

Case studies – Reshaping the workforce to deliver the care patients need

Case studies appendix
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In association with



About this appendix

Having the right number of appropriately skilled staff is a critical determinant of the quality and efficiency of health care. Yet there is a growing gap between patient needs and the skills and knowledge of the workforce that cares for them. The Nuffield Trust report *Reshaping the workforce to deliver the care patients need*, which was commissioned by NHS Employers, aims to give practical guidance and help to those wishing to reshape their workforce; identify key enablers and obstacles to change, with lessons for local leaders; and produce recommendations for national and local bodies about key actions to support change. The report draws on a review of relevant literature, interviews with a wide range of stakeholders, a survey of local Health Education England leaders and a number of short case studies. This appendix provides further detail on each of the case studies summarised in the main report.

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1. Bradford District Care NHS Foundation Trust: band 4 associate practitioners in community mental health teams

Context

Bradford District Care NHS Foundation Trust provides mental health services, learning disability services, community health services and dental services. It has nearly 3,000 staff over 200 in-patient beds and serves Bradford, Airedale, Wharfedale and Craven. The trust comprises hospital care settings as well as five community properties.

Drivers for change

The overarching driver for employing band 4 associate practitioners in community health teams was the realisation that those with mental health needs were not receiving adequate physical health checks. Evidence showed that people with serious mental illness die up to 20 years younger than the general population. This led to the introduction of Commissioning for Quality and Innovation (CQUIN) payments for improving the physical health care of people with severe mental illness. Secondary care organisations now receive payments for demonstrating full implementation of appropriate processes for assessing, documenting and acting on cardiometabolic risk factors in patients with psychosis.

In addition, on 1 April 2014, new shared care guidance gave secondary care services shared responsibility for assessing and monitoring the physical wellbeing of patients taking antipsychotic medication – which was previously the responsibility of primary care:

“The clinics were set up because the GPs do not have total responsibility for the physical health checks for this population any more.”

(Mental/physical health lead, Bradford District Care)

Bradford District Care, like other mental health services in secondary care, had to find a way to carry out these physical checks within their service. Leaders recognised that this could not be done with existing team capacity. Therefore, new staff would need to be recruited:

“We looked at what skill would be needed in order to deliver the physical health check element...and after reviewing a number of job descriptions and things decided that actually we could go for something different, we didn't need a qualified nurse, but we

needed somebody that was competent and able to take physical assessments such as ECG, phlebotomy etc.” (Service manager, Bradford District Care)

Role overview

Associate practitioners are responsible for carrying out physical health checks on patients who have been prescribed antipsychotic medication for the first time; those on a high dose of antipsychotic medication; and any patient who is referred from the community mental health team caseload. The content of the checks is set out in Box 1.1.

Box 1.1: Associate practitioner core competencies for physical health check

- Temperature taking – tympanic
- Heart rate recording
- Respiratory recording
- Blood pressure recording
- Oxygen saturation/pulse oximetry
- Height recording
- Weight recording
- BMI recording
- Peak flow recording
- Obtaining a standard urinalysis
- Obtaining a catheter specimen of urine
- Obtaining a 24-hour urine sample
- Use of the Malnutrition Universal Screening Tool (MUST)
- Blood tests
- Carrying out an ECG

The results of the tests carried out are shared with the patient’s GP. This information is shared electronically for those patients who are discharged from an in-patient bed. Work is underway for this information to be shared electronically from the clinics in the community – it is currently posted. Electrocardiogram (ECG) results are interpreted centrally by a local GP (based at The Ridge Medical Centre, Bradford), enabled through a service-level agreement (SLA).

Four associate practitioners are working in community mental health teams based across the five community sites. A physical health/wellbeing clinic has been set up on each site. The practitioners carry out the checks on a full-time basis. It usually takes 2 to 3 appointments to complete the check and they are undertaken over a 12-month rolling period for all eligible patients (although new referrals on antipsychotic medication are prioritised).

Implementing the role

The new approach was led by Bradford District Care’s mental/physical health lead. Prior to this, the lead was seconded to primary care to assess how physical health checks were carried out by GPs and to develop a Mental Health Physical Review template.

Raising awareness

Internally, team meetings were important for introducing the role. The associate practitioners also hold their clinics alongside the psychiatric clinic, and that visibility

helped to raise awareness. The practitioners also liaise with GPs regarding test results and follow-up care, so GP awareness and understanding of the role was very important. This was achieved through ongoing communication supported by established relationships between the community health teams and local GPs. Associate practitioners also enter the results of the physical health check onto the IT system used by GPs (SystemOne) to allow easy access to the results, and their own RIO system – securing good working relationships with GPs.

The trust did not raise awareness of the new role with patients. Doctors and the care coordinator explain the service at the point of referral, reducing any risk of fear or anxiety among patients. Associate practitioners wear the same uniform as qualified nurses and staff do not make a significant distinction between the roles to the patient.

Needs assessment

The trust thought hard about what was needed to carry out the physical health checks. Using the Calderdale framework, they developed a list of competencies and took the decision that band 4 staff could be trained to carry out the health checks. Other alternatives were considered, but it was felt that certain tasks (such as liaising with GPs over blood and ECG results) required more responsibility than that usually attributed to band 3 employees, and that the skills of a band 5 nurse were not warranted by the role requirements.

“We’d already been doing some work around Calderdale competencies around Band 2s, Band 3s and Band 4s. We already have Band 3s in the teams, we had some Band 2s within other services, so we kind of had an idea, so if you were a 2 this is what you did... we looked at ‘does it need a qualified nurse or doesn’t it?’, and ‘if it doesn’t need a qualified nurse, what does it need?’” (Service Manager, Bradford District Care supporting systems)

The associate practitioners are managed by an advanced nurse practitioner who is not part of the community mental health teams. They have a monthly meeting outside of the clinic to discuss any issues. The organisation has not experienced any concerns about the accountability of the associate practitioners. Managers felt, given that they are fully trained to undertake their role (and that GPs read and interpret the results of the check), the associate practitioners would be accountable if something went wrong – despite the fact they are not professionally regulated:

“The ECGs are read more or less straightaway and we get reports back pretty quickly, and... most of the information is relayed back to the GPs via the template with a letter as well [so] in terms of concerns about things going wrong, there’s never been any concerns expressed.” (Advanced nurse practitioner and associate practitioner line manager, Bradford District Care)

Training and induction

The trust will only recruit those that have already been working at a band 3 level into the band 4 role. Therefore, training is provided for band 4 competencies which are not present in a band 3 role, as well as training for working in a mental health environment if required.

Training for undertaking ECGs and phlebotomy is provided in the first week by an external training provider and is funded by Health Education Yorkshire and Humber. All other training is undertaken internally and funded through the community mental health team budget.

A one-week induction consists of intense training, followed by a period of nurse shadowing in which the trainee is shown (and is able to undertake) tasks. Once the practitioner and the nurse feel the practitioner is competent, they perform the task with a patient while being assessed by a qualified practitioner, who is then able to sign off the competency. Once the practitioner shows they are competent in all required competencies, they can work without direct supervision. Within 4-6 weeks the associate practitioners are in the clinic and carrying out the physical health checks autonomously.

Some competencies are re-evaluated on a bi-annual basis. This is initiated by the manager and involves the practitioner being observed by a qualified practitioner.

Sustainability

As highlighted above, sound governance processes have been put in place to ensure the sustainability of the role. Practitioners have been encouraged to get mentors, but they have not been systematically assigned:

“They’ve all been encouraged to get mentors... someone they feel they can go to if they’ve got any issues or concerns that they want to raise or discuss.” (Advanced nurse practitioner and associate practitioner line manager, Bradford District Care)

An associate practitioner also felt that there were good training opportunities and chances to progress:

“I think any further training is always open to us in our roles as well.”
(Associate practitioner, Bradford District Care)

Other enablers

Good relationships with GPs

GP buy-in to the approach was particularly important to the role working well. The shared care guidance, which stated that secondary care were required to take some responsibility for the physical wellbeing of patients with serious mental illness, helped to secure this buy-in:

“GPs were already quite keen on us taking on that role as a consequence of the shared care protocol, so it wasn’t very difficult... to say ‘actually, we’ll be doing this and we’ll be getting in touch with you.’” (Service manager, Bradford District Care)

Good existing relationships with local GPs meant that they were willing to work with the associate practitioners, interpreting results and liaising with them about follow-up care.

Supportive leadership

The service manager, director and CEO were very supportive of the approach from the beginning, allowing the teams the freedom and autonomy to set up the physical health/wellbeing clinics and take the approach forward:

“We got full support from our chief executive, medical director, senior management; and line manager was brilliant.” (Mental/physical health lead, Bradford District Care)

Robust, systematic template

The band 4 associate practitioners use a template for carrying out the physical health checks, which is built into the RIO and provides a step-by-step guide for carrying

out and recording the assessment. The template was initially produced for GPs in SystemOne. The template was developed during the time the project lead was seconded to primary care from Bradford District Care NHS Foundation Trust. It has been fully piloted and rolled out with GPs in Bradford and Airedale and constitutes a robust tool to support the associate practitioners to carry out their role:

“We’ve got a very robust, systematic, hazard review tested, template in place that had been rolled out across Bradford to 80 GP practices and more recently developed for secondary care for use across in-patients and within the physical health/wellbeing clinics for community. The template guides clinicians through a systematic standardised set of interventions; it takes...12 to 30 minutes to complete.” (Mental/physical health lead, Bradford District Care)

Other barriers

Professional resistance

Despite general acceptance of the new roles, some GPs were initially resistant to the approach. They felt that any physical health problems identified within secondary care should remain the responsibility of secondary care staff – rather than being passed to the GP for follow-up. This has since been successfully resolved and is working well with responsibilities defined.

