability to negotiate increased remuneration following an increase in skills or tenure. Participants (Studies Two and Three) discussed how GPNs would move employers to improve training, pay, terms, and conditions, which was seen as destabilising the GPN workforce. The Sonnett Report (2021) identified similar themes, acknowledging the 'job hopping' culture to improve contracted pay terms and conditions. These national inconsistencies are regularly reported on social media sites (General Practice Nurse, 2024), with many GPNs using these sites to align their working conditions with their national counterparts. Gregory and Cunliffe's (2021) national mixed methods study echoed these findings, discussing the lack of a formalised employment infrastructure for GPNs. However, Ashwood et al. (2018) noted that a locality pay scale linking pay to skills and competency framework in a London borough may provide national reassurance. This work, whilst nationally acknowledged was not widely rolled out. GPN employment contracts were identified as a challenge in recruiting NQNs into

General Practice. While senior stakeholders acknowledged that this is being discussed at a national level, the challenge remains about how General Practice will balance the books if GPNs are placed on AfC.

7.5. Summation of the research findings

The research aimed to better understand key stakeholders' perceptions of NQNs' entering General Practice as a first post destination. The current remodelling of the NHS (DoH, 2014; NHS, 2019) with the movement of care from secondary care into primary care requires a well-staffed, supported and valued workforce. Butler (2022) reported that GPNs provide a projected 340 million consultations annually, supporting patients with long-term condition management, health prevention, promotion and generating General Practice's income streams through meeting QoF requirements. Baird et al.'s. (2016) Kings Fund report noted an increase in the complexity, intensity and volume of a GPNs workload, which was not represented or recognised within funding, policy, or pay (Baird *et al.*, 2016). Clifford et al. (2021) considered GPNs to be '*leading the way' (p.5)* in the future of primary care, driving cost-effective value in patient contact. However, as discussed in Chapter One, the GPN workforce is undergoing a recruitment and retention crisis, which could impact General Practice health care provision.

The research findings are significant because whilst several key themes emerged during the three studies, two overarching key findings encapsulate these. These two findings are important as they provide a comprehensive understanding of the challenges faced by those NQNs who wish to enter General Practice. The first, which permeated all three key themes, was the lack of consistency experienced throughout the entire GPN journey, discussed below in section 7.5.1. The second key point that emerged related to GPN's professional identity, a topic of significant importance that will be discussed below in 7.5.2.

7.5.1. General Practice nurse workforce inconsistencies

This research identified significant challenges encountered by both NQNs and GPNs at various career stages. It highlighted the limited availability of General Practice placements and the lack of information and education regarding GPN roles during the student nursing journey. Building on existing evidence, this research demonstrated that exposure to clinical settings significantly influenced student nurses' career decisions, underscoring the importance of providing General Practice placements. These placements offer visibility and networking opportunities that can support recruitment efforts. The research also highlighted inequalities in funding, development, and support between professional clinical groups, which could impact recruitment to these essential roles.

The research found inconsistencies in GPN recruitment, including misleading role titles, role advertisements, and a prevalent ‘job hopping’ culture. Participants felt that using standardised national GPN role titles linked to a career and competency framework could improve recruitment and support novice and established GPNs in planning their career paths.

Participants discussed how their employment pay, terms, and conditions were inequitable compared to their NHS-employed peers, making it more challenging to attract NQNs or established RNs into General Practice. The research demonstrated that non-standardised pay scales affect GPN recruitment and retention, enhancing our understanding of how inconsistent employment packages destabilise the GPN workforce. Establishing a national standardised pay, terms, and conditions scale would provide clear recruitment and career opportunities for all GPNs, helping to stabilise the GPN workforce and labour market.

The findings corroborate existing evidence that postgraduate training and support are essential for new and existing GPNs to deliver safe and effective patient care. Postgraduate training is typically facilitated by HEIs or local ATP providers with support from General Practice colleagues. However, the research found inconsistent providers, delivery methods, and employer support for the required training modules, with some

GPNs reporting they had not received allocated study time or mentor support. This diversity in training providers and support means that GPNs receive non-standardised training, often through non-accredited modules, undermining the value of the GPN role. This could lead to unequal learning outcomes and, consequently, inequitable healthcare delivery.

Participants expressed that the allocation of national and organisational funding and policy support for GPNs was inequitable compared to both the NHS and their GP colleagues. The current primary care workforce was considered insufficient to support the national initiative of moving patient care out of secondary and into primary care. Some senior stakeholders highlighted that NQNs transitioning into General Practice would benefit from a structured induction program. However, the funding, availability, and accessibility of these programs was fragmented with inconsistent support, with study participants noting reduced funding, increased expectations, and fewer resources.

As this research has demonstrated, GPN workforce inconsistencies create significant challenges for both aspirant and incumbent GPNs.

7.5.2. General Practice nurses' professional identity

The second significant finding pertains to GPNs' professional identity, intersecting with various themes. Professional identity, a fundamental aspect of any profession, involves the professional relationship with oneself and others (Mbalinda et al., 2024). Allan (2008) and Allan et al. (2016b) discussed how a lack of recognition for nursing as a profession could lead to feelings of inferiority and devaluation.

The research reflected published findings (Mbalinda et al., 2024) that nurse educators often lack direct clinical experience in their teaching areas, risking the neglect or misrepresentation of clinical areas outside their specialties. Hill (2023) highlighted how positive educational and clinical experiences can contribute to a favourable professional identity and enhance patient-centred care.

Despite their extensive knowledge and impact on local health, GPNs feel undervalued and unrecognised within the healthcare system (Clifford et al., 2021), which can result in feelings of inferiority and disillusionment (Allan et al., 2016b). For those degree educated NQNs who wish career development the lack of GPN Professional identity may act as a deterrent. The research identified that GPNs are a fundamentally disempowered group, impacting their ability to establish a strong professional identity. GPNs need support, allyship, and advocacy to improve their standing within the healthcare system. However, this research recognised that GPNs are often neglected in strategic and financial discussions about primary care development, further impacting their professional identity.

As discussed in section 7.4.3.2., GPNs are contracted under inconsistent employment contracts, which could impact their professional identity and deter NQNs from entering the GPN workforce. Different pay terms and conditions create problems due to a perceived lack of professional respect and transparency, leading to an erosion of trust in their employers. These perceptions negatively impact their professional identity as they question their value and contribution to General Practice. The research has shown that the current inconsistency in GPN employment contracts does not foster, develop, or support a GPN's professional identity.

All NQNs require professional support, advocacy, and allyship to develop and thrive in their new positions. When considering the GPN role as a first post destination, the current lack of GPN professional identity may suggest that support, advocacy, and allyship are unavailable, making the role unsuitable. Overcoming these obstacles is crucial for nurturing a strong professional identity among GPNs (Mbalinda et al., 2024), enabling NQNs to recognise their professional status and inherent value.

7.6. Recommendations

ID is designed to provide a meaningful and relevant understanding of the study area (Thorne, 2016). Through using ID this research has identified two key findings: ongoing

GPN workforce inconsistencies and challenges with GPNs' professional identities. These are relevant for informing further study, consideration, and recommendation.

7.6.1. through 7.6.4. will discuss the key recommendations generated from this research's findings regarding education, practice, health policy and further research. These are summarised in Table 16.

Table 16 – Recommendations

Education	Consider ICB collaboration to increase supported GPN placements. Provide information on primary care and where this fits within the evolving healthcare landscape. Collaborate with ICBs when supporting careers fairs.
Practice	Address GPN's inconsistent remuneration package. National adoption of a career and competency framework.
Health policy	Nationally adopted and funded GPN career and competency framework. Equitable funding GPN representation within policy writing.
Further research	National understanding of the current enablers and barriers facing GPNs National picture of NQNs first post-destination Understand post-COVID-19 GPNs' value and how this affects recruitment, retention and attrition.

7.6.1. Recommendations for education

The research presented in this thesis adds to the existing evidence base on the myths surrounding the preparation needed to pursue a GPN pathway. The belief that secondary care experience is required and that the role might deskill nurses suggests that General

Practice is not a suitable first post destination for NQNs. However, various actions, undertaken within HEI's could effectively challenge these myths.

Study participants consistently affirmed that undertaking a General Practice placement during their student nurse journey improved their knowledge and awareness of the GPN role. Although securing these placements can be challenging due to the lack of available mentors and assessors, HEI collaboration with local ICBs could help provide more centralised placement opportunities. Locality ATPs could facilitate ICB-supported placements, showcasing the variety, skill, importance, and impact of the GPN role.

A further consideration is how General Practice is discussed and taught within the student nurse curriculum. The study demonstrated minimal discussion or education about General Practice within HEIs. Given the shift of many services into primary care, it is crucial for healthcare students to understand how General Practice fits into the broader healthcare system and the integral role of GPNs. Strengthening GPN pathways in academic practice, through clinical academic roles or GPN guest lecturing, could address the current lack of General Practice discussion in student nurse education.

The research findings also demonstrated that HEIs often support career planning through discussions or career fairs, where General Practice is frequently absent. Collaborative efforts with locality ATPs or ICBs could ensure General Practice representation at career fairs, supporting career discussions and improving the visibility and awareness of the GPN role.

By addressing these recommendations, the challenges faced by NQNs and GPNs can be mitigated, fostering a stronger professional identity and improving recruitment and retention in General Practice.

7.6.2. Recommendations for practice

The research presented in this thesis highlighted the absence of a clear and transparent GPN career pathway and identified the need for equitable pay terms and conditions to support GPN recruitment and retention. Implementing a nationally adopted career and competency framework with clear role titles and linked competencies would address

various GPN workforce challenges. This framework would demonstrate an investment in the professional development of both aspiring and current GPNs, providing tangible evidence of educational advancement and its impact on professional standing, remuneration and patient care. From an employer or commissioner perspective, the framework would define performance expectations, aligning them with the practice's or locality's strategic goals. Additionally, this framework could limit the 'job hopping' culture used to negotiate better working benefits, thereby supporting visibility, stability, and value within the GPN workforce and contributing to a stronger professional identity.

Encouraging NQNs to enter General Practice could enhance the longevity of GPN careers and provide stability to the workforce. However, the research findings indicate an urgent need to address the current pay terms and conditions for GPNs. Inconsistent employment packages destabilise and devalue the GPN workforce, impacting recruitment, retention, and attrition. To address this, General Practice should recognise the value GPNs bring to primary care healthcare delivery and consider the expectations and requirements of degree-educated NQNs. A national salary scale linked to the competency framework would be valuable in supporting both current and aspiring GPNs. Adopting a national career framework linked to a standardised salary package may require national funding and policy adjustments.

