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Development

Local pilot, new profession: developing Medical Care Practitioners in primary care

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The role of physician assistant has been established in the US for some time, and has proved a useful and effective adjunct to the medical profession. A similar role is being developed in England by the National Practitioner Programme, and this article reports the early progress of a pilot that is training primary care Medical Care Practitioners (as they are called) (MCPs) in Waltham Forest. Three trainees, all former nurses, are currently undergoing a two year programme of study and placement in general practice. It is anticipated that MCPs will be able to see up to half of the cases at present seen by general practitioners (GPs). The pilot has had to face many challenges. The role has needed to be defined, and its basis in a 'medical model' was not originally fully understood; training has had to be devised and provided 'on the hoof', before national competency and regulatory frameworks have been developed and agreed; the senior input required from the Primary Care Trust and its higher education provider has been substantially in excess of funding support received. Despite the commitment of pilot participants, a pilot is probably the wrong change management model for the creation of a new health care profession.

Key words: general practice; new roles; pilot projects; skill mix

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Background

In the US, the role of Physician Assistant (PA) is well established. The role was designed and developed in the mid-1960s in response to a shortage of primary care physicians, and has been developed and consolidated since (Mittman *et al.*, 2002). PAs in the US are usually science graduates or paramedics from the armed forces who undertake an intensive two year accredited training programme. After graduation, they must log 100 hours of continuing medical education every two years, and sit a recertification examination every six years. They are then qualified to carry out some surgical or medical care. Research has consistently shown that they provide competent care and patient satisfaction (Sox, 1979; Mittman *et al.*, 2002).

The National Health Service (NHS) Plan (Department of Health, 2000) briefly mentioned (para 9.15) that discussions were underway which might result in the introduction of the equivalent role into the NHS. In 2004, the then Modernisation Agency Changing Workforce Programme funded six pilot projects in London, four in the acute sector and two in primary care, to develop roles based on the US PA model. The role was original known as PA but now has a working title of Medical Care Practitioner (MCP). At the same time, US trained PAs have been working in the West Midlands for some time (Woodin *et al.*, 2005).

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Since 2004, the Modernisation Agency has been disbanded: the work is now led at national level by the National Practitioner Programme (NPP). For the sake of simplicity, this acronym will be used throughout, though this will on occasion be anachronistic.

This article gives an account of the early life of one pilot project to develop the new role of the primary care MCPs, in Waltham Forest Primary Care Trust (PCT). In common with many inner-city PCTs serving deprived urban populations, Waltham Forest PCT faces many challenges in the provision of primary care. A profile of UK General Practitioners undertaken in June 2004, and updated in August 2005 by the Royal College of General Practitioners indicates a serious shortage of GPs in the medium and long term within North-East London (RCGP, 2005), making it difficult to sustain and develop health care services. Using skill-mix to increase the supply of primary health care is a key emphasis of recent NHS policy (Department of Health, 2004). New workforce models include salaried GPs working in both General Medical and Personal Medical Service models, the development of Nurse Practitioners, and GPs and nurses with special interests. An economic incentive to develop the role is that MCPs will undergo two years of NHS-funded training, in contrast with much longer periods needed to train GPs.

The Royal College of General Practitioners is working closely with the NPP to develop the role. But it is understandable that not all GPs will welcome this new role, which does after all call into question GPs' claim to be uniquely qualified to diagnose and treat in primary care. Heath (2004) argues that only fully trained GPs can offer diagnosis of a sufficient standard, and that deprived populations should receive a high quality service. However, inner-city PCTs that continue to be unable to recruit sufficient GPs cannot do nothing, as this would have the consequence that patients would ultimately be denied access to general practice. They therefore have no choice but to explore alternative roles and skill-mix in order to provide basic access.

This article will briefly describe the pilot, and will then consider the pilot under the following headings:

- uncertainty and anxiety
- the MCP role
- training
- regulation and risk management
- costs.

This article is based on detailed notes taken during steering group and other meetings from September 2004 onwards. A draft summary of those notes was circulated to steering group members, trainees and their mentors, a number of whom provided comments that have been included in this article. All parties have agreed to the naming of the PCT in this article.

The pilot project

Of the three current MCP trainees, two began in September 2004 and one in April 2005. MCPs work 3.5 days in practice, and have 1.5 days a week for study and training. At present, MCPs see patients together with GPs, although in time they will see patients alone. The training period has been planned to last two years. All were previously primary care nurses. Due to the staff turnover, the team currently involved in implementing the pilot are not the same as the people who initially agreed to the pilot taking place in Waltham Forest PCT.

The NPP has led work at national level to support the pilot, for example negotiation with Royal Colleges and Higher Education Institutions to determine regulatory, competency and education frameworks. Much of this work is ongoing and still to be finalized: for example, the competence and curriculum framework for the role is undergoing public consultation at the time of writing (Department of Health, 2005). The pilot team has been able to contribute to this work throughout. The NPP has held a number of events for MCP pilots, enabling the exchange of local and national intelligence and experience.

