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The well-being of nurses working in general practice during the COVID-19 pandemic: A qualitative study (The GenCo Study)

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Abstract

Aim: Exploration of experiences of nurses working in general practice during the COVID-19 pandemic to evaluate the impact on nurses' professional well-being.

Design: An exploratory qualitative study comprised of case studies of three general practice sites in England and a nationwide interview study of nurses working in general practice and nurse leaders. The study was funded by The General Nursing Council for England and Wales Trust. University of York ethics approval (HSRGC/2021/458/I) and Health Research Authority approval was obtained (IRAS: 30353, Protocol number: R23982, Ref 21/HRA/5132, CPMS: 51834).

Methods: Forty participants took part. Case site data consisted of interviews/focus groups and national data consisted of semi-structured interviews. Data collection took place between April and August 2022. Analysis was underpinned by West et al.'s (*The courage of compassion. Supporting nurses and midwives to deliver high-quality care*, The King's fund, 2020) ABC framework of nurses' core work well-being needs.

Findings: The majority of participants experienced challenges to their professional well-being contributed to by lack of recognition, feeling undervalued and lack of involvement in higher-level decision-making. Some participants displayed burnout and stress. Structural and cultural issues contributed to this and many experiences predated, but were exacerbated by, the COVID-19 pandemic.

Conclusions: By mapping findings to the ABC framework, we highlight the impact of the COVID-19 pandemic on the well-being of nurses working in general practice and contributing workplace factors. The issues identified have implications for retention and for the future of nursing in general practice. The study highlights how this professional group can be supported in the future.

Impact: The study contributes to our understanding of the experiences of nurses working in general practice during the COVID-19 pandemic and beyond. Findings have implications for this skilled and experienced workforce, for retention of nurses in general practice, the sustainability of the profession more broadly and care quality and patient safety.

Reporting Method: Standards for Reporting Qualitative Research (O'Brien et al. in *Journal of the Association of American Medical Colleges*, *89*(9), 1245–1251, 2014).

Patient or Public Contribution: As this was a workforce study there was no patient or public contribution.

KEYWORDS
burnout, COVID-19 pandemic, general practice, general practice nursing, nursing, primary care, qualitative, well-being

1 | INTRODUCTION

Internationally, general practice has experienced significant challenges during the COVID-19 pandemic (Mroz et al., 2020; Rawaf et al., 2020; Verhoeven et al., 2020; Wherton et al., 2020). Some international literature focuses on general practice nursing, and primary care nursing more broadly, during the COVID-19 pandemic (e.g. Aragonès et al., 2022; Ashley et al., 2021; Halcomb, Fernandez, Mursa, et al., 2022; Halcomb, McInnes, et al., 2020; Halcomb, Williams, et al., 2020; Russell et al., 2022). However, there remains a paucity of exploration of the experiences of nurses working in general practice both in England (Russell et al., 2022) and internationally (Halcomb, Williams, et al., 2020). There are also few studies that specifically consider the experiences of nurses working in general practice throughout the duration of the COVID-19 pandemic and the subsequent implications for future practice. This is important because this group has a distinctive range of skills and knowledge (Clifford et al., 2021) and there has been significant recruitment and retention issues within the general practice nursing workforce prior to the COVID-19 pandemic (Health Education England, 2017).

2 | BACKGROUND

During the COVID-19 pandemic, rapid changes in working practices occurred in general practices in England (Mroz et al., 2020) and internationally (Rawaf et al., 2020; Verhoeven et al., 2020; Wherton et al., 2020) from March 2020 onwards. General Practices responded to the COVID-19 pandemic in a variety of ways. For example, expansion of triage, remote working, essential work being carried out differently, the postponement of some non-essential work (Verhoeven et al., 2020) and the development of COVID-19 'hubs' (Khan et al., 2020). Changes in secondary care provision also impacted on primary care providers (Verhoeven et al., 2020) as did a lack of personal protective equipment (Rawaf et al., 2020). Latterly, general practice was responsible for the large-scale delivery of COVID-19 vaccinations (Harnden et al., 2021).

Nurses working in general practice have distinctive roles which differ from other primary healthcare professionals (Clifford et al., 2021). This includes delivering the bulk of long-term condition management, public health interventions such as immunization and vaccination programmes (Public Health England, 2020), essential care which cannot be delayed and procedures requiring face-to-face consultations, for example, complex dressings, cervical cytology (Clifford et al., 2021; Russell et al., 2022). While General Practitioners' experiences of the COVID-19 pandemic have been variously explored, (Gray et al., 2020; Jefferson, Heathcote, & Bloor, 2022; Khan et al., 2020; Royal College of General Practitioners, 2020; Verhoeven et al., 2020), and potential implications for future practice considered, there has been much less consideration of the experiences of nurses working in general practice and how this has impacted on the professional well-being of nurses.

Several Australian studies of nurses working in a variety of primary healthcare settings were carried out in the early stages of the COVID-19 pandemic. These reported increased stress and anxiety (Ashley et al., 2021), negative effects on mental health (Halcomb, Fernandez, Mursa, et al., 2022) and highlighted specific concerns (Halcomb, McInnes, et al., 2020), support needs (Halcomb, Williams, et al., 2020) and self-care strategies (Ashley et al., 2021). Similarly, an international study of advanced nurse practitioners' experiences during COVID-19 found reduced levels of mental well-being (Rogers et al., 2022). In England, Russell et al. (2022) described negative emotions and tensions between general practice nursing teams and their GP employers, while a survey by the Queen's Nursing Institute (2020) found that general practice nurses felt undervalued. Disparity between the proportions of in-person consultations provided by clinicians working in general practice has also been reported (Murphy et al., 2021). The COVID-19 pandemic has contributed to 'alarmingly high' levels of staff stress, turnover, absenteeism and intention to quit across the wider nursing workforce in the United Kingdom (West et al., 2020). For general practice specifically, it is anticipated that one quarter of general practice nursing posts in England will be vacant in 10 years' time, with the legacy of COVID-19 implicated as a contributory factor (Oxtoby, 2022). Some general practice nurses are reported to be considering leaving their position (Launder, 2022) due to a lack of respect, support and poor employment conditions (Queen's Nursing Institute, 2020). However, there is a lack of robust workforce analysis relating to general practice and this has been identified as a national (UK) priority on which tackling the workforce crisis is dependent (West et al., 2020).

The level of practice of nurses working in primary healthcare differs internationally (Halcomb, McInnes, et al., 2020) with registered nurses working in general practices in England working at a high level of autonomy (Russell et al., 2022). Recruitment and retention issues have challenged the general practice nursing workforce in England prior to the COVID-19 pandemic (Health Education England, 2017) and general practice can ill afford to lose this highly experienced, skilled and knowledgeable workforce which are difficult to replace.

The GenCo Study (Anderson et al., 2022) aimed to explore the experiences of nurses working in general practice in England throughout the COVID-19 pandemic in order to develop recommendations for future practice. This paper is one of two papers produced from the study, the other focusing on remote and technology-mediated working during COVID-19 pandemic (Anderson et al., 2023). Here, we report on how the COVID-19 pandemic affected professional well-being and highlight implications for future practice in a post-pandemic primary healthcare landscape.