7.6.3. Recommendations for health policy

Undertaking a General Practice focused review of the NHS Long-Term Plan (NHS, 2019), NHS Workforce Plan (NHS, 2023) and identifying GPNs' contributions and potential in the General Practice Forward View (NHS, 2016) could address both GPN workforce inconsistency and GPN's professional identity issues. However, policy generation alone is insufficient, robust, equitable funding would also be required.

Equitable funding is recommended due to the current disproportionate and unstable funding distribution. Inequitable funding occurs across various platforms: secondary care receives more funding than primary care, GPs receive more funding and support for CPD than their GPN and AHP colleagues, and those short-term funding schemes which support

General Practice recruitment and retention. Given the ongoing shift of care into primary care settings amidst a workforce crisis, the current funding support requires re-evaluation.

Health policy should also recognise the integral role that GPNs play within the healthcare system. Currently, GPN representation within national policies is minimal, with primary care often viewed and delivered through a GP-centric lens. This perspective may stem from a historical medical viewpoint but is also influenced by the lack of experienced, knowledgeable GPN leaders being heard and valued.

7.6.4. Recommendations for further research

ID has provided a suitable methodological approach to explore the type of experiential research question that nurses or other allied health professionals may ask, as its focus is on developing practice (Thorne, 2016). Therefore, this may be an appropriate exploratory methodology for future research.

This research has provided a qualitative local picture of key stakeholders' perceptions of NQNs choosing General Practice as a first-post destination. However, it would be advisable to provide a national perspective of the current enablers and barriers for NQNs and those new to GPN roles. Undertaking national research would help provide a comprehensive picture of the GPN workforce and explore national barriers to recruiting and retaining GPNs.

Understanding the areas where NQNs choose to work after completing pre-registrant training could serve as a valuable metric for understanding their preferences and could support various research needs. Conducting this research over an extended period, could provide significant insights into the workforce, supporting recruitment and retention initiatives across multiple clinical areas.

Published research (Anderson *et al.*, 2023) indicated that GPNs' value was perceived as low during the COVID-19 pandemic. This research has identified that GPNs continue to feel invisible and undervalued, which could impact workforce numbers. Further research could determine if COVID-19 has continued to affect GPN recruitment, retention, and

attrition. As identified in this and other published research, the GPN workforce is in crisis, increased attrition could negatively impact healthcare delivery within General Practice.

7.7. Conclusion

ID aims to provide relevant knowledge that offers actionable output within a clinical context. Established research methods have provided a robust foundation for developing the key themes. This chapter combined the interlinked study's findings, relevant to understanding key stakeholders' perceptions of NQNs choosing General Practice as a first-post destination. It has also provided points for various stakeholders to consider.

Previous research in this area has primarily been undertaken abroad or unifocal, concentrating only on one component of a GPNs professional journey. In contrast, this research has expanded upon already published literature by exploring the concept of NQNs entering General Practice as a first-post destination through the lens of all invested partners. This research has provided valuable insight into highlighting the various challenges for NQNs, focusing on the current inequitable environment that GPNs operate in, and GPNs' decreased professional identity. Inequity was shown throughout the NQN and GPN journey with inequitable student nurse placements, recruitment methods, contracting, and training. The second major finding was that the visibility and value of GPNs were also a barrier to GPN's professional identity. The research findings may help us understand that not valuing or recognising GPNs could affect how GPNs' professional standing, status and identity are perceived. It's hypothesised that GPNs' poor professional identity influences all the invested partners throughout a GPNs journey.

General Practice nursing is integral to our health care systems, providing professional knowledge, support, and care for all they meet. This research has provided an important contribution to the existing published research and in the context of the current policies and processes within which they work. Using this research to consider and develop strategic national change will support, value, and acknowledge the vital work GPNs undertake, supporting NQNs to view this as a suitable first-post destination.

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Appendix 1 – Scoping Review Protocol

Title

What does the current research tell us about which factors influence the career choices of pre-registration and newly qualified nurses? A scoping review.

The aim of this scoping review is to map the current evidence on what influences the career choice of pre-registration and newly qualified nurses.

Background

The nursing profession in the UK is currently suffering a recruitment crisis, Health Education England (Health Education England, 2016c)reported that there were 26,700 vacancies in 2016. Hospitals are estimating they are 15,000 nurses short of the safe clinical staffing numbers required (National Health Service, 2016a; National Institute for Health and Care Excellence, 2014).

I have a keen interest in future proofing the primary care workforce. This scoping review aims to map what the research currently shows about the factors influencing the career choice for newly qualified and pre-registration nurses. Through identifying the influencing factors this may give further insight as to whether primary care is considered as a first post destination and if further research is required in the field around this area.

Currently within primary care HSCIC (NHS Digital, 2016)reports that nursing has grown by over 300 full time equivalent nurses in 2015. When this is analysed 31% of the workforce are over 55 and nearing retirement age (NHS Digital, 2016), with just 7.2% of nurses under the age of 35 (Jo, 2016). A higher proportion of older nurses (>50 years) work within a community/primary care setting and this older age profile of the practice nurse labour market therefore means a higher probability of staff attrition through retirement (Pike et al 2011).

Primary Care nursing within the UK is undergoing a turbulent time in ensuring there are sufficient nurses to support the ever increasing and complex workload (Addicott *et al.*,

2015; Baird *et al.*, 2016). Over the last 10 years the number of GP practices has decreased from 10,347 in 2005 to 9,458 in 2015 but the number of GP registered patients has risen by over 4 million (Health & Social Care Information Centre, 2016). The increased number of contacts and complexity of patients requiring assistance from their general practice is rising which increases the pressure on the general practice environment (Baird et al 2016).

To address the decreasing workforce and increasing patient populous the NHS published the General Practice Forward View (NHS, 2016) which pledges to invest £206 million in the workforce; this will include the development and training of practice nurses. HEE (2016) states the statistical analysis of between 2012 and 2016 84,000 FTE members of NHS nursing & midwifery staff will have been trained and graduated from university. 37,000 FTE members of the team will retire within this timescale(Health Education England, 2016c). Therefore, this gives an additional 47,000 nurses back into the NHS. These figures do not consider the inherent risk of attrition of nurses from the NHS for means other than retirement and this incrementally rising figure was given as 8.6% of the workforce in 2014/2015 (Health Education England, 2016b). There is no proposed increase in funding for post registration training in Practice Nursing (Health Education England, 2016b). Primary care currently faces an unparalleled workforce crisis (Lane, 2015)secondary to an aging workforce, staff attrition and difficulties with recruitment. Health Education England (2015) reports that many student or junior nurses did not see Primary care as a viable or desirable place to work.

Through carrying out this scoping review it is hoped to map which key concepts influence the career choice within the first two years of qualification and the range of research available (Daubt. Helena, Van Mossel. Catherine and Scott. Samantha, 2013). Through assimilation of this information, it is hoped to assess the available literature with a view to identifying recurrent themes and highlighting any gaps within the current literature. The results of this may inform future research within this area.

This scoping review will be carried out using the Joanna Briggs Institute (JBI) methodology (Peters. Micah *et al.*, 2015).

Inclusion Criteria

The studies to be included in the review will focus on the factors and influences surrounding career choice for pre-registration and newly qualified nurses.

No date range will be stipulated within the searches.

Participants

Studies which involve pre-registration and newly qualified nurses will be included.

Pre-Registration nurses are defined as any nursing student who is working towards registered nurse status and are at any point within their training.

Newly qualified nurses are defined as those who have been qualified as a registered nurse up to two years post registration; there is no stipulation on if they are working within a clinical setting.

Concept

Studies which focus on career choice will be included in the review.

Career choice is defined as all employment arenas both in the public and private sector, research nursing, nursing education, further study and attrition from training.

Studies examining nurse's experiences and perceptions of their career choice will be included.

Context

Studies will not have limiters applied based on geography, race, gender or setting.

Types of Sources

Articles from peer-reviewed sources which report primary research using any study design will be included in the review. Secondary research (reviews), commentaries, opinion papers and grey literature will be excluded.

Policy documents (accessed through HMIC) will be assessed for relevance against the inclusion criterion stipulated within this protocol. If the policy paper is relevant, it will be included.

Search Strategy

The aim of the search strategy is to comprehensively locate published literature. This will be done following the JBI (Peters. Micah *et al.*, 2015)three step approach.

Step one; a list of the perceived relevant search terms and key word strings will be developed from the premise of the scoping review to allow a highly sensitive search of the evidence. Population, Concept and Context (Peters. Micah *et al.*, 2015) (Appendix 2) have been utilised to allow structure to the search.

An initial search using the key preliminary key word terms and search strings will be carried out in Cinahl and Medline. A list of the initial search strings is shown in Appendix 1. Assistance from the specialist librarian will be utilised to aid in an effective search strategy.

Step two; due to this scoping review being an iterative process following an initial assessment of the key words, and subsequent results, these may be expanded upon. A rapid assessment of the result citations will be undertaken to identify any new key words, key terms, search strings and index terms. Once relevancy is exhausted and saturation of terms is met this rapid assessment will be discontinued. The updated terms will be added to the Participant, Concept and Context (PCC) table (Appendix 2) to progress onto a more inclusive search of a wider range of databases.

The databases to be searched utilising the amended PCC table are;

Medline

Cinahl

British Nursing Index

Health Management Information Consortium (HMIC)

PsycInfo

Step three; a review of the identified articles reference lists will be searched for additional relevant articles.

If further information is required on particular articles the authors will be contacted to gather any further data.

This scoping review is aimed at assessing published primary research and mapping those results, therefore grey literature and hand searching will not be undertaken for this review.

Articles published in English only will be reviewed secondary to no linguistic support is available for this scoping review.

There will be no date limiters set within the search methodology.

No scrutiny of methodological quality will be undertaken as is consistent with scoping review methodology.

Articles will be selected by and held within Endnote a reference/citation software package.

Extraction of Results

The results will be extracted to allow analysis of information. with a view to heterogeneity.