Impact

The approach has not yet been formally evaluated. However, as a result, more patients with serious mental illness are receiving physical health checks, a number of which have had physical health needs identified:

“One of the first patients I picked up on had liver failure and ended up at hospital seeing a specialist and being treated for that. I’ve picked up thyroid problems, possibly lymphoma, various things and the majority of patients I see I would say have never had a health check for years.” (Associate practitioner, Bradford District Care)

Table 1.1 shows how many checks were undertaken from November 2014 to October 2015, as well as how many of those assessed had certain physical health needs.

Table 1.1: Number of checks undertaken by associate practitioners from November 2014 to October 2015

Number of physical health checks undertaken	1036
Number of patients who are/were smokers	468
Number of patients receiving smoking cessation assistance	180
Number of patients with high BMI (i.e. > 25)	403
Number of patients with weight management assistance	281
Number of patients with high blood pressure (i.e. > 140 or > 90)	167

The associate practitioner team has also won an internal trust award for the delivery of patient care. Other organisations are now adopting the model in view of the success of the approach.

At a glance: band 4 associate practitioners in community mental health teams

Role and impact

- More patients with serious mental illness receiving physical health checks
- Reduction in 'do not attends' for physical health checks
- Positive patient feedback

Enablers

- Local education and training board (LETB) and clinical commissioning group (CCG) funding
- Good relationships with GPs, enabling service-level agreements to be put in place and liaison between associate practitioners and GPs over any issues
- Supportive management, directors and CEO
- Robust, systematic template that had been piloted and rolled out for clinicians to follow in both primary and secondary care
- Freedom to set up physical clinics

Barriers

- Professional resistance – some medics and consultants did not think band 4 staff should be doing the physical checks
- Some resistance from GPs who felt that the physical checks were adding to their workload, and that issues identified in secondary care should be followed up in secondary care (these issues have since been resolved)

Advice for others

- Recruit an engaged team with drive, determination and passion
- Gain leadership support and buy-in to the new approach
- Ensure clear communication across all involved

2. Nottingham CityCare Partnership: holistic workers

Context

Nottingham CityCare Partnership ('CityCare') is a social enterprise that is currently commissioned to deliver more than 65 nursing and health care services in and around Nottingham, including health visiting, community nursing, home rehabilitation for older people and NHS urgent care centres. It employs roughly 1600 people, operating from over 26 sites across Nottingham.

Drivers for change

The concept of the holistic worker came from CityCare's urgent care team. This was a new team made up of nurses, physiotherapists, occupational therapists and social workers that was commissioned on a pilot to urgently assess patients in their home following referral from a GP, ambulance teams, social care assessors and health practitioners. Referrals would be made for any patient with a breakdown in either health or social care who might be at risk of an admission to a hospital or care home. The service had a target to respond within two hours of receiving a referral and to perform a comprehensive assessment, ideally putting together a package of supportive health and social care interventions to prevent admissions and allow the patient to remain at home.

Within eight months it became clear to those working in the team that they were unable to respond to all of the patients' needs due to capacity demands. It was also clear that they required a broader range of skills to enable them to work more effectively:

"Because of a range of different demands on that team, basically because they were unable to respond to all of the types of different patient demands in that crisis response service, the solution... they...came up with was...[to have] a better and more competent understanding of each other's expertise and qualifications." (Assistant director)

The staff themselves were aware that their patients needed them to be equipped with new skills; hence, the organisation was motivated to create the new 'holistic worker'. Following the success of this new extended role in the urgent care team, it is being rolled out across the rest of CityCare.

Role overview

The holistic worker is a new breed of health care professional that is able to assess a patient's complete care needs. They are a registered professional by background – either a nurse, physiotherapist, occupational therapist or social care worker working at Agenda for Change (AfC) band 5 level or equivalent. They are then trained up to

‘assistant practitioner’ (AfC band 4) level across all four disciplines, so they have a broad range of skills outside their initial area of expertise. In addition, the urgent care team employs holistic assistant practitioners who are trained to band 4 level across all four disciplines.

Box 2.1: Holistic worker (urgent care team): role description, based on interviews and documents provided

- Assess patients in their home following referral from GP for breakdown in health or social care
- Assessments might include the following:
 - Functional activities (e.g. washing, dressing)
 - Physical activities (e.g. mobilising, sitting, standing)
 - Mental wellbeing
 - Clinical care (e.g. vital signs, falls risk, tissue viability)
 - Social care
- Use the outcomes of comprehensive assessments in order to develop individualised rehabilitation/ reablement goals
- Use clinical reasoning and a wide range of skills and knowledge to devise specialised programmes of care
- Use assessments to develop risk management plans
- Actively engage with families and carers in order to ensure the best outcome for the patient
- Be able to delegate appropriately
- Train and develop other team members and participate in the supervision framework as a supervisee and a supervisor, including the appraisal process.

Implementing the role

Leadership

The development of the holistic worker came from the urgent care team themselves and their managers. Stephen Upton, Assistant Director of Urgent Care, was one of the key leaders who created and then drove the development of this role within CityCare. The subsequent roll-out of the role across CityCare is being coordinated by Emma Self, Head of Professional Standards, who has senior support, protected time and a specific remit for driving this change across the organisation – all factors felt to be important enablers of the change:

“Senior management buy-in and the fact that I have dedicated time to get this done are extremely useful for helping the roll-out.” (Head of professional standards)

Raising awareness

As outlined above, the realisation that the model needed to change came from within the staff of the urgent care team themselves, who were mostly enthusiastic. However, there were some who were resistant to the idea, for fear of diluting existing competencies. This was overcome through discussion and a realisation that the delivery of care could be improved:

“I think that we could see as well that it was needed and we wanted to learn, we wanted to know more about nursing and OT [occupational therapy] and physio[therapy]; we wanted

to know that to be able to provide the best care that we could... [there were some] who were a little bit reluctant because I think they worried that they were diluting their skills or that they were going to lose their skills in their profession... I think in the end we all saw that actually the clinicians wouldn't be diluting themselves, they would just be gaining more skills and knowledge.” (Holistic worker)

As the model is expanded across the organisation, staff in other teams have become more resistant to change. This process has required careful management, since some staff are wary of the new role and are concerned that it will erode professional boundaries or lead to increased work levels. CityCare believes that the best approach is to explain the benefits to both patients and staff and has produced a video that aims to succinctly display the urgent care team's enthusiasm. By being open about the motivations and impact, this has enabled staff buy-in and they have found that the existing holistic workers within the urgent care team have acted as advocates and champions. In addition, they provide teams with plenty of notice of the change, along with the competency manual so they know what to expect. They also have the opportunity to talk directly to staff members who have already completed the competencies and are adapted to this new way of working. The roll out is taking place gradually over time so that lessons can be learnt and the process can be iteratively improved.

Needs assessment

In order to determine what competencies the holistic workers needed to acquire, CityCare took a very pragmatic approach and asked the workers themselves, along with their managers, to determine what they needed to learn:

“So we've said to team managers, ‘Think, with your team, would you generate the opportunity to be involved in this type of intervention within your daily practice?’ If the answer is ‘yes’, then it's highly likely that you need to do that competency.”
(Assistant director)

CityCare then used the Skills for Health assistant practitioner framework along with the Skills for Care social care competency framework to identify exactly what skills would be relevant for their holistic workers. They took those relevant competencies and described them in very granular detail, before grouping them together in their own holistic worker competency manual:

“We actually put [the competencies] into very practical, operational, granular, ‘This is what you need to do, this is how you do it and this is how you're proving that you're able to do it.’”
(Assistant director)

As the process is rolled out across the organisation, the initial competencies developed by the urgent care team have been extensively expanded, formalised and refined. They have also been modified to incorporate elements aligned to the Care Certificate. CityCare was keen to create a set of ‘core’ competencies that would be robust and relevant to all professionals within community teams. In order to decide on these, a steering group was created which evaluated the importance and relevance of each competency. In addition, team managers are encouraged to produce ‘bolt-on’ competencies which are specific for their team and relevant for their day-to-day clinical work:

“We're supporting each individual within identified multi-disciplinary teams to complete the whole competency framework. We believe that our set of ‘core’ competencies will be

relevant for all professionals working within community MDTs [multi-disciplinary teams]. However, managers may also identify 'service-specific' competencies which are particularly relevant to their area of practice. They can add these competencies to the overall framework as 'bolt-ons'. (Head of professional standards)

Supporting systems, governance and supervision

Holistic workers are registered professionals and so maintain registration with their 'home' regulators. As the additional competencies are attained at band 4 level, there is no requirement for further registration. Some professionals were concerned about acting outside their traditional scope of practice, but CityCare sought advice from the regulators in order to clarify the situation.

Holistic workers that are assistant practitioners (band 4 across all competencies) are unregistered in line with assistant practitioners working elsewhere. Those we spoke to felt that statutory regulation of these assistant practitioners would be a positive step and would improve their own confidence as well as external perceptions of the role.

Within the urgent care team, referrals are triaged by registered nurses or therapy staff who will allocate the case to a team member based on their area of expertise. Hence, if it is a particularly complex case or one with a specialist requirement (e.g. physiotherapy), they will not be assigned to an assistant practitioner, but might be assigned to a holistic worker who is registered in that specialty (e.g. a physio holistic worker). Additionally, there are two handover meetings within the urgent care team every day so the whole team can discuss cases:

"We have two handovers a day... at that point we can say if we feel that a physio and an OT or a nurse needs to go out if we feel they need to, or we can discuss any concerns or just discuss what we've done... obviously all the members of the team can get involved and have a discussion or if they feel that they need to do something more, they can." (Holistic worker)

However, due to the clinical independence of the workers, the organisation relies on individual staff members recognising the limits of their competence, or recognising that their skills need refreshing. Regular review should take place through regular management supervision; however, the process places heavy emphasis on self-evaluation.

