Research – supplement
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Staffing matters; funding counts –
Pressure point: Physician associates

Can the physician associate become a significant part of the NHS workforce?

The Health Foundation

About this supplement

This supplement is produced to accompany the report *Staffing matters; funding counts: Workforce profile and trends in the English NHS.*

During the research to inform the report, six particular pressure points were identified for the workforce of the NHS in England. The pressure points were chosen based on feedback from a stakeholder roundtable, held in October 2015, and analysis of recent policy reports.

The pressure points are:

- the proposed changes to nurse bursaries
- international recruitment to fill vacancies
- the recruitment and retention of GPs
- the potential of physician associates
- the potential of nursing associates
- the use of temporary and agency workers.

These pressure points need to be addressed if the health service is to have access to the staff it needs to deliver high quality care.

In addition to the discussion in *Staffing matters; funding counts*, more detailed information and analysis about each of these pressure points is available as part of a series of supplements, from www.health.org.uk/publication/staffing-matters-funding-counts.

Please note: While the focus of this supplement is on England, some of the national/international data sets are at UK level. Where UK data is reported, it should be remembered that the NHS in England is by far the largest component, employing approximately four in every five NHS staff in the UK.

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Can the physician associate become a significant part of the workforce?

Physician associates: The issue

In 2015 a National Physician Associate Expansion Programme was set up to increase the number of physician associates (PAs)working in the NHS in England. Earlier that year Health Education England (HEE) had noted that 'our current workforce planning process does not allow us to estimate demand for this [PAs] in a robust way. Working with our provider trusts, we understand that this new role is essential for trusts to address the service gaps created as more junior doctor posts are reconfigured to support GP expansion and the broadening of the Foundation Programme'.[1]

In its Proposed Education & Training Commissions for 2016/17, HEE proposed that the number of PAs be increased from 205 to 657, a 220.5% increase – the largest for any group.[2] However, NHS data show only 11 full-time equivalent (FTE) physician associates working in GP practices in England in 2015.[3]

More recently, in April 2016, NHS England reported in its *General practice forward view* that it planned to train 1,000 more PAs to work in GP practices by 2020.[4]

Physician associates: The evidence

When first introduced to the UK more than a decade ago, the title used for this role was 'physician assistant'. More recently, the role has been retitled as 'physician associate'. The title change does not appear to signify any related changes in job role as the earlier version of the title also continues to be used. The PA has been described by the Department of Health as someone who is:

> *'a new healthcare professional who, while not a doctor, works to the medical model, with the attitudes, skills and knowledge base to deliver holistic care and treatment within the general medical and/or general practice team under defined levels of supervision. The role is therefore designed to supplement the medical workforce, thereby improving patient access'.*[5]

The Department of Health summarises the assistant/associate role as to:

- formulate and document a detailed differential diagnosis having taken a history and completed a physical examination
- work with patients and, where appropriate, carers to agree a comprehensive management plan in light of the individual characteristics, background and circumstances of the patient

- maintain and deliver clinical management in collaboration with the patient and on behalf of the supervising physician while the patient travels through a complete episode of care
- perform diagnostic and therapeutic procedures and prescribe medications (subject to the necessary legislation)
- request and interpret diagnostic studies and undertake patient education, counselling and health promotion.[5]

The training of PAs in the UK is at post-graduate level, based on 90 weeks of training; at present there are several universities in the UK that provide courses.[6] Recruits are either science graduates, or individuals currently with nursing or allied health professional qualifications. There are currently small numbers of PAs working in England and Scotland in a wide variety of medical and surgical specialties. The Voluntary Register for Physician Assistants in the UK,[7] managed by the Royal College of Physicians, lists approximately 200 PAs in employment in the UK.

Initially introduced over 10 years ago to the NHS, growth in numbers has been slow. The role is well established in the US, and has been promoted in other countries, including Australia, Canada and the Netherlands, but progress in use in these countries has been variable.[8,9,10] Main constraints on increased use have included regulatory and legislative issues related to prescriptive authority, broader issues related to system preparedness to absorb a new role, and employment costs.

In 2013 there were approximately 88,000 PAs working in the US,[11] this represented 26.8 PAs per 100,000 population. Two thirds of the US PA workforce are Masters educated,[11] and while the initial focus of practice location had been in primary care, the majority of PAs in the US now work in hospital and acute care. PAs in the US have the right to prescribe, and are registered practitioners.

UK-based research suggests PAs could fulfil roles currently filled by medical staff, potentially saving resources, working in mid-level roles.[12,13,14] Patients were reportedly satisfied with PAs, but the scope of practice for PAs did not replicate US working practices, as PAs in the UK could not prescribe.

Physician associates: Conclusions

Despite policy interest over a period or more than 10 years, and evaluation suggesting that the role can play a part in more cost-effective and acceptable care, the data available suggest only about 200 PAs are working in the UK. In part, slow progress relates to limitations of the role currently in the UK, compared with the US, where the role was first developed. The absence of independent prescribing and registration means that the role in the UK is constrained, making it less attractive to employers. In addition, the clear message from the Department of Health that PAs are 'supplemental' staff for doctors, rather than substitutes, also means that employers need to consider funding constraints when looking at scope for expansion. Finally, the role of nurse practitioners, a comparable 'mid-level' provider, is already well established in the UK – it has prescriptive authority, making it an existing viable option in some care environments.

HEE funding to increase numbers in training will contribute to growth in the pool of recruits, but currently the PA role remains a somewhat exotic breed in the UK. In the introduction it was noted that HEE was reporting that the PA role was 'essential' for trusts to address service gaps. It took the US 50 years to reach a PA:population ratio of 26.8 per 100,000. Attaining a similar ratio in England would require about 14,000 PAs to be employed. With at best about 200 currently in employment, and a suggested intake to training of 650 per annum, it would take 20 years or more to reach a similar level of presence, assuming no attrition. Given the current funding constraints on any workforce expansion, the established existence of the nurse practitioner role, and continued regulatory barriers on full effectiveness, it seems unlikely that the PA role will become widespread and provide 'essential' gap filling any time soon.

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