At this protocol stage development of a form to chart the literature's key identifiers and the results or findings has been undertaken (Appendix 4). This form will be open to refinement as the process evolves. The key identifiers have been defined as;

Author (s)

Year of publication

Sources country of origin

Study Methodology

Study population/size

Participant stage (pre-reg/qualified)

Career choice

Influencing factors

The reviewer is aware there will be a degree of methodological bias secondary to the fact that this is a solo scoping review. Bias will be considered throughout, and the author will aim to limit selection bias. As the researcher has a keen interest within this subject area the possibility of selection bias will be high (Bell, 2005). To mitigate for this retaining a firm understanding of the purpose of the scoping review and only including articles that meet the inclusion criterion will be adhered to.

Presentation of Results

The results of the scoping review will be presented with both a narrative and charted discussion of the findings. The charted findings will allow mapping of any themes or recurring themes within the literature. The narrative summary will pull together these themes and address the initial scoping review question.

Attention will be paid to any researched recurrent themes present and will highlight any gaps within the current literature.

Appendix 2 – Key Terms

Participant	Concept	Context
Students nursing	Career planning and development	Nurse attitudes
Nurses	Personnel recruitment	Student attitudes
New graduate nurses	Personnel retention	Decision-making process
Education nursing	First post	Prefer*
Pre-registration nurs*	Career choice	
Newly qualified nurs*	Career	
Student nurs*	Employ* or job or recruit*	
Nqn		
Nurs* and degree or bachelor degree		

Appendix 3 – Search Strings

Search Strings

1	Students, nursing
2	Nurses
3	New graduate nurses
4	Education nursing
5	(Pre-registration nurs*)
6	(Newly qualified nurs*)
7	Student nurs*
8	nqn
9	Nurs* and (degree) or (bachelor* degree)
10	1 or 2 or 3 or 4 or 5 or 6 or 7 or 9 or 9
11	Career planning and development
12	Personnel recruitment
13	First post
14	Career choice
15	Career
16	Employ* or job or recruit*
17	11 or 12 or 13 or 14 or 15 or 16
18	Nurse attitudes
19	Student attitudes

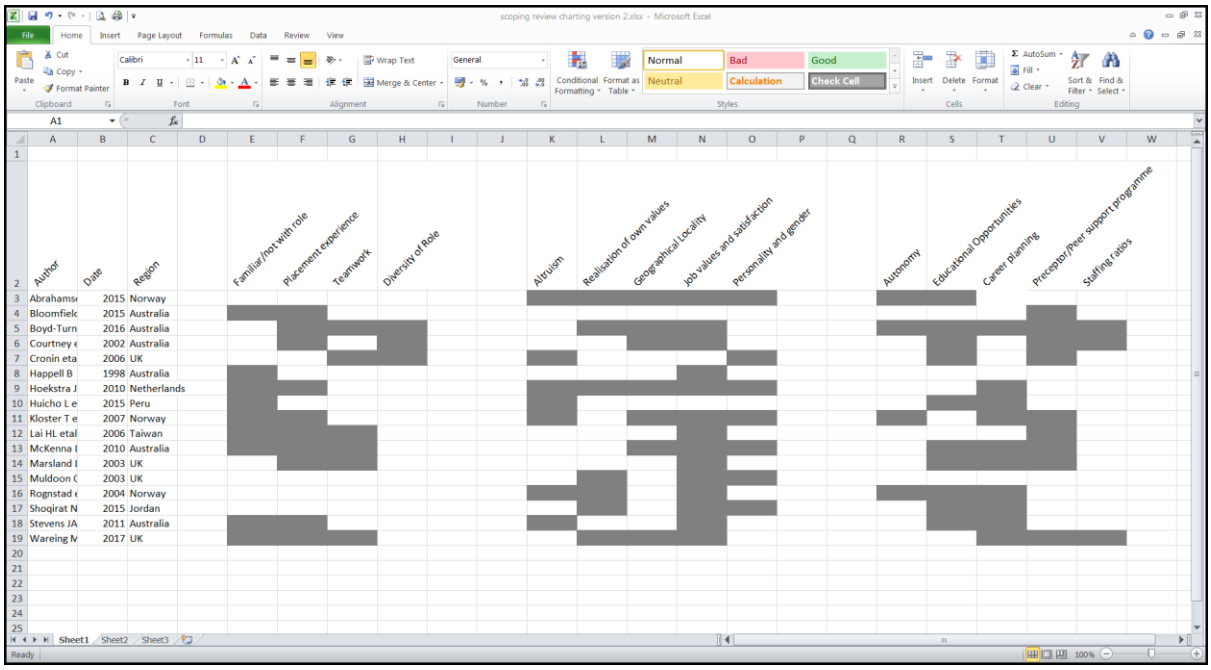
20 (Decision-making process)

21 Prefer*

22 18 or 19 or 20 or 21

23 10 and 17 and 22

Appendix 4 – Scoping Review Results



Appendix 5 – Scoping Review Research Articles

Author, year, location	Aim of study	Study design	Sample population	Study characteristics	Main findings	Emerging considerations
Abrahamsen B 2015 Norway	To investigate undergraduate's choice of clinical field post-graduation. This is linked to their professional qualifications and job values, particularly in the care of older people and psychiatry.	A qualitative longitudinal study. Questionnaire surveys. We analysed with multinominal regressional analysis.	290 undergraduate nursing students. Mean age of participants was 28.1 yrs. 87% female. Final semester students at 2 Norway universities.	A primary aim is to look at older people and psychiatry. Participants were given 4 categories; 1 general hospital 2 older/disabled 3 psychiatry 4 drug abuse and others within which to choose.	The study shows a correlation between the choice of clinical field and perceived qualification and job values. 4% of final-year students would choose to work in the care of older people, yet 1-year post-registration, 26% work in this field. Abrahamsen (2015) comments that the society served shapes the nurses' attitudes and practices towards the clinical field of choice within Norway. Feels this is secondary to the lack of financial resources. Clinical significance on the low number choosing psychiatry. The author feels recruitment strategies need to be developed to entice nurses into difficult to recruit/retain areas, i.e. psychiatry and older people. Recommends further study into motives for career choices (the author recommends this in light of psychiatry and older people).	Concentrating only on older people and psychiatry, can this data be extrapolated further? Based on the assumption that students will want to pursue careers that they have been exposed to as undergraduates – does this limit the findings? (do give theoretical context behind this). In Norway, older peoples' nursing is highly staffed with non-registered personnel, and RGNs are in the minority but making many clinical decisions. Psychiatry is the opposite – primarily RGN based and considered professionally challenging. Therefore, do Norwegians view elder care as a highly-skilled area?

						Influencing factors are categorised as Job Values in a 5 question format and analysed through a Likert scale – what process was used to decide on these 5 factors? This is not transparent.
Bloomfield JG et al 2015 Australia	Identify final year students' intentions to enter primary care (PC) as a career options post-qualification, combined with their exposure to PC during the education process. Is there a link between PC	Qualitative online survey (Survey Monkey) & Anonymous cross-sectional survey Participants recruited from 14 Australian Universities	456 participants Mean age of participants was 30.7 yrs 89.3% female Final year pre-registration students were recruited to the study.	A study was undertaken in July-August 2014. Primary care in focus. Questionnaires also aimed at students' understanding of the nurse's role and intentions to work in PC. 519 questionnaires submitted 456 were analysed.	14 Universities were used to ensure diverse rural and urban locations were sampled. Mixed demographic of students to ensure representative of populous. 98.2% of students were exposed to PC – only 22.8% of students identified this as an area they would like to work – they linked this to the learning experience during training. Familiarity or placement didn't alter the final destination choice. 91.9% wish to undertake a new graduate transition program, 73.2% expected to work full time during their first-year post-registration,	Research shows PC was not chosen but not investigated why within this research. The assumption that many need to gain a transition experience before PC - where does this assumption come from - doesn't give underpinning evidence on this. Mentions a Government initiative to increase the numbers of PC nurses through retention and transitions of acute care nurse strategies.

	exposure and PC career choice?				55.8% expected to work in an urban-based hospital, and 22.8% expressed an interest in PC as their first career choice. PC includes general practice, community settings and community based mental health. 1 in 4 potential viable career options.	
Boyd-Turner D et al 2016 Australia	Influence student placements can have on employment choice in the context of paediatrics.	Qualitative Semi-structured interviews last approx. 30 mins	6	Paediatric bias Newly qualified nurses within a year of qualifying and had completed at least placement in their 2nd or 3rd year. Exploration of what were perceived positive and negative aspects of the clinical placement. How were decisions made regarding future employment choices.	Looks at clinical placement experience Increased placement enjoyment in the supportive area High correlation between student support and career decision. 3 strong themes emerged; clinical support with student facilitation, educational opportunities with debriefing and career planning.	Interesting lit review section on student placement/socialisation Australia - uncertain job market – no references or research to back this up. We are based at a women/children's hospital, so it may bias results. Generic socialisation & mentorship comments received were not speciality focused.

Courtney et al 2002 Australia	Evaluation of the Clinical Placement Support Scheme as a recruitment strategy for students' employment intentions working in rural clinical placements.	Quasi-experimental pre-post test survey 38 item questionnaire (16 Likert scale questions, 15 closed questions and 7 open ended questions.	212 participants 49% <23 yrs, 51% > 23 yrs. 84% female. 16% male 36% were in a partnership 30% had dependants 78% also had >8 hours of other paid employment	Primary Care based Final-year nursing students. Participants were all from 1 university – clinical program in 2000. 65% (137) response rate pre-test and 57% (121) post-test. 38 Questions given were 16 Likert scale, 15 closed questions and 7 open-ended.	Pre-test, 49% of students indicated their intention to seek work in a rural setting at some point in the future. Following the clinical placement, 89% intended to seek pastoral work; this doesn't say the career stage. Reasons for not choosing a rural post-grad position are family issues 57%, desire to obtain clinical experience in hospital settings 16%. 3% feel there is no training support in a rural setting. Factors that would positively influence employment intentions are friendly, approachable staff (43%), diverse case mix (31%), good teamwork/relationships (20%), graduate programme/preceptor support (16%) and professional working conditions and environment (15%). Negative factors are unfriendly staff (45%), poor working conditions (22%), location (16%), unsupportive professional environment (16%) and lack of diversity 15%). Government financial incentive to work in PC.	Gives historical references to rural nurses being held in high regard. 1996 Queensland Uni offers a rural nursing programme, but this is not validated/referenced further within this document. Pre-test response; note positive rural employment intentions but not as a first choice. All pre and post-test positive responses wanted rural employment as a later career option. Reasons given were wanting hospital experience first.