3 | THE STUDY

3.1 | Aims

To gain insight into the experiences of nurses working in general practice during the COVID-19 pandemic to explore the impact of working practices on nurses' professional well-being. Experiences are explored through the analytical lens of West et al.'s (2020) framework of nurses' needs which underpin professional well-being.

4 | METHODS AND METHODOLOGY

4.1 | Design

This exploratory qualitative study comprised of interviews and focus groups at three general practice case sites and a nationwide interview study of nurses working in general practice/nurse leaders across England. The original protocol consisted of case sites only. However, we carried out data collection in the aftermath of the third wave of the COVID-19 pandemic in England and the resulting pressures on general practices meant data collection at our case sites was delayed and the timeframe shortened. Consequently, we were unable to follow the original study protocol (Anderson et al., 2022) and this limited the range and number of participants recruited to the general practice case sites. Therefore, our study design was adapted to add interviews with a variety of participants working in general practice nursing positions throughout England and national nurse leaders associated with general practice. This enabled us to situate in-depth case study data alongside a national overview. The study was underpinned by a social constructionist perspective, to gain in-depth understanding of the effects of working practices during the COVID-19 pandemic on nurses working in general practice. Interviews/focus groups conducted from multiple data sources (three case sites plus nationally recruited participants working in a variety of nursing roles) enabled qualitative data triangulation (i.e. to facilitate a more comprehensive understanding of the topic) (Hammersley & Atkinson, 2007). That is, investigating from different perspectives (Holloway, 2008) to explore comprehensiveness, (in)consistency and (in)congruence in order to add valuable insight. The study was funded by The General Nursing Council for England and Wales Trust.

4.2 | Participants

4.2.1 | Case sites

Three general practice case study sites in different localities in the North of England were recruited via a large community-based healthcare provider which oversees multiple general practices. These localities varied in terms of practice size, location and deprivation index. Nursing team members (general practice nurses, healthcare assistants, nursing associates, advanced nurse practitioners) were approached via an email from the nurse manager. We wanted to gain a range of experiences from all team members so that we could understand well-being of the nursing team in the round. A nursing student was also invited to take part in one of the focus groups, as a member of the nursing team at the time of data collection, and a 'GP lead' for nursing at the overarching organization was interviewed to provide broader context. Those expressing an interest in the study were provided with a participant information leaflet and invited to take part in an interview or focus group by the lead researcher [HA]. These were conducted within participants' contracted hours and were either in-person or via an online platform.

4.2.2 | National interview study

Potential participants were either working in nursing roles in general practice or were national or other leaders associated with general practice. Participants were recruited via professional and social media networks and through a snowballing technique (Patton, 2015), where participants were asked to share details of the study with colleagues or contacts who they thought would be interested in contributing. This was in order to gain a diverse dataset across England. The lead researcher engaged with key professional contacts who asked potential participants whether they would consider taking part in an individual interview. Recruitment via social media has become a recognized form of recruitment in healthcare workforce research (Hulse, 2022: Morley et al., 2022) and in this study the lead researcher [HA] posted on Twitter briefly explaining the study. We targeted key nursing groups on Twitter including @WeGPNs, @BAMEGPNs, @QNI, @NAPC_NHS, @RCNGPN Forum and @gpnsnn, as well as key nurse leaders, and asked them to retweet study information to their followers to gain maximum publicity for study recruitment and with the aim of maximum variation in potential participants. Potential participants were asked to make contact with the researcher if they were interested in taking part. They were then provided with a participant information sheet and invited to take part.

4.2.3 | Sampling strategy

The sampling strategy aimed to balance breadth and depth of data. We did not focus on saturation, but aimed to achieve representation

of a varied sample (Braun & Clarke, 2019), while allowing the data generated to be comprehensive and manageable (Pope & Mays, 2006). The sample size was consistent with qualitative sample size recommendations (Baker et al., 2012). We aimed to opportunistically recruit a range of practitioners (general practice nurses, healthcare assistants, advanced nurse practitioners, nursing associates and nurses in management positions) with variation in terms of gender, age, role and professional level within case sites and at a national level. Nurses working in national and other leadership roles relating to general practice during the COVID-19 pandemic were also considered key informants. Written consent was obtained from all participants. No incentives were offered and no participant expenses were accrued.

4.3 | Data collection

Data were collected between April and August 2022. At case sites, individual semi-structured interviews or focus groups were conducted. Most took place via Zoom/MS Teams, with a minority in-person. Interviews lasted between 30 min and 1 h 15 min. Focus groups lasted between 1 h and 1 h 45 min. For national interviews, individual semi-structured interviews took place remotely via Zoom, MS Teams or telephone and lasted between 50 min and 1 h 20 min.

Topic guides developed from relevant literature and study aims were used to guide interview discussion. These were iteratively developed to incorporate ideas as interviewing progressed (e.g. terms and conditions). Interviews/focus groups that took place remotely were recorded using video-conferencing software. In-person and telephone interviews were recorded using a password-protected audio recording device. A professional transcription service transcribed all recordings verbatim.

4.4 | Data analysis

Data analysis followed a framework approach described by Pope et al. (2000). This draws on a priori concepts as well as being grounded in the raw data. We used West et al.'s (2020) ABC framework of nurses' core well-being needs to inform the a priori concepts in our analysis. This proposes that for nurses to achieve a good standard of health and well-being, three core work needs are required (Box 1). We used this model as an explanatory framework in which to situate and analyse the raw data generated. Our linked paper drew on a different framework and focused on remote and technology-mediated working. Consequently, the findings from that analysis are reported elsewhere (Anderson et al., 2023).

Framework approach consists of: familiarization with the data; developing a thematic framework; indexing (coding) the data; charting; mapping and interpretation. Initially, transcripts were coded in relation to the ABC framework and inductive open coding was also applied to the dataset to capture ideas not directly associated with the framework (e.g. the gendered nature of nursing work). Codes were developed into descriptive accounts from which ideas and analytical themes and relationships were generated and then tested in the data. A constant comparative approach was undertaken, where data were collected and analysed concurrently and compared across contexts. That is, newly collected data were compared with previously collected data as interviews progressed, searching for similarities and differences on which analytic insights were developed. Data from different strands of the study (case study and national) were initially analysed separately, then compared and contrasted.

4.5 | Ethical considerations

The study was approved by the University of York Health Sciences Research Governance Committee (HSRGC/2021/458/I) and the Health Research Authority (IRAS: 30353, Protocol number: R23982, Ref 21/HRA/5132). The study was accepted for NIHR Clinical Research Network support and registered on the NIHR CRN Portfolio (CPMS: 51834).

Approaching and consenting participants was conducted according to the University of York's research governance and NIHR Good Clinical Practice guidelines. Information sheets explained the research and participants were advised they could withdraw from the study at any point without reason. As a workforce study, it was not considered to be ethically contentious. However, it focused on a small number of participants in-depth and this potentially impacts on protecting participants' identities. Therefore, information is presented at a level which limits potential for the identification of participants and sites.

