‘Non-medical practitioners’ within the skill-mix

A journey through some evidence

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Setting the scene

A note on nomenclature and positionality

- Plethora of individual job titles

- Grouped titles:
  - medical associate professions
  - non-medical practitioners/clinicians
  - mid-level practitioners' advanced practitioners

- Positionality:
  - 'advanced practice'
  - 'assistants/associates'
  - 'mid-level'

National policy / workforce context

There is a clear need for the NHS workforce to continue to grow and evolve. There were over 112,000 vacancies across the NHS workforce in March 2023 (an 8% vacancy rate) but with significant variation across regions and professional groups.

Some of the key roles for expansion are identified in Table 3, and examples of how they can be used are detailed below. The assumed impact of these roles is based on a combination of literature review, case studies and clinical and professional engagement.

Table 3: Key roles for expansion

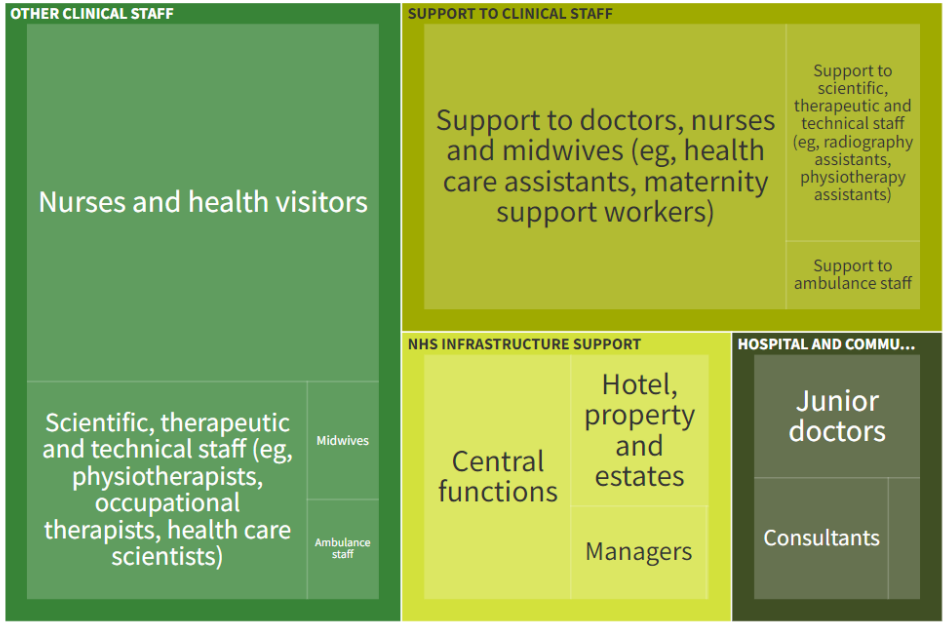
Roles	Estimated supply by 2036/37
Nursing associates	64,000
Physician associates	10,000
Anaesthesia associates	2,000
Advanced practitioners	39,000
Approved clinicians (mental health)	1,000
Roles covered by further expansion of primary care MDTs	15,000
Roles covered by primary care nurse expansion	5,400

73. Expanding these roles will release time for more experienced clinical professionals to provide the training and care delivery that only they can do. When implemented successfully, these roles can increase productivity by ensuring there is sufficient workforce capacity, making reliance on temporary staffing less likely.