Cronin et al 2006 UK	Explore the key reasons why A&E attracts newly qualified nurses.	Qualitative Focus Groups Convenience sample 3 separate focus group interviews over 18 months 8-10 participants took part in each interview.	25 participants Mean age of participants was 23 yrs	All participants were newly qualified with employment within A&E. The first section of their A&E induction programme. Skews data set slightly	A&E is a performance managed environment. Therefore it can lead to increased stress and eventual burnout – not attractive career facets. 5 themes emerged - challenge, teamwork, diversity, support and learning, and participants could rank the importance (teamwork is discussed interchangeably with peer support). The team concept is considered essential for A&E's 'specific' environment that A&E offers. The strongest theme to emerge was the concept of teamwork, followed by diversity and learning or skills development. Peer support in the guise of the experienced team members is shown as a positive influence in attracting staff. The acute environment is considered desirable for these applicants – specific to the personalities of A&E applicants. The author class A&E as intense, physically demanding, and having high work pressure.	She limited the methodology section. Small sample size. It states that NQN is not suitable for A&E, but there is no evidence to back this up. Is this concept transferrable to PC? This was not some research participants' first post.

Happell B 1998 Australia	Examines the attitudes of student nurses toward a possible career in community health. This aims to address this during the commencement, during and immediately before completing their training.	Questionnaire – pilot conducted with 30 students to ascertain reliability and validity. Open and closed questions are divided into 3 areas; demographic area, student's order of preference, and students' reasons for ranking career options. Longitudinal study	793 participants (48% response rate). 77% <23yrs <12% >30 yrs 83% F	Community based Diverse geographical participants 9 (out of 12)major University's participated This paper looks at the first stage of the study – the commencement of their training.	The premise is to increase how community nursing is presented in the curricula to improve student nurses' interest. It aims to look at this from 2 specific areas; the attitudes of student nurses and the effect of education on the degree to which these ideas are sustained or altered. Gives an area of first post preference. At the commencement of the course working with children and high tech areas (intensive care, theatres) accounts for almost half of all first-choice posts. The least popular were aged care and psychiatry. Community health is classed as not 'interesting' and ranks 7th out of 9. Students don't understand community care and perceive it as not an interesting place to work. Community care is perceived as; boring, not hands-on, not providing individual nursing, and more focused on health promotion.	Community care appears to be classed as low tech 'hands off' nursing. Seems more viewed as health promotion than clinical intervention. Note year of study – historical – is this still relevant in today's healthcare? Placement exposure or experience not discussed or mentioned.

					This preconception allows nurse educators to alter the curricula to educate on the role of community nursing.	
Hoekstra JK et al. 2010 Netherlands	Looks at how first-year nursing students' perceptions of psychiatric patients and mental health care influence their choice of specialism working within this sector.	A descriptive qualitative study. Questionnaire semi-structured interviews 3 questions are based on what perceptions the students have around MH, what factors influence the building of these perceptions, and how these perceptions affect career choice. 13 students participated in the interviews.	120 questionnaires were distributed with 100 participant response rates (83%). Mean age of participants was 21	83% response to questionnaires 13 students participated in Interviews. 12 students did, and 88 students didn't want to major in mental health. This article discusses the results of the semi-structured interviews. The participants were further split into 3 sub-groups those who would decide against a career in mental health, those who would choose a career in mental health and those who had no preference.	4yr course (2 years basic training and the 3rd and 4th year choose speciality area). All respondents showed high levels of motivation for altruistic reasons. It was felt that the respondents were identified as two different types of nurses – those who indicated they wanted to act efficiently and solve problems and those who wanted to develop therapeutic relationships with their clients. Students report negative findings for MH's poor training/understanding. Many saw MH nursing as institutionalised and viewed psychiatric patients as aggressive. It is felt not to be a highly valued career from a societal standpoint. It was perceived as a male-orientated environment.	A preliminary questionnaire sent to allow purposive participant selection does this bias choice of interview participants. Mean age 21 years -? What life experience/exposure to mental health would they have had.

					Most students had a preconceived stereotyped perception of the environment, and the recommendation is for educators to enlighten and raise awareness of this area.	
Huicho L et al 2015 Peru	This research explores students' perceptions about their career choices, employment expectations, motivation and potential to work in rural areas.	10 Focus group sessions and 20 in-depth interviews using purposive sampling. The themes for assessment and analysis were career choice, job expectations, motivations and incentives.	67 participants 73 % Female 36 nursing/midwifery students	Medical, nursing and midwifery students. 22 of the 67 were nursing students. Participants were from 2 Peruvian universities. Focus groups and interviews were carried out in their last 3 years of undergrad training for medical students and the last 2 years for nursing students. The interviews included career choice aspects, future job expectations,	The rural practice appears beset with linguistic, economic, and poorly equipped and isolating problems. Those who wish to work in rural settings, primarily nursing/midwifery, appear to wish this for philanthropic/altruistic reasons. Medics appeared to be more motivated by salary level, living conditions and geographical locality, akin to an urban setting. Cultural problems with undertaking rural posts /language barriers. Results show a preference for urban jobs across the board. Nursing students show a higher disposition for pastoral work. This is more evident in those who have come from a rural background.	The research focused on rural practice. The regulatory requirement to work in a rural setting as part of their training (SERUMS). The compulsory SERUMS is a transient phase of training; therefore, a proportion of rural staff will be transient, which may give the environment a feeling of workforce instability.

				motivations to work in a rural area, and incentives to work in a rural area.	Influential factors on career choice were; solidarity, better income, professional and personal recognition, early life experience and family models.	
Kloster T etal student2007 Norway	This report looks at a study of Norwegian undergraduate nurses' career preferences and their reasons for these at the beginning and end of their nursing education.	Longitudinal descriptive design. Questionnaires - closed questions around career preferences and open questions around the reasons for these preferences. The students were also asked to rank the 5 statements on level of importance; the geographical location of career choice, working hours, nursing challenges,	Participants; Phase 1 620 of 782 (79.2% response rate) Phase 2 386 of 473 (82.6% response rate) Mean age 27.8 91.8% female 60% < 27 years 66.9% had worked as a nursing auxiliary previously.	Change of sample size reflects student withdrawal or study breaks 5 Norwegian University colleges were invited to participate in the 2001/2002 cohort.	Changes in the preferences between the first interviews and the end of the nursing course were shown. Phase 1 results show midwifery and paediatrics as ranking highly, and at the end of phase 2, working in medical or surgical wards alongside mental health was preferred. Interesting note phase 2 students, 49% chose MH nursing. Working in geriatrics remained unpopular throughout. 83.7% agreed that practice experience influenced the choice. 79% felt that nursing challenges were important in career choice. Hospital-based choice? Links with student feelings of insecurity and lacking confidence - need the support of more experienced colleagues working in tandem with them.	This precedes Hoekstra's 2010 Netherlands study, which shows no interest in MH nursing. In contrast, this shows that MH nursing is a preferred area. Is this indigenous to the area, or has there been a change in the training/workforce that has engineered this. Change in perception of training/workforce/society – unsure which. Statements were made around 'nurses educating themselves away from patients' and NQN feeling insecure in the skill mix. Does this intimate why they wish to work in secondary care/hospitals as NQNs to allow support and perceived improved mentorship?

		experience from clinical studies and salary.				
Lai HL et al 2006 Taiwan	The study design is to investigate the career choices of Taiwanese nursing students. The objectives were to look at subjective reporting of career decisions and competence,	Convenience sample. Descriptive comparative sample survey. A questionnaire was comprising visual analogue scales, Likert scales and closed questions.	248 Questionnaires were distributed to 231 participants resulting. (93% response rate). Mean age 19.27 100% F	Eligibility = 4th year of study and had 2 months of clinical experience in medical/surgical nursing. (5-year college course). College program of students which stands between DipHE and BSc.	Questionnaires were administered at the beginning of the Spring term. 65.4% would not continue to a nursing career; the course was used as a stepping stone to study further. Course classed as a foundation course is often used as a stepping stone to study further. 35.1% of students cited parental advice as to the reason for enrolment to study, and 30.3% stated that it is due to the low academic entry requirements.	Competency self-assessment - This was a self-initiated measure instead of a subjective measure; this may need to be interpreted with caution. ? altered nurse training system in Taiwan – as it does not appear to represent the academic standard required in the UK.

motivational and situational related factors on vocational choice.	60.6% were of Taiwanese origin	Looked at four areas, general (demographics), competence, motivational and situational factors.	Competency - participants self-rated their clinical and academic competence as low. Motivational – Past exposure to the profession or dealing with illness increased motivation and significantly positively affected results. Situational – those who reported nursing as a career option marked stress factors as significantly less than those who didn't. This was also echoed in the view of support received in clinical and theoretical training. Increased socialisation with clinical placements decreased fear and anxiety.	They are implying that nurses' stress during placement factors deeply in the nursing attrition rate – no evidence to back this up.

McKenna L et al 2010 Australia	Reports on nursing findings sought to explore the influence of students' clinical placements on their future career intentions.	Qualitative study showing thematic data analysis. Purposive sampling. Focus groups &/or Interviews	13 participants (no demographic data was supplied).	No individual research questions were being tested. Students were invited to participate who had completed year one or their final clinical placement in year 3. 6 questions guided interviews 7 undergrads - 6 graduates. 10 in individual interviews and 3 in the focus group.	Findings; - three main themes: 'reaffirming career choice', 'working in a particular area' and 'work location'. Placements aid in re-affirming career choices, and exposure to working in a particular area allows awareness of professional realities. Poor placements increased first-year students' uncertainty about continuing with nursing as a career. They also altered students' desire to apply for a position there in the future. Clinical placements influence guiding/decision making for future employment. Allows exploration into previously unknown/unconsidered clinical areas. Clinical placements were unusual in providing first-year students with a preferred career choice post-graduation. Most students indicated their first position would rather be in an acute setting to garner experience and confidence.	Small study size - ? was taken from a larger study, but this is not clear in this paper. Look at Lea et al. (2008) report that placements in rural areas leave students feeling less supported with high work demands and lower levels of mentorship. – Is this an Australian phenomenon or wider-reaching? Placements allow decision making from a geographical and clinical standpoint - ? this may aid in career trajectory planning.