4.6 | Rigour, trustworthiness and reflexivity

Standards for Reporting Qualitative Research (O'Brien et al., 2014) have been used to support the quality of reporting findings from this study. In terms of study quality, we drew on Hammersley's (1998) stance that trustworthiness is demonstrated through comparison between findings and wider knowledge, recognisability of the account to readers (credibility), the relevance of findings to similar settings and reflexivity. We allowed assessment of credibility through accurate and transparent documentation of the research process. While not aiming for probabilistic generalizations, qualitative knowledge is theoretically generalizable through thick description, linking findings to established and developing theories, comparison to previous work and resonance with existing experiential knowledge (Holloway, 2008). Consequently, we drew on information-rich data to draw out complexity and used a theoretical framework to inform analysis and discussion. Because interviews were conducted at case site and national levels, and included a range of participants, findings may resonate across similar institutions and workforces and wider healthcare contexts. For example, general practice and primary care organizations, as well as wider healthcare settings, may use information generated to plan future workforce strategies. We also compared and

BOX 1 ABC framework of nurses' core work needs (West et al. 2020).

Autonomy:

The need to have control over own work life.

To be able to act consistently with own values.

- Authority, empowerment and influence:

  Influence over decisions about how care is structured and delivered, ways of working and organizational culture.
- Justice and fairness:

  Equity, psychological safety, positive diversity and universal inclusion.
- Work conditions and working schedules:

  Resources, time and sense of the right and necessity to properly rest, and to work safely, flexibly and effectively.

Belonging:

The need to be connected to, cared for, and caring of others at work.

To feel valued, respected and supported.

The importance of working in nurturing cultures and climates.

Having a clear, enacted and shared vision.

Effective team and inter-team working.

- Teamworking:

  Effectively functioning teams with role clarity and shared objectives, including team member well-being.
- Culture and leadership:

  Nurturing cultures and compassionate leadership enabling high quality, continually improving, compassionate care and staff support.

Contribution:

The need to experience effectiveness and deliver valued outcomes.

The need for contribution is met when:

- workloads do not exceed the capacity of staff to deliver valued outcomes.

  Staff have enabling supervisory support.

  There are cultures of learning and accountability rather than directive, controlling cultures focused on blame.
- Nurses are supported to continuously learn, develop skills and grow professional knowledge.

- Workload:

  Work demand levels that enable sustainable leadership and delivery of safe, compassionate care
- Management and supervision:

  Support, professional reflection, mentorship and supervision to enable staff to thrive in their work
- Education, learning and development:

  Flexible, high-quality development opportunities that promote continuing growth and development for all.

contrasted findings to the wider literature to underpin, and add authenticity and veracity, to our study findings.

The lead researcher (HA), as a registered nurse who previously worked in general practice, took a reflexive approach to all aspects of the study. Disconfirming cases and alternative explanations were looked for in the data. Meetings were held with the wider research team, mainly with JA, but also PG and AS, who were not directly involved in data collection or analysis. Consequently, research team meeting discussions facilitated reflection and questioning of analytical ideas.

5 | FINDINGS

5.1 | Sample characteristics

A total of 40 participants took part in the study, $n=13$ from case study sites and $n=27$ national participants. Participants ranged in experience from newly qualified nurses to those with over 40 years' experience, as well as one student nurse and one GP. Most participants had worked in general practice for a number of years. $N=3$ participants were male and the rest were female. $N=38$ were white. There were a range of levels of practice within the term 'general practice nurse', with some participants working as 'treatment room nurses' focusing on aspects of nursing including wound care, cervical cytology, contraception, immunizations. Others focused on managing long-term conditions and/or managing minor illness, sexual health and some undertook a mixture of work. Healthcare assistant work included phlebotomy and health monitoring measurements as well as aspects of wound care and supporting registered nurses in long-term condition management. Advanced nurse practitioners were mainly involved in managing acute 'same day' issues. Many registered nurses taking part in the study also held a prescribing qualification. Some participants also managed nursing teams and undertook non-clinical work. While we aimed for maximum variation, and this was largely achieved, we were not as successful in recruiting a range of healthcare assistants or assistant practitioners/nursing associates.

Information about participants is presented at a level to maintain anonymity. Table 1 details nationally recruited participants. Case study participants were recruited from three general practice locality sites within one overarching organization across the north of England. The overarching organization was given the pseudonym 'Woodlands', with the individual sites 'Yew', 'Sycamore' and 'Hawthorn'. Thirteen individuals took part in either an interview or focus group (semi-structured interviews $n=6$, focus groups $n=3$ with between 2 and 3 participants in each group). Case site and participant details are set out in Table 2.

First, we provide an overview of experiences of participants during the COVID-19 pandemic to set the context in which they were working. Following this, we map study findings against the three domains of West et al.'s (2020) ABC framework of nurses' core work needs and these are summarized in Tables 3, 4 and 5. Each domain is explored in turn, although due to the complexity of the data, insights crosscut and overlap in parts.

5.2 | Setting the scene—An overview of the experiences of nurses working in general practice during the COVID-19 pandemic

At the beginning of the COVID-19 pandemic, general practice was required, at pace, to rethink how care would be delivered. Although generally led by GP partners and practice managers, some nurse participants reported having some involvement in this, ranging from nominal to significant. Some participants were told what their clinics/consultations would look like and how care was expected to be delivered, 'I think [nurses] didn't really have much of a voice. What was decided, and how the work was undertaken, was decided by the GPs and the practice management' (ANP4 National). Remote working mainly consisted of telephone consultations, but for many participants, the majority of nursing work continued to be carried out in-person. Technology was used as an adjunct, rather than replacement for, face-to-face care. In the experience of many participants, the nursing profession and provision of nursing care was considered to be an afterthought in the strategic planning of service reconfigurations during the COVID-19 pandemic, 'They installed software and webcams onto every camera apart from mine in the treatment room. I think they just ran out of cameras, honestly. But I didn't really need one because I was seeing my patients face-to-face' (GPN2 National). Participants made a major contribution to setting up COVID-19 vaccination centres and delivering the bulk of vaccinations although this, and the wider work of nurses in general practice, was perceived by many participants to go unrecognized by colleagues, the media and the public more broadly, 'there is hours and hours of work behind the scenes that we have to do on top of seeing patients which I don't think is always appreciated' (Nurse Manager4 Hawthorn Case Site). Participants experienced significant challenges to their working life, their nursing practice and their personal and professional well-being. While some thrived on the opportunities that workplace changes associated with the COVID-19 pandemic offered, the majority experienced challenges and some displayed symptoms of burnout and stress.

> last year over the winter period because of all the flu clinics and COVID clinics...it came to the point where we [nurses] said, "look we can't do everything from this September, you've [GPs] got to help us out" because it was all like, "well the nurses will do all the flus again, they can keep on doing COVID clinics. Why do we need to do it?"....they [GPs] tried everything to get out of them! Towards March/April time I almost felt burnt out to be honest because of the time I'd been working.....and I hit a bit of a wall and felt that I can't continue and I feel a bit like that now. I feel a bit subdued and [it] makes me really sad. I don't know. I'm getting emotional about it [participant tearful]. (GPN9 National)

TABLE 1 National participants.