NHS England » NHS Long Term Workforce Plan

Nurses and health visitors are the largest staff group, followed by support to doctors, nurses and midwives

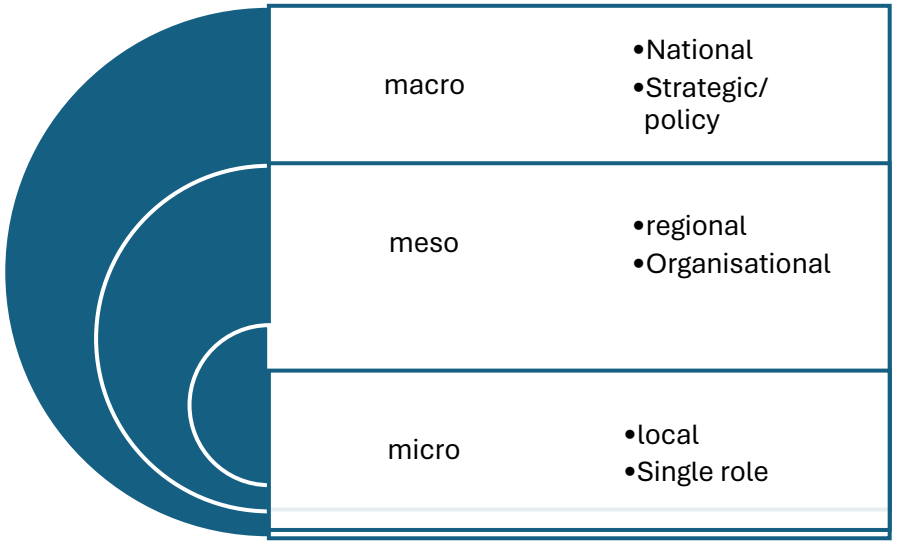
Full-time equivalent (FTE) staff by staff group