Marsland L et al 2003 UK	The first survey phase investigates if nurses' course experiences affect employment plans.	Longitudinal questionnaire survey (Qualification, 6 months, 18 months and 3 years post qualification). Focus on adult branch These findings are taken from the 'at qualification' questionnaire	2109 questionnaires were submitted, and 1596 returned questionnaires (87% response rate)	These findings represent the 'qualification' findings of the 1997-1998 qualifying cohort – of 37 Universities. Original research funded by DoH includes all 4 nursing disciplines – Adult, Mental health, Learning disabilities and paediatrics. The questionnaire covered demographics, pre-course experience,	The geographical location of the workplace (authors feel this needs further study). Geographical location and professional isolation altered the student's preferred permanent location. 99% of participants had some community exposure during their training (does this reflect an educational vs exposure shift in the curriculum)? Course experience/exposure was more likely to influence career choice than discourage; this was the case for 23 out of the given 28 specialities. Variation in these figures could be symptomatic of the different University approaches to the variety of placements facilitated. Influential factors were found to be job availability and gaining experience in long term career planning.	DipHe course, historical data, does this meet with the historical concept of experience before community working

				course experience, obtaining the first post and combining work with family.	A high degree of participants (12%) recorded 'community' within their long term career plans (this matches A&E, surgery & medicine) – all other specialities <5%.	
				Considering both theoretical and clinical experiences, there is no overt representation of the theoretical or clinical experience findings.	A stronger association exists between course influences on the long-term career plans (>3 years post-graduation) than on the graduation career plans.	
					1340 students had obtained their first job at qualification over 53 differing specialities. Commonly presented first posts were medicine, general surgery, elderly care and orthopaedics.	
					Gaining experience relevant to longer-term career goals was cited as an influential factor.	
Muldoon et al 2003 UK	This study looks at the gendered view of nursing within society and whether this influences	Cross-sectional design questionnaire 384 participants 350 women Mean age 20.7	384 participants (representing a 91% response rate) 350 women Mean age 20.7	Pre-registration student nurses in the first four weeks of the first year of study	Participants rated jobs they viewed as more appropriate for men/women. Environments with a highly female rating were female and child-related clinical areas. Environments consider generic female areas	Are male nurses being manipulated by societal perceptions into making their career choices.

	students' career choices.	Primarily Caucasian. The instruments used were the Bem Sex Role Inventory Likert scales and an amended Occupational Self Efficacy Scale (representing nursing only)		Aim; student rating on the gender appropriateness of a range of nursing careers. This is examined concerning its desirability and whether it is a barrier to student career choices. Dip He course Data was gathered on career expectations and the perceived gendered nature of various career options.	as generalised departments, and management/acute areas were classed as gender-neutral areas. The males who answered the questionnaires tended to express career choices within the gender-neutral categories. Career choice in the medial category classed as 'female generic areas' was not related to gender role identity. Age was not found to be a significant predictor of career choice. Psychologically male nurses tend to go for gender-neutral roles in acute settings – mental health and learning disabilities. Mental health was rated most appropriate for men – but was the most unpopular career choice. Perceptions of sex-typing in particular clinical fields may alter nurses' career choices.	The number of male participants is small – nevertheless, this is representative of males within the profession This may represent more of a societal view as the participants are only 4 weeks into their training
Rognstad MK et al 2004	The study looks at the motivational career plans for	Questionnaires with closed questions and semi-	No data provided	This study reflects an earlier survey surrounding motivation and beliefs in first-year student nurses. The initial	Students wish to be in careers that offer 'meaningful' and 'engaging' environments with personal development.	What are Norway's training programmes for nurses? Further educational qualifications may educate the profession beyond the

Norway	nursing students and assesses the career preferences in today's society.	structured in-depth interviews 442 questionnaires were administered in this study phase with a 68% response rate (301 responses). 301 questionnaires – containing 54 closed questions and Likert Scales. 18 student interviews	survey was undertaken 7 months upon commencement of training and followed up at 2.5 yrs into training – 1998-1999. This data relates to the 2.5 years of findings. Recruitment from 3 classes of students at 3 different colleges in Oslo.	Most students who wished for further education expressed they didn't want to remain on the wards for more than 1-2 years. 92% wished to undertake further education. High technology areas, midwifery and paediatrics are popular first career choices, with geriatrics and psychiatry being the least popular preferences. Younger students are more geared towards high salary and career progression than their older counterparts Patient contact was highly valued, and everyone expressed altruism Further education was high on the agenda for those wishing for specialisms. A wish to work with healthy people was expressed, i.e. public health visitors and midwifery.	generic nursing role, but how do we fill the generic nursing role?

Shoqirat N et al 2015 Jordan	Explores the future employment planning and career preferences of final year Jordanian nurses.	Convenience sample Focus groups – semi-structured narrative. Four separate interviews were undertaken, and each lasted between 45-90 mins.	52 participants were recruited, and 27 participated. 17 females and 10 males Age 22- 26, mean age 23 years	Final-year nursing students Jordan has had a recent change to nursing education in HE institutes. Translated into English from Arabic. Themes emerged – *being uncertain and hesitant, being a real nurse, and where I want to be.*	At the research time, there were concerns over job availability due to nursing saturation of the job market – all recipients voiced this. 74% voiced concerns over public perception of nursing – more predominant in the male participants. All males (10) felt nursing was not for men (secondary to public opinion and placement experience) and planned further education. Clinical placement altered career choice – participants preferred critical care areas, and all males expressed critical care as their preferred choice due to the availability of work outside of Jordan. 58% of female participants felt that gender was a factor in the preference of working area – religion and culture were sighted as reasons. Job security and salary benefits ranked high, as did working with patients who weren't deemed to be demanding i.e. ICU Opinions are shaped by placement atmosphere, gender, family and culture.	Cultural perspective of males working in a female-dominated environment. Female nurses working alongside male colleagues may also have cultural implications

Stevens J A 2011 Australia	Student nurses' career preferences on working with older people. The ethos was to develop a profile of nursing career preferences and the rationale behind those preferences—comparing these results with other studies.	Repeated measure design. Survey questionnaire using a non-probability sample of undergraduate BSc students. 300 distributed, 203 returned in the first stage (68% returned) 250 distributed,189 returned in the second stage (76% returned) 200 distributed, 160 returned in the third stage (80% returned) 150 used in research	150 participants 62.6% women 124 women and 26 men. Age range from 17-64 years, with a mean age of participants of 26.	6 campuses were originally approached, and 3 agreed to participate. Undergraduate BSc students. Investigated preferences on commencement, middle and end of the study. Stage one was the first week of the first semester of the programme. Stage two was at the end of the 3rd semester of, the midway point of the programme Stage three was in the last week of lectures in the final semester.	Ranked career preferences show alteration over the three years, i.e. child nursing ranked as 1 for the first 2 years, then down to 6 by year 3. Nursing for older people ranked 7th in the first stage, 10th in the second stage and 9th when students graduated. 36 participants who had ranked working with older people as low had previous experience being Assistants in Nursing. The correlation between the longer spent on clinical placement when working with older people increased the lack of desire to work in this area. Conversely, the time spent working within intensive care correlated with an increased desire to work in this area. Surgical nursing ranked the most popular with graduating students, which allows the development of skills and experience. Clinical experience through placement was given as the reason for changes in the first post choice	A higher proportion of men in this survey than in the national workforce figure. Intimates salary scale is less for aged care.

				Decreasing numbers compared with course attrition and fewer attendees at lectures.	Previous employment as an Assistant in Nursing alters career decisions. Career progression is a determinant of first post choice. High tech and low-tech environments alter career choices.	
Wareing M et al 2017 UK	Exploration of how clinical placements influence adult nurses' first post choice. Transitioning into a new role is challenging, and this examines whether their clinical placement shapes the perception of the staff nurse.	Pilot study. Single-phase qualitative and quantitative data using a single instrument Questionnaire 61 questionnaires were sent out 35 were completed (57% response rate)	100% female 18-51 years old 66% originated with the county of study.	Nurses in adult field training only Pilot study. Primarily participants originated locally from the HEI	51% of participants had a preconceived preference for first post choice upon course entry – this materialised into 14% applying for this area – the author postulates this supports that career preference can be altered by education. 46% applied for posts in the placement area that they had defined as the most influential at the end of their third year. They felt that this had given them confidence and socialisation in the clinical area. The impact of clinical placement on first post choice increased as the course progressed, more predominant in year 6% rank placement as fairly important, 29% as quite important and 66% as significant.	Further study shows that the culture shock of qualification and working in fast-paced areas increases nursing attrition.

Participants preferred fast-paced acute environments – this gave the perception of more learning opportunities.

Poor staffing numbers and lack of support affected career choices.

Appendix 6 – Study One Interview Guide

INTERVIEW GUIDE

An interpretive descriptive study of student nurse and newly qualified nurses' perceptions of employment in general practice as a first post destination.

STUDY ONE – STUDENT NURSES

Student name; (REDACT ONCE ANONYMISED)

Anonymised code number.

University setting (REDACT ONCE ANONYMISED)

Date Time

Face-to-face/Digital platform

Housekeeping

Confirm informed consent and am happy to continue.

Curtain Raising Questions

QUESTION	RESEARCHER NOTES
"tell me a little bit about yourself – only what you feel comfortable saying."	
"Tell me about your thoughts around employment when you have completed your training."	
"What motivated or influenced these decisions?"	

Exploratory questions

"Could you describe what you want from your first registration post?"	
"What are your thoughts and feelings on a first employment post in general practice?"	
"What or who do you think has shaped these views?"	
"Tell me about where you would like to work in the future."	

Closing question

"Is there anything you may not have mentioned during the interview you would like to mention now?"	
"Is there anything you would like to ask me?"	

Researcher reflexive notes

……..

……..

Appendix 7 – Study One Ethical Approval

19 July 2019

Cheryl Lythgoe

PhD Candidate

University of York

Department of Health Sciences

York

YO10 5DD

Dear Cheryl

HSRGC/2019/352/A: Nurses perceptions of working in general practice as a first destination post

Your project was reviewed in July 2019 by a subcommittee of the Health Sciences Research Governance Committee, because it would have held the study up unnecessarily to wait for the next meeting of the full committee.

I am pleased to confirm that the subcommittee approved the project.

If you have any queries about this decision, or make any substantial amendments to the study, please contact me. Finally, if you intend to submit this letter or any other correspondence from the HSRGC as part of your assessed work (e.g., to demonstrate that your study has ethical approval) please make sure you edit the letter in order to maintain anonymity.