Uncertainty and anxiety

The overarching themes of uncertainty and anxiety should be highlighted at the outset. The project team has found itself leading a project attended by far more uncertainties than anyone expected at the outset. The anxieties of trainees, their GP mentors and the pilot steering group have had to be contained when they could not be immediately addressed. It has rarely been possible to allay anxieties fully: so many of the questions could only be given provisional answers until national frameworks are established.

The MCP role

At the inception of the pilot (April 2004), there was confusion about the relationship between the new role and nursing. This was partly because the first cohort of trainees were indeed nurses, in accordance with the guidance of the Health Professions Council (2003) that it was necessary to pilot the role with staff who hold a recognized professional qualification. But also, there appears to have been a view that the role would be a natural career progression for experienced nurses.

It took some time to clarify at both NPP and PCT levels that the MCP role is based on a medical rather than a nursing model of care. Once this became clear, two trainees left, as they wished to remain practising nurses. MCPs require a thorough grasp of physiological systems, which requires training at a higher level than that generally received by nurses. The current understanding of the role is that MCPs will:

- have a 'generic' role, and will have the ability to work across the secondary and primary care interface (including urgent care);
- work as part of a clinical team, accountable for their own practice but responsible to a lead clinician.

MCPs will work to locally agreed protocols, carrying out health assessments, decision making, using diagnostic reasoning skills, planning, implementation and evaluating episodes of care. They will be able to:

- obtain full medical histories and perform appropriate physical examination;
- diagnose, manage and treat illnesses within their competence;
- request diagnostic tests and interpret the results;
- provide patient education and preventative health care advice regarding medication, common problems and disease management issues;
- decide on appropriate referral to, and liaison with, other professionals.

Organizationally, as opposed to conceptually, the MCP role is positioned between nursing and GPs: the three MCP trainees are qualified nurses placed in general practices with GP mentors. Naturally both MCPs and mentors have tended to see the role through the lens of their own disciplines. Also, it is not straightforward to distinguish the scope of MCP practice from that of some nursing roles (see Cox, 2001; Mittman *et al.*, 2002), or from the role of GPs. Interestingly, a baseline audit in the three practices participating in the pilot was carried out in December 2004. Clinicians were asked to record, in the case of every patient they treated at a designated time, 'who has the competencies to meet the presenting need of the patient?' The initial audit of the MCP role asked GPs and other members of the primary health care teams the same question. Possible answers included MCPs, practice nurses, pharmacists and health care assistants. The results suggested that:

- MCPs will be able to substitute for at least 50% of GPs' work;
- GPs currently see themselves as best able to provide medical care for people with complex needs, including mental health problems.

It is not clear whether these perceptions will change once trained MCPs have had time to build relationships both with their GP colleagues and with individual patients. The evaluation of the West Midlands experiment using US trained PAs suggests that it takes time and close co-operation for GPs and MCPs to build trust and to negotiate work allocation (Woodin *et al.*, 2005), but that doing so pays dividends: PAs were valued team members, and indeed some do provide care and treatment for complex cases and people with mental health problems. However, PAs working in different practices had different case-mixes, and it seems likely that the exact responsibilities of trained MCPs need to be negotiated in practice to reflect local skill-mix.

The West Midlands evidence shows how it takes time to discover how new roles actually develop in specific contexts, and this cannot be predicted exactly in the case of MCPs. Perhaps for this reason, there has been uncertainty at national level about the best name for this role. Whereas the US model is usually called PA, the original NPP name was 'physician practitioner'. This has been changed to MCP. None of these names convey the nature of the role unambiguously. PA underplays the extent to which PAs substitute for doctors, while physician practitioner and MCP may suggest full equivalence with someone medically trained. Heath (2004) interprets the choice of name as an intention to deceive the public. However, role labels like 'nurse', 'consultant' or 'allied health professional' are not in themselves clear and unambiguous

Box 1 National MCP programme

- Ninety weeks long (six semesters, over two or three years).
- 3150 hours of study time.
- At least 1600 clinical learning hours, of which a minimum of 1400 hours will be spent in practice in clinical areas (time spent with doctor, on ward rounds, in clinics, GP consultations; tutorials; independent learning facilitated by doctor; time spent with other health care professionals).
- Placements to include: community medicine (280 hours); general hospital medicine (350 hours); accident and emergency (160 hours); mental health (70 hours); obstetrics and gynaecology (70 hours) and paediatrics (acute setting) (70 hours). The remaining 400 hours to be designated by individual institutions.

either: any new and unfamiliar term has the potential to mislead for a while, until all stakeholders, including the public, learn what is actually meant by an imprecise label.

Training

A major issue has been that the training programme had to begin before either a curriculum or a competency framework had been agreed nationally. A national programme has now been agreed (see Box 1), and the draft competency framework was published for public consultation late in 2005. While contributing to this national work, the pilot has in the meantime had to develop training 'on the hoof', drawing on both GP and nurse training traditions to create an education programme for each MCP (all of whom started from different baselines and therefore have different needs). This has been an operational challenge, partly because customizing or creating courses for very small number of students is not economically feasible within the current education and commissioning arrangements. Additionally, where courses suitable for the training needs of MCPs did already exist, course timetables did not always fit MCP availability.