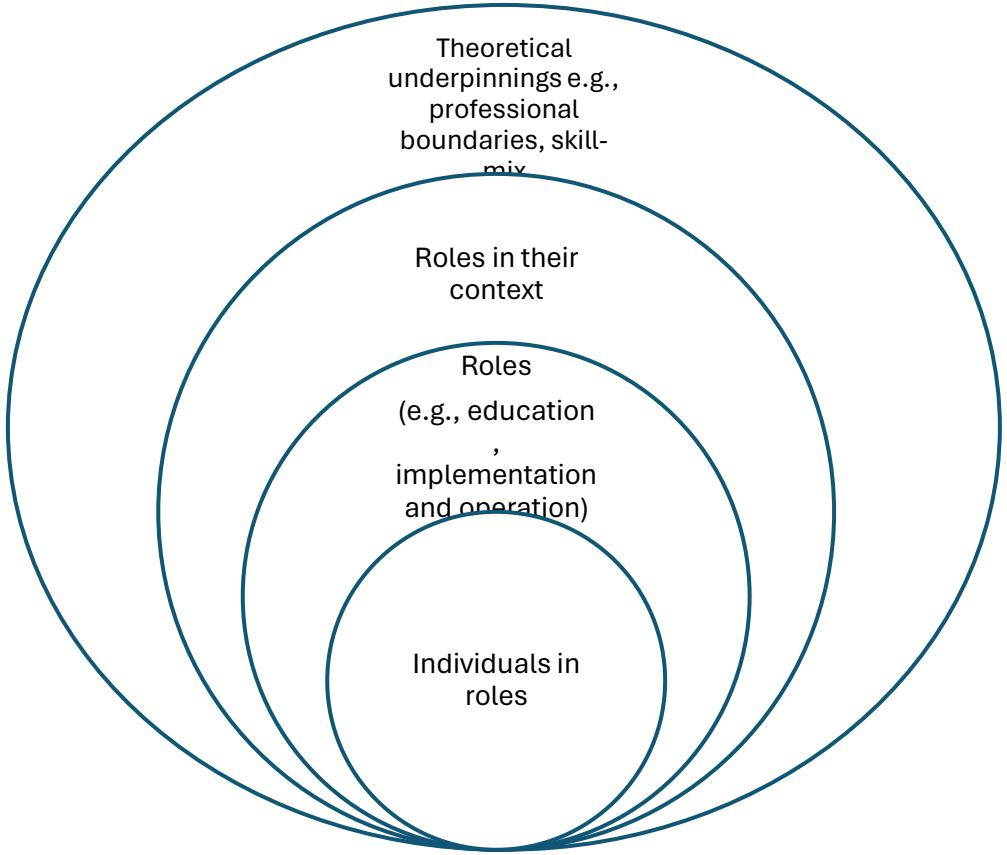


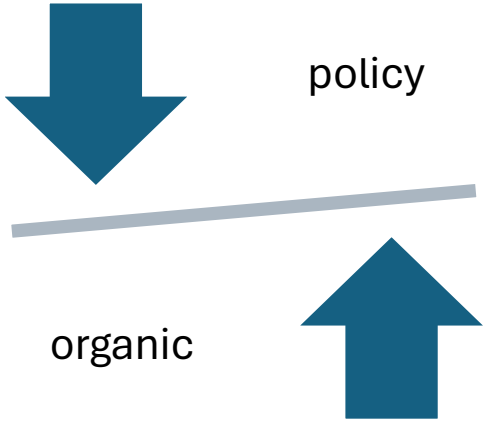
Source: NHS England (2024)

NHS Workforce Nutshell | The King's Fund (kingsfund.org.uk

Ways of looking at 'non-medical practitioner' roles







Skill-mix: definition

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Table 1.1 *Definitions: skill-mix and its typologies*

Term	Definitions and examples
Skill-mix	Changes to the skills, competencies, roles or tasks within and across health professionals and health workers (including community-based workers, peers, informal caregivers) and/or teams
Skill-mix typologies	
1. Re-allocating tasks	Task-shifting (other terms: delegation, substitution) between physicians, nurses, pharmacists and other providers. Examples include: nonmedical prescribing of medicines, diagnosis performed by advanced practice providers, screening performed by nurses or pharmacists
2. Adding new tasks/ roles	Supplementation of tasks or add-on of new roles that did not previously exist or were not routinely provided. Examples include care coordination role, patient navigator, eHealth monitoring, health promotion role
3. Introducing or changing teamwork	Changes to the (way) of collaboration between at least two professions or more. Examples include shared care provided jointly by physicians and nurses and multiprofessional collaboration

Source: Based on and modified from the following sources (Buchan & Dal Poz, 2002; Friedman et al., 2014; Laurant et al., 2005; Sibbald, Shen & McBride, 2004).

Skill-mix Innovation, Effectiveness and Implementation: Improving Primary and Chronic Care (who.int)

Our evidence journey

Evidence this presentation is informed by

Roles studied:

- Nurse practitioners in primary care
- Nurse case managers
- Emergency Care Practitioners
- Physician assistants (primary care)
- Physician Associates (secondary care)
- Physician Associates (national expansion programme)
- Medical associate professions
- Advanced Clinical Practitioners
- Non-medical practitioners in the Emergency Department skill-mix

Physician assistants in primary care

Investigating the contribution of Physician Assistants to primary care in England - NIHR Funding and Awards 2010-2013

Design: The overall evaluative framework examines the impact PAs make to the effectiveness, appropriateness, efficiency, acceptability and costs of primary health care

The study had two elements:

- Macro /Meso level
  - 1) a rapid review of empirical evidence
  - 2) a national scoping survey of senior key informants from departments of health, professional, regulatory, commissioning, and patient organisations
  - 3) a survey of PA activity in general practice via UKAPA and known PA employing practices
- Micro level
  - 4) a comparative case study of 6 general practices
    - a) Semi structured qualitative interviews of practice staff and workload survey diaries
    - b) A sample of anonymous electronic patient records examining case mix and volume
    - c) Patient survey and semi-structured qualitative interviews
    - d) Video recorded observations of a sample of same day appointment patient consultations by PA and GPs
    - e) practice papers/reports on performance and resource use.