Yours sincerely

S. Holland

Stephen Holland Chair: HSRGC

cc. Prof Steven Ersser and Prof Paul Galdas

Appendix 8 – Consent Form

UNIVERSITY of York
The Department of Health Sciences

Participant Consent Form

An interpretive descriptive study of pre-registrant and newly qualified nurses' perceptions of employment in general practice as a first post destination.	**Please confirm agreement to each statement by putting your initials in the boxes below**
I have read and understood the participant information sheet [7/11/21 V4]	
I have had the opportunity to ask questions and discuss this study	
I have received satisfactory answers to all of my questions	
I have received enough information about the study	
I understand my participation in the study is voluntary and that I am free to withdraw from the study: - 1 At any time 2 Without having to give a reason for withdrawing *3* Any interview data already obtained will be included within the final study	
I understand that my interview will be audio-recorded.	
I understand that data collected during the study may be looked at by the lead researcher, Cheryl Lythgoe, Prof Paul Galdas and Dr Beth Hardy. I permit these individuals to have access to the study data.	
I understand that any information I provide, including personal data, will be kept confidential, stored securely and only accessed by those carrying out the study. Audio recordings of interviews will be destroyed once successful transcription has been confirmed. Study data (coding, analysis and commentary documents) will be retained for ten years post-study completion.	

I understand that any information I give may be included in published documents, but all information will be anonymised.	
I agree to take part in this study	
Name of participant Participant Signature …… Date	
Name of Researcher Researcher Signature ……. Date	

Appendix 9 – Participant Information Sheet

UNIVERSITY of York
The Department of Health Sciences

An interpretive descriptive study of key stakeholders' perceptions of newly qualified nurses entering General practice as a first post destination.

Participant Information Sheet

I want to invite you to participate in the study named above, but before you decide, please read the following information.

What is the purpose of this study? There is a current nursing staffing shortage within the UK, and trends appear to suggest this will continue to rise, proving challenging for employers and the broader health economy. Understanding the influencing factors for employment choice is necessary to advance how health arenas can address workforce recruitment and retention. Queens Nursing Institute identified varied career pathways into general practice but no clearly defined pathway for newly qualified nurses (NQN's), with only a small percentage of nurses entering general practice within five years of qualifying.

Who is doing the study? This is a PhD study with me, Cheryl Lythgoe, as the sole researcher. My research supervisors are Professors Paul Galdas and Dr Beth Hardy, and we are all based within the University of York's health sciences department. The sponsor organisation is University of York – Health Sciences, and the nominated sponsor is Michael Barber.

Why have I been asked to participate? This study is part of three interlinked studies within which to explore the study question. The focus is on newly qualified nurses who are undertaking their first nursing role within general practice, and the aim is to explore your beliefs about your journey to your first registered post as a nurse and what has influenced them.

Do I have to take part? Study participation is entirely voluntary. If you would like to participate, you will need to sign a consent form that will outline any study requirements.

What will be involved if I take part in this study? This qualitative study will explore your views and influences related to your first employment choice as a nurse. To participate, you will be required to participate in an audio taped interview that could last between 30-60 minutes. The audiotaped interview will be at your employers at a mutually agreed date and time.

Alternatively, if this proves difficult, we can utilise MS Teams/Skype. MS Teams/Skype meetings will be recorded, and you can choose if you wish to have the camera on or off.

What are the advantages/benefits and disadvantages/risks of taking part? Exploring and understanding your perceptions on employment choice will allow professional self-reflection for yourself and help to build a broader picture of workforce choice. This study also can inform future approaches to support student/newly registered nurses in their career decision-making and enhance nursing staff recruitment in future years. There will be no monetary benefit to taking part, and there are no perceived risks.

Can I withdraw from the study at any time? You can withdraw from the study at any stage and do not have to surrender a reason for doing so. If you wish to withdraw once the interview has been undertaken, the data collected within the interview will still be used.

What sort of patient data does health and care research use? There are lots of different types of health and care research.

How does research use patient data? In lots of research, most of the research team will not need to know your name. In these cases, someone will remove your name from the research data and replace it with a code number. This is called coded data, or the technical term is pseudonymised data. For example, your blood test might be labelled with your code number instead of your name. It can be matched up with the rest of the data relating to you by the code number.

In other research, only the doctor copying the data from your health records will know your name. They will replace your name with a code number. They will also make sure that any other information that could show who you are is removed. For example, instead of using your date of birth they will give the research team your age. When there is no information that could show who you are, this is called anonymous data.

What are my choices about my patient data?

- You can stop being part of a research study at any time, without giving a reason, but the research team will keep the research data about you that they already have. You can find out what would happen with your data before you agree to take part in a study.

- Researchers need to manage your records in specific ways for the research to be reliable. This means that they won't be able to let you see or change the data they hold about you. Research could go wrong if data is removed or changed.

What happens to my research data after the study? Researchers must make sure they write the reports about the study in a way that no-one can work out that you took part in the study.

Once they have finished the study, the research team will keep the research data for several years, in case they need to check it. You can ask about who will keep it, whether it includes your name, and how long they will keep it.

The organisation running the research will usually only keep a coded copy of your research data, without your name included. This is kept so the results can be checked.

If you agree to take part in a research study, you may get the choice to give your research data from this study for future research. Sometimes this future research may use research data that has had your name and NHS number removed. Or it may use research data that could show who you are. You will be told what options there are. You will get details if your research data will be joined up with other information about you or your health, such as from your GP or social services.

Once your details like your name or NHS number have been removed, other researchers won't be able to contact you to ask you about future research.

Any information that could show who you are will be held safely with strict limits on who can access it.

You may also have the choice for the hospital or researchers to keep your contact details and some of your health information, so they can invite you to take part in future clinical trials or other studies. Your data will not be used to sell you anything. It will not be given to other organisations or companies except for research.

Will the use of my data meet GDPR rules? GDPR stands for the General Data Protection Regulation. In the UK we follow the GDPR rules and have a law called the Data Protection Act. All research using patient data must follow UK laws and rules.

Universities, NHS organisations and companies may use patient data to do research to make health and care better.

When companies do research to develop new treatments, they need to be able to prove that they need to use patient data for the research, and that they need to do the research to develop new treatments. In legal terms this means that they have a 'legitimate interest' in using patient data.

Universities and the NHS are funded from taxes and they are expected to do research as part of their job. They still need to be able to prove that they need to use patient data for the research. In legal terms this means that they use patient data as part of 'a task in the public interest'.

If they could do the research without using patient data they would not be allowed to get your data.

Researchers must show that their research takes account of the views of patients and ordinary members of the public. They must also show how they protect the privacy of the people who take part. An NHS research ethics committee checks this before the research starts.

What if I don't want my patient data used for research? In most cases you will also have a choice about your patient data being used for other types of research. There are two cases where this might not happen:

- When the research is using anonymous information. Because it's anonymous, the research team don't know whose data it is and can't ask you.
- When it would not be possible for the research team to ask everyone. This would usually be because of the number of people who would have to be contacted. Sometimes it will be because the research could be biased if some people chose not to agree. In this case a special NHS group will check that the reasons are valid. You can opt-out of your data being used for this sort of research.

Who can I contact if I have a complaint? If you want to complain about how researchers have handled your information, you should contact the research team. If you are not happy after that, you can contact the Data Protection Officer. The research team can give you details of the right Data Protection Officer.

If you are not happy with their response or believe they are processing your data in a way that is not right or lawful, you can complain to the Information Commissioner's Office (ICO) (www.ico.org.uk or 0303 123 1113).

How will the information and personal data I give be handled? The University of York is the sponsor for this study based in the United Kingdom. We will be using information from you to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly.

Before the interview, you will be asked to sign a consent form that will hold your given name and general practice setting. The consent form will be stored within a secure setting at the University of York. During the interview, I will use an interview guide, this will contain interview questions and any interview notes I make. The interview guide will hold a code that links with your consent form. The interview will be audiotaped and stored securely on the University's secure IT system; this will be stored with the same linked code. Therefore, the interview guide and audio files will be pseudonymised. Once transcribed, the transcriptions will be allocated the same pseudonymised code and following confirmed successful transcription, the audio file will be deleted. All digital files will be held within a file repository on the University of York's computer system.

Any local transfer of files will be managed through the University secure server; these are not expected to be transferred outside the EU. All relevant data will be kept in a secure location for ten years post-study completion. Any non-relevant data will be destroyed post-study completion.

All personal data will be handled following the General Data Protection Regulation

(GDPR). For further information about our lawful basis for processing your data, how we will keep your data secure (including keeping it safe if it is transferred internationally), your rights over your data and your right to complain about how your data is processed, please refer to the following: https://www.york.ac.uk/records-management/dp/.

https://www.york.ac.uk/records-management/dp/guidance/gdprcompliantresearch/

https://www.york.ac.uk/records-management/dp/your-info/generalprivacynotice/

Data access throughout the study will be limited to Cheryl Lythgoe and my supervisor's Professors Paul Galdas and Dr Beth Hardy.

For further information on how your data will be managed please see appendix 1.

How will we use information about you? We will need to use information from you for this research project.

This information will include your

name,

date of birth

employer

People will use this information to do the research or check your records to make sure that the research is being done properly.

People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead.

We will keep all information about you safe and secure.

Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

What are your choices about how your information is used? You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.

We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used? You can find out more about how we use your information

- at www.hra.nhs.uk/information-about-patients/
- our leaflet available from **: www.hra.nhs.uk/patientdataandresearch**
- by asking one of the research team
- by sending an email to cl813@york.ac.uk
- by sending an email to the sponsors (University of York) data protection officer dataprotection@york.ac.uk

What will happen to the results of the study? After your interview, you will be offered a copy of your transcribed interview notes to enable you to discuss changes or retractions. The

resulting concepts and themes from this part of the study will be reviewed with the findings from a previous study in which pre-registrant nurses were interviewed to explore their beliefs and influences on first employment choice. After completing the study, you will be offered access to a summary of the main study findings. The findings from both studies will be used to generate a third study where key decision makers will be asked around their beliefs and perceptions of general practice nurse recruitment.

Who has reviewed and approved this study? University of York's Health Sciences Research Governance Committee has provided ethical approval for this study in addition to the Heath Research Authority (HRA).

Who do I contact for more information about the study? If you would like further information or discuss your participation in this study, please email the researcher Cheryl Lythgoe at Cl813@york.ac.uk.