Participants	Interviewed
General Practice Nurses	12
Advanced Nurse Practitioners	8
Nursing Associate/Assistant Practitioner/ Healthcare Assistant	1
Nursing Leaders	5
Other Roles	1
Total	27

TABLE 2 Case study site and participant information.

Case site pseudonym	Deprivation decile (PHE)	CCQ rating	Number of participants at each site	General practice nurses	Nurse managers	Nursing students	Other nursing roles	General practitioners
Woodlands			4		1		2	1
Yew	Second least deprived	Outstanding	5	3	1	1		
Hawthorn	First to fourth most deprived	Outstanding	1		1			
Sycamore	Third most deprived	Good	3	1	1		1	
Total			13	4	4	1	3	1

TABLE 3 Domain A of West et al.'s (2020) ABC framework of nurses' well-being needs: circumscribed autonomy.

ABC framework		Summary of GenCo study findings	
Domains	**Work needs**	**Positive**	**Negative**
Autonomy: The need to have control over own work life. To be able to act consistently with own values.	Authority, empowerment and influence: Influence over decisions about how care is structured and delivered, ways of working and organizational culture	• Most participants had autonomy in clinical work and decision-making. • Some participants had influence over the structure and organization of their work, but this was not universal.	• Most practices and Primary Care Networks adopted a top-down approach in which nurses had little involvement. Participants felt undervalued, overlooked and unable to make valuable contributions to service design.
	Justice and fairness: Equity, psychological safety, positive diversity and universal inclusion		• Participants continued seeing patients face to face. While some felt well supported, others considered that their personal safety was not risk assessed. • Lack of technological equipment for participants • In some practices, participants were excluded from clinical meetings, 'huddles' and other aspects of support that were put on place for GP colleagues • Some participants did not receive the same IT training as their medical counterparts • Many participants did not receive pay, terms and conditions equitable with their NHS employed nursing colleagues, including pensions, maternity and sick pay.
	Work conditions and working schedules: Resources, time and sense of the right and necessity to properly rest, and to work safely, flexibly and effectively	• The pandemic enabled reflection on patient care management. Participants valued this time to reconsider how they could organize work for patient benefit.	• Participants worked for long periods of time in PPE and undertook cleaning of rooms between participants. They also sometimes had to work outdoors, in car parks and gazebos to deliver nursing care. • As the pandemic progressed, workload increased due to pressure from secondary care, community nursing and GP colleagues, as well as increased patient need. • The pace of work increased as the pandemic progressed and was unsustainable, exacerbated as nursing colleagues retired or left and practices were unable to appoint effective replacements.

Many of the challenges discussed by participants pre-dated COVID-19, sometimes by years and decades, but had been exacerbated by the COVID-19 pandemic. Consequences for the retention of both newly qualified and experienced nurses were evident as a result, with several revaluating whether they wanted to continue working in general practice and in what capacity. Others had already left general practice, taken early retirement or had reduced their working hours.

5.3 | Mapping of findings to ABC framework

West et al.'s (2020) framework identifies three domains which are of central importance to nurses' well-being: (1) Autonomy, which includes influence over decisions, working conditions and justice and fairness; (2) Belonging, which includes connection to others, feeling valued and respected, working in a nurturing workplace culture and compassionate leadership, as well as effective teamwork and shared vision and (3) Contribution, which includes being effective at delivering valued outcomes, having an appropriate workload, having access to supervisory support and a learning culture which supports educational opportunities and development. Three themes mapped to the framework are detailed below. Each is explored with a summary of findings in an associated table.

1. Circumscribed autonomy—'How much of a voice we have is controlled' (Table 3)
2. Levels of Belonging—'they didn't even realise what we were doing' (Table 4)
3. Invisible Contribution—'we're very highly skilled professionals and we make a massive contribution in general practice but it's not visible' (Table 5)

TABLE 4 Domain B of West et al.'s (2020) ABC framework of nurses' well-being needs: levels of belonging.

ABC framework		Summary of GenCo study findings	
Domain	**Work needs**	**Positive**	**Negative**
Belonging: The need to be connected to, cared for, and caring of others at work. To feel valued, respected and supported. The importance of working in nurturing cultures and climates. Having a clear, enacted and shared vision. Effective team and inter-team working.	Teamworking: Effectively functioning teams with role clarity and shared objectives, including team member well-being.	• Participants mainly felt supported by their nursing colleagues and some by their GP and practice manager colleagues. • There were opportunities to develop the ways nursing was delivered.	• Many participants felt that their GP and practice manager colleagues, as well as wider society, did not understand the role and value of nurses working in general practice. • At some practices, participants felt in-person work was deflected onto them from other members of the multidisciplinary team. • The well-being of participants was not perceived to be important and was seen as secondary to that of their GP colleagues. • At some practices, inter-team working was considered dysfunctional.
	Culture and leadership: Nurturing cultures and compassionate leadership enabling high quality, continually improving, compassionate care and staff support.		• There was a perception that it is the nature of nurses to 'just go on with the work' and absorbed the challenges of the pandemic and this led to participants being overlooked and undervalued • Participants did not always feel they were supported if they challenged other members of the wider team or during complaints processes • While some employers and organizations offered well-being support, this was often considered inconsistent and superficial

5.3.1 | Circumscribed autonomy—'How much of a voice we have is controlled'

While some participants contributed to higher level decision-making during the COVID-19 pandemic, this was mostly circumscribed within narrow confines of what were considered 'nursing decisions', rather than wider practice or higher-level contributions to service design, such as sitting on boards of 'Primary Care Networks' (groups of general practice and other local community organizations). Even within nursing contexts, managers and GP employers mainly controlled the structure of nursing work. This relates to West et al.'s (2020) assertion that autonomy is linked to nurses' ability to have influence over decisions about how care is structured and delivered, ways of working and organizational culture.

> there wasn't a voice, no, for the nurses....the final decision-making would come from the GPs. So whether or not [nursing] was valued as important at the time was based on their decision....I think we work together as a team really well until there's an issue based on a nursing problem that you're concerned about, a risk or something that you're doing, and a lack of understanding from medicine at that point shows the divide between us (ANP4 National)

While participants were responding to interview questions specifically relating to their experiences during the COVID-19 pandemic, it was apparent that, for many, the COVID-19 pandemic had laid bare and further exacerbated long-established issues around autonomy and the underpinning culture experienced by nurses working in general practice.

> We're locked up in rooms [doing QOF]. What we do is controlled. How much time we spend doing those things is controlled. How much of a voice we have is controlled..... [General practice] partners control how much education we get. Partners control how much exposure we get outside of the practice because they are frightened that if we get that exposure we might go and work somewhere else. (Other Manager1 National)

Related to West et al.'s (2020) argument that autonomy includes justice, fairness, equity and safety and inclusion, reconfigurations in models of service delivery during the COVID-19 pandemic were often considered inequitable, with participants continuing to see the majority of patients in-person while GPs worked remotely. Some nurses felt they 'were treated as cannon fodder during COVID and GPs went to all telephone calls, whereas nurses were still expected to see a lot of face-to-face appointments' (GPN12 National).