Physician Associates (secondary care)

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- Investigating the contribution of physician associates (PAs) to secondary care in England: a mixed methods study - NIHR Funding and Awards

2015-2018

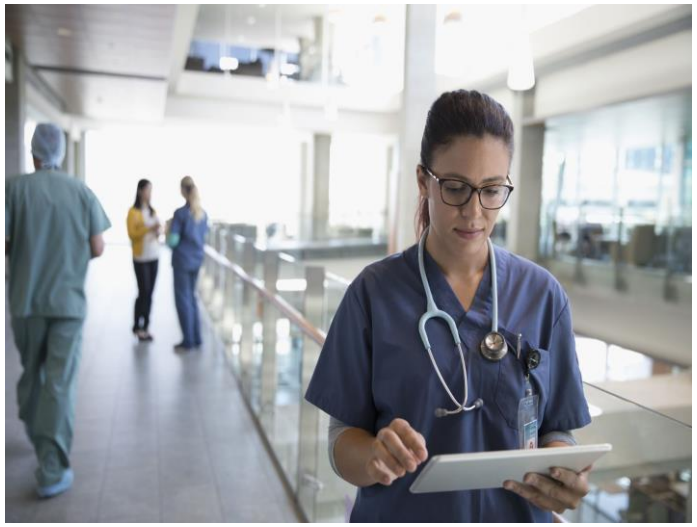
Aim: to investigate the contribution and impact of including physician associates (PAs formerly known as physician assistants) to medical teams on the organisation and delivery of patient care in hospitals in England.

interlinked research work-streams:

- Work stream I investigates the extent of the employment, deployment and role of PAs in hospital medical teams using two electronic surveys; one to medical directors of NHS acute Trusts and the other to PAs through their professional organisation.
- Work stream 2 investigates evidence of impact and factors supporting or inhibiting the adoption of PAs through a systematic review and policy review.
- Work stream 3 undertakes a more detailed investigation in four different types of hospitals each employing between 4 and 20 PAs in different specialties. These case studies include a) interviews with patients, managers, team and service members, b) analysis of routine management data and reports, c) observation of PAs at work and PA diaries of their activities, and d) a comparative analysis of patient outcomes and costs between consultations with PAs and doctors in the minors section of the emergency department.

SkillMix-ED

Skill mix in the emergency department research



Microsoft 365 image

SkillMix-ED is independent research funded by the National Institute for Health Research (NIHR Health Services and Delivery Research, NIHR131356 - Implementation of the non-medical practitioner workforce into the urgent and emergency care system skill-mix in England: a mixed methods study of configurations and impact.) The views expressed in this publication are those of the author(s) and not necessarily those of the NHS, the National Institute for Health Research or the Department of Health and Social Care."

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- **2021-present**

Aim:

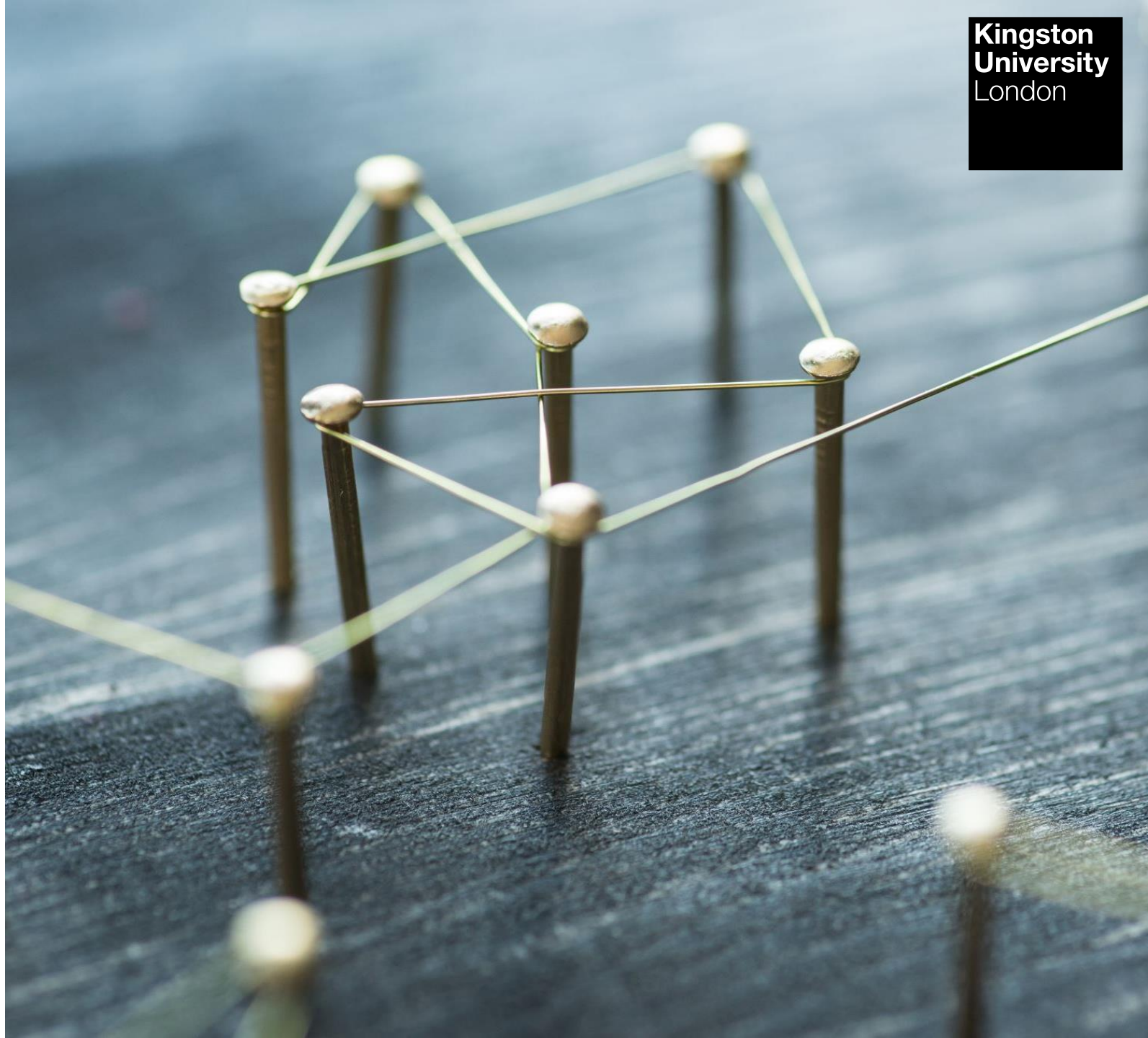
- To explore how NMPs are being deployed and the impact of different skill-mix including NMPs in EDs and UTCs on patient experience, quality of care, clinical outcomes, activity, staff experience and costs in acute NHS trusts in England, in order to inform workforce decisions of clinicians, managers and commissioners.

Questions (on NMPs in EDs/UTCs):

- What is the research literature and policy evidence regarding effectiveness, acceptability, levels of supervision and independence?
- What is the current workforce profile and what strategic aims exist for its development?
- **How independently or with what level of supervision do NMPs work?**
- **What is the impact of different NMP skill-mix on patient and service processes and outcomes?**
- What recommendations can be made to inform clinicians and managers in deciding skill-mix that includes NMPs in staffing EDs and UTCs in NHS acute hospitals?