Who do I contact in the event of a complaint? If you have any complaints about this study's organisation or data collection, please contact Professor Paul Galdas at paul.galdas@york.ac.uk or Dr Beth Hardy at beth.hardy@york.ac.uk.

If you are unhappy with how your data has been handled, please get in touch with the University's Data Protection Officer at dataprotection@york.ac.uk. If you are still unsatisfied, you have a right to report your concerns to the Information Commissioner's Office at www.ico.org.uk/concerns.

Thank you for taking the time to read this information sheet

Appendix 10 – Study One Recruitment Email

On Mon, 14 Oct 2019 at 19:18, Cheryl Lythgoe <cl813@york.ac.uk> wrote:

Good Evening

I am a part time PhD student at the University of York undertaking research that explores student and newly qualified nurses perceptions of choosing General Practice as a first post destination.

Further to recent correspondence with **XXXX** and yourself I am writing to request that the below invitation to take part in the study is sent to all final year nursing students. The study has been granted ethical approval from University of York Health Sciences Research Governance Committee; I am more than happy to provide evidence of ethical approval / a study protocol if required

I would be most grateful if you could confirm when the email has been disseminated.

"Dear Student

I am a part time PhD student at the University of York, and I am undertaking an interview study to explore student and newly qualified nurses' decision making around their first employment destination. I am particularly interested in exploring student nurses' perceived barriers and facilitators to choosing General Practice as a first post destination and would like to invite you to take part in an interview with me.

"What's the catch/I don't have time" I hear you cry. All participation in the study will require will be to take part in an audio recorded interview at a location and time to suit; this should last approximately one hour. The interview can be conducted face to face or over Skype if this would be easier. The interview and transcripts will be anonymized and kept strictly confidential.

Interested? Then please contact me on cl813@york.ac.uk and I will forward you more details about the study and what participation would involve, answering any questions you may have.

Kind regards

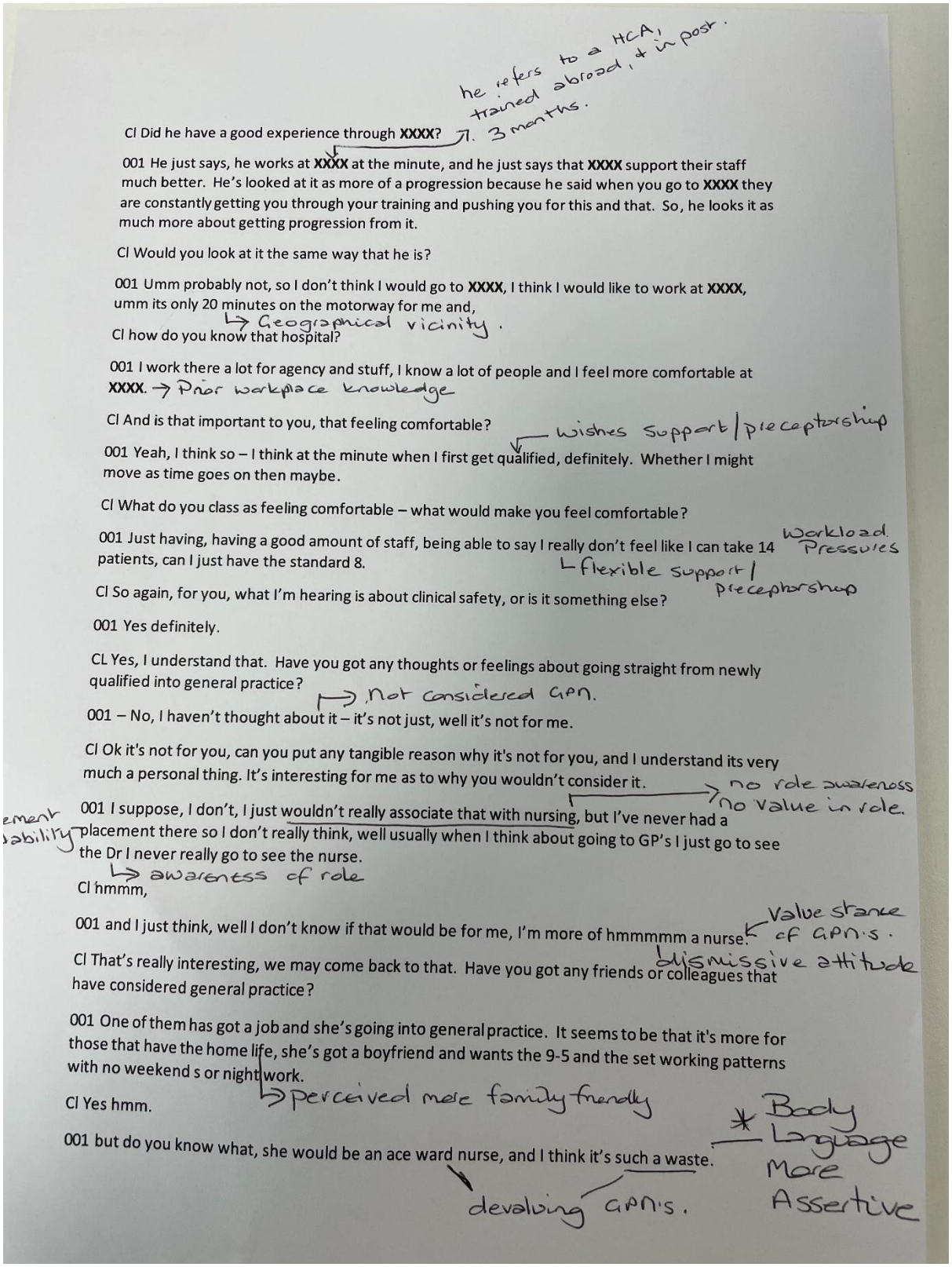
Cheryl Lythgoe"

Many thanks for all your assistance with this.

Best wishes

Cheryl Lythgoe

Appendix 11 Working Copy of Study 1 Interview 1



he refers to a HCA, trained abroad, 4 in post. 3 months.

CI Did he have a good experience through **XXXX**?

001 He just says, he works at **XXXX** at the minute, and he just says that **XXXX** support their staff much better. He's looked at it as more of a progression because he said when you go to **XXXX** they are constantly getting you through your training and pushing you for this and that. So, he looks it as much more about getting progression from it.

CI Would you look at it the same way that he is?

001 Umm probably not, so I don't think I would go to **XXXX**, I think I would like to work at **XXXX**, umm its only 20 minutes on the motorway for me and,

→ Geographical vicinity.

CI how do you know that hospital?

001 I work there a lot for agency and stuff, I know a lot of people and I feel more comfortable at **XXXX**. → Prior workplace knowledge

CI And is that important to you, that feeling comfortable?

← wishes support/preceptorship

001 Yeah, I think so – I think at the minute when I first get qualified, definitely. Whether I might move as time goes on then maybe.

CI What do you class as feeling comfortable – what would make you feel comfortable?

001 Just having, having a good amount of staff, being able to say I really don't feel like I can take 14 patients, can I just have the standard 8.

Workload Pressures

└ flexible support/ preceptorship

CI So again, for you, what I'm hearing is about clinical safety, or is it something else?

001 Yes definitely.

CL Yes, I understand that. Have you got any thoughts or feelings about going straight from newly qualified into general practice?

→ Not considered GPN.

001 – No, I haven't thought about it – it's not just, well it's not for me.

CI Ok it's not for you, can you put any tangible reason why it's not for you, and I understand its very much a personal thing. It's interesting for me as to why you wouldn't consider it.

→ no role awareness
no value in role.

001 I suppose, I don't, I just wouldn't really associate that with nursing, but I've never had a placement there so I don't really think, well usually when I think about going to GP's I just go to see the Dr I never really go to see the nurse.

→ awareness of role

CI hmmm,

001 and I just think, well I don't know if that would be for me, I'm more of hmmmmm a nurse.

← Value stance of GPN's.

CI That's really interesting, we may come back to that. Have you got any friends or colleagues that have considered general practice?

dismissive attitude

001 One of them has got a job and she's going into general practice. It seems to be that it's more for those that have the home life, she's got a boyfriend and wants the 9-5 and the set working patterns with no weekend s or night work.

→ perceived more family friendly

CI Yes hmm.

001 but do you know what, she would be an ace ward nurse, and I think it's such a waste.

devaluing GPN's.

* Body Language More Assertive

Appendix 12 - Study One - Example of Theme Generation

Original themes	**Final theme title**
Career advice available	GPN career journey
Career advice not available	
Career decision factors	
Career pathways	
Alternative careers	
Pre-registrant career choice	

Appendix 13 - Study Two recruitment email

Good Morning

I contacted yourselves in 2020 with a view to facilitating participant recruitment into my doctoral study looking at pre registrant and newly qualified nurses perceptions of employment choice within general practice as a first post destination. Unfortunately, due to the pandemic the study was placed on hiatus, but I am now ready to begin participant recruitment. All relevant ethical approvals have been reached (University of York HSRGC/2021/458/C, IRAS Project 304245 PENDING).

As I am sure you are aware 33% of General Practice Nurses are due to retire within the next 12-18 months with only a small percentage of nurses enter general practice within five years of qualifying. My study findings are aimed to provide a local picture of the perceptions of pre-registrant and newly qualified nurses entering general practice, exploring their successes and challenges.

In 2020 you kindly agreed to facilitate email distribution to practice nurses enrolled in the GPN Ready Scheme or the VTS scheme. Eligibility criteria are all newly qualified nurses within 24 months of qualifying who have chosen general practice as a first post destination.

I have attached the Participant Information Sheet and wondered if you could disseminate the below email to all eligible participants, (If you could possibly alert me when the emails are sent I would appreciate this). If you have any upcoming training events that may be relevant for this cohort I would be more than happy to attend or for my study to be discussed with attendees.

Many thanks for your support and assistance with this – please do not hesitate to contact me if you have any questions

Dear Colleague

I am a part time PhD student at the University of York, and I am undertaking an interview study to explore newly qualified nurses decision making around their first post destination. I am particularly interested in exploring the facilitators and challenges of choosing general

practice as a first post destination and would like to invite you to take part in an interview. As a newly qualified nurse entering general practice I feel your insight would be valuable.

'What's the catch, I don't have time' I hear you cry. All participation in the study will require is for you to take part in an audio-recorded interview at a location and time to suit you; the interview length is approximately 30 minutes. The interview can be conducted over a digital platform (Zoom/Skype/Teams) or face to face. The interview and transcripts will be anonymised and kept strictly confidential.