> we're in a COVID pandemic, this is new to all of us and I'd seen 30 patients today and the GPs haven't. I don't know where that decision came from, if that came from the partners, the GPs or management....I

TABLE 5 Domain C of West et al.'s (2020) ABC framework of nurses' well-being needs: invisible contribution.

ABC framework		Summary of GenCo study findings	
Domains	**Work needs**	**Positive**	**Negative**
Contribution: The need to experience effectiveness and deliver valued outcomes. The need for contribution is met when: • workloads do not exceed the capacity of staff to deliver valued outcomes. • staff have enabling supervisory support. • there are cultures of learning and accountability rather than directive, controlling cultures focused on blame. • Nurses are supported to continuously learn, develop skills and grow professional knowledge.	Workload: Work demand levels that enable sustainable leadership and delivery of safe, compassionate care	• Participants were proud of their work during COVID. They adapted to new ways of working and delivered safe and effective care for patients. They delivered COVID and flu immunization clinics, catch-up clinics (e.g. cervical cytology, long-term conditions). They worked additional hours to cover for colleagues who were on sick leave or who were isolating due to COVID.	• Many participants expressed that workload was unsustainable and had exceeded capacity. • Quality of care was impacted by the pandemic (e.g. delayed long-term conditions reviews) and pragmatically shifted aspirations in terms of patient care (e.g. prioritization on the basis of risk rather than universal) • Participants expressed experience of stress and burnout, as well as recognizing it in their nursing colleagues. • There were concerns about risks associated with new ways of working during the pandemic (e.g. safeguarding risks and risks to patients and nurses as a consequence of remote consultations • Participants felt that there was largely a top-down culture in practices and PCNs, there was sometimes a culture of fear about whether participants, because they are nurses, would be supported in times of adversity or if something went wrong and had little expectation of support in relation to nursing's professional associations.
	Management and supervision: Support, professional reflection, mentorship and supervision to enable staff to thrive in their work	• Some practices used online platforms to hold team meetings. While this was not considered to be as useful to in-person meetings, they did improve access for some team members had practical benefits such as saving travel time.	• Participants felt that opportunities for supervision and support decreased due to the pandemic because colleagues were not working in the same physical space, had to maintain social distance for each other due to COVID restrictions or where split into 'bubbles'.
	Education, learning and development: Flexible, high-quality development opportunities that promote continuing growth and development for all.	• Access to some elements of education and training was improved during COVID because it was moved online.	• In some areas, practice nurse education and training were halted leaving participants who were newly qualified nurses feeling vulnerable and unsupported. • Where education was continued, this was done differently and led to participants not experiencing the same level of support compared to pre-pandemic. They also had to adapt the training to new working practices brought about by the COVID pandemic.

think maybe sometimes we just think that GPs work by different rules. So questioning that is, I don't know, it's not something you question I don't think. (GPN3 Yew Case Site)

While participants acknowledged that the nature of their work necessitated more in-person consultations, many felt work was being deflected onto nurses, who did not have access to equipment (or training) which would allow them to work remotely, 'we couldn't get

laptops, you couldn't get cameras, so unfortunately the nurses were the ones who probably missed out' (GPN7 National). Not enough consideration was given to what work could be carried out remotely, the safety of nurses and the support they might need.

> we [did] the BAME risk assessment forms….[nurses] deemed as at risk were….re-deployed into a completely different area [and] out of their comfort zone. Near retirement. So [they] just thought, "I can't do this. I'm not being supported. They don't want me. After all my years of commitment!"….That's the word, devalued, absolutely. Yeah total lack of empathy as well (Nurse Leader1 National)

Some participants discussed not having access to well-being support such as daily huddles and clinical meetings which were in place for GP colleagues, 'They have a clinical meeting everyday but the nurses aren't invited…no, it's for the doctors' (GPN1 National). This was perceived to indicate a lack of value and fairness, 'It's not deemed that we need to go which is a bit upsetting because it almost feels like our mental health doesn't matter' (GPN9 National).

Participants also considered inequitable pay, terms and conditions, in comparison to their NHS employed nursing counterparts, to be unfair, unjust and difficult to challenge. This was felt to impact negatively on both recruitment and retention as well as being implicated in inhibiting autonomy.

> practice nurses are treated inequitably to all other members of staff in NHS pension schemes….what the pandemic did was very quickly it became apparent that these nurses are not on NHS paid terms and conditions. They [don't] have statutory sick leave. They don't have maternity leave. All of the stuff that we knew but, for me, it [the COVID-19 pandemic] brought it into complete sharp focus….and frankly it's not good enough to say to people, "you'll need to sort this out with your employer" because of that proximity of employer to employee. It's not the same as working in a Trust. There's something about that proximity and [being] a medic and a nurse and there's all that socialisation stuff that goes on that is really difficult for people to challenge….But [nurses] are the people that are going to be living in poverty in retirement, terrible. (Nurse Leader2 National)

Additional pressures brought about by the COVID-19 pandemic led to further inequities which participants often found difficult to negotiate, as this brought about tensions between the needs of patients and those of the participant, 'I've got more pressure on me doing extra clinics [to catch up post initial COVID-19 wave]. However, one big gripe [is]…I'm paid a little bit more than a phlebotomist, but when I do a phlebotomy clinic I've got to have a phlebotomist's pay' (Healthcare Assistant1 National). Furthermore, the COVID-19 pandemic had brought inequity between different professions carrying out the same work, leading to some participants feeling undervalued.

> The other things that are really not good in terms of what happened during COVID with the vaccination programme. You know GPs were getting, at one point, £25.00 per vaccination and they were giving nurses diddly squat. It was disgrace and no one is holding them to account for that.
>
> (Nurse Leader3 National)

Working conditions for participants were challenging during the COVID-19 pandemic and they had to adapt to different ways of delivering care. As the COVID-19 pandemic progressed, nursing workload increased to the point that many considered it relentless and unsustainable.

> I'm working harder now than I've ever worked with 40 years plus of nursing. My clinics I'm seeing 50 to 60 patients a day, telephone or face-to-face. I'm also doing a lot of the e-consults plus all the pathology. I rarely have a break. This is why it's so important that we get this message out there….We can't meet that demand….clinicians are having a lot more verbal abuse from patients and it all wears on your own well-being (ANP8 National)

For some experienced nurses in this study, despite having a rewarding nursing career, the future of the profession was considered to be unsustainable in its current form.

> would I recommend someone to go into nursing?…. It's not safe out there now and everyone I speak to it feels endemic. It's not just one person, it's everyone I speak to….and it makes me frightened for the future. (GPN4 National)

5.3.2 | Levels of belonging: 'they didn't even realise what we were doing'

In terms of belonging, participants, in the main, felt supported by their nursing colleagues during the COVID-19 pandemic and some considered the challenges had led to positive opportunities to negotiate ways of working differently. This reflects West et al.'s (2020) characterization of 'belonging' in terms of feeling connected, effective team working, shared vision and nurturing cultures in order to support nurse well-being.