"If there is something we're not happy with or we feel like perhaps we may have been signed off a little while ago, but we've not come across that since, then it's up to us [to address it]." (Holistic worker)

Training

Training takes place as theoretical/classroom-based sessions followed by practical demonstration. Following this, the holistic worker demonstrates their competencies in the field. Once their assessor (a registered professional in that discipline) is satisfied that they can perform the competency, they are signed off. Protected teaching time is provided for the theoretical training and allowances are made for training and assessment in the field. This requires planning and support of the team and managers:

"Yes, obviously they [the managers] understood that we needed to go out and get signed off in the field... you needed a lot of good communication within the team and everyone needed to be aware what was needed... but everyone understood and we got a lot of support." (Holistic worker)

For the wider expansion process, the Head of Professional Standards performed a detailed analysis of how much training would be required and by whom. She estimated that training 450 staff (all those working in community multidisciplinary teams), delivered in-house by registered experts, would cost roughly £20,000. A business case was then put forward on the basis that the holistic worker would lead to improved patient outcomes and fewer visits by staff.

CityCare have also explored the possibility of accrediting the competencies with the University of Derby. This process is ongoing but the outcome of this looks positive.

Sustainability

As mentioned throughout this case study, due to the success of the holistic model within the urgent care team, it is currently being rolled out across all multidisciplinary teams within CityCare. This process is being conducted formally and is led by a dedicated Head of Professional Standards and steering group. It is hoped that, within two years, all staff working in community multi-disciplinary teams will be 'holistic workers', trained in the holistic model and capable of providing a much more comprehensive service to their patients.

Impact

The new role has enabled more effective working and has promoted diversification and development among the team. All team members report more confidence in dealing with unexpected situations and have a deeper understanding of the skills of colleagues. It has also led to more efficient use of resources – more can be done in a single visit and the scheme won a *Health Service Journal* 'Value in Healthcare' award (*Health Service Journal*, 2014).

While CityCare have not carried out a formal evaluation to date, they have commissioned an external evaluation of the roll out going forward. This will be conducted by the Office of Public Management and aims to assess the impact of the scheme on number of visits, number of inter-team referrals, patient outcomes and clinician-reported outcomes.

At a glance: holistic workers

Role and impact

- More coordinated and efficient care leading (anecdotally) to fewer visits
- More confidence among staff
- Won *HSJ* 'Value in Healthcare' award
- Formal evaluation planned going forward

Enablers

- Openness about motivation of and reason for change
- Staff could easily see why the change was required
- Staff who have had their role extended are able to advocate and champion the process and benefits
- Promotional video helps disseminate information
- Teams who will be trained in the holistic model are given time and warning about the plans
- Leaders are given dedicated time
- Senior management within the organisation are supportive and positive about the programme

Barriers

- Some resistance from some professionals about not wanting to work outside traditional scope of practice
- Takes time to gain competencies and train

Advice for others

- Recognise the improvements that this model can bring to patient care and use this to lever change
- Engage staff and ensure buy-in to the process – meetings and circulated information, such as videos, can aid this process
- Allow individual teams to determine the competencies they require based on the type of service they deliver
- Give managers in charge of implementation dedicated time and resource

3. South East Coast Ambulance Service: paramedic practitioners

Context

South East Coast Ambulance Service (SECAmb) is a large ambulance trust covering 3,600 square miles across Kent, Surrey, Sussex and North East Hampshire, employing 3,661 staff working across 110 sites. In 2013/14, SECAmb received over 860,000 emergency calls.

They have been pioneering in the introduction of the role of paramedic practitioner (PP), a specialist paramedic role with higher training in physical assessment and management of patients and an emphasis on providing treatment of patients in the community, preventing conveyance to hospital.

Drivers for change

The main driver for the introduction and development of this role was an understanding within the paramedic profession that the patient population they serve, and the role they perform, had radically changed from being a true emergency service to one that mainly deals with patients with long-term conditions. This is summarised neatly by the Chief Clinical Officer:

“In the early eighties and indeed the second half of the twentieth century generally, patients were having their heart attack, their strokes, crashing their cars and suffering other ‘emergencies’ and naturally the education [of paramedics] was commensurate with that patient profile. Throughout the nineties, and certainly into the early 2000s, it was becoming abundantly clear that the number of 999 calls was increasing rapidly, while at the same time the patient mix and the ratio between ‘life-threatening’ and those with ‘urgent’ health concerns was shifting, with more community health care or long-term community health care being provided, reflecting changes in the age structure of the population, changes in the provision of health services, particular primary care/out of hours services and other social changes... The effect being to move away from a preponderance of ‘time critical’ ‘emergency’ patients to a far higher proportion of frail elderly people/elderly fallers, patients with mental health needs, dementia, minor illnesses... Thereby necessitating a broader and deeper educational preparation for paramedics, which is now increasingly at degree level.”

Indeed in 2013/14, while the trust received over 860,000 calls, only 5,863 (0.7%) of those were categorised as immediately life-threatening (category A) (South East Coast Ambulance Service NHS Foundation Trust, 2016).

Role overview

The paramedic practitioner is designated by the College of Paramedics career framework as a ‘specialist paramedic (urgent and emergency care)’ and practises with a higher level of education and training with roots ‘firmly in primary care’, but can

respond to all grades of urgent and emergency undifferentiated patients. They are independent and broadly autonomous professionals who are trained to work alone, but not in isolation, and make decisions, whether to convey a patient to hospital or whether they can be safely treated at home. Their versatile range of skills enables them to effectively work in a range of settings (see Box 3.2).

Box 3.1: Paramedic practitioner: role description, based on interviews and job descriptions

- Assess and treat patients with chronic illness
- Assess and treat patients with minor illness/injury, including performing therapeutic procedures such as:
 - Joint immobilisation
 - Medication administration (patient group directions)
 - Injections
 - Wound management
- Rapid response to emergency calls
- Refer patients to specialists or hospitals if needed
- Health promotion
- Collaborative working with community teams
- Follow up with repeat review of patient if necessary
- Participate in the development and clinical supervision of staff and students
- Assist in audit and quality improvement

Box 3.2: Paramedic practitioner: scope of work

- ‘On the road’: PPs operate out of an emergency response vehicle (SECAmb has developed a specialist vehicle for this role), attending emergency calls at a patient’s home. They can attend alone, or following a referral from an ambulance crew who can call on their advanced training to aid with decision-making and treatment, potentially preventing a hospital referral.
- In the emergency operations centre (EOC): PPs can staff desks in the emergency call centres, primarily giving advice to crews on the road. They can be called by crews who would like to discuss a case and get a senior opinion or they can prompt crews to call them – via the IBIS system (see below – a form of electronic health record) – to proactively give advice.
- In other settings. PPs are versatile clinicians who can effectively operate in primary care (either consulting in practice or performing home visits), emergency and urgent care or in acute inpatient care.
- PPs often work in a mixture of the above settings – for example working a couple of days a week in a GP practice and the other days for an ambulance trust.

Implementing the role

Leadership

The implementation of the PP role within the trust was driven by the senior clinical leadership team. The chief nurse had extensive experience of developing new roles and had previously been involved in the development of early, developmental iterations

of postgraduate paramedic schemes. She therefore played a leading part in the design of the PP training course. In addition, the chief clinical officer and a consultant paramedic recognised the clear need for this role in order to meet changing patient profile and hence drove its implementation within SECAMB.

Raising awareness

When the role was introduced, there was some resistance from existing staff; however, this subsided with time:

“I think they’ve gone through a stage where there was a little bit of resentment, like you’ll get in any walk of life. There was maybe a slight element of elitism came in which was resented but I think that’s gone now and think we’re coming up out the other side. We’re getting some really good PPs coming through, they’re doing some great work and I think, generally, overwhelmingly, they are very well received.” (Paramedic practitioner)

It is important to make existing crews aware of PPs, and this can be done through informal information and word of mouth spread. This can take some time and a number of months may be needed to embed the new role. This is an important lesson as there are not always enough PPs to provide consistent cover, creating additional challenges for embedding the new role.

Needs assessment

As described, within the paramedic profession, there was a realisation of the requirement for an enhanced professional role that could attend emergency calls and manage patients who may not necessarily need conveying to hospital. This was corroborated and formalised in the Bradley report (2005), which recognised that ambulance services needed to be “transformed from a service focusing primarily on resuscitation, trauma and acute care” into a “mobile health resource” that can deliver care to patients in the community.

A large body of work was undertaken to understand the skills and attributes required by health care professionals able to take on this role, as well as the support processes and protocols to aid decision making. A large amount of literature exists on this topic and is discussed in our accompanying report. As the chief nurse at SECAMB explains, this work and a clear understanding of what PPs are required to do was used to inform and underpin the way they are trained:

“If you are moving any profession into an enhanced role you bridge the gap in physical assessment and clinical decision making... so we took that as the core and all PPs still do those modules. What we then did was look at the practicalities of what were they making the decisions about, so they were making decisions about minor illness, minor injuries, elderly people, some mental health. Therefore, we made four core modules: assessment skills, decision making, minor injuries, minor illnesses, because they were the clinical caseload that we felt that the PPs could work to and these were patients if you could deal with them in the community, would be much better left at home.” (Chief nurse)

Training and induction

Based on the understanding of what PPs were required to do, as outlined above, a course and curriculum was developed in partnership with St George’s University London (SGUL), and training of PPs commenced in 2006. The course takes 18 months (part time), and includes a number of modules, as outlined above, as well as

an eight-week GP placement. PPs can now train at either SGUL or at the University of Surrey.