It has become clear that the MCPs need a knowledge of anatomy and physiology that goes deeper than that acquired by the trainees during their nurse training. A fast-track 'intensive' programme has been created and delivered in practice by a local GP and a university lecturer, who have together adapted an existing master's level anatomy and physiology programme to meet the trainees' needs.

Training currently being undertaken will be accredited using APL and APEL (Accreditation of Prior Learning and Accreditation of Prior Experiential Learning). Each MCP will create a learning portfolio which it is intended will be assessed against the national curriculum. Just how this is to be done will need to be determined once the curriculum is confirmed.

If the content of the training currently planned for this pilot turns out to be imperfectly aligned with the final agreed competency framework, it may need 'topping up'. It is possible that this will not be achievable within the two year training period originally intended. This is a risk that pilot participants have to live with, but one which naturally causes anxiety.

There have also been issues about training placements. At the start of the pilot, not all the practices offering to provide placements were approved training practices for GP registrars. Additional support was provided to ensure that mentorship would be recognized as being at a sufficient standard, although one practice later withdrew from the scheme, having found the work load too demanding. Training placements must now be in an approved training practice, and provide protected mentor time for teaching and tutorials. A learning contract has been developed to identify the tasks and functions to be undertaken by the GP mentor and the practice.

Trainees have had to face more personal issues, too. Becoming learners after having been expert practitioners has resulted in their feeling deskilled. They have had to 'unlearn' or at least reframe what they already knew, not having previously worked within a medical paradigm. Furthermore, they have had to face these challenges in a climate of uncertainty about both the role and their training.

Regulation and risk management

As with any health professional role, there are many issues of liability, registration, accountability and regulation to be addressed in relation both to training and to practice. Intensive work is required to clarify and/or develop relevant frameworks and

standards that meet the requirements for the development and registration of new roles (Armitage and Shepherd, 2005). A local pilot can do little about some of the processes that need to be completed: the establishing of a process of national regulation of the new profession; negotiations with Royal Colleges. Ensuring that these happen is the role of the NPP.

However, some issues are pressing and the pilot has had to find the answers itself. For example, it took some time to clarify arrangements for professional indemnity for the trainees (it is provided by GPs via clause 46 of the new General Medical Services contract). Existing PCT assurance mechanisms for safety and quality have had to be revisited and adapted to protect trainees, their mentors, their patients and the PCT.

Costs

At the outset, the expectation was that the costs of the project would consist of: trainees' salaries; the project manager's salary (two days a week); the costs of developing and delivering training; and paying GP mentors. Some funding was secured for the first two years of the project. However, the costs were underestimated and funding to maintain the pilot remains an unresolved issue between the PCT and the Strategic Health Authority (SHA). This, and the other pressures described throughout this article, mean that considerable senior management time has been needed both to sustain progress at a practical level, and to contain and manage uncertainty and anxiety.

The original assumption was that MCPs could begin substituting for some GP work quite early in their two year training, and that their host practices would therefore be able to set that benefit against the cost of mentoring. When it became clear that MCPs would not be able to work unsupervised until fully trained, it became equally clear that more time would be needed to support the pilot than had been expected. Not surprisingly, there are concerns that the reimbursement to practices inadequately reflects the call on GP mentors' time and the development work required in the practice. Once training is complete, MCPs will work a probationary 6 months with a level of supervision higher than that which will follow.

The amount of planning involved in the pilot means that considerable opportunity costs have been and will continue to be incurred. In particular, a substantial amount of senior academic time has been required to assess the needs of the role in general, and the trainees in particular, to arrange relevant academic provision, and to support trainees, particularly when they have felt very deskilled. This has used up a lot of the education and training budget which would otherwise have been spent on postgraduate education and training for all nurses within the PCT.

As the training has been organized in the pilot in a way that will not be repeated once the profession is established, pilot costs cannot be taken to be accurate predictors of future training costs.

Conclusion

Pettigrew *et al.* (1992) suggest that change is triggered by long-term environmental pressure. The challenge of recruiting GPs represents such an environmental pressure in Waltham Forest, triggering the change which this pilot initiates. However, the pilot raises an important question which reaches beyond one PCT. It appears from steering group discussions that those who initiated the pilot in the PCT had not fully realized that a new profession was being created; this fact gradually became apparent to the pilot team that 'took over the baton'. It is not unusual that the full significance of a policy development is not seen at first. But it is questionable whether local pilots are an appropriate mechanism with which to create a new profession. The role of pilot projects is surely to implement and test service developments that have already been designed, at least in outline. The pilot has borne substantial extra costs (workload and uncertainty) because so much preparatory work has been done *in parallel with* rather than *prior to* implementation.

A process evaluation of the pilot is to be carried out in late 2005, based on semi-structured interviews with key pilot personnel. This should enable the emergence of richer and more personal accounts of what has often been a confusing process than has been possible in this article, which is primarily a descriptive summary of steering group minutes. It will be interesting to see if those data will throw any light on what is perhaps one of the most surprising aspects of this pilot, the tenacity and commitment of pilot participants in the face of so many challenges.

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