> something that we've all agreed on in practice is that actually COVID has opened our eyes to smarter ways of working and embracing technology….and doing

> things in a different way to try and manage people's care better (GPN3 Yew Case Site)

Some practices saw the value of working to retain their experienced nurses and had taken steps to engage with individuals in order to keep them in the workforce, either in clinical or mentorship/leadership roles. The COVID-19 pandemic had created positive working relationships which employers were keen to capitalize on and this provided potential to futureproof the workforce.

> During the COVID vaccine time….we employed a lot of zero [hours] contract vaccinators, and a few of them said, "I wouldn't mind a few hours". So we knew that we were struggling to recruit so thought, "well if we bring in some of these people who want a few hours but make it very specific in practice nursing, then we're keeping their competencies"……one of them she just does baby vaccinations now, one is doing care homes…… We wouldn't have got that [without COVID-19] (Nurse Manager1 Sycamore Case Site)

However, many participants did not feel valued by their GP employers, practice managers, the media and wider society, and perceived a lack of understanding about the complexity of nursing in general practice, even among colleagues and the wider nursing profession.

> it's not highlighted nationally the value and the benefits nurses can offer, I think, as far as that more advanced practice, that specialism in diabetes, women's health, respiratory, all those long-term conditions. I don't think that's talked about nationally about what nurses can offer….I even take that as far as vaccinations…in general practice it's the nurses and that's not valued at that level. (GPN7 National)

Many felt the well-being of nurses working in general practice took second place to that of other members of the team. That participants, because they were nurses, were considered to 'just get on with the job' and absorb the challenges of the COVID-19 pandemic was considered to contribute to participants' feeling of being overlooked and undervalued.

> [During Covid] I think they didn't even realise what we were doing, that we were actually still meeting QOF requirements, still seeing people for their reviews. Still meeting our targets. Still giving really good care as much as we possibly could. Nothing slipped and I don't think they realised. I don't think they noticed. I think, with your GP colleagues, they don't notice until things go wrong, or you didn't meet the targets, or whatever it might be, and then it's [let's] have a talk about it. But I suppose we didn't complain either, we just got on with it (GPN8 National)

Participants did not always feel supported to challenge their employers or others due to the hierarchical nature of general practice and the close working proximity between nurses and their GP employers. This impacted on the level at which participants felt they 'belonged'.

> When you've got GPs who are also partners you feel like the world is against you if you do something wrong….I never felt fully safe….I always felt like, even though I wasn't doing anything wrong, my PIN was constantly at risk. COVID felt so tense. There was so much tension during COVID….So I did always feel very vulnerable….I think it just came down to a power thing. They didn't want to say they had more power but they knew that they did. (GPN2 National)

Many participants experienced and spoke of the gendered nature of nursing as related to the professional identity, visibility and value of nursing in general practice. Traits aligned with nursing as a gendered profession were referred to as becoming more significant due to the close working relationship with medicine, the proximity to medical hierarchy and the socialization between medicine and nursing.

> We tend to get pushed to the side so much [because] probably lots of reasons. We don't voice our opinions as well as other professions. We're seen as very much caring, giving, and very feminine profession. (ANP8 National)

As one participant explained, gender, hegemony and socialization interacted to inhibit nurses' voices being heard.

> I was literally sat there and I was the only [nurse], the only female and the only non-partner….I just sat there and said to them 'Five partners and me!' (Nurse Manager1 Woodlands Case Site)

5.3.3 | Invisible contribution—'we're very highly skilled professionals and we make a massive contribution in general practice but it's not visible'

This section focuses on the 'contribution' as per West et al.'s (2020) framework. There is some overlap with previous sections, where we explore the level of belonging participants felt in their working life, related to teamwork and workplace culture. However, in this section we examine the contribution of participants working in general practice, how this is perceived and understood, the levels at which participants are able to contribute, workload capacity, access to education and support from managers.

In our study, many participants had experienced increased capacity and complexity of workload which sometimes resulted in

challenges to the delivery of valued outcomes. During the COVID-19 pandemic, participants experienced additional workload stresses included taking on work usually provided by secondary care or district nursing teams or work delegated by GP colleagues. Participants were also conscious of risks associated with both new ways of working and the increase in demand and complexity of workload. This left some participants feeling vulnerable. It resulted in concerns about the support they might receive if an adverse event occurred against this backdrop, made worse as, for practical reasons, opportunities for supervision and support decreased during the COVID-19 pandemic due to remote working and physical distancing. However, the pandemic notwithstanding, general practice was not considered particularly supportive.

> [During COVID] we never saw each other to give support. There were no meetings where this could be brought out into the open. So, no I didn't feel particularly supported but I didn't expect to get huge amounts of support because that's not really the way things work is it? I don't think anyone else felt particularly supported either (ANP2 National)

Workload challenges had a negative impact on participants' well-being because this did not align with their sense of professional identity in relation to delivering high-quality care and making an effective contribution. Some participants recognized limitations in their ability to deliver high-quality care throughout the COVID-19 pandemic and some had shifted their expectations about what could pragmatically be delivered.

> Your tolerance quickly changed because when you first started you were like, "oh their HbA1c [diabetes blood test] is high, we'll get them back in", but then that would be everybody. So you think, "well actually we need to look at the one's whose HbA1C is in the 80s or 90s". And that's one of the things isn't it? Where do you prioritise? (Nurse Manager2 Yew Case Site)

Workload during the COVID-19 pandemic had increased both in terms of demand and complexity. This was described by many as unsustainable and was considered to regularly exceed capacity. This became intolerable for some and challenged a fundamental sense of self. Many participants expressed that they had experienced stress and burnout during this time and recognized this in their colleagues. Some had left general practice as a result and this continued to have a longer-term impact, 'I handed my notice in and then I just wept for two weeks'. (GPN4 National).

> I thought, "if I do continue like this, I will make a mistake" and that will be on me and I didn't want to leave it like that and I think COVID caused me a lot of anxiety, I know that. I have anxiety anyway but that was definitely exacerbated by COVID and the environment and the frustration from patients. It was just exhausting day-to-day ….So I handed in my notice. (GPN2 National)

Furthermore, participants did not generally consider nursing's professional associations and organizations to lead, support or represent general practice nursing roles, something which some participants felt strongly about as it was considered that nursing in general practice was largely isolated from, and ignored by, the wider nursing profession.

West et al. (2020) suggest that flexible, high-quality educational opportunities that promote continuing growth and development are required if nurse' well-being needs are to be met. This sits within their overarching heading of 'contribution'. Education and training opportunities changed during The COVID-19 pandemic. While some training was cancelled, other training and education moved online. This was, paradoxically, easier for some to access as it meant they did not need to be released from practice to undertake training. However, it did mean that participants could be expected to carry out training in their lunch breaks or outside their usual working hours. This again added to the increasing and unseen workload nurses were expected to undertake.