As well as the academic exam that all PPs must take at the end of the course, SECAMB has developed an additional ‘specialist paramedic’ exam that tests practical clinical skills used by PPs. While not compulsory, it is highly encouraged and is necessary for career progression within the trust.

Supporting systems

In terms of regulation, PPs are not able to prescribe, although this is currently under review. However, they are able to give patient group directives (i.e. a range of drugs for specific conditions) and so can already administer a limited set of medications. Their work is therefore not overly limited currently, but if their role were to further expand into primary care, the need for prescribing could grow. ‘Paramedic practitioner’ is not a protected title. Those at SECAMB note that regulators have scaled back from the use of protected titles due to increasing complexities, although there was a feeling that the quality of PPs might vary nationally due to a lack of protected title.

Mentoring and ongoing supervision are in place for PPs but are relatively limited and continue to develop. This can create tensions – particularly if adverse events/complaints are investigated by a non-clinical manager who does not understand the role:

“What we lack at the moment are leaders and managers of paramedic practitioners... a lot of the managers are more traditional ambulance people... so when it comes to looking at some of the jobs that they’ve the PPs have done or whether when they come to appraising them at the end of the year, they find it very difficult to do that because they’re not of the same clinical grade.” (Paramedic practitioner)

However, the lack of formal clinical supervision is not perceived to be a major issue due to the highly autonomous nature of existing paramedic practice. In addition, as time goes by and existing PPs become more senior, a line management system will naturally develop. With this in mind, the consultant paramedic team have commissioned the first cohort of advanced paramedics who, when their education is complete, will provide the next level of direct leadership and supervision, thereby giving better access to support locally rather than from the limited number of clinical leads responsible for specialist practice programmes.

Sustainability

It is envisaged that PPs will continue to follow the NHS career framework for allied healthcare professionals that is formalised for paramedics by the College of Paramedics (College of Paramedics, 2015). This sets out how paramedics can progress to specialist paramedic (e.g. as PPs who also sit the specialist exam), advanced paramedic (with masters-level training) and then consultant paramedic. By having a clear pathway outlining steps for progression and competencies required, PPs have a formal and sustainable way to grow and develop their careers. SECAMB believe that their use of the career framework, and the sustainability it offers makes them a desirable employer.

“We do attract... staff from up and down the country... we are an attractive employer because we have the career framework.” (Chief clinical officer)

Other enablers

The skills of a PP can add enormous value in some situations, whereas they can be wasted in others. For example, as they operate out of cars, if a patient needs conveying to hospital, a PP is unable to do this, whereas if they are sent to see somebody who has cut themselves, they might be able to suture the wound and provide antibiotics, preventing a hospital attendance.

SECamb has found that the most impact gained from deploying PPs comes when they were allocated to specially selected patients ('out of plan'). When used 'in plan', PPs are used as another ambulance resource and are allocated jobs based on geographical proximity and urgency. However, if they are instead only sent to those jobs where they can add the most value, they can have a much greater impact (Box 3.3).

In addition, SECamb uses the IBIS computer system, which contains a limited patient record of relevance to ambulance crews. In particular, it has information on those patients with special health needs and who might be frequent 999 callers. IBIS is managed by PPs in the emergency operations centre who can use the information contained on IBIS to advise crews on the road. For example, if a crew is dispatched to a frequent caller with chronic obstructive pulmonary disease (COPD) who has an IBIS record, they are prompted to call the PP in the operations room for advice. The PP can then discuss the patient's background, including normal oxygen saturations and care plan, with the crew and potentially give telephone guidance and advice. This has been found to be an extremely useful clinical tool and enables the PPs to add value to a large number of clinical situations.

Box 3.3: The out-of-plan paramedic practitioner

In order to try and deploy their workforce more intelligently, SECamb launched a pilot study to evaluate the use of PPs 'out of plan' (OOP). In this situation, they are no longer used as an 'as and when' resource, but are dispatched to carefully selected cases where they might add maximal value. Often the PP will select these cases themselves. The results from this pilot have been impressive:

- PPs had lower conveyance rates during the OOP (by approximately 10%)
- PPs received an increased number of referrals from paramedics during the period
- Non-PPs reported greater levels of satisfaction and morale by having greater access to leadership and support
- PPs in the OOP pilot saw more patients per shift
- An impact calculation estimated that the overall impact of the programme (the number of patients not taken to hospital) increased by 100%.

Other barriers

The main barriers experienced at local level were the initial resistance of existing paramedics, which was temporary, and the small number of PPs meaning that an inconsistent service was provided, reducing awareness for the role.

National factors were also identified as hindering the effective introduction of this new role. In particular, the pressure that the ambulance service faces in terms of hitting response targets makes allocating PPs 'out of plan' particularly challenging. At busy

times, they may be used as another resource ('in plan') in order to get to calls in time. In addition, a number of initiatives to create generic advanced roles in emergency care have been met with resistance by the paramedic profession, who are keen to retain a defined professional identity.

Impact

Data from SECAMB demonstrate that:

- PPs have, on average, a 20% lower conveyance rate than other paramedics
- PPs with specifically triaged patients (out of plan PP – see Box 3.3) have a further 10% lower conveyance rate
- PPs have higher referral and discharge rates, but attract the fewest complaints
- Staff interviewed were very enthusiastic about what PPs can offer the ambulance service and the benefits they can provide in terms of career progression and development.

In addition, PPs working in primary care have been well-received by GPs:

"[Paramedic practitioners doing home visits] has drastically reduced the number of visits that our GPs are having to go on. The feedback from the GPs is excellent. Very rarely have they had to go out again because of the paramedic, unless the paramedic has specifically said, 'I can't deal with this. I need a GP to... So it's working exceedingly well."

(GP practice manager)

At a glance: paramedic practitioners

Role and impact

- Lower conveyance rates (referring patients to hospital)
- Low level of complaints despite high case load
- Job satisfaction and attractive career pathway for paramedics
- Provide clinical support for paramedics on the road

Enablers

- Detailed analysis of what patients needed from PPs allowed an effective education and training programme to be designed
- Use of a clear career framework attracts staff
- Use of paramedics 'out of plan' allows them to be deployed to those cases where they can have maximal impact
- Technology (IBIS system) provides PPs with tools to add maximal clinical impact

Barriers

- Demands on the service, including targets, may hinder the ability to use PPs 'out of plan'
- Initially some resistance from existing staff about new role
- Lack of formal line management and senior PPs for supervision

Advice for others

- Have a clear idea of what you want PPs to be able to do and base training, education and deployment around this
- Deploy PPs to selected cases, 'out of plan'
- Use existing frameworks and pathways (e.g. Paramedic Career Framework) in order to facilitate the development and sustainability of new roles
- It takes time and investment to develop new roles effectively; be prepared for middle-term gains

4. Haxby Group Practice: extended roles for pharmacists and paramedics

Context

The Haxby Group Practice consists of 10 GP surgeries across York and Hull that deliver care to just under 50,000 patients. The Group also provides community-based minor-surgery, and owns shares in four local community pharmacies.

The Haxby Group Practice has a culture of education and innovation. One of the partners sits on the board of the Local Education and Training Board (LETB) and is also clinical lead for the supporting federations programme at the Royal College of General Practitioners. The Group has invested in their nursing workforce, transforming their nursing team over the last ten years. Haxby is an advanced training practice hub for North and East Yorkshire and Hull, offering training placements for nurses as well as coordinating training placements for other local practices. They have two advanced nurse practitioners and are developing career pathways for nursing. The Group also includes GP trainers and hosts GP trainees and medical students. The practice has a thriving apprenticeship scheme for clinical and non-clinical staff.

The Group is led by 21 GP partners and one non-clinical partner. It also consists of 19 nurses (17.5 whole-time equivalent (WTE)); one head of nursing; 14 health care assistants (12.9 WTE), one paramedic and three pharmacists (2.7 WTE).

Drivers for change

Hull is an under-doctored area and, in 2015, only 50% of training posts in Hull were filled. The Haxby Group faced increasing difficulty recruiting GPs and was experiencing a growing clinical and administrative workload. Diversifying their workforce was one route to addressing these pressures. The practice was supported in this by some funding from the local LETB:

“...historically, in general practice, doctors are involved in everything and there was an increasing awareness that maybe that didn't need to be the case, and so we started looking at all aspects of what we did.” (Partner, Haxby Group)

Extended role for pharmacists

Specific drivers

The extended role for a pharmacist came out of a time and motion study in the practice that showed a large proportion of GP time was spent re-authorising and managing prescriptions. This, alongside established close working with community

pharmacy, triggered the decision to employ a pharmacist in the practice to take on this work:

“They’re really forward thinking here and they could see it’s about getting the right person to do the right thing.” (Pharmacist practitioner, Haxby Group)

Role overview

The pharmacists’ main role (see Box 4.1) is medicines management. Most of their work is done remotely and over the phone, although they do carry out face-to-face medication reviews at dispensing GP sites. Prescriptions are signed off by GPs, although this may change in the future as the role develops.