Implementation of the non-medical practitioner workforce into the urgent and emergency care system skill-mix in England: a mixed methods study of configurations and impact. - NIHR Funding and Awards

Evidence threads



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Thread 1: Drivers/facilitators

- National policy:
  - Rising patient ‘demand’ coupled with workforce shortages
  - New workforce available, e.g., advanced clinical practitioners
  - e.g., decisions on PA numbers in primary care

- Local:
  - Context-specific strategic goals, e.g., workforce shortages, commitment to roles
  - Role of champions and/or opposition

- Individual:
  - Career advancement, niche roles, control over decision-making, quality of care, advancement of a profession

Thread 1: Drivers: example quotes

"It's [employing NMPs] *just a new way to bring capacity into the system, and we desperately need it."* Participant 6, national, policy

"Unless they're going to suddenly train a whole load of medical students to become doctors, but that's going to take five years, ten years, even if the numbers went up. You've got to think about it differently. You've got to stop thinking hierarchy and think about, if you're a patient and you're ill, who is the best person to treat you, and who can you get to see the patient, and who is available to see the patient?'' Participant 10, regional , sub regional , clinician.

"..a lot of it is probably to do with whether there's someone in senior management wanting to champion that [NMPs] *as a kind of way of improving the workforce. .....someone who's moved from somewhere else where they've been doing that, and then there's kind of like a snowball effect I think sometimes..... they take that idea with them"*. Participant 11, national, lay.

SkillMix-ED study

Well we didn't have a choice. We were so short on junior doctors that it made sense to hire a PA who can do some of the basic roles..

(ID 172) PA secondary care study

Thread 2: quality and safety

- Comparative elements:
  - Non-inferiority found on quantitative comparisons of practitioners versus usual providers on standard measures e.g., re-consultation rates in primary care or at the ED
  - Primary care – video recorded consultations blind judged to be appropriate, competent, and safe
  - Secondary care – chart documentation blind reviewed as ‘appropriate’ or ‘with no errors or omissions that resulted in significant probability that the patient might be harmed’ for most cases

Thread 2: quality and safety

- Qualitative elements:
  - Providing continuity and stability
  - Freeing up junior doctors for training
  - Relieving the medical workload
  - Bridging medicine and nursing

but.....

"I'm kind of new to the ward but acting as a senior as I'm having to okay certain stuff without seeing a patient myself.
(ID058, Foundation Year doctor)

Doctors' qualitative views in PAs in secondary care study

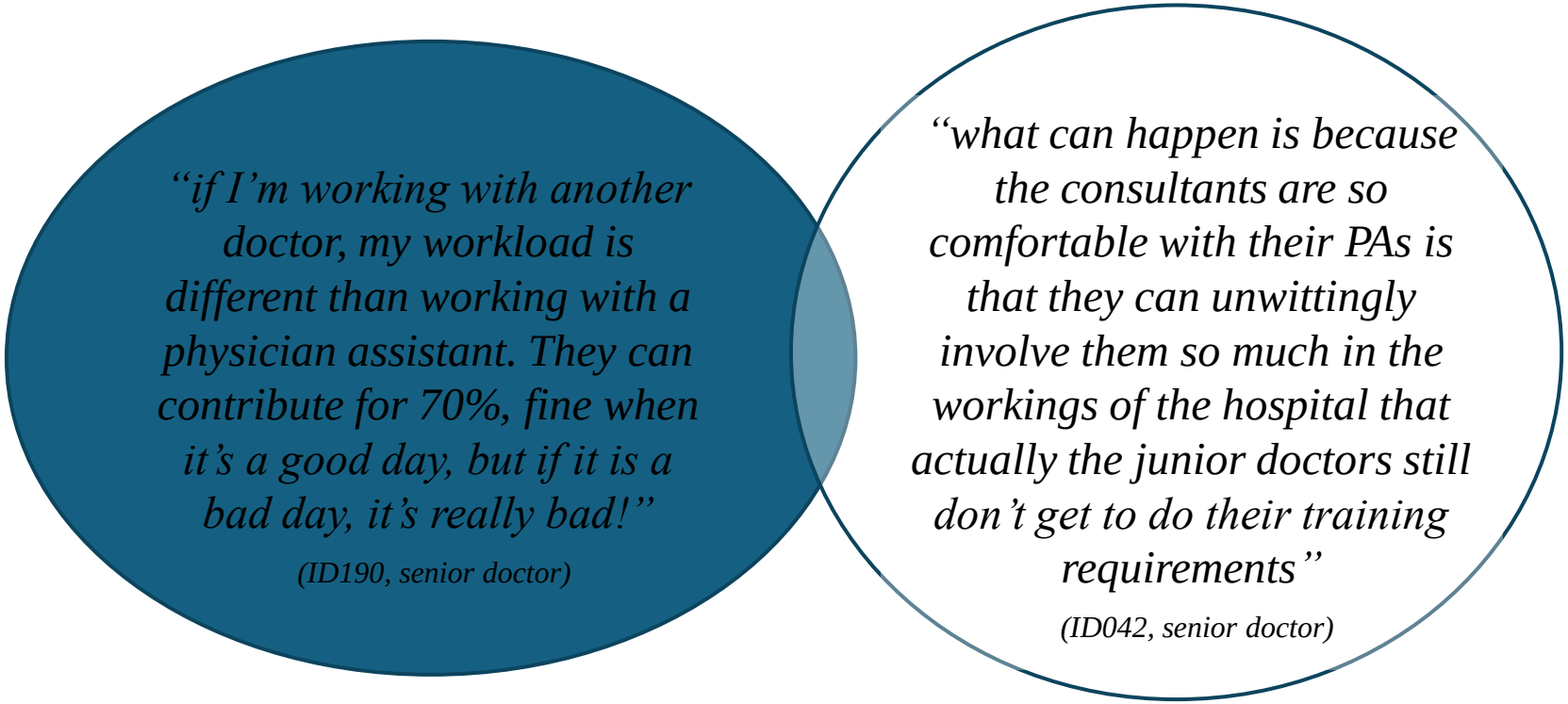
Thread 3: Mixed views & contested boundaries