> There's been so much education that's been so much easier because if you've been at work all day you come home and you can tap into it on-line or lunchtime, that's been absolutely fantastic. Ironically it's been quite easy to maintain competence and knowledge and update yourself through COVID and it would be good if some of that is maintained. (GPN9 National)

COVID-19 pandemic restrictions meant that participants undertaking educational courses were not able to gain the usual pre-pandemic support and expertise of peers and had to learn a wider range of ways to both learn and deliver care.

> You're having to do a lot of it in your own time…. It's taking more of your time as well because you're having to learn two different ways things are done [in-person and remotely]….Doing the training amongst all that was quite difficult because you don't have that normal way that you'd shadow the clinic and understand it better because, when you're [just] reading it in theory, you don't understand it (GPN1 Sycamore Case Site)

Many participants felt ill equipped to offer challenge or engage in higher-level decision making at both practice and Primary Care Network levels. The top-down culture of most organizations prevented them from making wider contributions, as did the ever-increasing workload.

> We've got loads of ideas but, we're constantly at the grindstone, so you don't actually get a time or chance to do things and yeah we're not included. We're not at the table so we don't have a voice (GPN8 National)

Despite this, participants felt they made a valuable contribution during the COVID-19 pandemic. They were proud of what they had achieved in difficult circumstances, despite feeling nursing work went largely unrecognized, 'I loved being part of the initial immunisations. You felt you were doing something amazing. As practice nurses we've vaccinated thousands, millions and there's been no acknowledgement' (GPN 12 National). Participants' experiences during the COVID-19 pandemic appeared to underscore long-held perceptions that the contribution of nurses working in general practice was invisible, 'we're very highly skilled professionals and we make a massive contribution in general practice but it's not visible' (Other Manager1 National). There was an incongruence between their crucial, patient-facing roles, that they were needed more than ever and their adaptability and skill in meeting the challenges brought about by the COVID-19 pandemic, and the profession of nursing not having appropriate recognition. This, together with lack of support, lack of control and influence and increasing workload demands, along with broader experiences of living through the COVID-19 pandemic, had led some to re-evaluate their perceptions of nursing and the future of the general practice nursing workforce more broadly.

> I think because the pandemic was such a life changing experience for everybody it makes you question where you are within your life and whether or not this is what you want to be doing? And I think, particularly for nurses, if there's lack of support or they felt they're being put into a risky situation, then that adds to that question…So, yeah I think it will affect recruitment and retention long-term (ANP4 National)

6 | DISCUSSION

This paper reports findings from the GenCo Study which focus on the well-being on nurses working in general practice during COVID-19. By mapping findings to the ABC framework of core nursing needs for professional well-being: autonomy, belonging and contribution, we highlight that the COVID-19 pandemic had a significant impact on the well-being of nurses working in general practice and the workplace factors which contribute to negative effects on well-being. That the data were 'messy' and complex and could be carved up in ways which were crosscutting, reflected the multifaceted nature of the elements underpinning professional well-being of nurses in this space. This study offers insight into this complexity and suggests that potential ways of addressing this will also necessarily require a multifaceted approach. While there were some benefits and opportunities afforded by the COVID-19 pandemic, negative aspects had implications for this skilled, highly educated and experienced workforce, for retention of nurses working in general practice, the sustainability of the profession of nursing more broadly and, as a consequence, impact on care quality and patient safety. Areas have been highlighted which indicate where attention needs to be paid in order to support the well-being of nurses working in general practice moving forward.

The negative impact of the COVID-19 pandemic on nurses' well-being across different contexts has been reflected in the United Kingdom and internationally (Couper et al., 2022; Maben et al., 2022; Rogers et al., 2022; Tokac & Razon, 2021) and has long-term effects which cannot easily be resolved (Maben et al., 2022). Issues relating to nurses working in general practice, and primary healthcare workers more generally, are echoed in international studies. For example, lack of support, both professionally (Ayaslıer et al., 2023; Halcomb, Fernandez, Ashley, et al., 2022; Halcomb, McInnes, et al., 2020) and from the public (Ashley et al., 2021; Ayaslıer et al., 2023), psychological distress (Aragonès et al., 2022), depression, anxiety and stress (Ashley et al., 2021; Halcomb, Fernandez, Mursa, et al., 2022) lack of fairness (Mizumoto et al., 2022) and feeling undervalued (Ashley et al., 2021; Halcomb, Williams, et al., 2020; Russell et al., 2022) have been identified in primary healthcare professionals, including nurses, in a range of primary care contexts. Similarly, an international systematic review of general practitioners' well-being during the COVID-19 pandemic identified a negative effect on psychological well-being (Jefferson, Golder, et al., 2022). However, the COVID-19 pandemic affected different primary care professionals in different ways, with lack of autonomy and feeling unappreciated being important contributors to burnout in primary healthcare nurses (Ayaslıer et al., 2023). This paper highlights how, as well as sharing commonalities with the international literature, nurses working in general practice in England face specific issues.

Our study indicated that the COVID-19 pandemic had laid bare significant underlying cultural and structural issues. This related to workplace dynamics, how work was organized and delivered, hierarchical relationships and longstanding socialization practices between medicine and nursing, which were complicated by the proximity of GPs, who were also employers. Perceived injustice, lack of fairness and inequity, as well as lack of recognition and value were all brought to the fore by the COVID-19 pandemic. This made participants question whether general practice, and even the profession of nursing, was one in which they wished to remain, or encourage people to join. While some of these issues are associated with the idiosyncratic nature of the structure and ownership of general practice in England (where general practitioners are also employers), there were some international commonalities. In a study exploring the psychological well-being of primary care nurses in Australia, Ashley et al. (2021) found that nurses felt undervalued by their employers and were not involved in decision-making during the COVID-19 pandemic. It is of note that doctors hold dual roles as employers and medical colleagues in some Australian primary healthcare settings, reflecting some of the structural issues faced by nurses working in general practice in England.

Participants in our study perceived that much of their work during the COVID-19 pandemic was invisible, not valued and unrecognized and this has been reflected elsewhere. An Australian study of primary care nurses called for greater recognition of their value (Halcomb, Williams, et al., 2020), while a study of general practices in England during the COVID-19 pandemic (Russell et al., 2022) identified that participants felt vulnerable and overlooked, with their GP employers perceived to place less value on the safety of nurses than on GPs. In our study, additional nursing workload brought about by the COVID-19 pandemic of was considered to go unseen, while the ways nurses engaged with education also changed, leading to additional invisible work which, alongside other unseen work of nurses, added to a perceived lack of recognition. The Sonnet Report into the role and value of nurses working in general practice in England indicates that the importance and centrality of these highly skilled nurses to the delivery of general practice care is little known and, as a consequence, undervalued (Clifford et al., 2021). However, in our study there was some evidence that employers were beginning to recognize the value to retaining experienced nurses in some form within general practice indicating there is potential for progression of positive and proactive retention strategies going forward.