Box 4.1: Pharmacy practitioner role description

The role is primarily focused on medicines management, including:

- Re-authorising prescriptions
- Dealing with a range of prescription-based queries
- Medication switches and alternatives
- Amending prescriptions following hospital discharge or outpatient appointment
- Synchronising prescriptions (so that renewal falls at same time)
- Suggesting removal of prescribed items
- Commenting on polypharmacy in the elderly and people with complex needs.

It also involves carrying out prescribing audits and dealing with any related regulatory issues.

There are currently three pharmacists working across 10 sites. Haxby employed its first pharmacy practitioner in 2012, followed by a second in 2015 (who is managed by the first) and a third has joined the team in early 2016.

“I absolutely love my job... There are so many benefits of being part of a team where you are treated with so much respect and you are involved in decision making and you feel you are making the patient better.” (Pharmacist practitioner, Haxby Group)

The first pharmacist employed was a senior pharmacist who came from secondary care and had undertaken a clinical diploma and an independent prescribing course. The practice also aims to develop the practice pharmacist’s role to include clinical elements. This may involve managing acute presentations and monitoring long-term conditions.

Implementing the role

Raising awareness

Internally, raising awareness of the pharmacist practitioner role consisted of ‘educating the right people’ through email, team meetings and clinical meetings. It was important that the on-site community pharmacy knew exactly what the role entailed, and could approach the pharmacist directly for any medicines management queries. The pharmacist also quickly established relationships with GPs through communication and collaborative working, and the role became embedded in the team. As very little of the pharmacist practitioner role is patient-facing, there was less of a need for external communication, although the role was included in the patient newsletter and has since been presented at conferences and symposiums.

Line management and clinical supervision

One of the GP partners conducts an annual appraisal with 360-degree feedback. There are also regular review sessions – both formal and informal. Any prescribing issues are taken to the prescribing lead in the practice.

Impact

The practice estimates that the pharmacist is now managing to do, in 35 hours a week, work that was taking the GPs 60 hours a week. The quality of medicines management has also improved with quicker, more reliable prescribing; less polypharmacy; and more patient and professional education. There has not been an increase in medication errors or adverse incidents.

Primary care practitioner: extended role for paramedics

Specific drivers

One of the Group partners saw an opportunity to use the paramedic skill set due to work he had done in out of hours services:

“They’ve had training in clinical assessment and talking to patients and we are using that skill set to build on in a primary care setting.” (Partner, Haxby Group)

These skills could be applied both to patients with urgent/minor illness in the practice and those housebound or in a care home. At the same time, the local LETB were offering funding to cover two years’ salary and training costs for advanced clinical practitioner roles. The practice obtained this funding for one of their new roles.

Role overview

The primary care practitioner works across three GP surgeries and primarily deals with same-day appointments. The role is evolving as the confidence and skills of the current postholder grows. All patients on the primary care practitioners’ list are triaged by GPs and have been deemed appropriate to be seen by them:

“The role is new within the Haxby Group so we’re developing it all the time and in many ways a lot of it comes through negotiation with the GPs... We sit down every day and talk about what I did and didn’t feel comfortable with, and if I report they’re stretching me too far, I don’t see that type of patient again until I’m more experienced”
(Primary care practitioner, Haxby Group)

The job description is competency and activity-based rather than being specific to specialty or background.

Box 4.2: Primary care practitioner: role description

The primary function of this role is undertaking assessments of patients presenting with urgent/minor illness, including the following:

- Assessing patients offered same-day appointments for minor illnesses (90% time)
- Assessing patients at home including people in care homes
- Assessment may include undertaking ECGs and interpreting the results
- If unable to resolve an issue may refer to a GP or other services
- As a paramedic they are not able to prescribe independently. However, they have an agreed list of medications (patient group directions) that they can recommend. The GP then signs them off following a discussion of the case
- Teaching other staff (for example on how to undertake and interpret an ECG).

The Group has just offered positions to four primary care practitioners – three from a paramedic background and one nurse (who may be titled an advanced nurse practitioner).

Implementing the role

Training and induction

The primary care practitioners had one month's induction in which they sat in with GPs.

“We were very cautious with the paramedics... we wanted to understand exactly what they were comfortable with doing, so they sat in with GPs for a little while and then GPs sat in with them, they weren't seeing patients on their own from day one... we were understanding where their knowledge gaps were and then supporting them to fill in those gaps.”

(Partner, Haxby Group)

While the level of GP supervision is decreasing over time, GPs still set aside time in their clinics to answer queries from the primary care practitioners. The current primary care practitioner is undertaking an advanced practice postgraduate diploma. It is an 18-month course which could be extended a further six months to be converted into a full master's degree. The course involves two days a week studying. The course also requires the practice GPs to observe and sign off advanced clinical competencies.

Raising awareness

As this role is primarily patient-facing, significant effort went into raising patient awareness. It was featured on BBC's 'Look North' as well as in local newspapers, the patient newsletter and on social media. The Group employs a PR company to help disseminate messages externally. Awareness was also raised through the patient participation group.

Line management and clinical supervision

After every clinic, the primary care practitioner debriefs with a GP to talk through what they encountered and to ask any questions. They are also able to seek guidance or supervision from GPs whenever anything arises during a patient consultation, and a number of GPs have allocated time built into their clinics to support the primary care practitioners. Instant messaging facilities on the Group's patient management system (SystemOne) support this interaction. Once every two weeks, the primary care practitioner also has a formal tutorial with a GP to cover any issues that have arisen.

Professional indemnity cover

The Group faced challenges indemnifying the primary care practitioner role. It is felt by some within the Group that indemnity providers have little experience of these new, emerging roles and that the issue may require national guidance:

“If the general practice workforce is going to evolve in this way, there needs to be a joined-up approach to indemnifying all clinicians that work in primary care.”

(Partner, Haxby Group)

Impact

The primary care practitioner has only been in post for six months, and the role is still in the early stages. However, as the practitioners become more experienced and are exposed to a wider range of conditions, and can consult more quickly, it is hoped that the service will become more effective. To date, the cost-effectiveness of the programme remains unclear given the supervision time required, and the longer appointment times of the practitioner, although there are already patients that the primary care practitioner is comfortable seeing independently.

At a glance: pharmacy practitioner and primary care practitioner (paramedic trained)

Roles and impact

Pharmacy practitioner

- Significant reduction in GP medicines-related workload
- Improved medicines management
- Cost effective – net savings to practice

Primary care practitioner (paramedic trained)

- Some reduction in acute/urgent assessment workload for GPs
- Cost-effectiveness uncertain

Enablers

- Culture of innovation and education
- Funding from local LETB for advanced practitioner training
- Supporting communications strategy
- Instant messaging facilities (SystemOne)
- Scale of large group practice

Barriers

- Obtaining necessary professional indemnity cover for primary care practitioner role
- Lack of supporting guidance for development of new roles
- Current regulatory barriers to paramedic prescribing
- Need to contextualise skills within general practice (requires training on the job)
- Lack of time to do necessary development work

Advice for others

- Ensure whole team buys in to the concept
- Put in strong governance mechanisms – clinical supervision and mentorship for new roles
- Be prepared to be flexible and adapt roles to local circumstances

5. Sheffield Teaching Hospitals NHS Foundation Trust: advanced clinical practitioners

Context

Sheffield Teaching Hospitals NHS Foundation Trust consists of five hospitals. The main sites are Northern General, which is home to the A&E unit, has over 1,100 beds and employs more than 16,000 staff; and Royal Hallamshire, which has around 850 beds for the care of inpatients, a number of specialist outpatient clinics and a minor injuries unit. The other hospitals comprise a purpose-built maternity unit, a dedicated cancer hospital with an integrated cancer research centre, and a specialist dental hospital.

Drivers for change

The trust started developing advanced clinical practitioners (ACPs) in 2006 in response to the European Working Time Directive, which restricts the number of hours that junior doctors are permitted to work, resulting in a shortage of junior doctors to provide 24/7 cover. The approach was department-led, and cardiac was the first department to realise the need for alternative workforce approaches:

“Cardiac was pushed into it by that... ‘You can’t sit back and do nothing, and neither are we going to get the medical staff we require in the future, so what can we do that’s safe, that’s effective, and how can we develop these practitioners?’” (Education Commissioning Manager, Sheffield Teaching Hospitals)

The decision to develop the role at scale was driven by a further shortage of junior doctors in 2012. This, combined with the availability of local education and training board (LETB) backfill funding for the ACP role led to the identification of areas that would benefit from ACPs across the trust:

“Because of some of the pressures currently, where F1s and F2s [foundation year 1s and foundation year 2s] are being taken out of the system and the funding has been taken out as well, it became almost...another crisis point in the trust...[We realised] we really can’t provide the standard of care if we don’t do something, and because it was a doctor medical gap; it had to be advanced practitioners really” (Education Commissioning Manager, Sheffield Teaching Hospitals)

Role overview

The trust defines ACPs as:

‘... a professional who has acquired the expert knowledge base, complex decision-making skills and clinical competencies for expanded practice, the characteristics of which are shaped

by the context and/or country in which s/he is credentialed to practice. A master's degree is essential for entry level.' (Health Education Yorkshire and Humber, 2015)

In reality, the specific competencies required for the role vary depending on the area in which they are working. However, there are a set of core competencies that align with Health Education Yorkshire and Humber's Advanced Practice Framework. These are set out in Box 5.1.

