Where I end and you begin:

additional roles in British general practice

General practice increasingly works under a multidisciplinary team (MDT) model involving traditional and innovative roles. Within the NHS Long Term Plan, primary care networks (PCNs) are focusing on using the skills of a greater range of allied healthcare professionals and expansion of the MDT to offset a projected gap between supply and demand within primary care. The Additional Roles Reimbursement Scheme (ARRS) aims to fund 26 000 additional roles in general practice, including roles such as clinical pharmacists, community paramedics, and physician associates (PAs). In *BJGP Life*, Abrams and Eaton described how these *'essential roles are required to be responsive to the existing workforce and patient needs'*, but highlight the need for job role clarity, appropriate allocation of work, and adequate supervision.

While some of the roles under the ARRS, for instance, dieticians and physiotherapists, seem fairly well defined and understood by clinical teams and patients, other roles such as PAs, nurse practitioners, and community paramedics are more recently emerging and involve duties that overlap with the traditional remit of a GP. A recent BBC *Panorama* investigator, who went 'undercover' as a receptionist at an Operose Health-operated practice, states that *'Our investigation found the company let less qualified staff see patients, rather than doctors, without adequate supervision.'* Here, 'less qualified' is a loaded statement given an MDT approach, but it is important to consider the public understanding of additional roles in primary care.

PATIENTS' UNDERSTANDING ON ALLIED HEALTH PROFESSIONALS

Patient perceptions can affect whether or not changes to the primary care workforce changes are accepted, and the extent to which new roles gain legitimacy. Public acceptability and understanding of these roles remain unclear. In a study of patient experiences when consulting with PAs, understanding about this role fell into one of three categories: certain and accurate, certain and inaccurate, and uncertain. The 'certain and inaccurate' and 'uncertain' categories are concerning. The finding is mirrored in research looking at deployment of nurse practitioners in practice. The variability in understanding of the PA role was intrinsically linked to provision of information about the role from the practice and from the PAs themselves. While PAs generally inspired high trust and confidence, patients felt deceived by their practice and the PA if the role was not fully explained to them. Deception is never a good feeling for a patient to come away with after a healthcare encounter.

And what's in a name? These additional roles are varied and evolving. Alarmingly, a study of specialist nursing roles (including some based in hospital) revealed 595 job titles (including nurse practitioner and advanced nurse practitioner) in use across almost 18 000 specialist nurses. A systematic review of the contribution of paramedics in UK primary care echoed confusion around the job titles of paramedics both among patients and clinicians, who were unclear about the role and scope of practice of the paramedics. Perhaps the confusion is due to a lack of standardised practice; the review by Eaton *et al* highlights the role of paramedics as assessing and treating urgent, non-complex patients, but emphasised that paramedics in UK primary care are working at different levels of autonomous practice in different primary care settings.

PANORAMA, PUBLIC PERCEPTION, AND A SPOTLIGHT ON PAs

Much of the recent BBC *Panorama* investigation focused on Operose Health and its rapid growth across England (now Britain's biggest GP chain). It looked at links between Operose and the US-based Centene Corporation and levels accusations about profiteering, claiming that the chain of GP surgeries was using PAs because they are 'cheaper' to employ than GPs.

PAs are a relatively recent addition to the primary care team; US-trained PAs were only introduced to the UK in 2003. The level of supervision required has been compared to that of a trainee clinician or trust grade doctor; PAs can work autonomously and are responsible for their actions and decisions with appropriate support. The Faculty of Physician Associates is clear that PAs cannot replace GPs, warning that:

'By employing a PA, it does not mitigate the need to address the shortage of GPs or reduce the need for other practice staff. They can help to broaden the capacity of the GP role and skill mix within the practice team to help address the needs of patients in response to the growing and ageing population.'

On the flipside, some GPs have warned that the evidence for PAs reducing workload and costs is uncertain. As more of them join GP surgeries, we need to look closely at whether these roles are achieving the aims set out by their introduction to UK primary care.

THE FUTURE FOR ADDITIONAL ROLES

MDT working is here to stay, and we are all likely to see more emerging roles in our practices as the ARRS scheme expands. At the micro-level, patients should be made aware that they are seeing an allied health professional when booking their appointment and with a simple introduction supplied during the consultation. And while awareness-raising work about additional roles can be implemented at the practice level to help with issues around nomenclature and roles (providing information on the practice website), Evans *et al* emphasise a need for macro-level awareness campaigns at a national level to promote acceptance and engagement. What will be interesting as time goes on is our increasing understanding about the actual versus the promised clinical and cost-saving contribution of additional roles within the primary care workforce.

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This article (with references) was first posted on *BJGP Life* on 28 June 2022; https://bjgplife.com/roles

DOI: https://doi.org/10.3399/bjgp22X720341