Our study indicated that the well-being of participants was negatively affected by value incongruence. That is, personal and professional values are central to motivation for nurses and if these values are not aligned with what they can pragmatically deliver, this can result in chronic stress and burnout, as well as negatively impacting on patient safety and recruitment and retention (Dunning et al., 2021). Changing working practices brought about by the COVID-19 pandemic were considered to have impacted on fundamental nursing work, such as long-term condition management, both in our study and elsewhere (Ashley et al., 2022; Halcomb, Fernandez, Ashley, et al., 2022). Indeed, an increased rate of non-COVID-19 mortality has been associated in a reduction in routine diabetes care during the COVID-19 pandemic (Valabhji et al., 2022), reflecting the professional conflict some participants in our study felt about the way care had been delivered and prioritized. Concerns around risk and fears of making a significant mistake associated with changed general practice working practices during the COVID-19 pandemic are identified in our study and mirrored elsewhere (Wilson et al., 2021). Furthermore, reduction in support and supervision during the COVID-19 pandemic may affect nurses' satisfaction with their work (Halcomb, Fernandez, Ashley, et al., 2022). These factors all have implications for both well-being and retention.

The importance to their professional well-being of nurses being involved decision-making at practice and higher strategic decision-making levels was clear in our study and reported previously (Halcomb, Williams, et al., 2020). This is because nurses themselves understand how their work is done, rather than their work-as-imagined by others who make decisions (Leary, 2016). The exclusion of nurses' voices from national decision-making around the COVID-19 pandemic has been identified more broadly (Rasmussen et al., 2022). Similarly, pre-pandemic, there were a lack of nurses holding strategic level decision-making positions and nurse-led general practices, with only 1.6% of nurses working in general practices holding partnership positions (Bhardwa, 2016). Our study indicates that for nurses to engage in higher-level decision-making, structural and cultural issues such as making space for, and gaining, 'a seat at the table', addressing gender imbalances and healthcare hierarchies and hegemony, support to gain the skills to effectively contribute, and the time and headspace to make a contribution, are required in order for this to be effectively realized. However, the gendered nature of nursing has long been implicated in the lack of professional recognition of nursing (Davies, 1995) and the leadership skills of nurses continue to be discounted (Mitchell, 2022).

General practice more broadly continues to face ongoing challenges post-pandemic. Like the nurses in our study, general practitioners experienced stress and burnout which has implications for GP workforce retention (Jefferson, Heathcote, & Bloor, 2022). That both nurses in general practice and general medical practitioners face such pressures is significant considering both professions are experiencing recruitment and retention crises. Recent projections by The Health Foundation (2022) predict that one in four GP and general practice nursing posts in England are likely to be empty by 2030–31 (up to one in two in their more pessimistic scenario). This led them to express 'serious concerns around future primary care provision in terms of patient safety, the quality of care and equity of access'.

Addressing support needs of primary care nurses has been identified in assisting retention (Halcomb, Williams, et al., 2020). It is therefore important to address factors associated with well-being and retention and to consider the specific needs of nurses working in general practice. While we do not make claims to representativeness, this paper sets out the ways in which the COVID-19 pandemic has impacted on experiences of nurses working in general practice and, in doing so, indicates specific issues faced by, and the support requirements of, this group of professionals. To this end, we set out some considerations for future practice (Box 2).

6.1 | Strengths and limitations

Due to COVID-19-related delays in starting data collection, and the subsequent shortened data collection timeframe, we were unable to follow the original study protocol (Anderson et al., 2022). This limited the range and number of participants recruited to general practice case sites. We had not fully anticipated the negative impact of ongoing restrictions, and increased demand, related to the COVID-19 pandemic on primary care and our access to 'case site' study participants. This meant we were required to change our sampling strategy and some methods of data collection. We pragmatically adapted the study design to interview a variety of participants working in general practice nursing positions throughout England and we recruited nurse leaders associated with general

BOX 2 Key factors to consider post-pandemic.

Nurses working in general practice should be involved in key decision-making at senior levels (practice, local and national levels) about adapting and developing new ways of working. Nurses themselves understand how their work is done, rather than their work as imagined by others who make decisions. This shift towards embracing nurses as decision-makers will require structural and cultural shifts in general practice relationships and support for nurses to work confidently at this level.

The role and value of nursing in general practice should be recognized by colleagues and employers, as well as by the media and public more generally. The nursing profession, and its professional organizations and associations, have a role to play in promoting and supporting nursing in general practice and strengthening the voice of nurses.

Nurses working in general practice should be provided with the technological equipment and training to further develop ways of working established during the COVID pandemic on an equal basis to others in the practice. This means having access to the means to conduct consultations in ways which are effective for their patients and support their own personal and professional circumstances. Timetables should be adjusted to allow for extra work associated with new ways of working and additional 'invisible' nursing work, including education and training.

Opportunities for nurses to work differently, for example, consulting with patients remotely or offering flexible contracts, can be further developed in order to promote positive working experiences for nurses and improve access for patients. Such initiatives may support nurses to continue working in general practice.

Recruitment and retention need to be strategically addressed. Pay, conditions and pensions equitable to, and competitive with, nurses directly employed by the NHS may address some recruitment and retention issues. Addressing pension abatement issues may also help retain some nurses in some capacity within general practice. Innovative ways of retaining experienced nurses in general practice at some level (e.g. in supporting and mentoring nurses new to general practice, focusing on a single aspect of care provision, flexible contracts) may all contribute to retention.

Support from practices, and other groups such as Primary Care Networks, as well as nursing's professional associations and national leadership, to develop strategies to prevent and reduce stress and burnout among nurses working in general practice is necessary in order to retain the skills, longer term, of this highly qualified professional group.

HEIs and educational institutions will need to adapt teaching to reflect new and hybrid ways of working and learning

practice. On reflection, while the study was not completed as intended, our adaptation of the study design ultimately strengthened our study as we were able to analyse data from nurses with a broad range of experience and a variety of roles across England. From this, we were able to identify shared experiences and themes across contexts. Using the ABC framework (West et al., 2020), may enable organizations to recognize key factors which they can choose to use to provide support for their general practice nursing workforce. We would have liked to have recruited a wider range of participants in terms of ethnicity and role (i.e. more representation of healthcare assistants/nursing associates as their work differs from that of registered nurses) as this would have further enhanced our study findings.

7 | CONCLUSION

Nurses working in general practice experienced significant challenges to their working life, nursing practice, and personal and professional well-being during the COVID-19 pandemic. While some embraced opportunities that workplace changes associated with the COVID-19 pandemic offered, the majority experienced challenges and some displayed symptoms of burnout and stress. Many experiences predated the pandemic, sometimes by years and decades, but had been exacerbated and laid bare by the pandemic. Many nurses did not have recognition, a voice or a seat at the decision-making table. Structural and cultural issues such as medical hegemony, socialization within healthcare hierarchies and the gendered nature of nursing contributed to this, as did lack of time, emotional headspace and confidence to contribute. These issues have implications for retention of newly qualified and experienced nurses and for the future of nursing in general practice.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE): (1) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data, (2) drafting the article or revising it critically for important intellectual content.

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DATA AVAILABILITY STATEMENT

Data available on request from the authors: the data that support the findings of this study are available from the corresponding author upon reasonable request.

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