Box 5.1: Advanced clinical practitioner core competencies

- Provide specialist knowledge and skills
- Utilise a high level of scientific theory and knowledge to underpin any practical work undertaken
- Provide expert advice
- Analyse a wide range of complex and challenging facts and situations
- Provide clinical leadership to ensure the highest standards of clinical care and act as a role model
- Demonstrate critical thinking and a high level of judgement and decision-making
- Be accountable for planning and managing total episodes of care
- Independently undertake assessment of patients using a range of different methods
- Develop and deliver programmes of care
- Optimise continuity of care for patients
- Autonomously make decisions and diagnoses (such as ordering investigations, identifying a deteriorating patient, identifying contraindications and precautions)
- Undertake non-medical prescribing
- Evaluate interventions and treatments
- Work independently and take responsibility for own case load
- Supervise and support junior members of staff and promote staff development
- Participate in teaching and mentoring activities
- Contribute positively to leadership and demonstrate exemplary practice
- Lead or participate in research and development in order to identify innovative ways of working to improve the quality of health care
- Ensure that all actions performed are evidence based
- Monitor risk
- Evaluate impact and effectiveness and act on findings

There are 70–80 ACPs working across Northern General and Royal Hallamshire hospitals. They are spread across the hospitals in night services, critical care, operating theatres, A&E, renal services, haematology services, cardiology, neonatal intensive care unit, acute medicine and surgical services. There are also developing generic ACPs who are undertaking their training across both medicine and surgical services, with the intention being for them to work within the restructured assessment services in the trust.

Implementing the role

Needs assessment

When LETB funding became available for the ACP role, the Education Commissioning Manager conducted a mapping exercise to understand the advanced and specialist roles that already existed in the trust, set out the required competencies for the role, and identify other areas that would also benefit from ACPs. Critical care was one of the first areas to realise it was facing a workforce shortage and to put together a proposal to fill the gap:

“Critical care was our flagship...they were the ones who felt most affected [by a lack of junior doctors].” (Education Commissioning Manager, Sheffield Teaching Hospitals)

Critical care produced a comprehensive business plan, and other departments facing similar challenges followed. As part of this exercise, patient need was mapped to clinical competencies.

“We plotted out the patient pathway from the point at which they came into the hospital to where they were discharged...we categorised what’s happening to them and that then determined the training needs of the individual we wanted...we knew we would need...diagnosing, prescribing [and] assessing.” (Nurse Director, Sheffield Teaching Hospitals)

Raising awareness

Sheffield Teaching Hospitals raised awareness internally through intense communications, staff meetings and handbooks. Buy-in at the consultant level really helped:

“We certainly got consultants’ buy-in and they owned it and drove it...you can’t just put [ACPs] in there if people don’t know why it’s needed...so we did a lot of PR and educational sessions.” (Nurse Director, Sheffield Teaching Hospitals)

Supporting systems

Sheffield Teaching Hospitals has a robust mentorship and supervision programme for its ACPs. Each practitioner has a consultant supervisor who signs off the trainee as they go through the programme, and a mentor who acts as a second port of call if the supervisor is unavailable. Those working across surgery and medicine have one from each area:

“We like the trainees to meet up formally with a supervisor every three months and [it’s] similar with the person that’s providing professional support...the trainees feel very well supported.” (Nurse Consultant, Sheffield Teaching Hospitals)

Training

The trust has standardised training requirements for ACPs. ACPs take two to three years to complete the postgraduate diploma from the Master’s degree in Advancing Professional Practice at Sheffield Hallam University. Once they are in substantive posts, ACPs are supported and expected to complete the full Master’s degree programme. Most trainees are supernumerary, which the trust has found to be the most effective way of training them. When ACPs were first introduced in the Hospital at Night service they were not supernumerary, and some struggled to cope with

balancing their clinical workload with training requirements. Hospital at Night ACPs now devote 50% of their time to training and the other 50% to delivering a clinical service.

The trust has a formal partnership with Sheffield Hallam University. It worked with the university to tailor the modules on the course and recruit students with the right aptitude and values. The trust also supplements Sheffield Hallam University modules with in-house training modules, which trainees can receive academic credit for if required:

“There were times when we realised that some of the modules...didn't really cover as much as we needed, so we worked with the university...they've been really, really helpful.”

(Head of Learning and Development, Sheffield Teaching Hospitals)

It is also hoping to establish formal connections with the University of Sheffield, which has been invited to join the faculty board (see ‘Other enablers’ below).

The trust gained full funding for the training and backfill (at Agenda for Change band 6) of 60 ACPs from the LETB. Once the current tranche of ACPs are trained at the trust, £4.35 million will have been invested by the LETB.

Sustainability

To date, the trust has received significant financial support from the LETB. However, this funding will be reduced to 50% in 2016, which may affect the pace of training:

“Once the LETB stops putting this amount of money in...I think that [training] will slow down.” (Head of Learning and Development, Sheffield Teaching Hospitals)

In the longer term, one manager felt that it would eventually become clear which areas in the hospital ACPs could really add value, and their position there would be solidified:

“From a sustainability point of view there will come a point within hospitals where it will become very clear where they really make a difference, where they really add value.”

(Head of Learning and Development, Sheffield Teaching Hospitals)

The trust also faced challenges around pay conditions for the ACPs. The LETB funded trainees at Agenda for Change band 6 and the trust committed to paying Agenda for Change band 7 on completion of the training. However, other employers in the South Yorkshire area had higher rates of pay. This resulted in difficulties with retaining qualified ACPs. As a result, hospitals involved in the South Yorkshire task and finish group (organised through the LETB) have tried to standardise pay, with an understanding that if ACPs are fulfilling all aspects of the role, and have completed the Master's programme in Advancing Professional Practice, they can be paid at band 8a. This is to avoid the ‘poaching’ of fully trained ACPs by other employers in the area.

The trust has also faced challenges in ensuring all trainees have a permanent post on the completion of training, owing in particular to the time lag between submitting the business case for trainees and ACPs becoming fully qualified.

The organisation does not have a sense of the total investment made into implementing ACPs. However, elements of some faculty roles are part-funded by slippage LETB funding consisting of approximately £100,000.

Other enablers

Central organisational approach

The department-led approach to developing ACPs resulted in a variety of roles, which lacked a common definition and training process. In response to this, the trust developed a Faculty Board for Non-Medical Advanced Clinical Practice covering the South Yorkshire region. The role of the Faculty is to act as the quality assurance mechanism, setting training standards, supervision requirements, role definitions and job descriptions. The Faculty Board focuses on strategic issues, while an executive operational group has been established to manage the ACP training programmes:

“A lot of this is simply about tracking all of the individuals in the system, making sure they’re getting what they need, working out...who’s coming upstream in a year’s time, but crucially...ensuring that [all] trainees are all going into funded posts at the end of [their training]” (Head of Learning and Development, Sheffield Teaching Hospitals)

‘Slippage funding’ from the LETB is being used to support the setting up, backfill and running costs of the Faculty Board for the first two years. The faculty board sits alongside a new workforce and education board and a clinical operations function.

Buy-in to the roles

When the trust started its ACP journey in the cardiac department, clinical buy-in was important:

“We had a really good lead consultant who said...I’ll take responsibility for talking to my colleagues about the impact of us not having SHOs [senior house officers]...and the fact that we need to do something.” (Education Commissioning Manager, Sheffield Teaching Hospitals)

Medical champions in each department have increased buy-in and many consultants are willing to act as supervisors and mentors. This buy-in has continued at all levels of the hospital. The Deputy Medical Director strongly buys in to the generic ACP roles and executive board approval for project plans and proposals has been sought at each stage of the journey:

“None of this will work if you don’t have that level of support; it’s too big to try and do from the bottom up.” (Education Commissioning Manager, Sheffield Teaching Hospitals)

Comprehensive business cases and the potential of cost savings through avoiding agency costs also helped to ensure board-level support as well as the fact that the LETB was offering funding.

Devoted roles to take the approach forward

The trust employs a nurse consultant who has a joint appointment at Sheffield Hallam University. She has been able to work closely with the Education Commissioning Manager and other clinicians to refine training components of the role and take the approach forward:

“[Our staff] have worked tirelessly with the directorates to identify where ACPs could make a difference, how we might move forward” (Head of Learning and Development, Sheffield Teaching Hospitals)

Other barriers

Professional resistance

Buy-in to the new roles has generally been good. However, some consultants felt they did not have time to act as a supervisor or mentor, and refused to do so. The trust overcame this by bypassing those consultants and identifying those willing to engage. However, one manager stated that funding to release the time needed for supervision would be beneficial.

There was also some professional tribalism from junior doctors, who were concerned that ACPs were taking their roles:

“One of [the barriers] has been doctors thinking that we’re taking their jobs. That’s been quite a big thing, really.” (Nurse Director, Sheffield Teaching Hospitals)

Impact

A comprehensive evaluation of ACPs in the trust has not been carried out, primarily because they have not been in post very long. However, anecdotal feedback has been positive:

“The junior doctors on [the acute medical unit] and [other] staff... have said how good the trainees are and what a difference it makes when they’re on.” (Nurse Consultant, Sheffield Teaching Hospitals)

“In cardiothoracic they do not have any delays with TTOs [to take out – prescriptions for medicine given to a patient on discharge from hospital] because practitioners write up the prescriptions overnight. It’s the only area that they’re meeting the target and getting timely TTOs written because the ACPs are writing them.” (Nurse Director, Sheffield Teaching Hospitals)

At a glance: advanced clinical practitioners

Roles and impact

- No evaluations have been conducted but anecdotal feedback has been good

Enablers

- LETB funding – including £4.35 million for training and full backfill of 60 ACPs and funds to support the faculty board
- Coordinated organisational approach
- Strong buy-in (at clinical and board level) and medical champions
- Strong partnerships with Sheffield Hallam University
- Strong mentorship and supervision programme (supported by willing and enthusiastic consultants)
- Education Commissioning Manager role that could devote significant time to the process (with a clinical background)

Barriers

- Retaining ACPs due to others paying higher rates and ensuring there are suitable permanent post-training posts
- Some staff sceptical of new role
- Some consultants unwilling to act as supervisors due to time commitment

Advice for others

- Understand why you need the new role
- Engage with stakeholders from the very beginning (LETB, executive board, staff) and ensure buy-in at all levels
- Use clinical champions to cement support

6. St George's University Hospitals NHS Foundation Trust: physician's associates in acute care

Context

St George's University Hospitals NHS Foundation Trust is a large provider of acute and community services, employing nearly 8,500 staff and serving a population of 1.3 million people across south-west London (St George's University Hospitals NHS Foundation Trust, 2016). The main site, St George's Hospital in Tooting, is a large acute trust with associated medical school, at St George's University of London (SGUL). SGUL runs one of the UK's leading physician's associates (PA) degree programmes and organises clinical rotations for its students in clinical departments of St George's, while a number of the consultants at the hospital teach on the course. Due to this close association, St George's employs a large number of PAs and currently has 10–15 working across a wide range of departments (from urology to plastic surgery, haematology to paediatric intensive care). This case study primarily focuses on the neurosciences care group (directorate) at St George's, which has funding for 10 PA posts and, until recently, employed the second-highest number of PAs in the country.