Interested, want more information? Then please contact me cl813@york.ac.uk and I will forward more details about the study and participation would involve, answering any question you may have.

Kind regards

Cheryl Lythgoe

Intranet posting

We are actively recruiting into a study that explores the perceptions of newly qualified nurses who enter general practice as their first post destination. If you are a newly qualified nurse, who's gone straight into general practice within the last two years please do contact cl813@york.ac.uk for more information.

Appendix 14 – Study Two Ethical Approval

Ymchwil Iechyd a Gofal Cymru
Health and Care Research Wales

NHS
Health Research Authority

[redacted]

Email: approvals@hra.nhs.uk
HCRW.approvals@wales.nhs.uk

25 November 2021

Dear Mrs Lythgoe

[redacted]

Study title:	**An interpretive descriptive study of pre-regrant and newly qualified nurses perceptions of employment choice within general practice as a first post destination.**
IRAS project ID:	**304245**
REC reference:	**21/PR/1355**
Sponsor	**University of York**

I am pleased to confirm that **HRA and Health and Care Research Wales (HCRW) Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

Please now work with participating NHS organisations to confirm capacity and capability, in line with the instructions provided in the "Information to support study set up" section towards

Appendix 15 – Study Two Interview Guide

INTERVIEW GUIDE **STUDY TWO – GENERAL PRACTICE NURSE**

What are the experiences of newly qualified nurses entering General Practice as a first post destination?'

Name Anonymised code number.

Geographical work area

Date Time Face to Face/Digital Format

Housekeeping ☐

Confirm informed consent and happy to continue ☐

Demographics

Age Sex Ethnicity

Curtain Raising Questions

DISCUSSION TOPICS	RESEARCHER NOTES
Personal and professional information ○ *Nursing discipline (adult/child/MH/LD)* ○ *Pre registrant university* ○ *Family background* ○ *Previous job history*	
Pre-reg career preference *Placement areas/experiences (if GP placement did they*	

consider this a good learning environment)	
What/who shaped this	
Why did you choose general practice as your first destination post?	

Exploratory questions

General practice employment information – how did you hear about this post?	
Yours/peers perceptions of general practice	
Availability of preceptorship, professional support, or professional skill consolidation.	
Do you feel general practice provides a good training ground for NQN – if so why/why not	
Challenges/benefits of GPN (be aware of answers concerning altered terms & conditions, awareness of post availability and perception of secondary care experience first)	

Closing question

Any questions	

Researcher summation/clarification points	

Researcher reflexive notes

Appendix 16 - Study Two – Example of Theme Generation

Original Theme	**Final Theme Title**
Employment terms and conditions	GPN salary, terms and conditions
Aware of GPN pay structure	
Not aware of GPN pay structure	
Perceived challenges of GPN pay	
Impact GPN infrastructure has on pay	
Role title and salary	

Appendix 17 – Study Three Ethical Approval

From: approvals@hra.nhs.uk <noreply@harp.org.uk>

Sent on: Wednesday, March 30, 2022 3:01:52 PM

To: **XXXXXXXXX**

Subject: IRAS Project ID 304245. HRA and HCRW Approval for the Amendment

Dear Mrs Lythgoe,

IRAS Project ID:	304245
Short Study Title:	Nurses perceptions of general practice as a first post destination
Amendment No./Sponsor Ref:	Amendment 01 non substantial
Amendment Date:	30 March 2022
Amendment Type:	Non Substantial Non-CTIMP

I am pleased to confirm **HRA and HCRW Approval** for the above referenced amendment.

You should implement this amendment at NHS organisations in England and Wales, in line with the guidance in the amendment tool.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/.

Please contact amendments@hra.nhs.uk for any queries relating to the assessment of this amendment.

Kind regards

James Davies

Health Research Authority

Ground Floor | Skipton House | 80 London Road | London | SE1 6LH

E.amendments@hra.nhs.uk

W. www.hra.nhs.uk

Appendix 18 – Study Three Recruitment Email

Good afternoon one and all

As many of you are aware, I am currently undertaking a self-funded PhD qualitative study exploring the perceptions of key stakeholders on newly qualified nurses entering general practice as a first post destination. As I am sure you are aware I am a passionate advocate of general practice nursing and have undertaken this study with a view to potentially increasing awareness and knowledge around some of the factors to entering general practice nursing.

The study consists of three interlinking studies to allow a rounded view to be obtained. Study one has been undertaken and explored the view of pre-registrant nurses entering general practice as a first post destination - this study has now been published. Study two is still ongoing and is exploring the experiences of those nurses who have entered general practice as their first post destination.

This study, study three, aims to understand the perceptions of senior stakeholders on the current general practice workforce and the benefits and challenges in recruiting to this area. Therefore, I wondered if you would be able to spare 30 minutes of time to undertake an audio-recorded interview. The interview can be held at a date and time to suit your schedule and can be done either face to face or over a digital platform. A participant information sheet is attached which provides further detail of the study.

Ethical approval has been obtained both from my university (University of York) and HRA (REC reference 21/PR/1355, IRAS reference 304245)- copies of the agreement can be provided if required.

Please don't hesitate to contact me if you require further information or clarity on anything. I look forward to hearing from you.

Best wishes

--

Cheryl Lythgoe

Appendix 19 – Study Three Interview Guide

INTERVIEW GUIDE **STUDY THREE – SENIOR STAKEHOLDERS**

'*What are the perceptions and experiences of senior stakeholders on newly qualified nurses entering General Practice as a first post destination?*'

Name Anonymised code number.

Geographical work area

Date Time Face to Face/Digital Format

Housekeeping ☐

Confirm informed consent and happy to continue ☐

Demographics

Age Sex Ethnicity

Curtain Raising Questions

DISCUSSION TOPICS	RESEARCHER NOTES
Personal and professional information ○ *Work area* ○ *Job role* ○ *Primary care interaction*	
Your perception of GPN workforce	
What/who/which policy shaped this	

Exploratory questions

General practice employment information – what do you perceive the challenges and wins as?	
What are the workforce challenges that you have seen in general practice nursing?	
Your perception of GPN funded new started schemes i.e. GPN Ready, VTS scheme. *Have you had any experience of this?*	
Have you ever or do you advertise for GPN's – what methods do you use for recruitment?	
Educators – Do you feel the pre-registrant training course discusses and prepares for all clinical areas (primary secondary and tertiary care)?	

Closing question

Any questions	
Researcher summation/clarification points	

Researcher reflexive notes

Appendix 20 - Study Three – Example of Theme Generation

Original themes	**Final theme title**
Current employment area	Participants employment history / role
Has primary care experience	
No experiential primary care experience	
Previous employment	
Alternative workstreams	

Appendix 21 – Primary Health Care Published Article

Pre-registrant nurses' perceptions of general practice as a first-post destination (rcni.com)

Why you should read this article:

- To be aware of the barriers to recruitment of newly qualified nurses to general practice nursing roles
- To understand nursing students' perceptions of entering general practice as a first post
- To learn about approaches to improving recruitment of newly qualified nurses to general practice nursing roles

Pre-registrant nurses' perceptions of general practice as a first-post destination

Cheryl Lythgoe, Paul Galdas and Beth Hardy

Citation
Lythgoe C, Galdas P, Hardy B (2022) Pre-registrant nurses' perceptions of general practice as a first-post destination. Primary Health Care. doi: 10.7748/phc.2022.e1758

Peer review
This article has been subject to external double-blind peer review and checked for plagiarism using automated software

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Conflict of interest
None declared

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Abstract

Background There is a widespread nursing shortage within the UK, with trends suggesting that vacancies will continue to rise. The challenge is particularly acute in primary care, where unclear recruitment and career pathways mean that only a small proportion of nurses enter general practice within five years of qualifying.

Aim To explore pre-registrant nursing students' perceptions of entering general practice as a first-post employment destination.

Method A qualitative interpretive description study was undertaken, recruiting final year pre-registrant nursing students. Semi-structured interviews were analysed through a thematic analysis framework.

Findings Three key themes were identified: myths and perceptions of the general practice nurse (GPN) role, the requirement for secondary care experience and a perceived lack of career advice on entering general practice.

Conclusion Visibility and awareness of the GPN role have still not been realised and further work in this area is required.

Author details

Cheryl Lythgoe, doctoral student, department of health sciences, University of York, York, England; Paul Galdas, professor of nursing and deputy head of department (director of teaching and learning), University of York, York, England; Beth Hardy, senior lecturer, health sciences, University of York, York, England

Keywords

careers, career pathways, newly qualified nurses, primary care, professional, professional issues, professional development, role development, students, student recruitment

Background

There is a widespread nursing shortage within the UK. In 2019, national nursing vacancies stood at 38,785 (Macdonald and Baker 2020), with trends in recruitment, retention and attrition suggesting that this number would continue to rise (Murray 2017). The challenge is particularly acute in primary care, where there are unclear recruitment and career pathways (NHS England 2018). Research by Ipsos Mori (2016) and The Queen's Nursing Institute (QNI) (2016) identified this lack of clarity in primary care recruitment as a particular issue for newly qualified nurses, with only a small proportion entering general practice within five years of qualifying.

As a branch of nursing, general practice primarily recruits mature and experienced nurses aged over 40 years (NHS Digital 2021). Thirty-three percent of general practice nurses (GPNs) were due to retire by 2020 (QNI 2016) and various strategies have been introduced to support the rapidly dwindling workforce, including the NHS England (2018) 'ten-point action plan for general practice nursing'. The action plan aimed to achieve tangible outcomes in recruitment and retention by raising the profile of GPNs, increasing post-registration education and continuing professional development, increasing the number of pre-

Appendix 22 - Meta synthesis Example for General Practice Business Infrastructure

Study One	Study Two	Study Three	Final Theme and sub themes
Pay, terms & conditions Aware of difference Not aware of difference GPN Career advice Available Not available Being investigated Decision factors Clear Unclear	GPN role Awareness Isolation Preceptorship programmes Available Not available Salary terms and conditions Aware of difference Not aware of difference General Practice professional structure Perceived challenges of altered T&Cs Job Hunting Adverts Offers	General Practice communication Pros Cons Funded training schemes Aware Not aware GPN career pathways GPN decision making Involved Not involved GPN nursing leadership Good Poor Invisible Pay terms and conditions GPN role advertising & recruitment visibility employment variety Policy & initiatives Local National	General Practice Business Infrastructure How do I become a GPN? Pay terms and conditions.