- Confusion in role and professional identity
- Evidence of negotiated, accepted and contested boundaries of jurisdiction - covert and overt resistance, e.g.,

"If it's a doctor, they often help but if it's a nurse doing independent work, they're not for it … For example, a doctor finishes a consultation, they come, they take the patient out. But if I finish a consultation, I have to push the wheelchair out of the room. They won't help." (ACP 2)

"You can impinge on historical people doing particular roles … There can be disputes around who should be doing it, whether it is a nurse etc … And you have to take people on that journey with you." (ACP 7

Thread 3: Mixed views & contested boundaries



PAs in secondary care

Thread 4: scope of practice and regulation

- Lack of regulation
- (and attendant lack of authority to prescribe medicines and order ionising radiation)

- Observed and described:

- variability and workarounds
- double handling for task management
- who is responsible?
- chief inhibiting factor to PA employment

"*Prescribing is the Achilles' heel of the physician associate; not being able to prescribe has meant that their essential contribution of hours has been less than we would have wanted it*." ID 48 senior clinician PAs in secondary care

It's a real hindrance, because somebody's then got to do it……the PA's doing all the discharge planning ….so then has to wait for a junior doctor to come along and do it. They've got the clinical knowledge to do that…..that's something that we must get in place for them." (ID 185)

Thread 4: Regulation

- Patient safety boost as medical associates to be regulated - GOV.UK (www.gov.uk)
- Future regulation of PAs and AAs - GMC (gmc-uk.org)
- Advanced practice review - The Nursing and Midwifery Council (nmc.org.uk)

Thread 4: staff, patient and public role understanding

- Overall, patient participants did not clearly understand the PA role; most were not aware they had met a PA:

e.g., PAs in secondary care *"I've heard of it but I don't know what it means"* ID064 patient

- Individual staff approaches vary; where clear explanations were observed or described, patients often still referred to staff as doctors

- Organisational approaches / responsibilities differ

"I presumed that he was a fully-qualified doctor yes his approach and everything was absolutely 100%, that is what, particularly an older person likes, you know what I mean? Yes, to feel that they care yes and that's how you felt with him". ID120 patient

e.g., organisational commitment

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BIG Splash

NHS

Interim Management and Support

Partner focus...