Drivers for change

A lack of existing staff (junior doctors) was the main driver for the introduction of PAs. While the neurosciences care group is able to fill its places for doctors with national training numbers, limits on these numbered posts means that insufficient junior doctors can be recruited to match the increase in neurology care delivered as the department has expanded. Locums have previously been used to fill gaps. A lack of available locums drove the department to consider alternative options:

“We don't have enough trainee numbers to run a service and I don't know if anywhere does, actually, so all neurology departments I know have a lot of staff grade appointments and locum appointments to service.” (Consultant neurologist)

This lack of existing junior doctors drove the care group lead, Dr Anthony Pereira, to search for a viable solution. He chose to introduce PAs because the novelty of their role meant that there was less associated bureaucracy and he had more autonomy and control over how they were employed. In addition, a positive experience with a PA doing an elective placement showed their potential and enthused Dr Pereira to take this role forward:

“A lot of the other [roles] already are very structured with a lot of associated bureaucracy,

whereas physician associates basically had no bureaucracy. Because I took a lead in organising them I was permitted a significant amount of flexibility.” (Care group lead)

The PA role at St George’s

Role overview

The PA’s role is to take on tasks traditionally performed by junior doctors. Within the neurosciences care group, PAs will attend ward rounds, assess patients and organise aspects of the management plan (see Box 6.1). They are also able to undertake lumbar punctures, following careful consideration from the consultant body, and there is a view to increasing the scope to routine outpatient work.

“I’m part of a medical team who assesses, examines, investigates, and manages medical problems within the neurosurgery and neurology speciality under the supervision of consultants.” (Physician associate)

Box 6.1: Physician associate in acute care role description, based on interviews and job description

- Assess new or unwell patients, formulate differential diagnosis and management plan based on clinical assessment.
- Refer patients to other services as required
- Request and interpret laboratory or other investigations as appropriate
- Recommend and explain diagnostic tests, procedures or treatments
- Perform diagnostic tests and procedures based on training (e.g. venepuncture, cannulation, arterial blood gas, urethral catheter, lumbar puncture)
- Communicate sensitive and complex diagnosis to service users and relatives
- Take part in ward rounds as a member of clinical team
- Instruct and educate patients in preventative health care
- Practice under the supervision of a consultant
- Engage in audit and quality improvement projects
- Engage in continuous professional development and aid in the teaching and training of colleagues
- Participate in research studies

Implementing the role

The growth of PAs at St George’s has been very department-led with individual ‘care groups’ opting to implement the new role based on departmental need. There is cross-organisational oversight of the PA programme, which is governed by a PA board. This meets quarterly and agrees on organisation-wide policies. However, the scope, scale and implementation of PAs is determined at departmental level. Within the neurology care group, Dr Anthony Pereira, a consultant neurologist and care group lead, led the implementation of the PA role.

Selecting the role

A formal analysis of service need was not performed. However, the decision to formally employ PAs in the department was based on lived experience of hosting a PA on elective placement and witnessing what they were able to do in a clinical context.

“I formed an opinion when this person was on elective that they would work hard, were able to learn, and that they were reading... this person was exceptional. They seemed to have the right skills to take a chance on them when they applied for our post.”

(Care group lead)

Following this positive experience, the numbers were expanded once the department was able to recruit individuals of a high standard.

Obtaining support within the organisation

The introduction of PAs had board-level support within the trust with a large amount of autonomy given to individual care groups. At care group level, the importance of consultant buy-in was recognised. Through discussions at consultant meetings, the case for PAs was made and support for the introduction of this role was obtained.

“The care group lead... really sold it well to the consultant body, so there was a lot of consultant buy-in to the idea and then that feeds down... some of it was just spelling out the numbers to us and saying ‘look, this is the reality, this is how many trainee posts we need, this is what we’ve got.’” (Consultant neurologist)

In addition, the fact that the PAs were competent and useful members of the team facilitated the change management process.

Raising awareness among existing staff

Once senior buy-in was achieved, a similar process was undertaken to inform, educate and convince existing staff about the benefits of the new role.

“It’s the same sort of PR job with [junior doctors] as there was with consultants in saying ‘look guys, you’ll be less stressed, you’ll be more able to free up and learn the stuff that you need to do... this will support you, it’s not going to take work away from you, it’s going to enable the whole team to function better.’” (Consultant neurologist)

Additionally, all new staff are briefed about PAs at their induction when they first start work at the trust, and senior PAs themselves come and introduce themselves and their role at induction meetings.

“What we are doing at trust level is we now send PAs to trust induction. So every trust induction we have, we have a PA representative there telling people about the role of the PA and what we do.” (Physician associate)

However, while this improves integration of PAs within the trust, junior doctors may still feel threatened by PAs and have reservations about loss of training opportunities.

Training and development

A structured programme of teaching and supervision for the PAs was organised within the department. All PAs work on the stroke unit initially, before being deployed to other departments. As the stroke team is led by Dr Pereira, he was able to personally deliver training and ensure that the PAs were performing at a high standard:

“What we set up was a lead in programme for them. We would meet every week for about half an hour, and we would set homework... You have to have some sort of structured programme for about two years so they can consolidate their knowledge... So basically we went through the stuff that they would see on the ward... what happens is if somebody has

chest pain, what happens if someone is short of breath. We went through the medicine and then I got them to do short presentations in neurology, so a two minute summary of multiple sclerosis, a two minute summary of epilepsy... They all came through stroke first which is my subspecialty, so I could make sure that they were developing and setting up the right habits for lifelong learning. I didn't want anyone to fall into bad habits.” (Care group lead)

Following the ‘lead in’ programme, the PAs can then rotate through a range of specialties (such as neurosurgery or neurology), adding variety. Such a system of rotations possibly makes the job more attractive for PAs, although might not suit everyone.

Line management and clinical supervision

As well as being mentored through the ‘lead in’ programme, as outlined above, PAs have a named consultant educational supervisor and are supervised day-to-day by the consultant covering the ward, in a similar manner to junior doctors.

PAs do face a number of regulatory issues and the inability to prescribe or request ionising radiation is a barrier to their effective working – particularly in neurology and stroke medicine. All the PAs that we spoke to were in favour of statutory regulation and were of the opinion that the GMC would be best placed to provide that, given that they are trained to practise within the ‘medical model’:

“PAs practise medicine. We don't practise nursing, we don't practise physio, we don't practise occupational health. PAs practise medicine, within the scope of practice of our supervising doctors.” (Physician associate course director)

Sustainability

PAs do not have a clear career progression, and this is a possible area for concern. Possible solutions to this could be allowing the PAs to take on more outpatient or procedural roles, or finding a particular area of clinical practice for them to specialise in:

“I think that I'm going to have to start branching out with them into more challenging areas, maybe a mix of outpatients and helping on the ward... the other thing I've thought about is whether we could set up a ward that they could help run in a more independent manner ... that might be quite fulfilling... You could imagine somebody doing that for quite a long time.” (Care group lead)

However, many PAs find the lack of formal career progression an attractive feature of the role, enabling them to follow their interests, develop skills of relevance to them or potentially work across a number of specialties:

“I think that is part of the beauty of the PA role, in the sense that you can drive... what your individual needs are. So in orthopaedics... two of us have interests in going more the theatre route, so they will try to create more opportunities to go to theatre... I think that is the beauty of it, everything is not uniform.” (Physician associate)

Impact

A formal evaluation has been conducted but unfortunately St George's were unable to share their results as it is currently under submission for publication. However, anecdotally both PAs and senior medical staff were very optimistic about the impact

of the programme. PAs in particular noted that maintaining general skills allowed them to move between departments, citing transferability and variety of available work as a particular advantage of the role. The benefits brought by continuity of care – particularly in an environment where junior doctors frequently move departments – was highlighted, while it was noted that PAs could have a positive impact on the confidence and development of other staff.

“Certainly a lot of our patients when I’ve been on the ward they are very often highly complimentary, and it’s clear... certainly in neuro, it’s been a real positive.”