[redacted] NHS Trust have recently begun introducing Physicians Assistants (PAs) into their hospital. [redacted], the Chief Executive of the Trust, has asked his clinical staff to share an article with NHS IMAS relating to this work.

Acute Hospital Trusts in the United Kingdom continue to face challenges in providing a high quality service to patients whilst also coping with a reduced junior doctor workforce[1,2].

[redacted] NHS Trust faced this challenge on the wards and from the increasing demands on Emergency care and acute medical admissions. Average waiting times, particularly for ambulatory patients had been increasing and rota changes were required to bolster the medical on-call team. Such changes could reduce ward continuity and affect patient experience. One solution was in the recruitment of Physician Assistants (PAs) working in Medicine.

"Physician Assistants are a new healthcare professional who, while not a doctor, work to the medical model with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and, or general practice team under defined levels of supervision" (Department of Health[3]). They are permanent staff members not assigned to medical rotations and as such can offer a continuous presence within the medical team.

Evaluations of employing PAs elsewhere, suggests that staff are often unaware of the role, skills and limitations of the PA. Successful integration requires pre-employment planning to gain positive engagement of all staff[4]. A pre-employment survey at [redacted] concurred with these findings with only 55 percent of staff having a clear understanding of the role.

Despite this, 63 percent and 57 percent of staff saw a potential to reduce workload on both the wards and medical take.

[redacted] employed six Physician Assistants in June 2013; two in Acute Medicine; two in Acute Geriatrics; one in Cardiology and one in Respiratory Medicine. Whilst their individual job plans differ within specialty, each is ward based and works a standard 40 hour working week. The PAs in Acute Medicine attend morning ward rounds and have dedicated sessions in ambulatory assessment and on the medical take. In addition to assessment, the Acute Geriatric PAs provide support to the Older People's Advice and Liaison Service (OPALS).

A perception among doctors is that the August changeover can affect patient care and safety[5] and indeed mortality is

[redacted] Chief Executive, [redacted] NHS Trust

higher on the first Wednesday in August[6]. Feedback from our Foundation Year One doctors suggests that the transition to working life was and could be significantly eased by the presence of PAs.

Minor teething issues were similar to those experienced at other Trusts, including consequently unfounded concerns about reduction of training opportunities for juniors[4]. [redacted] has developed integrated teaching

continued on page 6 »

Thread 5: independence, supervision and interdependence

- Varying levels of supervised or autonomous working - individual, role, organisational policy and setting differences
- Hidden costs of supervision for senior clinicians
- Accreditation commitment

- Work in progress in SkillMix-ED study to measure against objective criteria

Thread 5: interdependent teams

- How do we extract the individual role from the team to measure costs and consequences?

- Dependencies:
- - setting
- - case-mix
- - local policies

> *"ACPs are not cheaper than middle-grade* [doctor] *counterparts; that's not true. In fact, ACPs are ever so slightly, for hour-for-hour of direct patient care, slightly more expensive. However, when you compare that to a locum, which is your only real other alternative to that* [middle grade doctor] *workforce, [ACPs] are considerably less financially burdensome".*
>
> Participant 1, regional, clinician, manager SkillMix-ED study

- Skill-mix and independence as key variables

The contemporary climate for this evidence

- Unprecedented demand on services
- All grade doctor strikes
- Public and professional debate…….

GP practice stops employing physician associates after patient death - Pulse Today

Social media ……..

BMA position statement on physician associates and anaesthesia associates

Questions

- How / does the evidence to date support managerial decision-making?
- How is evidence heard in the context of rapidly evolving public views/ professional bodies' position statements, etc.?
- What answers are sought for by those planning and delivering services and how can research/ers deliver those?