(Consultant neurologist)

At a glance: physician’s associates in acute care

Role and impact

- Physician associate who takes on some tasks previously undertaken by junior doctors (SHO grade)
- Good feedback from patients and staff, some existing staff may still hold reservations about impact of PAs on their own training and work
- High job satisfaction and well-regarded by consultants

Enablers

- Strong leadership from care group lead and time taken to develop the individual PAs into high performers
- Strong consultant buy-in
- Flexibility for individual departments to have autonomy over scope and implementation
- Flexibility for PAs to determine their own career paths

Barriers

- Concern from existing staff about role erosion and loss of training opportunities
- A lack of formal regulation leading to inability to prescribe or request ionising radiation

Advice for others

- Invest time and energy in ensuring that the PAs continue to be trained, supervised and mentored following qualification
- Recruit the individuals carefully
- Plan how you will thoroughly engage the consultant body as well as staff at all levels throughout the department
- Implement more than one PA at a time – introducing a group in one go can bring benefit and prove the concept

7. Birmingham and Solihull Mental Health NHS Foundation Trust: physician associates in mental health

Context

Birmingham and Solihull Mental Health NHS Foundation Trust (BSMHFT) offers a range of mental health services, including inpatient wards, community teams and psychiatry liaison services. It employs over 4,000 staff and operates from over 50 sites across the West Midlands. BSMHFT began to employ UK trained PAs in late 2011. It currently has eight PAs in post (Gill and others, 2014), working across liaison psychiatry, forensics and the homeless community mental health team. It is the only mental health trust in England to be employing PAs.

Drivers for change

BSMHFT was driven to look for solutions to large gaps in its doctor workforce. The West Midlands does not have enough psychiatry trainees and for the five years from 2009 to 2013, all of the psychiatry training posts were under-filled (Royal College of Psychiatrists, 2015). This situation was compounded by a cap on training numbers, changes to visa requirements and restrictions to doctors' working time. In addition the trust was aware that the training requirements of doctors and their frequent rotations meant that there were issues with continuity of care, particularly important for mental health where patients can be admitted for a long period of time:

“The main driver was: one, failure to recruit core trainees in forensic psychiatry; two, our difficulty in providing ongoing clinical care if we didn't have enough junior doctors to cover the hospital; three, they [PAs] are a more permanent member of staff, whereas your trainee will rotate every six months.” (Consultant psychiatrist)

In particular, the trust was keen to recruit staff into a role that was able to assess and look after the physical health needs of mental health patients. While other staff were considered, such as advanced nurse practitioners, the fact that PAs are trained in a 'medical model' and are therefore well placed to manage physical health needs made them an attractive choice:

“They were basically medical roles... there's a big gap in medical components to the teams, things like physical examinations... that was an area that the physician assistants [sic] were particularly competent.” (Deputy medical director)

“We considered ... the advanced nurse practitioner, which, obviously, a few units have. At

the time, we felt the physician's associate was a better option for us because they worked in the medical model.” (Consultant psychiatrist)

The physician associate in mental health

Role overview

The PA's role depends on the department in which they work, but in effect they take on similar tasks to junior doctors (senior house officer (SHO) grade) (see Box 6.1). Their role places particular emphasis on attending to the physical health of patients but they also undertake mental health assessments, are involved in ward rounds and write medical reports. For those working in outpatient settings, they can be responsible for a full spectrum of both mental and physical health assessments.

Box 6.1: Physician associate in mental health role description, based on interviews and job descriptions

- Conduct initial psychiatric evaluations, take patient histories and perform physical examinations
- Perform assessments of physical health
- Formulate differential diagnosis and management plan based on clinical assessment
- Refer patients to other services as required
- Arrange mental health act assessment as required
- Perform diagnostic or therapeutic procedures such as ECGs, basic life support, cognitive assessment or mental state examination
- Request laboratory or other investigations as appropriate
- Communicate sensitive and complex diagnoses to service users and relatives
- Take part in ward rounds as a member of clinical team
- Write medical reports
- Practice under the supervision of a consultant psychiatrist

Implementing the role

Leadership

The introduction of the role was led by Dr Chris Vassilas, Deputy Medical Director and Consultant Psychiatrist. He recognised the need to address workforce shortages and explored the possibilities that PAs could offer.

Selecting the role

While a formal role analysis was not undertaken, BSMHFT was very clear what it required from any new roles: the ability to perform mental and physical health assessments, take on some tasks previously performed by doctors and provide long-term continuity of care. Senior leadership at the trust spent time understanding the training that PAs undertake and visiting universities in the United States to explore whether PAs would be a good fit:

“We had quite a few discussions with [a faculty member at Birmingham University] and he had a senior physician's assistant [sic] who had actually qualified in the States who came across and spoke with us. Initially we were thinking about getting maybe somebody with a bit more experience and training in mental health, possibly from the States... but it became clear that that wasn't going to happen... so we made a decision to see if we could maybe run a pilot with a small number [of UK-trained PAs].” (Deputy medical director)

Obtaining support within the organisation

Effort was invested in gaining senior support for the role throughout the organisation at both board and directorate level. Buy-in from clinical directors was obtained with direct meetings, outlining the problem faced and the potential solution offered by PAs. Enthusiastic clinical directors and consultants volunteered to have PAs work with them as part of a pilot study. The PAs were therefore initially assigned to a variety of departments where there was a motivated consultant:

“The consultants who had these physician assistants attached to them were a self-selected group, so they were keen to make the thing work.” (Deputy medical director)

Five PAs were hired in the pilot and were well-received, working effectively despite initial concerns from staff (Ostler and others, 2012) . Following this successful pilot period, the trust expanded the number of PAs to eight.

Raising awareness among existing staff

Efforts were undertaken to raise awareness of the PA role among existing staff in order to facilitate implementation within existing teams. This was not always successful and PAs did experience confusion about their roles. In addition, existing staff sometimes showed resistance towards the new role:

“There were some that were passively aggressive and had difficulty in including [the PA] in the various team meetings.” (Consultant psychiatrist)

“A lot of people thought I was a paramedic. And it was only after I'd been in my own team three months that I realised that everybody had got this incorrect perception of my background.” (Physician associate)

On the whole, however, this was temporary, and subsided once existing staff could see what PAs could offer. In some cases, subsequent PAs found it very easy to integrate.

“All the staff were prepared, even the junior doctors here who hadn't worked with a physician associate before and the nursing staff... I think it worked really well.” (Physician associate)

Training and development

Following their graduation from the two-year degree programme, PAs at BSMHFT are provided with ongoing training, particularly in mental health. They can attend teaching for the core trainee doctors and the trust was very keen to develop their knowledge and skills in psychiatry:

“We attended the MRCPsych training with the year one and year two trainees. So that was part of our structure. Then I managed to organise my own teaching sessions by attending the GP training for the junior doctors, so I'm always maintaining my general medical knowledge as well.” (Physician associate)

A major facilitator in being able to provide the PAs with ongoing support and training was the size of the organisation and existing teaching structures being in place:

“I think we were at an advantage because we're quite a big organisation and we have those kinds of support structures in place. I think it's probably trickier in a smaller organisation to ensure they've got that training and education.” (Deputy medical director)

The cost of the postgraduate training for PAs was £600 plus lost working time (roughly 15 full days) per annum. In addition, there were costs associated with senior consultants' time for meeting attendance and completion of administration tasks related to the setup of the programme. All funding was internal.

Line management and clinical supervision

PAs have regular, ongoing, clinical supervision with a consultant psychiatrist and have the opportunity to discuss clinical problems and address personal concerns – such as career development – in a formalised manner. This is felt to work well: consultants are generally happy to take on the responsibility of clinical supervision:

“I would see [myself as being ultimately responsible]... but I would see it that way for the trainees as well because I would see me as being the consultant for the care... I guess other trainees have got GMC or whatever... but once you're involved in the case, I think you're involved.” (Consultant psychiatrist)

Sustainability

There was also positive sentiment expressed regarding the importance of PAs going forward, and the role they can play within BSMHFT. However, there is uncertainty among the senior clinicians as to the long-term sustainability of the role. The organisation is still trying to determine how to keep the job interesting and attractive in the future.

“Longer term, I don't know where the role is going... I think it's very early stages to know where the role is going” (Consultant psychiatrist)

“I would think there would have to be a clearer understanding of exactly function they fulfil rather than just adding to the service provision.” (Consultant psychiatrist)

For the PAs themselves, the exact details of their career progression were also unclear, although career flexibility is something that many PAs we spoke to found attractive.

Impact

Since the pilot study (Ostler and others, 2012), a formal evaluation has not been undertaken. However, the PAs we spoke to were extremely positive about their role, as were staff working with them:

“They are so good and such a high standard. And, for me, because they're permanent, there's no worry about things slipping through the net.” (Consultant psychiatrist)

“I had a physician's associate working for me... I thought it worked very well; I think it achieved certainly what I hoped it would achieve.” (Consultant psychiatrist)

“I really enjoy my job, I think it's brilliant. You get a brilliant work–life balance where I currently work. Yes, it's brilliant, you're always learning and you feel like part of the team.” (Physician associate)

At a glance: physician associate in mental health

Roles and impact

- Physician associate who takes on some tasks previously undertaken by junior doctors (SHO grade)
- Pilot study found PAs were well received, worked effectively and were seen as valuable team members
- High job satisfaction and well-regarded by consultants

Enablers

- Enthusiasm from consultants – initially doing a small-volume pilot study only with consultants who were keen
- Help from university to demonstrate what PAs can offer and to aid with job descriptions and role definitions
- Supportive team environment

Barriers

- Initial resistance and suspicion from some staff
- An inability to prescribe
- Inconsistent line management (due to gaps in consultant cover)

Advice for others

- Have a clear outline of the role and what it can and cannot do, that everybody has access to and understands
- Invest in engaging the consultant body
- Ensure regular clinical supervision for PAs and encourage and foster a peer-support network for the new role

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